

WOMEN, RURAL, AND SPECIAL NEEDS VETERANS

FIELD HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

APRIL 21, 2008
FIELD HEARING HELD IN SANFORD, ME

Serial No. 110-84

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

43-050

WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON VETERANS' AFFAIRS

BOB FILNER, California, *Chairman*

CORRINE BROWN, Florida	STEVE BUYER, Indiana, <i>Ranking</i>
VIC SNYDER, Arkansas	CLIFF STEARNS, Florida
MICHAEL H. MICHAUD, Maine	JERRY MORAN, Kansas
STEPHANIE HERSETH SANDLIN, South Dakota	HENRY E. BROWN, JR., South Carolina
HARRY E. MITCHELL, Arizona	JEFF MILLER, Florida
JOHN J. HALL, New York	JOHN BOOZMAN, Arkansas
PHIL HARE, Illinois	GINNY BROWN-WAITE, Florida
MICHAEL F. DOYLE, Pennsylvania	MICHAEL R. TURNER, Ohio
SHELLEY BERKLEY, Nevada	BRIAN P. BILBRAY, California
JOHN T. SALAZAR, Colorado	DOUG LAMBORN, Colorado
CIRO D. RODRIGUEZ, Texas	GUS M. BILIRAKIS, Florida
JOE DONNELLY, Indiana	VERN BUCHANAN, Florida
JERRY McNERNEY, California	VACANT
ZACHARY T. SPACE, Ohio	
TIMOTHY J. WALZ, Minnesota	

MALCOM A. SHORTER, *Staff Director*

SUBCOMMITTEE ON HEALTH

MICHAEL H. MICHAUD, Maine, *Chairman*

CORRINE BROWN, Florida	JEFF MILLER, Florida, <i>Ranking</i>
VIC SNYDER, Arkansas	CLIFF STEARNS, Florida
PHIL HARE, Illinois	JERRY MORAN, Kansas
MICHAEL F. DOYLE, Pennsylvania	HENRY E. BROWN, JR., South Carolina
SHELLEY BERKLEY, Nevada	VACANT
JOHN T. SALAZAR, Colorado	

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

April 21, 2008

	Page	
Women, Rural, and Special Needs Veterans	1	
OPENING STATEMENTS		
Chairman Michael H. Michaud	1	
Prepared statement of Chairman Michaud	42	
Hon. Jeff Miller, Ranking Republican Member	2	
Hon. Thomas H. Allen	3	
WITNESSES		
U.S. Department of Veterans Affairs, Brian G. Stiller, Center Director, Togus Veterans Affairs Medical Center, Veterans Health Administration	35	
Prepared statement of Mr. Stiller	62	
American Legion, Department of Maine, Donald A. Simoneau, Past Com- mander, and Member National Legislative Council		22
Prepared statement of Mr. Simoneau	53	
Disabled American Veterans, Department of Maine, Joseph E. Wafford, Su- pervisory National Service Officer	28	
Prepared statement of Mr. Wafford	59	
Doliber, Dana, Sanford, ME	5	
Prepared statement of Mr. Doliber	42	
Hartley, David, Ph.D., MHA, Director, Maine Rural Health Research Center, and Professor, Muskie School of Public Service, University of Southern Maine, Portland, ME	16	
Prepared statement of Dr. Hartley	52	
Maine, State of, Bureau of Veterans' Services, Augusta, ME, Peter W. Ogden, Director, and Secretary, National Association of State Directors of Veterans Affairs	10	
Prepared statement of Mr. Ogden	44	
Maine Veterans Coordinating Committee, Waldoboro, ME, Gary I. Laweryson, USMC (Ret.), Chairman, Commander, Military Order of the Purple Heart, State of Maine, Judge Advocate, Marine Corps League, State of Maine, and Aide-de-camp to Governor John Baldacci	12	
Prepared statement of Mr. Laweryson	47	
Maine Veterans' Homes, Augusta, ME, Kelley J. Kash, Chief Executive Offi- cer	14	
Prepared statement of Mr. Kash	48	
Veterans of Foreign Wars of the United States, Department of Maine, James Bachelder, Commander	23	
Vietnam Veterans of America, Maine State Council, John Wallace, President .	26	
Prepared statement of Mr. Wallace	56	

WOMEN, RURAL, AND SPECIAL NEEDS VETERANS

MONDAY, APRIL 21, 2008

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

The Subcommittee met, pursuant to notice, at 10:03 a.m., Sanford Town Hall, 919 Main Street, Sanford, Maine, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud and Miller.

Also present: Representative Allen.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the Subcommittee to order. I would also like to ask unanimous consent for Mr. Allen to sit at the dais and to be able to ask witnesses questions. If there are no objections, it is so ordered.

I also would like to thank Sanford, the folks at Sanford Town Hall, for allowing us to use their facility today. I really appreciate it. Veterans' issues are extremely important, and this definitely will give us a venue so we can hear from our witnesses today.

I also would like to recognize in the audience Mike Aube who works for Senator Olympia Snowe's office, as well as Bill Vail who works for Senator Susan Collins' office, Kara Hawthorne, who is the new Director of the Office of Rural Health that Congress established a couple years ago, and Dr. Patty Hayes who is a Chief Consultant for Women Veterans' Health. They are both from Washington, DC. I want to thank both of you for coming here today to hear what veterans have to say about rural healthcare issues.

I also would like to recognize Adam Cote who is an Iraq War veteran. I don't know if there are any other Iraqi War veterans or Afghanistan War veterans here, but I want to thank you and all the veterans here in this room for your service to our great Nation. I am very pleased to see you here as well. I want to thank everyone else who I have not mentioned for coming here today to talk about veterans' issues.

Today, we will examine the U.S. Department of Veterans Affairs (VA) programs regarding rural veterans, women veterans and other special needs population. I am very happy that it is held here in Sanford, Maine, this morning. Sanford is home of a long-time veteran advocate, someone who I was honored to call a friend, Roger Landry. Roger worked and served in the Maine legislature. He

worked very diligently in the veterans service organization (VSO) community here in Maine, and he was very well-liked and respected by all. Roger served his country and his community with great pride and honor. Roger died, unfortunately, last year. He is sorely missed. I would like to dedicate this hearing to Roger Landry in honor of all of his hard work with and for our veterans here in Maine and all around the country.

It is appropriate that we are having this hearing in my home State of Maine. Maine is a very rural State. Because of this, we face many unique challenges in providing healthcare to our veterans. Many have to travel long distance for care, creating a significant burden for veterans and their families. The VA has instituted some innovative programs to provide much needed services to our rural veterans, and I look forward to hearing from our panels today about their ideas to improve access and decrease the travel burden for our veterans living in rural communities all across Maine and also all across the country.

At this hearing, we will also hear about women veterans. Women make up about 14 percent of the active-duty military; and consequently, they are making up more and more of our veteran population. Women have some unique healthcare needs. I look forward to hearing today about the unique needs of women veterans and hearing ideas about how the VA can improve their service targeted to women veterans.

When the United States made a commitment to care for veterans, we made the commitment to care for all veterans: Male, female, urban, and rural. Today, I hope that we will learn how the VA is meeting the needs of these populations, what challenges are on the horizon, and what can we do to provide services for these veterans in the most cost-effective manner.

I also want to thank Congressman Miller, who is the Ranking Member of the Subcommittee on Health of the Committee on Veterans' Affairs. Congressman Miller is from Florida. He has been a strong advocate for veterans' issues. We deal with the healthcare-related veterans' issues in Congress. And I know that this is actually a holiday here in Maine and Massachusetts, and I know that Mr. Miller has a lot of work in his home State that he has to do. We really appreciate him taking the time to come here, along with Committee staff, to hear what veterans have to say. Indeed, he is a true advocate for veterans' issues.

So, I would turn it over to Mr. Miller for an opening statement.

[The prepared statement of Chairman Michaud appears on p. 42.]

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. I am, in fact, very pleased to be here in your great State of Maine to examine how VA is addressing the healthcare needs of women, rural needs and special needs veterans. It is appropriate that we are here today on Patriots Day because I truly do believe that there is no greater patriot than the veteran, a person who has worn the uniform in defense of this Nation for all the things we stand for. It is great to be here with my friend and colleague, Tom Allen. We have had numerous opportunities to do things legislatively in Washington. We

have traveled together as well. It is a great pleasure to be with you here today.

I know that rural America does have a strong military tradition. A lot of people don't think of Florida as being a rural State, but actually Maine and Florida are ranked in the top 18 in the States in this country that, in fact, have access issues. The veterans in my district, which is Pensacola to Destin, northwest Florida, my veterans have to travel 3, 3½ hours to get to a hospital. Most people don't think about that when they are thinking about the State of Florida because the veteran population—I have—I actually have the largest veteran population of any Congressional district in the country, and I am proud to represent those individuals in Washington, DC. Certainly being here today to have a chance to hear from the folks from Maine and surrounding areas about how you are being dealt with or not being dealt with I think is very important. I do have a statement that I would like to have entered into the record.

I would also like to add that the Chairman has continued to promise me a taste of Moxie, and I have yet to get it. I continue to wait with great anticipation. So, it is a pleasure.

Mr. MICHAUD. You definitely will have an opportunity to have Moxie. As a matter of fact, I see it coming down the aisle right now. And I want you to know that, actually, Moxie is the official soft drink here in the State of Maine. So, enjoy.

[Whereupon Congressman Miller was handed a can of Moxie.]

Mr. MILLER. I like it.

Mr. MICHAUD. Well, I am glad you like it. There are plenty more.

It is now my distinct pleasure to introduce my colleague from the State of Maine who actually is in this district. I appreciate your willingness also, Congressman Allen, to take the time out today to hear what people have to say about rural veterans' issues, and also thank you for putting forward the name for our first witness.

So, I will turn it over to Mr. Allen.

OPENING STATEMENT OF HON. THOMAS H. ALLEN

Mr. ALLEN. Thank you, Mr. Chairman. It is nice to say those words in Mike Michaud's case. Thank you, Mr. Chairman, for holding, organizing this hearing, and also for allowing me to participate, even though I am not a Member of the Veterans' Affairs Committee.

I do want to welcome Congressman Jeff Miller. It is a real pleasure to have him here. He and I were on a trip together to Afghanistan and Iraq and Pakistan last August. And you get to know people pretty well when you are on a trip like that. And I think we both came away with an enormous respect for what the young men and women in the armed services are doing over there under extraordinarily difficult and challenging circumstances. And I just want you all to know, many of you veterans from other conflicts, and I see Adam Cote here who is an Iraq veteran, many of you from other conflicts that appreciate and understand how challenging and difficult the work there really is.

I also want to welcome today's witnesses to the hearing. I look forward to their testimony about how we can improve care for veterans in Maine and across the country.

Finally, I want to welcome and express my thanks to all of the veterans who are here today. I want to thank you for your brave and honorable service to this country. I thank you for your service and thank you for being here.

Maine is home to over 150,000 veterans who have sacrificed for our country. I have been honored for the last 12 years to represent the veterans in the 1st District of Maine. And I pledge to you I will continue my work in Congress to keep the promises we have made to those who have defended us past and present.

Today's hearing will focus on the particular needs of women veterans, veterans in rural areas and other special populations, including veterans with mental health needs. The percentage of women serving in the armed forces, their scope of responsibility, and their exposure to danger have all grown dramatically in recent years. Therefore, we must work even harder to ensure that the VA is ready to serve women veterans. Women who have served in the military must receive the same benefits as their male counterparts, but they also must have access to healthcare targeted to their specific needs, including gynecological care and mammography, an issue that given my wife's illness, I am more aware of than ever before.

Another important component of care for women veterans is the availability of military sexual trauma counseling at Togus' Women's Clinic and the VA Vet Centers throughout Maine. Vet Centers and community-based outpatient clinics (CBOCs) have been extremely important for our rural State. Because of the progress of these centers and clinics, most veterans no longer have to travel for hours to get the healthcare benefits that they have earned, though they still in many cases have to travel some distance.

I am glad that Congress recently increased the mileage rate from a meager 11 cents per mile that it was to 28.5 cents per mile. The rate is still, as you know, far less than actual costs and I am sure we can do better.

We are extremely proud of the dedicated VA employees here in Maine working under the direction of Director Brian Stiller. The VA is doing whatever it can to address the healthcare requirements of veterans with special needs. The post traumatic stress disorder (PTSD) program at Togus has been extremely helpful.

I recently introduced legislation to help veterans applying for disability compensation for post traumatic stress disorder. The Full Faith in Veterans Act would change the VA standard of proof for veterans who suffer from PTSD. The bill creates a common sense approach that is long overdue.

And as you may know, as many of you know, when veterans seek treatment and disability benefits for PTSD, they bear the burden of proof to establish, first, that they have a diagnosis of PTSD; and second, that the PTSD causing event happened during their service. To prove the second factor, they must produce existing military documentation about the event that proves the event happened and that they were present, or they have to come up with 2 buddy statements that attest to these facts.

Often, however, particularly in the case of Vietnam vets, no records were created at the time that document the event. In many cases, moreover, finding a veteran's buddy who was at the scene is

difficult, and the military services have not been especially helpful. This has led to situations where it is clear to medical professionals that a veteran's PTSD was caused by an event during the individual's service, but the veteran is not eligible to receive disability compensation because the veteran's military records are inadequate.

As I have learned from our veterans here in Maine, too many of our Nation's heroes are denied benefits because of gaps in military documentation that are not their fault. Forcing veterans to jump through these hoops to receive compensation they had earned while serving their country is simply unacceptable. Under my bill, a certified mental health professional could make a logical connection between the diagnosis of PTSD and the veteran's military service, and a service connection must be granted. The bill also directs the VA to improve their procedures for evaluating and treating PTSD.

I want, again, to thank Chairman Michaud for cosponsoring this legislature with me and working to ensure that this legislation gets considered by the full House of Representatives for a vote. I want to thank you all for being here again today. And, Mr. Chairman, I yield back.

Almost forgot, but not quite. Dana Doliber—

Mr. DOLIBER. Yes, sir.

Mr. ALLEN [continuing]. Is one of my constituents. He lives here in Sanford. He is a Vietnam veteran. He doesn't need much by way of introduction because he is going to tell his story. In many ways, I was saying to Dana earlier, he is the poster-child for the legislation that I have recently introduced about PTSD. And in a few minutes, you will understand why.

Dana, thank you very much for being here.

Mr. DOLIBER. Thank you, sir.

Mr. ALLEN. You have to turn on the microphone.

STATEMENT OF DANA DOLIBER, SANFORD, ME (VETERAN)

Mr. DOLIBER. First, let me say what an honor and a privilege it is to be here to provide this testimony for you.

In 1971, I filed my first claim with the VA. As PTSD was not a known accepted condition at that time, I was denied. In 1985, at my wife's urging, I began seeing Robert Paige, LCSW, for what in a short time was diagnosed by Mr. Paige and Dr. John Scammon as PTSD. A claim was again filed with the VA for service connected PTSD for service in Vietnam for service from 1967 to 1968.

From 1985 to 1992, despite documentation, the VA routinely ruled against my claim. The VA did not provide the veteran with assistance acquiring records when requested or ruled in the veteran's favor providing the benefit of the doubt in favor of the veteran or ruled in favor of the veteran without a preponderance of the evidence to disprove what the veteran provided as evidence. Those 3 of the VA's own regulations were not followed in every denial of the veteran's claim.

The VA's own record was inaccurate in its portrayal of the veteran's branch of service, birth date, and personal record prior to service. Doctors at the VA routinely diagnosed other conditions than PTSD due to their not being given the paperwork submitted providing stressors, which would have permitted the diagnosis of

PTSD, as that is what eventually happened. It reached a point that I felt I needed the serial number of the round being fired at me to prove my case, a standard that the VA seems to not have a problem requiring from many veterans.

With the submission of documentation of the combat action ribbon awarded in 1992, I was granted a percentage rating with service connection. From 1992 to the year 2000, the issue of clear CUE, or clear and unmistakable error, and retroactivity of date of service connection, along with percentage of disability was the issue which dealt with the past issues from 1985 to 1992. In 2000, I was awarded 100 percent PNT, that's permanent and total, retroactive to 1985. I agreed to drop the CUE case and retroactivity to 1971 as I felt this would drag the case out another 10 years. Claims for skin rashes and sores and hearing loss were also denied by the VA in much the same manner.

The VA has a choice to either be part of the problem or part of the solution. As part of the solution, the VA should improve claim processing being mindful to be proactive for the veteran, abiding by the laws as passed by Congress as the will of the people for the veteran as in the Haas Case, and to be proactive regarding veteran medical care. If doctors ask for equipment in the rehab of a veteran, provide it. If surgeries require rehab for the healing process, provide it.

The other part of the solution comes from both houses of the legislature, not with fancy pro-veteran sounding bills that are anti-veteran, such as the Noble Warrior Act or the America's Wounded Warrior Act, but proactive veteran legislation is what is required. Servicemen and women understand and expect that if they need help when they come home, that help will be there. America's veterans provided the—providing the freedoms that we have deserve no less than the full support of the VA and the Congress. The American people expect no less than your full support of our veterans. We should not disappoint them by a lack of action. Thank you.

[The prepared statement of Mr. Doliber appears on p. 42.]

Mr. MICHAUD. Thank you, Mr. Doliber. I really appreciate your willingness to come here today to give your testimony.

I guess my question is are you currently accessing the VA care for your PTSD?

Mr. DOLIBER. Yes.

Mr. MICHAUD. Do you have trouble getting appointments within the VA system to see your provider?

Mr. DOLIBER. For other medical problems that are ongoing, there seems to be extending waiting periods. If, for instance, 2 or 3 years ago I fell on the ice and I had a multiple compound fracture of my left arm. After getting treated at Henrietta D. Goodall Hospital, I was—and having notified the VA of the accident and everything like that, I called up the VA to request help with their rehab services and the follow-up appointment to have somebody from orthopedic to attend to my multiple compound fracture of my left arm.

I was told that I would probably have to wait a month or 2 for that. The physicians here in town felt that the medical help that was needed to be done within a week, not a month or 2.

Mr. MICHAUD. And the services that you have received from the VA, do you think that they have been helpful to you?

Mr. DOLIBER. What I term the VA medical care is benign neglect. They do not—they do not intentionally with malice, I believe, do these things. It is just that that's the way their system is set up. That's the way that the veteran, when he is seeking help, can find himself in a long waiting line.

It is not beneficial for the veteran who is seeking the aid and assistance from the VA for medical conditions or even for conditions for PTSD to be put off. Usually, for instance, like the PTSD, that's post traumatic stress disorder. That means that it has already gone past the point of where it needs to be dealt with. The veteran finally has to deal with it. And when they seek help from the VA, a lot of times you have to be put in a line or there is a waiting situation that has to happen because they have to get the doctor there. Sometimes you will see a physician assistant. There needs to be more proactive work from the VA toward the veteran.

Mr. MICHAUD. My last question is whether you have talked to other veterans who have the same problem, being put on a waiting list?

Mr. DOLIBER. Yes, yes. I talked with an Iraqi veteran when I was up at the VA about a month and a half ago. And he was there for traumatic head injury, and he was in the pay office and I was talking with him. And in the middle of the conversation with him, he stopped in mid-sentence and it was as if the lights were on, but there is nobody home. And he was there trying to seek help from the VA. And his wife is beside him, she's in tears. They are going financially broke. He is not being—he is only 40-percent disabled. That is the rating that the VA gave him. That is on the VA. He deserves far more attention.

Mr. MICHAUD. Thank you. Mr. Miller.

Mr. MILLER. Thank you very much. I appreciate your willingness to come forward and testify.

What did the VA tell you when they said it would take time for you to get into rehab? Just that there were no slots?

Mr. DOLIBER. They said the earliest that they could—the earliest that the appointment could be made for would at least be a month, possibly 2. The orthopedic doctor that had set my arm and had operated on it said I needed to see a doctor a week after that. Okay? I couldn't wait a month. As a result of that, I incurred the expense from the orthopedic doctor and all of the rehab services after that on my own.

Mr. MILLER. Do you think a solution is a fee-for-service type issue, where when you cannot get an appointment within an acceptable amount of time you have the ability to continue to use the physician that set your arm until you can get into the VA system?

Mr. DOLIBER. Yes, sir. Yes, I do. Fee-for-service has worked very well for a lot of veterans. It has been cut back because of lack of funding, because of budget cuts. And if I could, I would like to address the budget cuts part of it.

I had a conversation at one time up at the VA regarding budget cuts with the then director, Mr. Sims. And he said that the budget cuts are the responsibility of the Congress. And at that time, the VA budget and the U.S. Department of Housing and Urban Devel-

opment (HUD) budget were both tied-in at the same time when they were being considered. Well, since then, that has changed. The HUD budget and the VA budget, from what I understand, are 2 different things.

The problem was that I found out that the VA budget that gets submitted to the Congress, the requests, come from the directors of the Veterans Administration regional offices. In other words, if they are not asking for the increase in funding, the Congress has no way of knowing that an individual regional office needs that increase in funding. And to my knowledge, that is the way it is still being run.

Mr. MILLER. The budget process works where the President or the Administration submits a budget to Congress, but we are in fact—one of the main things we do is pass appropriation bills. So, Congress does have a very large impact. As you said, if the information doesn't get to us—

Mr. DOLIBER. Right.

Mr. MILLER [continuing]. That is why these field hearings are so critical. Sometimes the request is not made and we don't know, but we do, in fact, have control of the purse strings—

Mr. DOLIBER. Yes, sir.

Mr. MILLER [continuing]. In D.C. What other things, what other types of outreach do you think that the VA can use, especially in rural areas, to get the word out to those special needs veterans or to other groups of veterans?

Mr. DOLIBER. Well, the Vet Centers—I have never been to a Vet Center. Initially, when I began my PTSD therapy, it was being funded by the Vet Center in Portland. I had never gone to the Vet Center in Portland, but the Vet Center here in Sanford requested the funding from them. That soon was cut because their budgets were cut. So, the therapist I was seeing at the time began seeing me pro bono, and he saw me for years pro bono because the VA would not approve the funding for my therapy.

Outreach centers need to be there. They do provide a helpful service to the veteran, especially in rural communities. The funding, again, the 900 pound gorilla in the room is money, and that is what it comes down to. Now, the American people know that the funding—they want the funding for their veterans. They know the veterans need the funding. The VA needs to provide the request to the Congress for the funding. And to be penny-wise and pound foolish doesn't seem to make a whole lot of sense. And the first thing that can be done in rural areas is to have the Vet Centers because they do provide a needed service.

Mr. MICHAUD. Congressman Allen.

Mr. ALLEN. Dana, thank you for being here. I just have a comment about the funding issues. I sit on the Budget Committee, and I did want to make one clarification. Often the regional directors will be asking for more money than they actually get in the present budget, because the Office Management and Budget—

Mr. DOLIBER. Right.

Mr. ALLEN [continuing]. The presidential operation will trim down those requests. And then the regional VA director's kind of stuck with the number that they have been given. Maybe not the

number they asked for privately, but the number that they have been given by the Administration.

But as Representative Miller said, ultimately the decision is going to be made in the Congress. And I agree with him that the information that we get from our constituents is fundamentally important to understanding how we can drive that budget, as we did last year, in a much more positive direction.

I have a question; you indicated that you provided documentation to the VA to support your claim of service connection for your PTSD over all those years when you were trying to get—

Mr. DOLIBER. Yes, sir.

Mr. ALLEN [continuing]. Trying to get benefits, but there were certain gaps in the documentation that led to your claim being denied.

Can you talk a little bit more about what those gaps were, what it was you were being told you had to provide but could not?

Mr. DOLIBER. Well, the main requirement was to provide what the VA would term a stressor. Now, a stressor could be handling wounded, a stressor could be being shot at or being around explosions going off.

I provided pictures of my ship high-lining wounded from my ship to the hospital ships, *Repose* and *Sanctuary*. I provided documentation from my ship, albeit sketchy, and from the USS *St. Paul* cruiser that we operated with, the USS *Newport News*, another heavy cruiser that we operated with, and the USS *Collette*, another destroyer, where they spell-out in their record and their ship's log our receiving counter-battery from coastal defense units from North Vietnam and South Vietnam. We operated almost up to the Hai Phong Harbor in North Vietnam.

A lot of the American people believe that our participation in Vietnam stopped at the demilitarized zone (DMZ). We were routinely—and it wasn't any real big deal for us to be north of the DMZ. We received fire from islands off of the DMZ, from North Vietnamese, coastal batteries. I am at a loss as to how those records could be misrepresented on the ship that I was on, and yet to be so complete in the other vessels that we operated with.

Mr. ALLEN. Did you think at some level was there any chance the VA was thinking, well, you were on a ship, you weren't on the ground on the shore? Was that a piece of it?

Mr. DOLIBER. Well—

Mr. ALLEN. Or how would you try to explain it?

Mr. DOLIBER. Let me explain it this way. I had a conversation with a veteran's service officer at the VA. And he was an on-the-ground marine in Vietnam, and more power to him. When he heard that I had been onboard ship, he at that time would not take my case because in his words, we were on a cruise. It was if we were on the *Queen Mary*.

This was no *Queen Mary*. We were—we provided gunfire support for the 3rd Marine Division at the Battle of Hue. We were anchored in the Perfume—at the mouth of the Perfume River. I was in the rangefinder. I was looking through. I was watching it. I was providing—I was pressing the button on the rangefinder that fired the guns. This is no *Queen Mary*. They don't call them destroyers for nothing, and we did a damn good job.

Mr. ALLEN. Thank you very much.

Mr. DOLIBER. Thank you.

Mr. ALLEN. Thank you for your testimony.

Mr. MICHAUD. Thank you very much, Dana. Without objection, I would ask anything that has been said and for all the written testimony to be submitted in full for the record. Hearing none, it is so ordered.

I want to ask the second panel to come on up. While they are coming up, I just want to let you know, Dana, that in your written testimony you had asked that this Subcommittee be assured that there be no retribution against you for your testimony today. I assure you that there will not be any retribution. I want to thank you once again for coming here today.

Mr. DOLIBER. Thank you, sir.

Mr. MICHAUD. So, if the second panel could come forward. While they are coming forward, the second panel is Peter Ogden, who is the Director of Bureau of Veterans' Services for the State of Maine. We have Gary Laweryson, who is the Chairman of the Maine Veterans Coordinating Committee. Kelley Kash, who is the Chief Executive Officer of the Maine Veterans' Homes (MVH). And David Hartley, who is the Director of the Maine Rural Health Research Center. I want to thank all 4 of you for coming here today to give your testimony. We look forward to hearing your testimony here today.

We will begin with Mr. Ogden. Please proceed.

STATEMENTS OF PETER W. OGDEN, DIRECTOR, BUREAU OF VETERANS' SERVICES, STATE OF MAINE, AUGUSTA, ME, AND SECRETARY, NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS; GARY I. LAWERYSON, USMC (RET.), CHAIRMAN, MAINE VETERANS COORDINATING COMMITTEE, WALDOBORO, ME, COMMANDER, MILITARY ORDER OF THE PURPLE HEART, STATE OF MAINE, JUDGE ADVOCATE, MARINE CORPS LEAGUE, STATE OF MAINE, AND AIDE-DE-CAMP TO GOVERNOR JOHN BALDACCI; KELLEY J. KASH, CHIEF EXECUTIVE OFFICER, MAINE VETERANS' HOMES, AUGUSTA, ME; AND DAVID HARTLEY, PH.D., MHA, DIRECTOR, MAINE RURAL HEALTH RESEARCH CENTER, AND PROFESSOR, MUSKIE SCHOOL OF PUBLIC SERVICE, UNIVERSITY OF SOUTHERN MAINE, PORTLAND, ME

STATEMENT OF PETER W. OGDEN

Mr. OGDEN. Chairman Michaud, Congressman Miller, Congressman Allen, thank you for this opportunity to speak today on 3 extremely important issues for Maine's veterans: Access to rural healthcare, women's issues—

Mr. MICHAUD. Excuse me, sir. Is your microphone on?

Mr. OGDEN. The light's on. Okay. Should we start over? Okay.

Chairman Michaud, Congressman Miller and Congressman Allen, thank you for the opportunity to speak today on 3 extremely important issues for Maine veterans: Access to rural healthcare, women veterans, and outreach to veterans for benefits. My testimony today comes from 3 perspectives: The Director of the Bureau of Maine Veterans' Services, the Secretary of the National Associa-

tion of State Directors of Veterans' Affairs, and as a disabled combat veteran who uses the VA healthcare system in Maine.

I will begin with some facts that are key to understanding Maine and its veterans. First, in 2000, Maine had the largest per capita veteran population in the Nation and is still at number 2.

Second, Togus Medical Center is the oldest VA hospital in the Nation.

Third, Maine's aging veteran population is geographically dispersed across a large land area. Veterans living in northern Maine can drive 5 to 6 hours and up to 260 miles to reach the one VA Medical Center at Togus.

Fourth, 65 percent of our veterans are age 55 or older. This percentage should reach about 70 percent between 2020 and 2025, and these are the veterans that are most likely to need and use the VA healthcare system.

Fifth, 73 percent of our veteran population served during a wartime, which means they have more benefits available to them.

Last, we have over 52,000 or 36 percent of our veterans enrolled in the VA healthcare system, and about 38,500 who actively use the VA healthcare in Maine.

A lot of my speech will talk about the Capital Asset Realignment for Enhanced Services (CARES) program. The CARES market plan, the Far North Market—and Maine is unique because Maine as a State has its own market identified by the CARES plan—developed by Veterans Integrated Services Network (VISN) 1 recognized Maine's unique geographic characteristics, limited transportation infrastructure, and rural nature.

The CARES Commission Report made several points about access to VA healthcare in Maine, the Far North Market, that are relevant to this hearing. Less than 60 percent of our enrolled veterans are currently within the VA's access standards for hospital care. Inpatient medicine workload is projected to increase 209 percent by 2012. Only 59 percent of the veterans residing in this largely rural area are within the CARES plan guidelines are set for access to primary care. VISN 1 proposed only 5 new CBOCs, Community-Based Outpatient Clinics, all of them in Maine. In short, to improve rural access for veterans to VA healthcare in Maine and the Nation, implement CARES in Maine and in other rural States, and implement it as soon as possible.

Any conversation about aging veterans and access to healthcare should include the importance of State Veterans' Home Programs and the service they provide to our veterans. Maine is fortunate to have Maine Veterans' Homes with their 6 facilities spread across the State providing excellent care at the most reasonable cost. It is important that Congress continue to fund the State Veterans' Home Construction Program until each State has the capacity to provide long-term care to its veterans.

Maine has over 10,000 women veterans with less than 1,800 using the VA healthcare system. Quality or availability of types of care for women veterans does not seem to be as much of an issue as the access and outreach to those women veterans to know about their benefits. Approximately 40 percent of the women veterans using the VA healthcare system receive it at the CBOCs. So, access at the local area is important. The addition of the new CBOC in

the Lewiston/Auburn area and the access points in Houlton, Dover-Foxcroft and in Farmington will allow more women veterans to receive care closer to home and this will increase the usage numbers for all of our veterans.

While growth has occurred in VA healthcare due to improved access to CBOCs, many areas of Maine and the country are still shortchanged due to the geographic and due to the veterans' lack of information and awareness of their benefits. VA and State Departments of Veterans Affairs must reduce this inequity by reaching out to the veterans regarding their rights and entitlements. Maine and the National Association of State Directors of Veterans Affairs support the implementation of a grant program that would allow the VA to partner with the State Department of Veterans Affairs to perform outreach at the local level.

There is no excuse to veterans not receiving benefits to which they are entitled simply because they are unaware of those benefits. I would encourage the Committee to support S. 1314, the "Veterans Outreach Act of 2007," to help us with that.

State governments are the Nation's second largest provider of services to veterans next to the VA, and this role will continue to grow. We believe it is essential for Congress to understand this role and ensure we have the resources to carry out our responsibilities. The States partner very closely with the Federal Department of Veterans Affairs in order to best serve our veterans. And as partners, we need to continuously strive to be more efficient in delivering those services.

As I finish my testimony rather rapidly, I would like to once again thank you for the opportunity to speak to you today and thank you on behalf of Maine's veterans and the Nation's veterans for all you are doing to ensure they receive the proper healthcare and the benefits they have earned through their service to the Nation. Thank you.

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

Mr. MICHAUD. Thank you very much. Mr. Laweryson.

STATEMENT OF GARY I. LAWERYSON

Mr. LAWERYSON. Congressman Michaud, Congressman Miller, Congressman Allen, the Maine Veterans Coordinating Committee wants to thank you for allowing us to testify again. Our organization is made up of 14 different groups that do their best to work for all the veterans in the State of Maine.

As I testified on August 1st, 2005, on the CARES program, and you will see a lot of this overlaps everybody else, it has been 2½ years and we have opened 1 clinic, Houlton, possibly in June. And in that interim time period, there's been a CBOC opened down in Connecticut, which wasn't even on the table at that time. The rural veterans are not getting the care that they deserve or need.

At that time, we discussed the cost of fuel, the cost of living up here in Maine. And since that time, I bet it has tripled. The gas is out of sight, the fuel oil is out of sight. These people are working on a fixed income. They are not able to travel. And when they do go down to Togus, there is a cost share on the travel pay, they lose half of it, and it is already putting a tremendous burden on them as it is. I think we need to look at that again.

With Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) troops coming back, and they have been extended through a 5-year term with the VA. And I think that boots out after they redeploy again, which is another issue. The older veterans aren't getting the word that they can get in there. So, they don't come down because OIF/OEF has a first run on this or their assumption is that they do.

We discussed communications last time with the VA getting out the proper word to clear up the fog. That hasn't happened yet. We need to get more of the VA out into local communities putting out these town meetings to pull these rural veterans in. While Maine is a rural State, there is a subsection of rural up there, and you will speak with Mr. Rural later. That is where a large majority of your veterans are, especially your combat veterans. They like to be out and about away from the hustle and the bustle. We need to find out what's taking so long for VISN to get our other clinics open. And we need to get that moving, especially in the rural areas first.

The VA and Togus, we support, as we did back then. The past director, Jack Sims, was doing a great job with what he had. The new director has got a challenge and we are going to hold his feet to the fire, but he is doing a great job. We have a meeting with the Coordinating Committee once a month. He is there, he is an integral part of this. We get the word, we pass the word. And if there's any issues, we take it up and deal with them, not in a public meeting place but a private matter. Very effective, and Mr. Stiller is very receptive to that. We are lucky to have him.

We have done something in Maine that the other States haven't done yet, and that is called "Operation I Served." We put that package together. It has been very effective. And we are putting it out now in doctors' offices, waiting rooms of hospitals because the veterans do get that. They are allowed to call in. We have worked with the Bureau of Veterans Services in Maine, publish this, update it every year or so. It is a tremendous tool, and we just need to get more of that out in the public. And that goes along with what my brother, Pete, was talking about that that would be a tremendous, tremendous way to get this information out and if we can get the VA onboard and do more town meetings in the rural areas.

Women veterans. They are combat veterans. A veteran's a veteran. They have special needs. There's special needs veterans out there with amputations and traumatic brain injuries. There is no difference. They are veterans, and they should have first-care priority to any area, and that's the rural areas. Now, if we can't get them in out there, we could temporarily take care of them with fee services until we can get them down to the master hospital at Togus. Getting short on time here.

And the Coordinating Committee's opinion is still that VA should be a full-service hospital. We should not have to run down to Boston. It is counterproductive and it is not in the best interest of the veterans or their families. It wasn't before, and it especially isn't now with the cost of transportation and fuel.

We appreciate what you are doing for our veterans. We continue to look forward to working with you. And we will hold your feet to the fire to keep up the good work. Thank you.

[The prepared statement of Mr. Laweryson appears on p. 47.]
Mr. MICHAUD. Thank you. Mr. KASH.

STATEMENT OF KELLEY J. KASH

Mr. KASH. Mr. Chairman and Members of the Committee, thank you for the opportunity to testify this morning.

I am the Chief Executive Officer of the Maine Veterans' Home. MVH operates 6 long-term care nursing facilities providing 640 skilled nursing, long-term nursing, and domiciliary beds. The facilities are relatively small, each in size, 30 to 150 beds each. This allows them to be located throughout the State of Maine, allowing greater ease of access to our facilities by veterans living in the most rural parts of Maine.

MVH is part of a vital national system of State Veterans' Homes. The State Veterans' Homes system is the largest provider of long-term care to our Nation's veterans and provides 52 percent of the VA's total long-term care workload at well below the cost of care in a VA facility for civilian contract providers. The State Veterans' Homes provide long-term medical services at a cost to the VA of only \$71.00 per day, compared to approximately \$225.00 per day to the VA for the placement of a veteran at a contract nursing home, or over \$560.00 per day in its own VA facilities. As such, the State Veterans' Homes play an irreplaceable role in assuring that eligible veterans receive benefits, services, and quality long-term healthcare that they have rightfully earned by their service and sacrifice for our country.

Traditionally, State Veterans' Homes residents have been primarily male. However, more and more women are being admitted to State Veterans' Homes as veterans themselves reflecting the large and increasing numbers of women who have served in the military since the Korean war and before.

While our experiences in the Gulf War and present conflicts have given tremendous attention to post traumatic stress disorder, the reality and effects of PTSD have been present in every conflict. State Veterans' Homes provide a common culture, reassuring surrounding, greater appreciation, and understanding of the veterans' experiences and issues; however, much more can be learned in treating PTSD in general.

We feel strongly that the State Veterans' Homes should play a major role in meeting the many rehabilitative care needs for veterans and that we should be treated as a resource integrated more fully with the VA long-term care program. Here is one example of how the VA can partner with the State Veterans' Homes.

The State of Maine enacted legislation earlier this month to establish a veterans' campus at Bangor, Maine. The concept is to create a one-stop shop for veterans to receive most of their healthcare and social service needs. The proposed project will locate a new, larger, and more capable VA community-based outpatient clinic next to the MVH Bangor facility. Other veteran service organizations will be co-located at the campus, bringing a wide range of veteran services to a single campus, making it more efficient and convenient for veterans, families, and the various agencies that serve veterans' healthcare and social service needs.

The Bangor Veterans' Campus is a pioneering effort and it is the first of its kind in the Nation. It should receive special interest in our Nation's Capitol. The VA should streamline its awards process and its success should be replicated throughout the Nation.

The VA chronically has been slow to implement enacted legislation. Legislation directing the VA to pay the full cost of care for veterans with service-connected disabilities rated 70 percent or greater and to provide veterans with service-connected disabilities rated 50 percent or greater with prescription medications while residing in State Homes has yet to be implemented by the VA, even though Federal law required these provisions to take effect by March 2007. The result has been tremendous confusion and frustration for the many thousands of veterans who are waiting for these services and for the State Veterans' Homes which will be required eventually to provide these services.

Regarding VA grant funding, the administration has proposed cutting State Veterans' Home construction matching grant funding by almost 50 percent from \$165 million in fiscal year 2008 to \$85 million in fiscal year 2009. The backlog of construction projects to repair, rehabilitate, expand, and build new State Veterans' Homes is now approaching \$1 billion. Over \$200 million of this backlog are life-safety projects.

In conclusion, I will quickly reiterate the issues facing the State Veterans' Homes. First, thank you for your continued support in the VA per diem payment to the State Veterans' Homes. The loss or reduction of the VA per diem would place Homes in an untenable financial position and could lead to the closure of many State Homes, ultimately impacting our aging veterans.

Second, we believe Congress must increase funding for construction grants to State Veterans' Homes to at least \$200 million to address the growing backlog of projects.

Third, we believe Congress must require the VA to promulgate long-overdue regulations to strengthen State Veterans' Homes and the veterans they serve.

Finally, we believe that the State Veterans' Homes can play a more substantial role in meeting the long-term care needs of veterans. We support the national trends toward de-institutionalization and the provision of long-term care in the most independent and cost-effective setting. We would be pleased to work with the Committee and the VA to explore options to develop pilot programs, such as the proposed Bangor Veterans' Campus, providing innovative care and for more closely integrating the State Veterans' Homes program into the VA's overall healthcare system for our veterans.

Thank you for the opportunity to address you today, and thank you for your commitment to long-term care for veterans and for your support of the State Veterans' Homes as a central component of that care.

[The prepared statement of Mr. Kash appears on p. 48.]

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

Dr. Hartley.

STATEMENT OF DAVID HARTLEY, PH.D., MHA

Mr. HARTLEY. Well, thank you. Mr. Chairman, Mr. Allen, Mr. Miller, thank you for the opportunity to testify before this Committee. My testimony is based on my 12 years as a manager of substance abuse treatment programs in rural areas, and 15 years as a rural health researcher with a focus on access to mental health services in rural America. I would like to make 4 points in my testimony.

First, as you know, many veterans are returning from OEF and OIF with mental health issues including PTSD, depression, and traumatic brain injuries (TBI). A recent report from the RAND Center for Military Health Policy Research refers to these as the invisible wounds of war and reports that 31 percent of servicemen deployed since 2001 have reported symptoms of one or more of these injuries. This report I have here with me, it is very long. It just came out a few days ago, and I highly recommend it. What is not mentioned in the RAND Report is the significant portion of these combat vets who are from rural areas, nearly half are recent recruits.

My second point. The Veterans' Healthcare System has unique expertise and resources to devote to the healing of these injuries. In recent—excuse me. The VA also has an integrated health information network. I am sorry, my notes are out of order. I am going to have to switch to my other notes. Excuse me. (Pause.) In recent years, the VA has opened more community-based outpatient clinics, or CBOCs, to make their expertise and these resources available to veterans who live at significant distances from VA medical centers. We now have 6 CBOCs in Maine.

The VA also has an integrated health information network in the Nation, the best in the Nation, with evidence-based, patient-centered performance measures and a monitoring system to assure that all patients receive high quality care. That system gets very good outcomes for those veterans who receive care from VA clinics and from CBOCs and from contract providers.

There are several reasons why a veteran in need of help might not seek care at one of these facilities. While CBOCs have improved access in many rural areas, there remain vast remote areas in our most rural States, including Maine, where VA facilities are out of reach. Also, some veterans prefer to seek care from a non-VA system provider for a variety of reasons. This RAND report found that only half of those with these injuries actually seek help for them.

My third point. The Federal Government, through the Health Services and Resource Administration, has created several programs to attract providers to under-served areas to support them. These include federally qualified health centers, critical access hospitals, and rural health clinics. Some rural areas are also served by community mental health centers. Most of these programs exist in areas that are designated as under-served. While many of these programs are focused on primary care, it is common in rural areas to seek mental health services from primary care sites.

We have the technology and the expertise to help these rural sites provide care to rural veterans that is of the same high quality that urban vets receive. This can be done through telehealth,

through the VistA information system which is now available to non-VA providers, through direct and clinical consultation between the expert clinicians in VA medical centers and rural providers, and through the placement of VA providers in these non-VA rural sites, creating veterans' access points. Such cooperation between VA and non-VA providers must be encouraged.

My final point. To facilitate collaboration between Health Resources and Services Administration (HRSA) and the VA, this Committee should encourage HRSA's Office of Rural Health Policy and the VA's new Office of Rural Health to collaborate on demonstrations and on interagency research bringing HRSA's Rural Health Research Center and the VA's researchers together to explore options for improving access to high quality care for rural vets.

Thank you. I will be happy to answer your questions.

And I would like to add that I am accompanied today by my colleague, Dr. David Lambert, who is also an expert in rural mental health. Thank you.

[The prepared statement of Mr. Hartley appears on p. 52.]

Mr. MICHAUD. Thank you very much, Dr. Hartley.

Once again, I would like to thank the 4 panelists here.

Mr. Laweryson, you had mentioned the CARES process and CBOCs, and we are very much familiar with that whole process. We keep that book, I know I do, right on my desk in Washington to keep updated on how much progress we are making.

Former Secretary of the VA, Tony Principi said in order to move forward in the CARES process, that they would need about a billion dollars a year. That has not happened, unfortunately. However, I think that if you listened to all the comments made here thus far today, as well as in Washington, relating to rural health-care issues and access to healthcare, I think the CARES process would actually quite frankly solve a lot of problems with access points in rural areas.

My question is it is an expensive process. Part of that expense is establishing some major hospitals that could cost \$500 million to establish compared to a \$50 million dollar CBOC or access clinic.

What would you recommend? Should the Subcommittee focus on some of the lower-cost access points and put off maybe for a year or whatever some of the higher dollar figure major hospitals?

Mr. LAWERYSON. I think that hits it right on the head, sir. It is—it is like a triage in the battlefield. You get the veterans in. If they dictate that they have to go to further treatment, then we can move them down to a larger CBOC. For instance, we have Bangor. That is on the outreach of 50, 60 miles north of Togus. I think the problem there is that if we can get Togus up to speed, then these veterans don't have to travel even further south 2 or 3 hours into Boston, and that is from the lower section of the State.

But on the rural as an overall picture, if you have your access sites out there, you are going to find more veterans getting into them. And once they are diagnosed and triaged, for lack of a better word, then you can get them into the system and they will feel more comfortable with it. But to do that, we have to communicate to them that this is open, it is a great system, because for years they haven't been getting that word.

Mr. MICHAUD. I am relieved to hear that answer because actually later this week, Wednesday, I believe, our Committee will be marking up a construction bill, and we have language in there that will actually direct the VA to focus on exactly what we were just talking about.

My other question, you had also mentioned the gas reimbursement. As you heard earlier and you all know, we increased the mileage to 28.5 cents. However, the VA did put on a waiver or increased the waiver. When the Secretary was before us in the hearing to the full Committee of Veterans' Affairs, he said that the deduction is being waived.

Are you finding that to be true for your members?

Mr. LAWERYSON. No. I was told that it hadn't been waived. And it is—we really appreciate the 28 cents, you know, the increase to that. But when the gas goes up 28 cents in a day, that is—if they could take that waiver off, that would be really beneficial to a lot of them.

Mr. MICHAUD. So that deduction has not been waived?

Mr. LAWERYSON. At the last meeting, it hadn't been. We brought it up and was told it hadn't been.

Mr. MICHAUD. Okay, because the Secretary had told the Committee that it was.

Mr. Hartley, you had mentioned I think in your testimony that you suggested the VA should establish a Rural Behavioral Health Research Institute. What specific research questions would you like to see the institute address?

Mr. HARTLEY. I think the most pressing question right now is this fact that 50 percent of the folks who have these symptoms aren't seeking care for it. I think there is a whole variety of reasons why that must be the case. It is not just about geographic access. I think there are other reasons. I don't think we know the answers to those questions. This RAND report asks some of those questions and begins to point the direction, but that would be my first question.

Mr. MICHAUD. You also mentioned that you are an expert in rural behavioral health. How would you assess the VA's current system ability to meet the behavioral health needs for rural veterans? Do you think they are meeting all those needs?

Mr. HARTLEY. Well, clearly they can't meet all those needs in the most rural areas. And as a matter of fact, this isn't a problem that faces only the VA, it faces our entire healthcare system. Mental health needs and substance abuse needs in rural areas are frequently cited as the most acute need in the most rural areas by people all across the spectrum. So, it is true, they are not meeting those needs.

I think what we need to do is pool our resources that are out there that have been created through these Federal programs to do the best job we can to meet as many people's needs as we can.

Mr. MICHAUD. What are some of the specific things you think the VA can do to improve the access to rural veterans?

Mr. HARTLEY. Well, as I suggested here, I think they—and I like this idea of triage, of figuring out how to make a first point of contact, a first point of access where we can get folks in the door. And this may address some of those reasons for that 50 percent who

aren't seeking care. So creating what we call the "no wrong door" approach, which means wherever you show up, there will be somebody there who will say, yes, you have this problem and, yes, you are eligible for these benefits, let me help you.

Mr. MICHAUD. My last question, Mr. Kash, is do you have any programs specifically for women veterans?

Mr. KASH. No, sir, not specifically. Although, we are seeing more and more women and we are becoming much more adept at handling them. Normal nursing home, a civilian, is 75 percent women, where it is about 25 percent or less in our homes because of the nature of the veterans. But we are getting much more adept at how we handle women.

Mr. MICHAUD. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. For the record, I do believe the Secretary sent a letter out clarifying that he did, in fact, misspeak during our hearing in regards to the waiver, and he is, in fact, looking at expanding and doing research. I think we all support the waiver that he did in fact speak of.

Mr. Kash, you talked about the veterans' campus in Bangor. Could you elaborate a little bit on the benefits? I think it is a great idea. How did it come about and what are the options that we are looking for?

Mr. KASH. It came about a year and a half ago. A group, including several players in the legislature in the veterans' organizations. The CBOC at Bangor right now is about half the size that it needs to be. The veteran population there is growing and getting big, so they knew they had to replace the CBOC and they knew their lease was coming up due. So, a new one needed to be built. This was an idea, the Dorothea Dix Psychiatric Center up there is a large campus, and we are right next to it, we are part of it. And we thought here is a great opportunity to locate it nearer to where it is now, bringing a large area to build its clinic.

And then also other ventures that we are looking at doing up there, along with Veterans' Housing Coalition of Maine, is establishing housing, low-cost housing for homeless or needy veterans. And what we would also like to do for MVH is look into hospice, building a fixed hospice facility. So, here we have a bunch of ventures we would like to do to improve our services to the veterans, and we know that we can co-locate them all on one campus. We think that it will obviously be much more convenient for the families and the veterans themselves, but also the many service organizations that work together to provide those services. We saw it as a win-win opportunity.

So, the State of Maine took the initiative to go ahead and research it, to put it into action, to have a rather robust Committee look at it and make sure all the stakeholders are in agreement with it, and then to go ahead and pass legislation that will in fact deed land over to MVH to help facilitate the building and construction of that.

Mr. MILLER. Thank you. Mr. Laweryson, do you support the fee-for-service concept if veterans have no other options available, in particular rural veterans?

Mr. LAWERYSON. I think the fee-for-service is great if it is an emergency and it is also great for those veterans that suffer from

head colds, rashes, coughs, headaches, or for glasses. But your other, you know, major surgeries and stuff that can be done that are not emergency, they need to get to the VA hospital because the turnaround time on healing, because it is in a veteran's community, it is cut in half. These veterans, they love being around each other. And that is an important part of the system, that is why we have the VA hospital, especially the combat veterans.

But, yeah, on a case-by-case, if they don't need to be running down from Caribou or Presque Isle or Clayton Lake to get some cough syrup or something, that would be fantastic. You know, or if it was an emergency surgery, compound fracture, get it over here, get it taken care of right here locally. It is done, and the family unit is there to help with the healing process.

Mr. MILLER. I only ask that question because we do get pretty good push-back from the VSOs out there with regards to—and I understand part of the argument and the desire not to berate the healthcare that is being provided now by allowing veterans to, quote, “flee the system,” if you will. But we are all trying to find a way to get at access problems, even in the short-term, and it may be that fee-for-services is the way to go.

I don't know how we establish the severity of an issue, obviously, because there are a lot of people that will go to a doc in the box, if you will, for a minor issue rather than go to the hospital. I just wanted to see what your reaction was.

I am going to go ahead and yield my time over to Mr. Allen so he can continue to ask questions.

Mr. MICHAUD. Mr. Allen.

Mr. ALLEN. Thank you. Thank you all for your testimony. I had a couple of questions for Peter Ogden.

In your testimony, you say there are more than 10,000 women veterans in the State of Maine, but only 1,800—less than 1,800 receive their healthcare from the VA. You mentioned lack of access, lack of outreach as likely reasons for that number being as low as it is, or at least I think that is what you are saying.

So, I guess I am curious about what you think the limits are of your current outreach efforts, and really are there places that you think more could be done? I guess the first question is do we have a problem here or not?

Mr. OGDEN. Yes, we have a problem. Actually, outreach—I think part of our problem is I know about my World War II veterans, Korean war veterans that we are wrestling to bring into the VA system now. It is like the women veterans. They are there, we know they are there. We know—we can tell what counties they are in, but we haven't been able to reach to them and say, you have some benefits, please come use them.

And I think it has a lot to do with the female veterans that come back, the younger ones get married, they have families or those things. They kind of get drawn into other things. And because the access is not convenient for them to the women's clinic at Togus or any of the CBOCs that we have available to go to them, I think they kind of do other things in the process. I really believe that having the CBOCs, the access points out there, will bring more women veterans into the system.

And the other part is for us to reach out. And as a State, we struggle with how do we reach out to veterans. That is part of my job is outreach and working with the VA to be able to say to every one of those women veterans that here's the benefits available to you, here's what we need to do, please come see us. I write letters to every DD-214 that comes into my office. There's about 1,500, 1,800 this last year. I send letters to every one of those people saying, here's your benefits, if you have a question, come call to us.

Well, we still need to keep community outreach. A lot of those are young women veterans, and we have a lot of other veterans here. It is a problem with us. I think outreach would bring the veterans in, not just the women, but the other veterans. And to bring them in, we need the access points to bring them into because I think one of the things that we need to do is—because access points will give us primary healthcare.

And if we get primary healthcare in a preventive medicine kind of timeframe, we will reduce the cost and severity of those things when the veteran shows up down at Togus later on. If we can get them in sooner and take care of their healthcare and be preventative about what we are doing with those things, it will reduce the total healthcare costs because when they show up—if we haven't done that, they are going to show up with a more severe problem than needs to be, I think.

Mr. ALLEN. Is there a way to use other women's groups to reach women veterans? Part of the question is, should you be thinking about outreach to the women veterans any different than you do with men?

Mr. OGDEN. Well, the State of Maine has a Commission for Women Veterans. They work under my kind of control as a commission established by women veterans. There is no funding for the women veterans. I try to help them. I do the newsletters for them, we send them out and they work with us to try to outreach. It is about having some money to travel, having some money to have town hall meetings and those kind of things. These women are all volunteers. They don't get paid for anything they do, but they do travel around, they do work with those things.

Maine just has now—we have a great chapter of the WAVES National that are mostly World War II female veterans. We have now the Vietnam—actually, the Women Veterans of America just started a chapter in Maine. That is going to be helpful, I think, to gather the women into the process. But it is about outreach, and you need to have female veterans reaching out to female veterans.

Mr. ALLEN. My other question is for Kelley Kash. In your written testimony, you said that the VA recently estimated nationally that nursing care beds in the State homes are 87 percent occupied, but that many of the State veterans' homes nationally have occupancy rates near 100 percent and some have long waiting lists. In Maine, I understand it is around 97 percent.

Mr. KASH. Yes, sir.

Mr. ALLEN. Is that right? What do you think is going to happen? Has that number been stable? Is it likely to increase? Are we at risk of having longer lines, or do you think that, you know, you have been adding beds at a pace that will be able to take care of the potential influx in the population?

Mr. KASH. There are 155,000 veterans in the State of Maine, plus their families. And on average, about 5 percent of the aging population will require nursing home care. So you can see that that number is really askew. I think what is going to happen is even though we are legally constrained to 640 beds, we could easily grow and still not have enough room to provide all the services. So, the VA is going to have to look at other mechanisms to do that.

But the short answer to your question, I think we could use a lot more beds.

Mr. ALLEN. Do you think you are likely to have waiting lists in the future? Do you have waiting lists now?

Mr. KASH. Yes, we do. We have waiting lists right now, and a lot of those are family members who would like to get in as well. I think that we could address immediate needs in areas like York County. But then there are about 40 percent of folks, their primary reason for choosing a nursing home is convenience of location. And there aren't too many locations that are convenient in Maine. So, if we could deploy more homes, we could certainly, I think, fill those beds.

Mr. ALLEN. Thank you. I yield back.

Mr. MICHAUD. Thank you. Once again, I would like to thank the 4 panelists for your testimony this morning. I look forward to working with you as we move forward in dealing with these issues. Thank you very much.

Next, panel 3 includes Joe Wafford, who is the Supervisory National Service Officer for the Department of Maine Disabled American Veterans (DAV); Donald Simoneau, who is a past Department of Maine Commander for the American Legion; John Wallace, the Maine State Council President for the Vietnam Veterans of America (VVA); and James Bachelder, who is the Maine Department Commander for the Veterans of Foreign Wars (VFW) of the United States. I want to thank all of you for coming here today. I look forward to hearing your testimony.

We will start with Mr. Simoneau.

STATEMENTS OF DONALD A. SIMONEAU, PAST COMMANDER, DEPARTMENT OF MAINE, AND MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN LEGION; JAMES BACHELDER, COMMANDER, DEPARTMENT OF MAINE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; JOHN WALLACE, PRESIDENT, MAINE STATE COUNCIL, VIETNAM VETERANS OF AMERICA; AND JOSEPH E. WAFFORD, SUPERVISORY NATIONAL SERVICE OFFICER, DEPARTMENT OF MAINE, DISABLED AMERICAN VETERANS

STATEMENT OF DONALD A. SIMONEAU

Mr. SIMONEAU. Mr. Chairman, that has a nice ring to it, Congressman Miller, Congressman Allen, I thank you for the opportunity to present the American Legion's views on women, special needs, and rural veterans. The American Legion commends the Subcommittee for holding a hearing to discuss this vitally important issue.

According to the VA research, women make up approximately 15 percent of the active force serving in all branches of the military,

and the State of Maine has approximately 9,396 women veterans. Research has shown that women veterans encounter 3 large barriers when trying to access healthcare through the VA system: The lack of knowledge of the VA health administration services, unaware of the eligibility for healthcare benefits, and the perception that the VA caters to male veterans.

The American Legion recommends that once women veterans' needs are identified, the VA develop and implement policies to address these deficiencies in a timely manner and conduct an extensive outreach campaign to ensure that this special population of those who served and those who served them are aware of the enhancements in the healthcare services.

Special needs veterans. The American Legion is very concerned about the needs of all veterans, but we must reassure that special needs veterans do not slip through the cracks: The chronically mentally ill, the major affective disorders, post traumatic stress disorder, traumatic brain injuries, the frail, the elderly, those veterans 65 years of age or older with chronic health problems, and we must always be on-watch for the homeless veteran.

Recently, in my own hometown, a young man who served 2 tours in Iraq, found that he could not handle what he dealt with, and he took his own life. And it was a great loss to the community, a great loss to the Nation. He is one of those that slipped through the cracks. We cannot allow that.

The American Legion believes veterans, many of whom are elderly and infirm, are isolated from regular preventative medical attention they need and they deserve. The VA's ability to provide treatment and rehabilitation to rural veterans who suffer the ongoing wars in Iraq and Afghanistan will continue to challenge the system. The American Legion believes CBOCs that serve as a vital element of the VA's healthcare delivery system in States such as Maine, veterans face extremely long drives, shortage of healthcare providers, and bad weather.

The American Legion urges Congress to adequately fund CBOCs, construction and maintenance. The VA must enhance existing partnerships with communities and other Federal agencies to help alleviate the barriers that exist such as the high cost of contracted care in the rural setting. Lastly, the American Legion urges Congress to provide adequate funding to the VA to accommodate the modernization of all VA structures.

Mr. Chairman, I thank you for giving the American Legion this opportunity to present its views on such important issues. You can see a much more in-depth report in my printed report which I have submitted. I thank you for my time.

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

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

Mr. BACHELDER.

STATEMENT OF JAMES BACHELDER

Mr. BACHELDER. Mr. Chairman, Congressman Miller, and Congressman Allen, I want to thank you for being here today.

I would like to start by saying that we did have a communication problem due to the fact that Rosemary Lane is very sick. But I want to thank you for waiving the need to have my testimony

ahead of time. I am going to record it and I will get it to Jim Pineau at Congressman Allen's office for the Committee.

Mr. MICHAUD. Thank you.

Mr. BACHELDER. As the Commander of the Veterans of Foreign Wars in the State of Maine, a Board Member of the Veterans' Housing Coalition, Co-Chairman of the Southern Maine Veterans' Memorial Cemetery Association, the Chairman of the Sanford Veterans' Memorial Committee, the host of the Sanford veterans' cable access program which both Congressman Michaud and Congressman Allen have been to in the past and we hope to have you in the future, a driver of the Disabled American van in Sanford for Togus for 5 years, and a disabled veteran due to combat in Vietnam, I would like to put some light on some issues that we found in the VA healthcare.

Transportation. If you are not service-connected, you have to deal with the Disabled American Veterans' van system which is made up of volunteers. And due to health restriction of drivers, sometimes it is hard to have people drive the van. So in this area, in Sanford, if you need to go for a Tuesday appointment, you need to take a van ride on Monday. You need to spend the night at Togus. The VA will give you food and housing. You would have your appointment for 15 or 30 minutes on Tuesday, and you have to stay at Togus hospital Tuesday night and take the van back on Wednesday.

The VA healthcare has the best electronic records, and in those records are flags where the Mental Health Department can put in information about the patient, about the needs, about the concerns. And with research, I have talked with the computer department, I have talked with the schedulers, and those flags should be used so that the people that need to use the DAV van, when they make an appointment, they will know that these people should be able to get a ride on Monday and have the appointment before noontime and be able to return on the same day. And it would reduce the cost of housing and feeding these veterans, but we have not been able to get the Mental Health to allow these flags to be used for transportation reasons.

And when we have the van that needs to go to Boston, and somebody has to get there from up in Caribou, they have to come down the day before. They have to take the van to Boston. They have to have their procedure done. They have to take the van back to Togus. They have to spend the night in Togus and wait until there is a van to take them back to Caribou. So, the transportation issue is something that as veterans you know about, but we need Congress to understand. That if we have the communication in the records, then we can key-in to the transportation system and these veterans can be serviced in 1-day service.

Appointments. I just had a Ryan Lilly come down who is the Associate Director of the Medical Center. And when he came down, we talked about some letters that I received.

I had an appointment for May 30th. I received a letter that it was canceled because the doctor wasn't going to be available, so it was moved to the 7th of May. Then I received a letter that the 7th was canceled, it was moved to the 8th. Then I received a letter saying that the 8th was canceled, it was moved to the 9th. The letter

canceling the 7th and the 8th and the 8th and the 9th were written on the same day.

When I talked with Mr. Lilly, he said when you have a change in your appointment, the healthcare should be calling you to find out if you are available for the day that they are going to give you an appointment. That wasn't being done. And when he did get it taken care of, the employees did not have a very good attitude when they call up and try to arrange an appointment with you. And I just don't see that the veteran who is trying to get healthcare and isn't being cared for properly should have a bad attitude from an employee when they are being told to do their job properly. I did get to see a doctor, and that's been taken care of.

I do have another issue, and I am using myself as an example because of the fact that I can speak of what I know. But I do work as a service officer in the VFW here in Sanford, and I know that I am not the only person that has these issues. But I do have another appointment I called on, and it takes 2 months to get the appointment. And it would be nice if we could find a way to get these appointments quicker than 2 months.

Also, I was driving up to Togus 1 day, and I called up just to make sure that they understood I was on my way. And when I got to Brunswick they said, oh, don't bother coming, the doctor's not available. I have gone up to Togus at other times, the doctor wasn't available, and all of the people were coming in for their appointments and they were never notified that this doctor wasn't available and they continued to go to Togus. And it is not a one-time deal. This happens often, that they have too few of doctors, they have so many veterans, and an emergency comes up and the doctor has to be taken away. But nobody picks up the phone to try and call these veterans and tell them not to come.

The question about post traumatic stress and traumatic brain injury. Peter Ogden was just testifying from the Bureau of Maine Veteran Services. And his chapter had a meeting with all of the State commanders and with other people about making sure that we are servicing our National Guard, our Reserve, and any of the military that are coming back.

And in that meeting, it was stated that traumatic brain injury and post traumatic stress have the same symptoms. It is very difficult to try and find out what the cause is for the veteran. But it has also been found out that the post traumatic stress disorder therapy can be devastating to an individual with traumatic brain injury. So if you try to resolve the wrong issue not knowing, you could actually be putting the veteran's life in danger.

With the assessment of post traumatic stress disorder in relationship to this bill which Congressman Allen has created, if you have an analysis from a social worker, it can be overturned by a VA psychiatrist and you can lose your claim. The Vet Centers that are created by the VA are all staffed by social workers. If you go to a VA hospital for healthcare, you see a social worker. So the assessment that you have can be overturned by the psychiatrist that is now doing your competence evaluation.

So, how can individuals get an assessment that will be accepted by the regional office if the psychiatrist has the power to negate the assessment that you have gone through over months or years?

And that's a question that has been brought up, and I think that it needs to be looked at. And I understand that part of your bill may even address that.

Mr. MICHAUD. Well, thank you very much, sir. I really appreciate it. And if you want to submit your written remarks for the record, we will definitely include them.

And please give Rosemary Lane our best, our prayers and thoughts are with her as well.

Mr. BACHELDER. Thank you very much.

Mr. MICHAUD. Mr. Wallace.

STATEMENT OF JOHN WALLACE

Mr. WALLACE. Mr. Chairman, Ranking Member Miller, and distinguished Members of the Subcommittee, my guests, my name is John Wallace. I am a combat veteran who is presently Vietnam Veterans of America State Council President. I serve on Maine's BigMac and MiniMac since their inception, and that's for more than 20 years. I am also on the Network Communications Council. I also serve on the Veterans Coordinating Committee, the Caribou Veterans Cemetery Committee, the Maine Veterans' Home Liaison Committee in Caribou, and I participate in the Commanders Call with the Governor and National Guard General.

Mr. Chairman, the Maine Department of Veterans' Affairs is located in Togus, 6 miles east of Augusta. Opened in 1866, Togus was the first national home for disabled volunteer soldiers. This VA Medical Center provides medical, surgical, psychiatry and nursing home care. The VA operates community-based outpatient clinics in Bangor, Calais, Caribou, Rumford, and Saco to provide better access for veterans living in rural areas. In 2007, they opened a part-time clinic in Lincoln. There is also a Mental Health Clinic located in Portland.

More than 1,400 active-duty servicemembers and veterans of the Global War on Terror have sought VA healthcare in Maine. Many veterans from the conflicts of Iraq and Afghanistan have visited VA counseling centers in Bangor, Caribou, Lewiston, Portland, and Springvale. These community-based Vet Centers are an important resource for the veterans who, once home, often seek out fellow veterans for help transitioning back to civilian life. Over 6 million veterans live in rural areas across America, and most fall below the poverty line. They travel hours to get to the nearest VA medical facilities.

At a hearing of the Subcommittee on Health, Mr. Chairman, you pointed out that although 20 percent of the Nation's populace lives in rural areas, 40 percent of the veterans returning from deployment in Afghanistan and Iraq live in rural areas. This leads to a significant challenge maintaining core healthcare services. The average distance for rural veterans to access care is 63 miles according to the National Rural Health Association.

The difficulty in accessing healthcare is a significant problem for many Maine veterans. Although Togus is almost centrally located in Augusta, the State's geographic expanse makes it a problem for many veterans to use the hospital as a primary care provider. In 2004, the Government Commission expressed concern that only 59 percent of Maine's veterans were living within the geographical

guidelines for access to care which ranged from 60 minutes for urban areas and 120 for very rural areas.

Of Maine's 6 CBOCs, with 2 more planned under CARES, the closest CBOC is around 80 miles from its hub, the furthest is 260. For primary care, this is okay. But for specialty care services, veterans have to travel to Togus or Boston. The distance a veteran may have to travel is more than 300 miles, which is clearly outside the 75-mile radius established by the VA. To make matters worse, most rural medical care providers, weary of the paperwork and long delays involved in the Federal benefits system, often do not accept TRICARE.

There is evidence that the VA has known for some time about the need to focus more on rural care. In 2004, the study of 750,000 veterans found that those living in rural healthcare areas tended to have seriously high—more seriously high health costly problems than their urban counterparts. Perhaps the VA could reach a lot of veterans who live in rural Maine by expanding the use of fee-basis care, in which the VA contracts its services out to a third-party provider. Certainly, issues involved in providing rural healthcare must be addressed by the VA's new Office of Rural Healthcare, which has been slow to get started.

Mr. Chairman, we are in an emergency situation in Maine, and VVA is seeking your help in Congress to expedite the provision stated in lower P.L. 109-61. Otherwise, our disabled veterans, both young and old, would be forced to continue the long-distance travel for care and treatment to the nearest VA Medical Center, clinic, or hospital.

We pioneered the first rural, or rural-rural VA clinic as I like to call it, in Maine. We started out 1 day a week, and quickly went to 7. Excuse me, not 7, 5 days with 3 providers, staff, 2 mental health providers currently on, and telemental health being given access to. This covers an area bigger than the State of Rhode Island and Connecticut put together. We, the veterans, had to fight every step of the way for this. In the beginning, we were told this would never happen. We proved them wrong.

If you travel into the farm towns of any State in this union, you will see lots of veterans who need help and are having difficulty finding it. Should we lose veterans who protected this Nation so honorably because our government is unwilling to look past politics? I think not.

Women veterans' healthcare issues have come a long way, basically, in the last 15 years. There are 2 bills before Congress, 1 in the Senate, 1 in the House. The Senate version addresses the women veterans program manager issue, the House doesn't. At present, under the VA guidelines, they have 20 hours a week to work on that besides doing what they were actually hired for in the other position. This needs to be changed to a full-time position so that they can take care of our women veterans.

I will briefly discuss the rest of it. Mental healthcare issues with the women veterans. There is a big problem there because inpatient care for them, they are basically in with the men and it is hard for women to talk about military sexual trauma, spousal abuse, et cetera, and feel comfortable. The VA needs to get a lot more gender-oriented when it comes to women, especially with the

mental healthcare problems. When you take PTSD and military sexual trauma, they have very few, if any, clinicians—can't pronounce it—any qualified medical people that handle it that can handle both at the same time because it is a concurrent treatment. So, they do have a special problem there.

In the last 15 years, the VA, especially here in Maine, has come a hell of a long way with the Women Veterans' Clinic and their issues, regular veterans and their issues, but their hands are tied and they have been tied because of funding. They'd do a lot more with the buck they get, but they need the funding to be able to take care of these rural issues. And if they do not have sufficient funding there when the government year begins, and not 3 to 6 months later when Congress finally gets off its duffs and votes for a budget, you won't overcome any of these problems.

In closing, I would like to thank you, and I am open to any questions.

[The prepared statement of Mr. Wallace appears on p. 56.]

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

Mr. Wafford.

STATEMENT OF JOSEPH E. WAFFORD

Mr. WAFFORD. Good morning, Mr. Chairman, Congressman Miller and Congressman Allen. The DAV would like to thank you for inviting us to today's field hearing of the Subcommittee. DAV is a national veterans service organization representing 1.3 million members and is dedicated to rebuilding the lives of disabled veterans and their families.

The topics before the Subcommittee—women, rural and special needs veterans—are of acute interest to DAV both in Maine and nationwide. With the adult population of 970,000, Maine is home to 155,000 veterans who constitute 16 percent of our adult population, among the highest proportions in the State, in any State. In regard, we urge the Subcommittee to swiftly consider and approve H.R. 4107, the "Women Veterans Health Care Improvement Act," offered by Representative Herseth Sandlin and Brown-Waite, 2 Members of your Committee.

We are seeing a large number of rural veterans, both men and women, coming home from these wars with severe injuries and illnesses as we see today. Therefore, we are pleased that the Subcommittee is turning its attention to these issues, and urge you to maintain a strong focus.

As you know, VA operates a major regional medical center in Togus. It opened in 1866, and Togus is the first national home for disabled volunteer soldiers. Today, Maine's only VA Medical Center plays a major role in the community and State, providing medical, surgical, psychiatric and nursing home care. It is also a civilian employer, significant in Augusta.

The VA also operates community-based outpatient centers which have been attested to many times today. Mr. Chairman, as you know, the VA had planned to open a CBOC in Dover-Foxcroft, but those plans were shelved due to an insufficient veteran population base to support a full-time clinic.

The DAV believes that area still needs the VA's attention as it is very rural. And we highly recommend that Togus provide a sat-

ellite van or a portable physician office to serve veterans in that area. And once the veterans in the Dover-Foxcroft area become aware that the VA has established a healthcare presence for them, even on a part-time basis, this may help justify a full-time clinic at a later date in that community. And then that will allow the portability of the van to travel to other areas, other rural areas to provide service, and leave Dover-Foxcroft as a storefront operation, per se. We appreciate the Subcommittee making that recommendation to the VA.

According to VA, in 2006, latest information available, inpatient admissions to the VA healthcare facilities in Maine totaled 1,696, while outpatient visits reached 325,000. Also, 17,474 veterans 65-years of age or older that received healthcare from the VA in 2006.

Mr. Chairman, in Maine, more than 1,400 active-duty servicemembers and veterans of the Global War on Terrorism have sought healthcare here. Many veterans from the conflicts in Iraq and Afghanistan have visited our Vet Centers throughout the State.

The State of Maine operates 6 veterans homes, as you have heard earlier. One difficulty, however, that concerns us in the State homes, they do not provide a rehabilitation or convalescence capability. Given to our elderly population that needs these State homes, could offer veterans a greater new service if they embrace a rehab/convalescence mission in partnership with the Togus VA Medical Center. Many veterans that are in inpatient care at Togus live in Bangor or Caribou and other communities at a great distance.

In general, the current law limits the VA in contracting private healthcare services, entrances providing necessary, the VA facilities do not have the capability. And we feel that fee services and contracting are a good way to go. But beyond these limits, there is no general authority, though, in the law to support a VA—a broad VA contracting for an oversight, which needs to be addressed.

We believe the best course for most enrolled veterans in healthcare is to provide continuity of care in facilities under the direct jurisdiction of the Secretary of Veterans Affairs. And aside from these concerns, we know the VA's contract workloads have grown significantly.

The VA must ensure that the distance of travel be addressed because it does provide hardships in the face of consideration in the VA policy. VA must fully support the right of rural veterans to healthcare and insist that funding for additional rural care and outreach is appropriated for that purpose. Mobile Vet Centers should be established, or at least on a pilot basis, to provide outreach and counseling.

Recognizing that in areas of particularly sparse veteran population, the absence of VA facilities, the Office of Rural Health should sponsor and establish demonstrated projects with available providers of mental health and other health provided services to veterans, taking care to observe and protect the VA's role as coordinator of care.

Again, Mr. Chairman, most of this is provided in my legal or written testimony, and most of these recommendations are clearly applicable to our State. On behalf of *The Independent Budget*, we

hope that the Subcommittee will address these recommendations in oversight and further legislation, if needed, to ensure that they are implemented. Rural veterans, whether in the State of Maine or elsewhere, deserve access to quality VA healthcare, despite obvious changes and challenges we face in providing it.

Mr. Chairman, this concludes my testimony and I will be pleased to consider your questions on these important topics.

[The prepared statement of Mr. Wafford appears on p. 59.]

Mr. MICHAUD. Thank you very much.

Once again, I would like to thank all 4 of our panelists, not only for your testimony here today, but also for your service to this great Nation of ours.

I have a couple of questions I know some of you mentioned the CARES process. You wanted the Committee to move forward on the Dover-Foxcroft facility. Actually, we did pass a piece of legislation that required the VA to submit a business plan for the Lewiston/Auburn CBOC, the Houlton facility, as well as the Dover-Foxcroft facility within 180 days after the enactment of the legislation. The whole facility, I am sure the Togus director will probably talk about that, is moving forward. The Lewiston/Auburn CBOC, actually that's down in the central office in the VA, and they are looking at that as well as—I haven't heard anything about the Dover-Foxcroft facility.

As you know, we have a lot of issues before our Committee. The CARES process is part of it, dealing with women's healthcare issues, dealing with the Montgomery GI Bill, dealing with the traumatic brain injury, post traumatic stress disorder, just so many issues that we have to deal with and such a short time to deal with them.

I guess my question would be to each of you, if we had to focus on the top priority that is a must for Congress to pass this year, what would that top priority be for your different organizations?

We will start over here.

Mr. WAFFORD. Under rural healthcare, probably the satellite van should be a significant push because that will enable to touch more veterans. Similar, the DAV has a mobile service office to provide outreach to veterans that don't have the access or capability of coming to us, we go to them. And I think the VA should probably do the same, sir. Thank you.

Mr. MICHAUD. Mr. Wallace.

Mr. WALLACE. The speciality care to the clinics that are already in place, specifically orthopedics and dermatology. We, the Vietnam veterans, are now the older generation, and those seem to be the needs as we get older.

Mr. BACHELDER. Medical staff, because if you don't have the medical staff, then you can't have the appointments. And I think that is one of the biggest problems we have here in Maine, trying to find professionals to come in and take the positions so that the appointments can be set.

Mr. SIMONEAU. I still believe that it comes down to the CBOCs. We need to have the community-based outreach. We need those veterans to be able to go locally and get the help they need, whether it is in a time of crisis or whether it is in a time of just a check-up. But they need to know that locally they can turn someplace.

And if we cannot fund these CBOCs, then we need to find a way to fund it so that these veterans can get the help they need urgently at that moment they need help, not to be told, well come see me in 3 weeks or 6 months.

So whether it is a CBOC or whether we loosen up some way of funding for local doctors to help these people, we have to do this. We have to get the help to the veterans immediately, not postpone it.

Mr. MICHAUD. As you well know, we have heard a lot about rural areas and providing healthcare, and some of your organizations support more contracting out. When you look at the healthcare shortage we have here in Maine and all across the country, there is a healthcare shortage. There are not enough providers, whether they are Federal, State or private facilities.

Are there any concerns that your organizations would have as far as dealing with non-VA providers treating veterans, or is it only under certain circumstances should they contract out? I know some of you addressed that earlier, but if we can actually have each one of you address that.

Mr. WAFFORD. Yes, sir. I do believe fee service is a needed item and a plus for the VA. I do believe in cost control, monitoring. VISN 1 had a problem at one time, they over-contracted. So, it can be used and it should be used on a case-by-case basis, depending upon the individual's needs and the availability of the services.

As you know, Maine has no medical school. We have no "ologies" or "ologists" available to us on a rotating basis in this State. We have to go out-of-State. And that creates a very tough time for the director to get qualified individuals to provide healthcare at Togus. So, I do believe the fee-basis is a way to go to help alleviate the backlog.

Mr. MICHAUD. Mr. Wallace.

Mr. WALLACE. I believe fee-based—whoops. I believe fee-basis is a way to go, but there have to be some limit put on it. There has to be a proven track record. You can't just fee-basis out to every doctor out there. Most of our clinics are near a local rural community hospital. Maybe fee-basis with that hospital, at least those doctors will have a proven track record.

But the VA, if we do go that way, would also have to open up our medical records to those doctors so that unnecessary medical tests don't have to be repeated again, and those doctors will have a complete history of the veteran and not have to take it again. And also, the biggest problem with fee services in the civilian part of it is a lot of the civilian doctors don't understand the type of sicknesses we have, whether it be mental or physical. So, they have to be educated in that, and that is part of the thing the VA would have to do.

Mr. MICHAUD. Mr. Bachelder?

Mr. BACHELDER. A couple years back, we had a problem with the urology because they had a piece of equipment that needed to be calibrated. It was so old that the manufacturer said that the equipment shouldn't be calibrated, it should be replaced. The cost of sending the veterans out to have that service done outside was 4 times as much as it would cost to replace the equipment. With the help of Bill Vail, who is here today, his name was mentioned ear-

lier through Susan Collins' office, it was brought to the attention, the equipment was purchased, and we saved some money.

So fee-for-service is something that we need to help that veteran out in the middle of the countryside to get taken care of immediately, but we need to not disassemble the VA healthcare. We need to not take the funding necessary to make sure that the healthcare runs right because everybody is going to the local doctor and not being seen through the VA healthcare. It is a system that we have throughout the whole country. We need to fix it, not disassemble it. But fee-for-services does have the necessary time period where the veteran needs to be cared for.

Mr. SIMONEAU. Once again, CBOCs, fee-for-services. I think Mr. Bachelder made a very poignant point, and that is if we take all the money we use and we spend it on fees for other doctors, we are taking away from the VA system and the VA hospital that is a vital part of that network. We can't do that in order to do the fee-for-service, because we still have needs at that hospital that are way beyond anything that local doctors would have knowledge to or knowledge of.

So fees for service for the certain items, absolutely. For emergency items, absolutely. But we have to be very careful on how we use it, when we use it, and where it goes.

Mr. MICHAUD. Thank you. Mr. Miller?

Mr. MILLER. Thank you, Mr. Chairman. I understand not wanting to take money away from the VA system, but in a particular area such as Maine, it is so expensive to build a community-based outpatient clinic, and I am a big proponent of those. VA at one time was very central in their thought, they wanted everything to go to huge medical centers, and we are doing what we can to try to change that process within the VA program.

I think we just have to be very careful as we are looking at how to provide these services that we spend what little dollars are there as wisely as we possibly can. The dollars are there in Washington to do the job. You know, we are spending money on things that many of you in here, and both sides have done it in the past, where we probably should be spending money on them in our Federal role. We have needs right here in our own country that need to be done.

Mr. WALLACE, I am particularly interested to talk about the rural—rural healthcare. The mental healthcare that is being provided, the telemental health, how are veterans taking to that? There are a lot of people out there who have kind of shied away from that, and they don't want to do these things via the telephone, they don't want to do it via the Internet, they don't—you know, they feel like they have to be sitting right across from somebody.

How is that being received by the veteran population?

Mr. WALLACE. Well, I've got extensive knowledge on that. A little over 4 years ago when they pioneered it up in Caribou, the 2 social workers that were handling it retired suddenly. So, I volunteered and I took it over for almost 2 years. In that 2 years time, 3 veterans didn't like it, the rest did. And when the VA upgraded the equipment they had there so you actually sit in front of a wider TV screen that's crystal clear, you get the impression you are there with the doctor.

And the fact that they don't have to travel 250-plus miles to get there. Basically, the way that I can explain that, the veteran was traveling to Togus to see a psychiatrist, all uptight and wound up. Spent 20 minutes with the psychiatrist, got calmed down. And then got all uptight and wound up to travel home 250 miles. It was defeating its purpose. Now the longest they travel in Aroostook County is about 60 miles.

Now, in the beginning when the VA went to the CARES and they said 30 miles or 30 minutes, at the VISN level meeting at the BigMac, I said that don't apply to Maine. More like 60 miles, 60 minutes would fall in for us. Our road system doesn't go in a straight line. The VA figures things out from Togus, say, to Madawaska using the road going up there. But in the wintertime, they don't travel Route 11. They take the longer way around. Also, they take the longer way around in the spring and the fall so they don't lose their life hitting a moose or a deer.

Mr. MILLER. If you need help thinning out the moose and deer herd, I volunteer.

Mr. WALLACE. Well, there's over 100 of them dead along 95 now because they are out there eating.

Mr. MILLER. Mr. Wallace, I have also found in my 24 hours here that even your straight roads aren't straight.

I yield to my colleague, Mr. Allen.

Mr. MICHAUD. And Mr. Miller and the staff had a great opportunity to see what the potholes were like as well.

Mr. WALLACE. Do you really like that Moxie? Because I don't.

[Congressman Miller held up and crushed the empty Moxie can.]

Mr. BACHELDER. Mr. Chairman, the one thing that I wanted to also comment on was that the travel pay, when I went up to Togus a week ago, the deductible was increased also. I appreciate your looking into it.

Mr. MICHAUD. Yes, and that's one thing. I know the Secretary told the Committee that it is waived, and Mr. Miller had mentioned that there was a letter or a memo saying that the Secretary misspoke. Actually, we haven't seen that memo, so we will definitely want to look at that memo. That was not the intent.

Mr. WAFFORD. Yes, sir. It is waived on a case-by-case basis is what came down from the national headquarters, sir.

Mr. MICHAUD. Mr. Allen?

Mr. ALLEN. Thank you, Mr. Chairman. I have just one question for all of you.

What do you hear about traumatic brain injury or PTSD from the members of your organizations? I mean, can you just give us a flavor of problems you may see, just a fairly concise statement about what it is you are hearing these days about those 2 kinds of injuries.

Mr. WAFFORD. Yes, sir.

Mr. ALLEN. You know, what we need to do about them.

Mr. WAFFORD. The DAV, we have done—we have partnered with a lot of other organizations on these issues. We also feel that they are so intertwined at times, they cannot be separated. And with the rating system designed like it is, it is a 10 percent rating under Diagnostic Code 8517. So, that limits the amount that a veteran

may be rated unless it is rated under the residuals of a traumatic brain injury.

We need to look at the rating schedule. We need to—we need to separate it out. I understand about pyramiding where you cannot rate a condition on top of a condition if it is in the same area. But TBI is definitely intertwined with this, and we need to re-look at the rating schedule on that.

I just had a young man call me from Walter Reed last week. He came home to Sabattus on Tuesday. He has been in Walter Reed for the last 10 months. He is waiting on his Medical Evaluation Board (MEB) to be finalized. So this young man's coming home for the help under the Wounded Warrior program. He will be getting some treatment at Brunswick Naval Air Station, but they are very limited. So he will have a problem with this traumatic brain injury getting services through Togus because he is not discharged.

Mr. ALLEN. I think he is the young man I saw at Walter Reed.

Mr. WAFFORD. It may have been, sir, because he did say he was in touch with our Congressional, and I advised him to come and see me this week.

But he is a very good case to base the TBI on where he has had treatment and we are trying to get him converted over. He hasn't been totally discharged yet. We need to do the continuity of care. But when the VA gets to rate this young man's case, you know, he deserves more than 10 percent under that diagnostic code. And so, yeah, we do. And they look under that diagnostic code, PTSD is one of the things that are listed in there. We need to break it down, we need to upgrade 38 C.F.R. § 4.71. Thank you.

Mr. ALLEN. Mr. Wallace?

Mr. WALLACE. At the last BigMac meeting in Bedford, Mass., they gave us a thing on traumatic brain injury and what the VA is doing now. They asked them I believe it was 3 or 4 questions, and if they can answer yes to those 3 or 4 questions, they are then treated for traumatic brain injury instead of PTSD. The biggest thing I remember when they said that, I asked them—I said, then what are you doing about those Vietnam veterans because I can answer yes to all those questions. Does that mean I have been misdiagnosed all these years? They've got a long way to go.

Mr. ALLEN. Jim?

Mr. BACHELDER. The VFW, along with all these other organizations, if you read their magazines, they are very concerned about traumatic brain injury. The post traumatic stress disorder is life-threatening to the individual if suicide is an active symptom. Traumatic brain injury is life-threatening just in itself because if it is not diagnosed, the brain can have problems, swelling. It could be caused from other things, of actual bone material that has broken from these bombs that we have that is causing it.

So, it is a major concern that the Department of Defense has not built a clinic, is not examining these individuals to find out that they have a medical problem, they are not being diagnosed, it can end their life. And we need the Department of Defense to take responsibility to make sure that these individuals that have been through these roadside bombs, that—and it could be from not just that, it can be just from being in an explosion from a grenade or a missile that came by you that could cause a brain injury that will

end your life when you come back home. And where is the responsibility for the military to care for these individuals before they are being released?

Mr. SIMONEAU. Traumatic brain injury is something new. It is something that we have dealt with for years, but we haven't seen in the proportions that we are today. Traumatic brain injury/PTSD are 2 separate items, but they are linked. We need to make sure that the VA and the Department of Defense take a very close look at this because this traumatic brain injury is something that is just hiding behind that person, and we never know where that is going to be. We need to step forward. We need to make sure that these young men and these young ladies that are dealing with this are taken very good care of.

It is hard to admit, anybody, that they need help. It is hard for any of those soldiers to say I have had some things happen to me. But if you look at the past record, whether it is a Vietnam veteran or whether it is a World War II veteran, or anybody else, when they come home they want to go on with life. They don't want to say, I've got a problem. We have to reach out. We have to make guidelines that they fit and guidelines that work for it, and I believe that's a way to start. Thank you.

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

Mr. MICHAUD. Thank you. Once again, I would like to thank all 4 of you for your testimony this morning and thank you for your service to this great Nation of ours. Thank you.

Our last panel is Brian Stiller, who is the Center Director for Togus Medical Center, the Department of Veterans Affairs. I want to thank you, Mr. Stiller, for coming here this morning. I look forward to your testimony. I know you have only been at the VA for a year or a little less, so welcome to Maine.

**STATEMENT OF BRIAN G. STILLER, CENTER DIRECTOR,
TOGUS VETERANS AFFAIRS MEDICAL CENTER, VETERANS
HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS
AFFAIRS**

Mr. STILLER. Thank you, Mr. Chairman, and Members of the Subcommittee. Can you hear me? Is this on? There we go. Thank you very much.

On behalf of the employees and the volunteers at the Togus VA Medical Center and its outlying clinics, I thank you for the opportunity to discuss the care and services we provide Maine veterans. I will focus my remarks today on our ongoing efforts to improve access to care in a largely rural setting with an emphasis on meeting mental health and women veteran healthcare needs.

It is important to recognize that since 1999, we have grown from 19,000 veterans to 52,000 enrollees, with 38,000 of those enrollees accessing our VA healthcare system. Today, those veterans receive their care at Togus and 6 community-based outpatient clinics. These clinics are located in Bangor, Caribou, Lincoln, Calais, Rumford, Saco, and a part-time access point in Fort Kent. The new Bangor clinic plans include physical therapy, dental, optometry, radiology, part-time limited specialty services, as well as compensation and pension rating exams.

In addition to the Medical Center and its outlying clinics, we further provide care in rural and residential settings using home-based primary care. We have home-based primary care teams operating out of Togus in Portland. The home-based primary care teams provide primary care, nursing, social work services to the veterans with complex chronic diseases who are seeking to maintain an independent living situation. New home-based primary care teams are authorized for Caribou and Lincoln, and recruitment for these new positions is ongoing.

Togus leadership is working on the newest approaches to improving access as exemplified by the establishment of the VA Office of Rural Healthcare. We are working with the Office of Rural Healthcare to identify and address the needs and challenges of providing healthcare in rural areas. The Office of Rural Healthcare is leveraging rural health expertise from public and private sectors and is working on several rural health initiatives.

While recognizing our efforts to expand rural healthcare access, we also need to further improve and expand access to qualified healthcare professionals. Working with community educators and healthcare providers, Togus is recommitted to enhancing existing affiliations with State and national medical educational facilities, as well as establishing new affiliations. In October of 2008, we plan to host a "Medical Education and Research" symposium for medical education, healthcare and research organizations.

At Togus, we are using technology to improve access for rural veterans as well. We are currently providing 150 veterans with adjunct care via home telehealth. Staff use these devices to review medication, assess wounds, complete psychosocial assessments, and conduct follow-up reviews for medication changes. These devices provide timely, accurate data to provide healthcare while minimizing veteran travel.

Togus continues to be a leader in healthcare by identifying and employing new technologies. Maine recently received a \$25 million dollar Federal grant to develop telemedicine services throughout New England. Togus is coordinating with other Maine healthcare organizations to determine how best to further deploy and utilize this healthcare technology.

I would like to proudly share with you some of our accomplishments and successes in mental healthcare. Through the VA Mental Health Initiative process, during the period of fiscal year 2004 to fiscal year 2007, our mental health staff grew from 54 to 74, an increase of 39 percent. With additional staffing, we are able to provide better access to veterans and develop new programs in the areas of treatment.

Care for veterans in rural Maine improved with all our northern CBOCs having telepsychiatry connectivity and many having in-home videophone connections. All Maine CBOCs have an on-site specialized mental health provider, and mental health clinics are located in Bangor and Portland. We strive to provide intensive specialized mental healthcare and residential support for veterans in rural areas, particularly homeless veterans, those in extended PTSD treatment, and those with substance abuse problems.

To better serve OIF/OEF combat veterans, Togus reorganized its PTSD program into a 1-week intensive outpatient program. This

program utilizes a new evidence-based treatment that focuses on the needs of new veterans who have careers, families, and cannot attend a longer program. It provides a basis for follow-up care as necessary. This program is well-received with very favorable feedback. Moreover, 2 programs have already been conducted solely for women veterans to appropriately support their needs.

Women comprise about 14 percent of the active duty, Guard and Reserve forces with approximately 1,700 Maine women veterans receiving VA healthcare. Togus' women's clinic provides primary care, gynecology, and mental health services. Maternity care is provided via fee-basis by a community provider of the veteran's choice. Mammography is provided via fee-basis at any FDA approved site.

The VA has 2 performance measures which are specific to women's healthcare: Breast cancer screening and cervical cancer screening. In both of these measures, Togus exceeded the national benchmark. Veterans are surveyed with a clinical reminder regarding military sexual trauma and treatment services are available through Togus, CBOCs, Vet Centers and fee-basis as appropriate.

We have plans to purchase additional equipment to expand care for women veterans this year. VISN 1 is evaluating women's healthcare educational and equipment needs at CBOCs with the goal of providing increased access to routine gender-specific healthcare. Togus has a dedicated women veterans program manager. And to enhance their outreach efforts, Togus hosts an annual Women Veterans Information Fair and hosts Women Veterans of America meetings.

Mr. Chairman, as you know, I am relatively new to Maine. But as I have shared before, I remain impressed with the work being accomplished by the veterans organizations, the Maine National Guard, and other State programs. I look forward to continuing our work with them to better serve Maine.

Mr. Chairman, we must continue to closely monitor and meet the needs of Maine veterans. Our veterans have earned the right to the best care available, and it is our privilege to provide them with that care. We appreciate your interest and support in helping VA to successfully accomplish our mission of providing world-class care to all of those who have so honorably served our great country.

Thank you.

[The prepared statement of Mr. Stiller appears on p. 62.]

Mr. MICHAUD. Thank you very much, Mr. Stiller, for your testimony.

We appreciate all the work that you are doing and have done for our veterans both at your previous job and here at Togus.

I know Mr. Miller has a flight that he has to catch, so I will recognize him first for questions.

Mr. MILLER. Thank you, Mr. Chairman. I actually have a quick stop at Portsmouth first, the Naval Shipyard, and then on to the airport. So, if I do step out, it is not because I didn't want to stay through the entire hearing. I thank you for the invitation.

Mr. Wafford, from DAV, expressed concern about the CBOC not being constructed in Dover-Foxcroft. What are you doing in regards to access to healthcare for people in that general vicinity now?

Mr. STILLER. Currently, Mr. Congressman, we have put forth a series of plans which would include Farmington as well as a num-

ber of other areas, as well as Lewiston-Auburn (LA), and that gets into the circumference area.

And one of the other things that we are looking at is we have recently applied for a grant, and we are waiting to know if we have been approved, to go to a mobile clinic. What we want to do, as we have had success in the past with mobile clinics, is use the storefront approach coupled with that mobile clinic to address the needs of the veterans in that area.

Mr. MILLER. I know one of the biggest needs in rural healthcare is recruiting physicians and healthcare professionals into the area. Do you find the same problems here? What are you doing or what is the VA doing, I guess, to help overcome these obstacles?

Mr. STILLER. Well, I think larger—I can't speak to VA other than from my experience in VA, and that obviously the recent pay changes, Physician Pay Acts have helped significantly.

What we have done locally is we have actually employed a Title 38, if you will, headhunter recruiters I call them. And we also have 2 contracts now since my arrival that address the challenges of recruiting the specialty care providers.

I think it is incumbent on us in the State of Maine, as far as the Veterans Healthcare System, to educate the future students. So, affiliations is going to be a huge piece of this. I have been quoted as saying, "We want our medical center and CBOCs crawling with students." Obviously, it is part of our mission, and I think we have great opportunities to bring those future healthcare providers in and entice them into the practice of rural healthcare.

Mr. MILLER. I think you said, you talked about having students all over the campuses. One thing that the statistics do show is when medical students come to an area to do their residency and do some of their original practice work, they stay there.

Mr. STILLER. Yes.

Mr. MILLER. That is something that I know Maine will want to look forward to as well.

You've got an opportunity to take a shot at any one of us up here. Is there anything that Congress can do? I mean, obviously everybody is saying give more money, appropriate more money, but from the standpoint of outreach, what else can we do to help you reach out to the veteran population?

Mr. STILLER. Sir, I think that is an awesome question because right now our big stress, at least in the State of Maine, is we have a great relationship with the National Guard and getting to these young men and women who are coming home. We are there when they muster out and when they return from deployment.

Where we run into difficulties is with the Reservists. The young men and women who come home with the Reserve, we do not have one central contact that we can go to to find out when these units return to their drilling areas. So, if we had one central contact for the State of Maine, and it may be the same in other parts of the country, that would be extremely beneficial.

Mr. MILLER. Thank you.

Mr. MICHAUD. Mr. Stiller, just to follow-up on that.

Mr. STILLER. Yes, sir.

Mr. MICHAUD. We heard a lot this morning about the CARES process and how that would actually help with a lot of the prob-

lems that we have been hearing about veterans getting access to the care that they need, and you mentioned Dover-Foxcroft, Bangor.

Where does Togus, the remaining clinic that was recommended in the CARES process, how far along are you with moving that process forward?

Mr. STILLER. Right now, sir, as you know, we have submitted the LA, and it is in headquarters, and I believe it is going across the street to the Office of Management and Budget, as I understand. We are in the process, the first step of seeking a contractor for the Bangor replacement clinic. As I said, we are in a 2-step process for, first, applying for the grant, if you will, for the mobile clinic. But then the storefront for Dover-Foxcroft will be separate. The other ones are still in the planning stage and have not been submitted up the ladder, if you will.

Mr. MICHAUD. You have heard earlier as well, it is very important for the different VISNs to move forward projects that they need, and ultimately it is up to Congress to provide the adequate funding.

How do you go about the process of moving up to the VISN level? Will you be able to get everything you need here for Maine to take care of our veterans, or is there push-back from the VISN 1 level?

Mr. STILLER. No, sir. Actually, VISN 1 has been extremely helpful in helping us complete the financing, complete the business plans because of the technical acumen that is needed to complete these plans. So, they have been very successful and there has been no dropping off, if you will, and repeating them.

Mr. MICHAUD. Is the VA/Togus looking at expanding specialty services and inpatient services at Togus to a full tertiary care facility for our veterans?

Mr. STILLER. I know that we have opportunities to continue to expand specialty care within Togus. I think what we have to balance is the number of surgeries. I am not a medical professional, but in my training there is a certain amount, a certain number you want to hit for proficiency. We are trying to take care of all of the key ones such as urology, neurology, and then the more specialized services are better accomplished in Boston or Maine Medical or wherever we can purchase it.

Mr. MICHAUD. Would you provide to the Subcommittee how many veterans you are moving to or shipping to Boston for services at a later date?

Mr. STILLER. Yeah, I can get you the exact number, sir. I don't have that on the top of my head.

Mr. MICHAUD. And what type of services that they are going to Boston for.

Mr. STILLER. If I could, I would like to get you the exact pieces of that. I don't have that with me.

Mr. MICHAUD. No problem.

[The information from VA follows:]

Question: How many patients are being sent to Boston VAMC and Massachusetts General from Togus VAMC? (VHA)

Response: In FY 2007, 37,796 patients received healthcare services at the Togus VAMC. During this same time period, Togus VAMC sent 1,096 patients to the Boston VAMC. Togus VAMC does not refer patients to Massachusetts General Hospital.

Question: What types of services are being provided via fee basis at these hospitals (Boston VAMC and Massachusetts General)?

Response: Togus VAMC fee bases out gastroenterology, urology, cardiology and audiology to Maine Medical and Eastern Maine Medical Center. Patients are also referred to Boston VAMC as clinically appropriate. Togus does not fee out or refer patients to Massachusetts General.

Mr. MICHAUD. And my last question is, can you tell me what the hardest female medical service is for your agency to provide rural healthcare needs for our female veterans?

Mr. STILLER. I think that it would be the specialized care, and not any different than the private industry and that gender-specific specialized care. I have Dr. Hayes in the audience. She may be better able to speak to the specifics. The specifics, well, for the gender-specifics as you get further into rural America, it does get difficult.

Mr. MICHAUD. One more issue, actually. We just established the Office of Rural Health. How closely have you been able to work with the Office of Rural Health, and have they been responsive? Should we look at additional help in that office in your opinion?

Mr. STILLER. They have been really responsive. Sir, just anecdotally off to the side, after we had talked about—after you had visited the Medical Center and we had talked about the importance of reaching rural veterans, I had the luck of going to a training class and meeting Kara Hawthorne, the new director, and approached her. At the same time, your letter hit her office. So, we have begun a good dialog and we continue to—in fact, we are going to meet today to talk about some interesting things that we are going to try to accomplish.

Mr. MICHAUD. Mr. Stiller, thank you very much. Mr. Allen?

Mr. ALLEN. Thank you, Mr. Chairman. Thank you, Mr. Stiller, for the good work you are doing, and I was very impressed when I was last up there.

How many counselors do you have doing military sexual trauma issues?

Mr. STILLER. We have one major military sexual trauma coordinator who then, as I understand it, we provide the specialized training to the primary care physicians and the mental health providers to cover it. And so, like, in the CBOCs to be in the position to provide the services that the veterans would need.

Mr. ALLEN. And is it one person?

Mr. STILLER. One person initially coordinates it, and then there is a training template and there is an intensive training program.

Mr. ALLEN. And she does the training of the physicians who provide the care?

Mr. STILLER. As I understand it, sir, yes.

Mr. ALLEN. Okay, thank you. Lots of people sat at that table today and testified. Was there anything that you heard that you need or want to respond to to shed more light on, or was there anything that struck you in terms of the testimony that you wanted to comment on?

Mr. STILLER. I was pleased by the testimony. The one thing I am curious to continue to work on is that's the access. Access is critical. But the challenges we face in rural healthcare is availability, the specialty doctors. And I think the best way for us to address that is through bringing more education programs and affiliations

into the VA Medical Center at Togus, and we will see significant improvement in the areas of access.

But compared to where we were 3 years ago, which was some of the time lines, I am not quite sure that they would find that same experience. We do have some areas where we certainly will improve. But overall, it has been looking pretty promising in my opinion.

Mr. ALLEN. Well, all I want to say on that conclusion is, I remember what it was like when I was first elected, and let's just say relations between Togus and the VSOs were stormy. And I understand that the funding was inadequate and we were being squeezed, both at the Federal level and by the VISN. And a lot has changed.

Mr. STILLER. Thank you, sir.

Mr. ALLEN. Thank you very much for your testimony, and I would like to thank everyone else as well.

Mr. STILLER. Thank you, sir, for your support.

Mr. MICHAUD. Once again, Mr. Stiller, I want to thank you for your service to the country, but also thank you very much for what you are doing at Togus. I know you have only been there a short while, but from what I have seen so far, you are definitely a go-getter. You think outside the box. And as I told the Secretary at the beginning, your performance has been great.

As you heard testimony as well from the VSOs here this morning, there is still work that has to be done with access issues. Part of it you can do. I think part of it has to be on Congress to make sure that we do provide the adequate funding for VA healthcare, but also make sure that it is in a timely manner. That is our job, and we will do the best job that we can. We will continue to work with you and your staff, and we want to thank your staff as well for all the hard work that they do.

Once again, I want to thank Congressman Miller for his time and willingness to have a Congressional hearing here in Maine. I hope that you enjoyed your Moxie. We have some more available for you for your flight back to Florida.

I also want to thank Congressman Allen for his time and effort to come out this morning, and especially for the audience. We look very much forward to working with each and every one of you, especially the Office of Rural Health in dealing with issues for access. I want to thank Kara for your time coming up here as well. Hopefully you heard a lot from our veterans here today, and look forward to working with you and Mr. Stiller to make sure that every veteran has the opportunity to access good, quality healthcare when they need that healthcare.

So, once again, thank you everyone. This hearing is adjourned.
[Whereupon, at 12:27 p.m., the Subcommittee was adjourned.]

A P P E N D I X

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

The Subcommittee on Health will come to order. I would like to thank everyone for coming today.

Today, we will examine the Department of Veterans Affairs programs regarding rural veterans, women veterans, and other special needs populations.

I am very happy to be here in Sanford, Maine, this morning. Sanford is the home of longtime veteran advocate, and someone who I was honored to call a friend, Roger Landry. Roger worked in the legislature and in the VSO community here in Maine and was very well liked and respected by all. Roger served his country and his community with great pride and honor. Roger died last year and he is sorely missed. I would like to dedicate this hearing to Roger Landry in honor of his work with and for veterans.

It is appropriate that we are having this hearing in my home State of Maine this morning. Maine is a very rural State and because of this we face many unique challenges in providing health care to our veterans. Many have to travel long distances for care, creating a significant burden for veterans and their families.

The VA has instituted some innovative programs to provide much needed services to rural veterans. I look forward to hearing from our panel today about their ideas to improve access and decrease the travel burden for our veterans living in rural communities across the United States.

At this hearing, we will also hear about women veterans. Women make up about 14 percent of active duty military, and consequently they are making up more and more of our veteran population. Women have some unique health needs. I look forward to hearing today about the unique needs of women veterans and to hear ideas about how the VA can improve their services targeted at women.

When the United States made a commitment to care for veterans, we made the commitment to care for all veterans—male and female, urban and rural. Today, I hope that we will learn how VA is meeting the needs of these populations, what challenges are on the horizon and what we can do to provide these veterans with the best possible care available.

Prepared Statement of Dana Doliber, Sanford, ME (Veteran)

In 1971 in an attempt to address increasingly debilitating mental health circumstances I sought assistance from the VA at Togus VA Hospital. While there I filed a claim for what was termed then as a “nervous condition”. Associated with the “nervous condition” was a record of poly substance drug abuse. The emphasis that the VA chose to take was to emphasize the poly substance drug abuse as the cause of the “nervous condition” which they were incorrect as the poly substance drug abuse was an attempt at self-medication on my part to try to deal with my so called “nervous condition” as it was called as there was no terminology of PTSD at the time and interestingly enough while at Togus VA the emphasis on treatment besides group and individual psychiatric therapy was drug therapy with Thorazine, Elavil and a host of other mood altering drugs. My claim was denied. In 1985 after losing my first marriage and coming close to losing my second marriage, at the pleading of my second and present wife, many jobs and the loss of many, if not all friends and abject social isolation, recently being laid-off from my job and trying to work at the Navy Yard at Kittery, Maine, in the apprentice program, my depression reached an unbearable point where on the urgent request of my wife I sought help from a counseling service in Sanford and began seeing Mr. Robert Paige, LCSW.

I was diagnosed with PTSD at that time and upon seeing Dr. John Scammon, Psychiatrist at the counseling service, who concurred with Mr. Paige's diagnosis. Upon seeking assistance from the State of Maine Veterans Service Representative, Mr. Campbell Colton, a claim was filed with the VA at Togus VA Regional Center.

Subsequent claims for medical conditions, all service connected, were filed in later years. From 1985 to 1992 claim after claim was denied. I provided documentation, ships' logs from my ship, USS *Richard S. Edwards* (DD950), USS *Newport News* (cruiser), USS *Saint Paul* (cruiser), USS *Collette* (destroyer) that not only detailed firing on coastal defenses, gunfire support missions, harassment and interdiction fire but of receiving fire from various units of the enemy both from Vietnam but also islands off of the coast of Vietnam and north of the DMZ. Letters from shipmates (buddy letters) were also provided that corroborated my previous testimony. Photographs were provided showing wounded being high-lined to hospital ships such as *Repose* and *Sanctuary*. Because the ships log was incomplete and inaccurate the VA used that as a basis for denying my claim. I had to further provide a stressor was the VA primary qualifier.

It reached a point that I felt that unless I had the serial number of the round going past that I would never win. There was even one occasion in the process that the VA paperwork reflected that I was in the Army in 1971 with a previous record of being in trouble with the law and trouble in school while being born on July 3, 1952. The opposite was the true story, I was born in July 3, 1947, was in the Navy and had no problems with the law or school. This was all in one document. Even though my brother had no claim filed with the VA, the VA had my brother and I mixed up. This dual portrayal was not designed to help my claim but to cast doubt on the validity of what the evidence was. On one occasion I had an interview with a Psychiatrist because the VA failed to provide him with stressor documentation I had already provided made an other than PTSD diagnosis but after the documentation was provided a panel of Psychiatrists, a diagnosis of PTSD was reached.

From 1992 to the year 2000 the claim was pursued for increased rating and retroactivity. The decision for that was reached in December 2000. This was agreed upon as a result of my agreeing to not pursue my claim of CUE (clear and unmistakable error) that were a result of the VA Togus previous rulings being thoroughly vacated by the BVA in Washington and the Federal Appeals Court for the VA. During this claim process and evidence gathering process I requested assistance from the VA in acquiring evidence. It is my understanding that if the veteran request side from the VA in seeking records the VA is supposed to help. This assistance was not forthcoming. As I understand it the VA also gives the veteran the "benefit of the doubt" and that if the VA cannot provide a preponderance of evidence to counter the veteran's claim then they must rule in the veteran's favor. This didn't happen. Only when I found out from a shipmate that we had been awarded the Combat Action Ribbon did the VA relent. From that point on it was a matter of my filing claim after claim for percentage increases and retroactivity. During that time I felt it was necessary to retain counsel but in 1998 due to changes provided by legislation provided by Congress the VA regs created a situation where I had to give up counsel and after a time I asked the AMVETS for their assistance.

It needs to be noted that during the time between 1985-2000 in pursuing my claim I received help from Senators Cohen and Mitchell and Representative Tom Allen, Mr. Robert Paige LCSW (counselor) and contacted to provide information Judge Greene, United States Court of Veterans Appeals, Attorney General of the United States Janet Reno, Richard B. Standefer, Vice Chairman Dept. of Veterans Affairs Board of Veterans Affairs and sought confirmation of ships' activity from the Republic of Vietnam office at the UN. When I was finally awarded the 100 percent P&T for chronic and severe PTSD I lost the percentages that I had for medical disabilities previously awarded and the disability for hearing loss was removed from my medical record I just recently learned after seeking again treatment for sores and skin rashes that I associate with Agent Orange exposure that I filed a claim for in 1991.

The VA acknowledges Chloracne and Acne form disease as indications of Agent Orange exposure but blue water Navy isn't acknowledged by the VA as being exposed to chemical agents while offshore. I would have thought that the VA could make the leap from "sores and skin rashes" to Chloracne and Acne form disease. Apparently they can't. In their most recent action in that regard titled: VA Adjudication Procedures Manual, M21-1; Rescission of Manual M21-1 Provisions Related To Exposure to Herbicides Based on Receipt of the Vietnam Service Medal an interesting item the VA uses to discount blue water NAVY from being exposed is that because chemical agents used as herbicides when heated as on board ship to desalinate seawater for drinking, cooking, showers becomes concentrated much more than when diluted in seawater. The VA position is that it doesn't know if ships used desalinators while at sea to convert sea water to fresh. This borders on ludicrous. There are ships systems that require fresh water, people require freshwater. The ship I was on operated in I Corps and north of the DMZ. I was there in 1967-'68. I Corp was one of the heaviest sprayed areas in Vietnam. The years of the heaviest

spraying for I Corps is 1966-'69. My ship was anchored in DaNang harbor and on one occasion went up river that is mentioned in the ship's log. The conclusion I would draw from this is that we were subject to exposure to chemical herbicide agents.

The VA has several areas it could improve: 1) Claim processing with and for the veteran; 2) Abiding by the law as passed by the Congress, is: the HAAS case be Proactive FOR Veterans; 3) Medical: There are 100 percent Disabled veterans that doctors have asked for tools from the VA Togus to help with medical conditions that are being withheld. Veterans that should receive the gold standard in medical care whether having heart surgery or colon cancer surgery or treatment for peripheral neuropathy, traumatic brain injury whether in West Roxbury, Togus VA Hospital or wherever. Be more proactive in the VA medical care of its veterans with regard to budget requirements. Provide counseling, in-house—to veterans just after surgery for rehab services. My own brother recently had colon cancer surgery and was sent home 5 days later instead of going to a rehab facility. While at home the following day with coughing and sneezing and throwing up, all his stitches broke and his guts came out. After being taken to a hospital after being stabilized he was operated on again twice. Once to debride and remove the guts to clean and put them back and a couple of days later to close the wound leaving a space for the wound to heal from the inside out. He is scared to death of going back to Togus VA but tomorrow morning the 18 of April he is going. He was told that if he didn't go to the VA hospital the VA would not pay for his hospital care. He also is 100 percent disabled.

It is my hope that by providing this testimony that it in some way it helps. Either the VA can provide some relief to its veterans or the ironclad legislation necessary to compel the VA to do what is necessary for veterans should be forthcoming. The VA history regarding Agent Orange and the HAAS case is yet another example of the VA shirking their responsibility to the veteran. Add to this the attempt of the VA, at present time, to reinterpret the DSM IV protocol for PTSD to the benefit of the VA and not the veteran demonstrates a level of hubris that is amazing. The 900 lb. gorilla in the room that may prevent any good coming from this is money or rather, the lack of it. America's veterans providing the freedoms that we have deserve no less than the full support of the VA. The American people understand the need to support our veteran population. Servicemen and women understand and expect that if they need help when they come home the help will be there. We should not disappoint them by a lack of action. The one thing I ask from this Committee at this time is their assurance there will be no retribution against me or my family by the VA regarding my testimony. I submit as well a copy of suggested legislation designed to address Agent Orange legislation for blue water Navy.

Thank You.

**Prepared Statement of Peter W. Ogden, Director,
Bureau of Veterans' Services, State of Maine, Augusta, ME,
and Secretary, National Association of
State Directors of Veterans Affairs**

Chairman Michaud, Congressman Miller, Congressman Allen and distinguished members of the committee, thank you for this opportunity to speak today on three extremely important issues for Maine's veterans; access to healthcare, women veterans, and outreach to veterans on their benefits. My testimony today comes from three perspectives: as the Director of the Bureau of Maine Veterans' Services, the Secretary of the National Association of State Directors of Veterans Affairs (NASDVA), and as a disabled combat veteran who uses the VA healthcare system in Maine.

We greatly appreciate the leadership of Chairmen Akaka and Filner, Ranking Members Craig and Buyer and the entire membership of the Senate and House Veterans' Affairs Committees for their past and continued support of our veterans and the VA. Because of the War on Terror, we are now serving a new generation of veterans while we are struggling to bring our elderly WW II and Korean war veterans into the VA system. The new veterans are going to need our help as they return to civilian life while our elderly veterans need primary and long-term healthcare. We believe there will be an increased demand for certain benefits and services and the overall level of healthcare funding must meet that demand while continuing to serve those veterans already under VA care.

Maine is a unique State in several ways: In 2000 Maine had the largest per capita veteran population in the Nation and is still at number two or three; the Togus Medical Center is the oldest VA hospital in the Nation; and Maine's aging veteran population is geographically dispersed across a large land area. We have a saying

in Maine, “ya can’t get there from here,” while you can get to the one VA Medical Center at Togus from about anywhere in Maine it can take you five to six hours to travel up to 260 miles to reach Togus.

Maine presently has the distinction of being the oldest State in the Nation with a median age of 40.6 years old.¹ When you look at the age of Maine’s veterans you will find that 65 percent or 93,780 veterans are aged 55 and older.² These are the veterans that are most likely to need and use the VA healthcare system. Access for Maine’s aging veterans is of extreme importance.

Any conversation about aging veterans and access to healthcare should include the importance of the State Veterans Homes program and the services they provide to our veterans in long-term, residential, skilled, dementia and respite care. Maine is fortunate that we have the Maine Veterans Homes with their six facilities spread across the State that provide the best care at the most reasonable cost. While Maine has the maximum number of beds available by VA demographics standards, many other States do not and Congress should continue to fund the State Veterans Home Construction Program until they have the capacity to provide long-term care to their veterans.

Maine’s aging veteran population coupled with our rural geography presents problems to elderly veterans trying to access VA healthcare especially in Maine’s severe winter months. Maine has a limited transportation infrastructure and this compounds the access issue. The CARES market plan (Far North Market) developed in VISN 1 recognized Maine’s unique geographic characteristics, limited transportation infrastructure and rural nature. The resulting CARES Commission Report made several points about access to VA healthcare in Maine (Far North Market) that are relevant to this hearing.

*“In the Far North and North Markets, less than 60 percent of enrolled veterans are currently within the VA’s access standards for hospital care. The CARES standard is 60 minutes for urban areas; 90 minutes in rural areas; and 120 minutes in highly rural areas. Inpatient medicine workload is projected to increase . . . The Far North Market has the largest projected increase, with 209 percent over baseline by FY 2012.”*³

*“. . . the Far North Market is currently below the standard for access to primary care. Currently only 59 percent of the veterans residing in this largely rural area are within the CARES guidelines set for access to primary care services.”*⁴ The CARES definition for “Access to Primary Care” is “70 percent of veterans in urban and rural communities must be within 30 minutes of primary care; for highly rural areas, this requirement is within 60 miles.”⁵

*“The VISN had proposed five new CBOCs, (Community Based Outpatient Clinics) all in the Far North Market. These new CBOCs would be located across Maine in order to improve access to care and thus address current deficiencies in access in this market. . . . These CBOCs are also crucial to the VISN’s plan to expand inpatient capacity at Togus, by reclaiming old inpatient space that has been converted to outpatient services.”*⁶

The following table shows the aging of Maine’s veteran population over the next 25 years. As you can see we will continue to have the majority of our veteran population over age 55 for many years to come.

Year	Veteran Population*	Veterans > 55	Percent of Veteran Population
2007	144,007	93,780	65 percent
2010	138,551	91,200	66 percent
2015	129,091	86,700	68 percent

¹ Churchill, Chris. Maine: The gray State, Maine now has highest median age in the U.S., Kennebec Journal, March 11, 2005. Page A-1.

² Numbers were taken from the Veterans Administration’s Demographics Program VetPop2007 for the year ending September 2007.

³ CARES Commission Report, Chapter 5 VISN Recommendations, Page 5-15.

⁴ CARES Commission Report, Chapter 5 VISN Recommendations, Page 5-18.

⁵ CARES Commission Report, Appendix A, Glossary of Acronyms and Definitions, Page A-3.

⁶ CARES Commission Report, Chapter 5 VISN Recommendations, Page 5-18, 19.

Year	Veteran Population*	Veterans > 55	Percent of Veteran Population
2020	115,506	80,925	70 percent
2025	104,650	73,047	70 percent
2030	94,582	63,633	67 percent

* Based on projections from VA Demographics Program VetPop2007

Rural access to VA healthcare in Maine will greatly improve if and when the CARES Plan is fully implemented. Even if fully implemented in Maine today, we will still face challenges as the CARES Plan only addresses 70 percent of the veteran population which means that 30 percent or 43,202 veterans (2007 numbers) will still be outside of the CARES standard for healthcare access. New initiatives by the VA such as: home-based healthcare, telemedicine, tele-mental health, will help alleviate the access to care for these veterans.

While we would like to see additional Vet Centers in Maine to provide the necessary readjustment counseling to the large number of returning combat veterans to the State, we applaud VA's efforts to reach out to these individuals by establishing access points for mental health counseling outside of the Vet Centers.

The Veterans Administration at Togus does a remarkable job of taking care of Maine's veterans with their limited resources. I will be the first to tell you, we do have problems that arise occasionally but in my time as State Director they been extremely responsive to resolving issues that have been identified to them.

The recent influx of new veterans from Iraq and Afghanistan are being serviced well by Togus but this does have an impact on how they can take care of the older veterans that we are identifying and enrolling in the VA healthcare system. While the VA staffing continues to grow, it still takes a long time to credential employees and this does have an impact at the delivery of services level. In Maine we will continue seeing an increasing number of our aging veterans enrolling and seeking assistance from the VA. Currently we have over 52,000 or 36 percent of our veterans enrolled with about 38,500 who actively use the VA healthcare system in Maine.

Continued development of CBOCs has greatly improved veterans' access to VA healthcare. A shining example is the Lincoln clinic that opened last year and is providing primary care to more than 800 veterans. We continue to encourage rapid deployment of new priority clinics/access points over the next few years with the corresponding budget support to the corresponding VA Medical Centers. VA needs to quickly develop these additional clinics, to include mental health services. We support VA contracting-out some specialty care to private-sector facilities where or when access is difficult. CBOCs provide better access, leading to better preventive care, which better serves our veterans.

In short, to improve rural access for veterans to VA healthcare in Maine and the Nation, implement CARES in Maine and other States and implement it sooner than later.

According to the VA's demographics program VetPop2007 Maine has over 10,000 women veterans with less than 1,800 using VA healthcare. Quality or availability of types of care for women veterans does not seem to be as much of an issue as access and outreach. Approximately 40 percent of the women veterans using VA healthcare receive it at the CBOCs. The addition of new CBOC in the Lewiston/Auburn area and the access points in Houlton, Dover-Foxcroft, and Farmington will allow more women veterans to receive care closer to home and this will increase usage numbers.

While growth has occurred in VA healthcare due to improved access to CBOCs, many areas of Maine and the country are still short-changed due to geography and/or due to veterans' lack of information and awareness of their benefits. VA and State Departments of Veterans Affairs must reduce this inequity by reaching out to veterans regarding their rights and entitlements. Maine and NASDVA support implementation of a grant program that would allow VA to partner with the State Department of Veterans Affairs to perform outreach at the local level. There is no excuse for veterans not receiving benefits to which they're entitled simply because they are unaware of those benefits. I would encourage the Committee to support S.R. 1314, Veterans Outreach Act of 2007.

As the Nation's second largest provider of services to Veterans, State governments' role continues to grow. We believe it is essential for Congress to understand this role and ensure we have the resources to carry out our responsibilities. The States partner very closely with the Federal Department of Veterans Affairs in order to best serve our veterans and as partners, we are continuously striving to be more efficient in delivering services to veterans.

As I finish my testimony I would like to once again thank you for the opportunity to speak to you today and thank you on behalf of Maine's and the Nation's veterans for all you are doing to ensure they receive the proper healthcare and benefits they have earned through their service to the Nation.

Thank you.

**Prepared Statement of Gary I. Laweryson, USMC (Ret.), Chairman,
Maine Veterans Coordinating Committee, Waldoboro, ME,
Commander, Military Order of the Purple Heart, State of Maine,
Judge Advocate, Marine Corps League, State of Maine, and
Aide-de-camp to Governor John Baldacci**

MAINE VETERANS COORDINATING COMMITTEE

Military Order of the Purple Heart * AMVETS * Marine Corps League *
Disabled American Veterans * Korean War Veterans * WAVES *
Vietnam Veterans of America * Women Veterans of America * 40/8 *
Jewish War Veterans * York County Veterans * Paralyzed Veterans of
America * American Legion Aux * Disabled American Veterans Aux *

Honorable Congressmen:

Thank you for allowing me to testify on behalf of the Maine Veterans Coordinating Committee. Our organization is comprised of the above veterans service organizations and represents a united voice working for all veterans of Maine.

As I testified on August 1, 2005, the VA's Capitol Assets Realignment Enhanced Services (CARES) studied access to Maine's rural veteran population and concluded more Community Based Outpatient Clinics (CBOC's) were needed along Maine's north-south corridor and western Maine. These CBOC's would provide Maine's rural veterans increased access to the VA's outpatient and specialty cares.

Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) allows the National Guard and Reserve troops to access the VA system for 5 years after return from OIF/OEF. As these current arenas of combat continue, treatment of Traumatic Brain Injury, PTSD, amputations, multiple injuries and illnesses, as well as, the added numbers of women combat veterans further strains an already challenged VA system, especially in the rural areas. High fuel prices and loss of jobs in the rural areas have impacted the need for increased rural access to the CBOC's as many of these veterans are now seeking care through the VA for the first time.

CBOC's within Maine are filled to capacity and need additional space and providers to be able to continue to provide the quality care Maine's veterans expect and demand.

CARES studies demonstrated Maine is greater in area and veteran population than the entire VISN 1 area. With the new OIF/OEF veterans, Maine's veteran population has swelled from the projected 154,000 in 2004 to an estimated additional 5000 veterans eligible for care in the VA system.

Communication of the varied VA services available to all Maine veterans is imperative, especially to the OIF/OEF veterans. Through the efforts of the Maine Veterans Coordinating Committee and its subsidiary organizations, Togus VAMROC enrolled 500-700 new veterans each month from 2003-2005. While this trend has slowed, Togus continues to enroll new veterans each month. Many of Maine's National Guard and Reserve components returning from Iraq and Afghanistan are returning with illnesses and injuries requiring VA care, thus increasing the need for improved access to the VA system.

Due to Maine's unique geographical size and the rising cost of gas, it is difficult for Maine's rural veterans to travel to Togus and in some instances, the existing CBOC's. Maine has no mass transit system. Maine's veterans rely on the DAV shuttle bus for transport to Togus and the CBOC's. However, in the northern counties, there is only one bus available. Many of Maine's rural veterans are on a fixed income or unemployed and unable to afford transportation to the nearest CBOC or Togus. These veterans cannot afford health insurance or access to local healthcare.

The Maine Veterans Coordinating Committee believes Togus should be expanded to become a full service VA Regional Medical Center, independent of Boston. Maine's rural veterans must now travel several hours one way to obtain care at

Togus or a CBOC. To require Maine's veterans to travel an additional three to 8 hours to Boston to receive tertiary care is unacceptable. Maine has one of the top Cardiac Surgery Centers in the Nation and leads the Nation in long term care and end of life care provided to our veterans. Sending Maine's veterans to Boston removes the family and local veteran support systems needed to effect recovery.

The majority of the Nation is urban or metro and growth has slowed. Rural Maine has demonstrated a sustained growth and will continue this trend.

During my 2005 testimony, the Maine Veterans Coordinating Committee urged the VA to open lines of communication to all veterans, not just in Maine. Historically, veterans have not felt the VA was user friendly and as a result, many older veterans and those serving on active duty have failed to avail themselves of the quality care provided by the VA system. This has not improved.

In Maine, the veterans have banded together to educate our veterans on the many services available to them. "Operation I Served" is a joint project initiated to provide information on VA services, educational benefits, tax relief, financial assistance, housing assistance, long term care and end of life care available to Maine's veterans, their spouses and families. Maine has the leading long term care system in the Nation through the Maine Veterans Homes. "Operation I Served" has been requested and shared with many other States.

On behalf of the Maine Veterans Coordinating Committee and the Maine veterans we represent, thank you for allowing me this opportunity to testify. The Maine Veterans Coordinating Committee looks forward to continuing to work with Congress to enable the VA to provide quality care to all veterans.

Respectfully submitted.

**Prepared Statement of Kelley J. Kash, Chief Executive Officer,
Maine Veterans' Homes, Augusta, ME**

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on behalf of the Maine Veterans' Homes ("MVH") on the topic of "Women, Rural, and Special Needs Veterans," including the extremely important issue of continued access by veterans to quality long-term nursing care.

I am the Chief Executive Officer of MVH. MVH is a public body corporate created by the State of Maine to provide long-term nursing care to Maine veterans. MVH operates long-term nursing care facilities for veterans at Augusta, Bangor, Caribou, Scarborough, South Paris, and Machias, Maine. In the aggregate, MVH currently operates 640 skilled nursing, long-term nursing, and domiciliary beds for Maine veterans. We are very proud of the quality long-term care nursing services that we provide to Maine veterans.

Also, as one of the most successful State Veterans Homes systems in the Nation, MVH provides a crucial portion of the healthcare continuum for Maine veterans. Our facilities are each relatively small in size, 30 to 150 beds each, and this allows them to be located throughout the State of Maine, allowing greater ease of access to our facilities by veterans living in the most rural parts of Maine. In the future, we hope to develop additional in-patient and out-patient services at all of our six locations in order to offer rural Maine veterans greater access to all of the services that the Maine Veterans' Homes, the Maine Bureau of Veterans Services, and the United States Department of Veterans Affairs provide.

MVH is part of a vital national system of State Veterans Homes. The State Veterans Homes system is the largest provider of long-term care to our Nation's veterans. As such, the State Veterans Homes play an irreplaceable role in assuring that eligible veterans receive the benefits, services, and quality long-term healthcare that they have rightfully earned by their service and sacrifice to our country. We greatly appreciate this Committee's commitment to the long-term care needs of veterans, your understanding of the indispensable function that State Veterans Homes perform, and your strong support for our programs.

We especially appreciate the past support of this Committee in providing funding to assure per diem payments by the Department of Veterans Affairs to veterans who are residents in our State Homes. Adequate funding is absolutely key to providing top quality long-term care and access at affordable costs for our veterans. In addition, we greatly appreciate your efforts to provide more funding for VA construction grants to provide new, expanded, and more capable long-term care services and facilities to veterans.

The Maine Veterans' Homes is a leader in this national system of State Veterans Homes and a leader in the National Association of State Veterans Homes ("NASVH"). The membership of NASVH consists of the administrators and staff of State-operated veterans homes throughout the United States. NASVH members cur-

rently operate 132 veterans homes in 49 States and the Commonwealth of Puerto Rico. These homes provide over 28,000 nursing home and domiciliary beds for veterans and their dependents. These beds represent about 52 percent of the long-term care workload for the VA, while consuming just 12 percent of the VA's long-term care budget.

We work closely with the VA, State governments, the National Association of State Directors of Veterans Affairs, veterans service organizations, and other entities dedicated to the long-term care of our veterans. Our goal is to ensure that the level of care and services provided by State Veterans Homes meet or exceed the highest standards available.

Role of the State Veterans Homes

State Veterans Homes first began serving veterans after the Civil War. Faced with a large number of soldiers and sailors in critical need of long-term care, several States established veterans homes to care for those who served in the military.

In 1888, Congress first authorized federal grants-in-aid to States that maintained homes in which American soldiers and sailors received long-term care. At the time, the payments amounted to about 30 cents per resident per day. In the years since, Congress has made several major revisions to the State Veterans Homes program to expand the base of payments to include nursing home, domiciliary, and adult day health care.

For nearly half a century, State Veterans Homes have operated under a program administered by the VA which supports the Homes through construction grants and per diem payments. Both the VA construction grants and the VA per diem payments are essential components of this support. Each State Veterans Home must meet stringent VA-prescribed standards of care, which exceed standards mandated by federal and state governments for other long-term care facilities. The VA conducts annual inspections to assure that these standards are met and to assure the proper disbursement of funds. Together, the VA and the State Homes represent a very effective and financially efficient federal-state partnership in the service of our veterans.

VA per diem payments to State Homes are authorized by 38 U.S.C. § 1741–1743. Congress intended to assist the States in providing for the higher level of care and treatment required for eligible veterans residing in State Veterans Homes. As you know, the per diem rates are established by the VA annually and may not exceed 50 percent of the cost of care. They are currently \$71.42 per day for nursing home care, \$64.13 per day for adult day healthcare, and \$33.01 per day for domiciliary care. Our State Veterans Homes cannot operate without the per diem payments from the VA.

Construction grants are authorized by 38 U.S.C. § 8131–8137. The objective of such grants is to assist the States in constructing or acquiring State Veterans Home facilities. Construction grants are also utilized to renovate existing facilities and to assure continuing compliance with life safety and building codes. Construction grants made by the VA may not exceed 65 percent of the estimated cost of construction or renovation of facilities, including the provision of initial equipment for any project. State funding covers at least 35 percent of the cost. Our program cannot meet our veterans' needs without an adequate level of construction grant funding.

In recent years, State Veterans Homes have experienced a period of controlled growth—the result of increasing numbers of elderly veterans who have reached that point in life when long-term care is needed. In fact, we face the largest aging veterans population in our Nation's history. From 2000 to 2010, the number of veterans aged 85 and older is expected to triple from 422,000 to 1.3 million. If the State Veterans Homes program is to fill even a part of this unmet need for long-term care beds in certain States, and to respond to the increase in the number of veterans eligible for such care nationally, it is critical that the State Veterans Home construction grant program be sustained.

Traditionally, State Veterans Homes residents have been primarily male, as the VA per diem and construction grant requirements mandate that at least 75 percent of residents at any time be veterans. However, more and more women veterans are being admitted to State Veterans Homes as veterans themselves, reflecting the large and increasing numbers of women who have served in the military since the Korean war.

While our experiences in the Gulf War and present conflicts have given tremendous attention to post traumatic stress disorder (“PTSD”), the reality and effects of PTSD have been present in every conflict. While State Veterans Homes provide a common culture, reassuring surrounding, appreciation, and understanding of the veterans' experiences and issues, more can be learned and provided in treating PTSD in general.

The State Veterans Home program now provides about 52 percent of the VA's total long-term care workload. The VA recently estimated nationally that nursing care beds in the State Homes are 87 percent occupied. MVH beds are approximately 97 percent occupied. Many of the State Veterans Homes nationally have occupancy rates near 100 percent, and some have long waiting lists. The State Veterans Homes provide long-term medical services to frail, elderly veterans at a cost to the VA of only \$71 per day, well below the cost of care in a VA nursing home, which exceeds \$560 per day.

Although there are no national admission requirements for the State Veterans Homes, there are State-by-State medical requirements for admission. Generally, a State will demand a medical certification confirming significant deficits in activities of daily living (an assessment of basic living functions) that require 24-hour nursing care. Moreover, no per diem is paid by the VA unless and until a VA official certifies that nursing home care is required. Veterans qualifying for long-term nursing care at a State Veterans Home are almost always chronically ill and elderly, and many are afflicted with mental health conditions.

State Veterans Homes as a VA Resource

The State Veterans Homes should play a major role in meeting these requirements and be treated as a resource integrated more fully with the VA long-term care program. We have proposed that our beds be counted toward the VA's overall long-term care census. Doing so would allow the VA to meet its long-term care bed requirements. A nursing home bed in a State Veterans Home is a very cost-effective alternative to a nursing home bed in a VA-operated facility. Congress's goal should be to provide long-term care to veterans in a manner that expands the VA's capacity to provide services, while paying the lowest available per capita cost for each eligible veteran. Including State Veterans Homes nursing beds in the mandated VA long-term care totals could allow the VA to meet its legislative mandate, shift some of its maintenance care and other specialty services to the State Veterans Homes, and ultimately increase the capacity of the VA to provide greater short-stay, highly specialized rehabilitative care.

This goal can be accomplished by the State Homes at substantially less cost to taxpayers than other alternatives. The average daily cost of care for a veteran at a long-term care facility run directly by the VA has been calculated nationally to be \$563.45 per day. The cost of care is \$225.30 per day to the VA for the placement of a veteran at a contract nursing home, which is not required to meet more stringent State Veterans Home standards. The same daily cost to the VA to provide outstanding quality long-term care at a State Veterans Home is far less — only \$71.42 per day for nursing care.

This substantially lower daily cost to the VA of the State Veterans Homes compared to other available long-term care alternatives led the VA Office of Inspector General to conclude in a 1999 report: "the SVH [State Veterans Home] program provides an *economical alternative* to Contract Nursing Home (CNH) placements, and VAMC [VA Medical Center] Nursing Home Care Unit (NHCU) care" (emphasis added). In this same report, the VA Office of Inspector General went on to say:

A growing portion of the aging and infirm veteran population requires domiciliary and nursing home care. The SVH [State Veterans Home] option has become increasingly necessary in the era of VAMC [VA Medical Center] downsizing and the increasing need to discharge long-term care patients to community based facilities. VA's contribution to SVH per diem rates, which does not exceed 50 percent of the cost to treat patients, is significantly less than the cost of care in VA and community facilities.

In another example of how the VA can partner with State Veterans Homes, the State of Maine enacted legislation earlier this month to establish a veterans' campus at Bangor, Maine. The concept is to create a one-stop shop for veterans to receive most of their healthcare and social services needs. The proposed project will locate a new, larger, and more capable VA community-based outpatient clinic next to the MVH Bangor facility. Other veteran service organizations will be colocated at the campus, bringing a wide range of veteran services to a single campus and making it more efficient and convenient for veterans, families, the State Bureau of Veterans Affairs, VA, and various agencies and veterans service organizations that serve veterans' healthcare and social service needs. The Bangor Veterans Campus is a pioneering effort and the first of its kind in the Nation. Its success should be replicated throughout the Nation.

full cost of care for veterans with service-connected disabilities rated 70 percent or greater, or for veterans who need nursing home care as a result of their service-connected disabilities. The same legislation authorized the VA to provide veterans with service-connected disabilities rated 50 percent or greater with prescription medications while residing in State Homes. Federal law required these provisions to take effect by March 22, 2007, yet we are still waiting for the VA regulations with no forecasted date of implementation. The result has been tremendous confusion and frustration for the many thousands of veterans who are waiting for these services, and for the State Veterans Homes, which will be required eventually to provide these services.

Section 201 of Pub. L. No. 108-422 authorized the VA to pay up to 50 percent of the cost for State Veterans Homes to implement an employee incentive scholarship to recruit and retain nurses. While the VA announced that its regulations and implementation instructions will be completed this summer, Federal law required the VA to begin making payments to States no later than June 1, 2005 — 3 years ago!

VA Construction Grant Program

Under current law, there are strict limits and standards for funding the construction and renovation of State Veterans Homes. The system is working very well under the provisions of the Millennium Bill, which establishes priorities for funding according to life/safety, great need, significant need, and limited need.

Moreover, under the requirements of the Millennium Bill, the VA prescribes strict limits on the maximum number of State Veterans Home nursing beds that may be funded by construction grants. This is based on projected demand for the year 2009, which determines which States have the greatest need for additional beds. This process assures that additional State Veterans Home beds are built only in those States that have the greatest unmet need for such beds.

However, the Administration has proposed cutting State Veteran Home construction matching-grant funding by almost 50 percent, from \$165 million in FY 2008 down to \$85 million for FY 2009. The backlog of construction projects to repair, rehabilitate, expand, and build new State Veterans Homes is now approaching \$1 billion. Over \$200 million of this backlog are life-safety projects. These are critical and immediate needs. Moreover, habitually under funding these projects puts the State Veterans Homes and their veteran residents at risk.

Conclusion

Thank you for your commitment to long-term care for veterans and for your support of the State Veterans Homes as a central component of that care. In conclusion, I will reiterate the key issues facing the State Veterans Homes.

First, thank you for your continued support of the VA per diem payment to the State Veterans Homes. The loss or reduction of the VA per diem would place Homes in an untenable financial position and could lead to the closure of many State Homes, ultimately impacting our aging veterans severely.

Second, we believe Congress must increase funding for construction grants to State Veterans Homes to at least \$200 million to address the growing backlog of projects. Inadequate or delayed funding will continue to grow the nearly \$1 billion backlog that now exists, including over \$200 million in life-safety projects.

Third, we believe Congress must require the VA to promulgate long-overdue regulations to strengthen State Veterans Homes and the veterans they serve. In particular, increased payment for nursing home care and the provision of prescription medication in State Veterans Homes for veterans with service-connected disabilities of 70 percent or greater and 50 percent or greater, respectively, have been delayed indefinitely by the VA.

Fourth, we believe that the State Veterans Homes can play a more substantial role in meeting the long-term care needs of veterans. NASVH recognizes and supports the national trend toward deinstitutionalization and the provision of long-term care in the most independent and cost-effective setting. In a letter to VA Secretary Nicholson dated April 5, 2005, NASVH proposed that we explore together creative ways to provide a true continuum of care to our veterans, both rural and urban, in State Veterans Homes and in the community. We would be pleased to work with the Committee and the VA to explore options for developing pilot programs, such as the proposed Bangor Veterans Campus, for providing innovative care and for more closely integrating the State Veterans Homes program into the VA's overall healthcare system for veterans.

**Prepared Statement of David Hartley, Ph.D., MHA,
Director, Maine Rural Health Research Center, and
Professor, Muskie School of Public Service,
University of Southern Maine, Portland, ME**

Thank you for the opportunity to testify before this Committee. My testimony is based on 12 years as a manager of substance abuse treatment programs followed by 15 years as a rural health researcher, much of which has been focused on access to mental health services in rural America. I brought that expertise to bear when I served on the Institute of Medicine's Committee on the Future of Rural Health which met throughout 2004 and released its report early in 2005: *Quality through Collaboration: The Future of Rural Health* (IoM 2005). Two years ago, I testified before this subcommittee in Washington DC, and reported that several of the recommendations of the IoM Committee were directly relevant to the challenge of delivering high quality health care services to rural veterans.

Since 44 percent of new recruits come from rural places (Tyson 2005), we are seeing an increase in the numbers of veterans from Iraq and Afghanistan who are returning to rural America recovering from complex combat-related injuries, both physical and emotional. The Veteran's Healthcare System has unique expertise and resources to devote to the healing of these injuries. In recent years, the VA has opened more community based outpatient clinics or CBOCs to make this expertise and these resources available to veterans who live at significant distances from VA medical centers. We now have six CBOCs in Maine.

The Department of Veterans Affairs has arguably the best integrated health information network in the Nation. It also has extensive, evidence-based, patient-centered performance measures and a monitoring system to assure that all patients receive high quality, guideline concordant care. That system gets good outcomes for those veterans who receive care from VA clinics, and from Community-Based Outpatient Clinics and contract providers who can meet the VA's high standards of care. There are several reasons why a veteran in need of help might not seek care at one of these facilities. While CBOCs have improved access in many rural areas, there remain vast remote areas in our most rural States, including Maine, where VA facilities are still out of reach. Also, some veterans prefer to seek care from the non-VA system, for a variety of reasons. The significant numbers of veterans whose combat experience was with the National Guard are often in this category. Citizen soldiers may be more familiar with citizen health care, and often do not register for VA benefits. While many veterans prefer to receive care from VA providers, others feel just the opposite. Our VA healthcare system needs to reach out to our civilian health care system to assure that these combat veterans get care consistent with their needs, and concordant with the special expertise of the VA healthcare system.

Clearly, one way the VA system can do this is by contracting with non-VA providers in rural areas where it is not efficient to open a CBOC. The federal government has created several programs to attract providers to underserved areas, and to support them. These include federally qualified health centers (FQHCs), critical access hospitals, and rural health clinics. Some rural areas are also served by community mental health centers. These programs were created as a federal response to the difficulty of recruiting providers to serve remote populations. They exist in areas that have been designated as underserved. In many rural areas, hospitals, clinics and health centers collaborate in recruiting efforts, often with the help of their state office of rural health, or state hospital association. For the VA to open a new CBOC in a community that is already served by one or more of these entities is inefficient. Rather, I would suggest that we have the technology and the expertise to help these rural sites provide care to rural veterans that is of the same high quality that urban vets receive. This can be done through tele-health, through the VistA information system which is now available as open-access software to all providers, through direct clinical consultation and supervision between expert clinicians in VA medical centers and rural providers, and through the placement of VA providers in these non-VA rural sites, creating veterans' access points. With these resources at our disposal, care provided in a rural site for some of these combat injuries can be of the same high quality as that provided in a VA medical center.

My research has been in the area of rural behavioral health. The IoM rural report found that behavioral health needs in rural America are not being met, due to a fragmented, under-funded, non-system. Much of my research has sought to document the lack of specialty mental health services in rural areas, and to discover alternative models for delivering such services in the absence of psychiatrists, psychologists and psychiatric facilities. The need for mental health services in rural

America has been repeatedly identified as one of the topmost issues facing State-level officials and policymakers. It now faces the VA healthcare system as well.

Evidence of the need for mental health services among veterans can be found in the high rates of combat zone suicide (Army News Service 2004), post-traumatic stress disorder, often not manifesting until a year or more after returning home, and in the VA's recently published studies of rural-urban disparities in health-related quality of life, both for veterans with psychiatric disorders (Wallace et al. 2006) and for veterans in general (Weeks 2004). Lacking specialty mental health services, rural people with psychiatric problems have typically sought help from their primary care practitioner. Research tells us that such care has not always been of the highest quality, and often does not follow evidence-based guidelines for conditions such as depression, anxiety disorders and children's mental health issues (Rost et al. 2002). Two specific conditions of veterans now returning from Afghanistan and Iraq may not be accurately diagnosed by primary care practitioners who are not familiar with these conditions: post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). Once such disorders are suspected, it may be possible to refer vets to a VA specialist, and travel from a rural to an urban area for specialty care may simply be the only way to get quality care. In many of our most rural States, however, there is no VA TBI program. Moreover, the symptoms of PTSD typically affect the whole family, and may lead to domestic violence, child abuse, divorce, substance abuse and suicide. Here too, the lack of services in rural areas poses a significant barrier to effectively addressing these problems.

My research suggests that creative solutions are needed to meet the need for mental health and substance abuse treatment in rural areas. Behavioral health research often entails precisely designed trials of various clinical interventions, many of which are unlikely to be implemented in rural areas. Creative solutions to meet the behavioral health needs of rural veterans can be found by establishing a rural behavioral health research center charged to explore and evaluate new models for delivering care to veterans in remote areas. This can best be accomplished through collaboration between a VA medical center and a federally funded rural health research center. Such a collaboration might be facilitated by the VA Office of Rural Health and the Federal Office of Rural Health Policy, in the Health Resources and Services Administration, working together.

As I stated to this subcommittee two years ago, the Veterans Administration has an opportunity to take advantage of decades of research, policy, and programs serving rural Americans, and combine those resources with its own, so as to improve access to quality care for rural veterans, and to bring its unique resources for quality improvement and information management to rural providers. We can do this for our veterans.

References

Army News Service (2004). Army suicide rate in combat zones elevated. March 26, 2004.

Institute of Medicine, Committee on the Future of Rural Health Care (2005) *Quality through Collaboration: the Future of Rural Health*. Washington DC: The National Academies Press.

Rost K, Fortney J, Fischer E, and Smith J (2002) Use, quality and outcomes of care for mental health: The rural perspective. *Medical Care Research and Review* 59(3): 231-265.

Wallace AE, Weeks WB, Wang, S, et al. (2006) Rural and urban disparities in health-related quality of life among veterans with psychiatric disorders. *Psychiatric Services*. 57(6):1-6.

Tyson, AS (2005) "Youths in rural U.S. are drawn to military." *Washington Post*. November 4, 2005.

Weeks WB, Kazis LE, Shen Y, et al. (2004) Differences in health-related quality of life in rural and urban veterans. *American Journal of Public Health* 94:1762-67.

Prepared Statement of Donald A. Simoneau, Past Commander, Department of Maine, and Member, National Legislative Council, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on women, special needs, and rural veterans. As more eventual veterans return from Iraq and Afghanistan, a higher emphasis is being placed on the Department of Veterans Affairs (VA) to provide the highest quality of care to all veterans who have served our Nation and earned the entitlement.

Within the veteran population, the provision of quality health care to women veterans, special needs veterans, and rural veterans has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. Other challenges such as miscommunications and misperceptions of Veteran Health Administration (VHA) services also continue to impede the delivery of quality care to the veteran population. The American Legion commends the Subcommittee for holding a hearing to discuss these vitally important issues.

Women Veterans

According to VA research, women make up approximately 15 percent of the active force, are serving in all branches of the military, and are eligible for assignment in most military occupational specialties except for direct combat roles. The increase in the number of women serving in the military significantly impacts the services provided by the Department of Veterans Affairs (VA). VA also projects that by the year 2010, women will comprise well over 10 percent of the veteran population, an increase of 6 percent over current figures. The State of Maine is comprised of approximately 9,396 of these women veterans.

Although integrated within the ranks, these women veterans require special treatment to ensure they have the best chance of returning to good health. Research has shown that female veterans encounter three large barriers when trying to access health care through VA. These barriers include: lack of knowledge about VHA services; unaware of eligibility for health care benefits; and the perception that VA only caters to male veterans. During various site visits to VA Medical Hospitals, Vet Centers, and Community Based Outpatient Clinics (CBOCs), the American Legion met with various managers who stated their greatest challenge was accommodating women who suffered from Military Sexual Trauma (MST). It is imperative that VA has adequate funding and resources, to include staffing, to ensure tools such as private entrances are in place, thereby encouraging more women to come forward and obtain care.

The American Legion recommends that once women veterans' needs are identified, VA develop and implement policy to address these deficiencies in a timely manner and conduct an extensive outreach campaign to ensure this special population—and those who serve them—aware of enhancements in health care services. We also urge Congress to also appropriate adequate funding to maintain these enhancements, once in place.

Special Needs Veterans

The American Legion is concerned with the needs of all veterans; to add, we must reassure to all that special needs veterans (SNV) don't slip through the cracks of the VA health care system. Recently in my hometown here in Maine we lost one of these Special Needs Soldiers, who served two tours of duty in Iraq but slipped through the cracks, in the VA system. This should not have happened, to anyone, especially someone who gave so much to us, but it is happening all across the Nation. Special Needs Veterans, according to the Diagnostic Statistical Manual (DSM) IV, include the chronically mentally ill, which are conditions of schizophrenia or major affective disorder including bipolar disorder, or Post Traumatic Stress Disorder (PTSD). Many older veterans are dealing with PTSD and have for years and are never diagnosed. Many returning veterans are dealing with TBI or Traumatic Brain Injury, which is one of the newest Special Needs Veterans issues. Special Needs Veterans also include the frail elderly or those veterans who are 65 years of age or older with one or more chronic health problems; and limitations in performing one or more activities of daily living. The last major group with special needs is the homeless.

The issue of homelessness affects every category of veteran. The VA Advisory Committee on Homeless Veterans 2007 report states the need and complexity of issues involving women veterans who become homeless are increasingly unexpected.

The increased risks of homelessness among each of these populations, warrant funding for special needs grants. The American Legion strongly urges Congress to provide VA with the adequate funding, ensuring more grants be put into place to assist those veterans with special needs.

Special Needs Veterans also encounter barriers when trying to access health care through VA. These obstacles include: lack of knowledge about VHA services, not knowing that they may be eligible for health care benefits, and a negative perception of VA.

The American Legion maintains that VA has a duty to constantly seek new ways to bring information to veterans—ALL veterans.

Rural Veterans

The American Legion believes veterans, many of whom are elderly and infirm or unable to travel, are isolated from the regular, preventative medical attention they need and deserve. Providing quality health care in a rural setting has proven to be challenging with such dilemmas as limited availability of skilled care providers and inadequate access to care.

VA's ability to provide treatment and rehabilitation to rural veterans who suffer from the "signature ailments" of the on-going wars in Iraq and Afghanistan (Traumatic blast injuries and combat-related mental health conditions) will continue to be challenged if it lacks the appropriate resources to accommodate new returning and existing veterans. According to Title 38, United States Code, section 1703, VA has the authority to contract for services where they are needed.

Mr. Chairman, with that measure in place, we have to persistently ensure funding and resources are available to facilitate the needs of veterans who reside in rural locations. We also encourage VA to periodically assess the resources in place and match against those who have returned. This assessment will determine the future needs of our Nation's veterans, to include those who reside outside normal distances of the VA Medical Center system.

The American Legion believes that where there is limited access to VA healthcare, it is in the best interest of veterans residing in highly rural areas to have local care made available to them. This would alleviate the unwarranted hardships rural veterans encounter when seeking access to VA health care services. Veterans should not be penalized or forced to travel long distances to access quality health care because of where they choose to live.

On October 15, 2004, the VA Office of Inspector General (VAOIG) released the "Evaluation of Department of Veterans Affairs Policies and Procedures Addressing the Location of New Offices and Other Facilities in Rural Areas." This report examined VA's policies and procedures to give first priority to locating new offices and other facilities in rural areas, as outlined in the Rural Development Act (RDA) of 1972.

The report determined that despite not having formal policies in place, VA did make a significant effort to improve access to VA services for veterans living in rural areas. The American Legion commends VA's efforts, however, we urge the Congress to ensure there are an adequate number of resources for veterans, as well as provision of adequate funding and care whilst VA is making efforts to accommodate the veteran.

The American Legion believes that CBOCs serve as a vital element of VA's health care delivery system when rural veterans are being discussed. As is widely known, there is great difficulty serving veterans in rural areas. According to the 2000 Census, many rural and non-metropolitan counties across the Nation had the highest concentrations of veterans in the civilian population aged 18 and over from 1990-2000. The State of Maine has the fourth highest proportion of veterans living in rural areas in the Nation at 15.9 percent. Studies have further shown that veterans who live in rural areas are in poorer health than their urban counterparts. In States such as Nevada, Nebraska, Iowa, North Dakota, South Dakota, Wyoming, Montana, and Maine, veterans face extremely long drives, a shortage of health care providers and bad weather. In Maine we are waiting for the funding for Lewiston, Dover/Foxcroft, Farmington and Norway/So. Paris CBOCs and grateful for the Lincoln CBOC that opened recently. The Veteran Integrated Services Networks (VISNs) rely heavily upon these CBOCs to close the gaps. The American Legion urges the Congress to adequately fund VHA to ensure an adequate number of CBOCs are constructed and maintained.

Although effective, CBOCs are not the only avenue with which VA can provide access to quality health care to rural veterans. VA must enhance existing partnerships with communities and other federal agencies to help alleviate barriers that exist, such as, the high cost of contracted care in rural settings. The American Legion believes coordinating services with Medicare or other healthcare systems based in rural areas is another way to provide quality care.

In closing, providing quality health care to women veterans, special needs veterans, and rural veterans has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. Other challenges such as miscommunications and misperceptions of Veteran Health Administration (VHA) services also continue to impede the delivery of quality care to these veteran populations.

The American Legion believes all veterans who are entitled to VHA services should receive it in a timely and quality manner. Last The American Legion urges the Congress to provide adequate funding to VA to accommodate the modernization

of all VA structures. The modernization of VA structures would readily provide telehealth and telemedicine to all veterans who reside in rural areas.

Again, thank you Mr. Chairman for giving The American Legion this opportunity to present its views on such important issues. We look forward to working with the Subcommittee to bring an end to the disparities that exist in access to quality health care to women veterans, special needs veterans, and rural veterans.

For God and Country.

**Prepared Statement of John Wallace, President,
Maine State Council, Vietnam Veterans of America**

Mr. Chairman, Ranking Member Miller, Distinguished Members of this Subcommittee, and guests, my name is John W. Wallace. I am a combat veteran who is presently Vietnam Veterans of America Maine State Council President. I serve on the Maine VHA MiniMac, BigMac, and Network Communications Council. I also serve on the Maine Veterans Coordinating Committee, the Caribou Veterans Cemetery Committee, the Maine Veterans Home Liaison Committee in Caribou and I participate in the Commanders Call with the Governor/General.

Today, I will briefly discuss with you some of the health related issues facing veterans in the State of Maine, which is home of more than 154,000 veterans and their families.

Mr. Chairman, the Maine Department of Veterans Affairs Medical Center is located in Togus, 6 miles east of Augusta. Opened in 1866, Togus was the first national home for disabled volunteer soldiers. This VA Medical Center provides medical, surgical, psychiatric, and nursing home care. The VA operates community-based outpatient clinics in Bangor, Calais, Caribou, Rumford, and Saco to provide better access to care for veterans living in rural areas. In 2007, the VA opened a part-time clinic in Lincoln. There is also a Mental Health Clinic located in Portland.

More than 1,400 active-duty service members and veterans of the Global War on Terror have sought VA health care in Maine. Many veterans from the conflicts in Iraq and Afghanistan have visited VA counseling centers in Bangor, Caribou, Lewiston, Portland, and Springvale. These community-based Vet Centers are an important resource for veterans who, once home, often seek out fellow veterans for help transitioning back to civilian life. Over six million veterans live in rural areas across America, and most fall below the poverty line. They travel hours to get to the nearest VA medical facilities. At a hearing of the Subcommittee on Health, Mr. Chairman, you pointed out that although 20 percent of the Nation's populace lives in rural areas, 40 percent of veterans returning from deployments in Afghanistan and Iraq live in rural communities. This leads to "significant challenges maintaining 'core health care services.'" The average distance for rural veterans to access care is 63 miles, according to the National Rural Health Association.

The difficulty of accessing health care is a significant problem for many of Maine's veterans. Although Togus is centrally located in Augusta, the State's geographic expanse makes it a problem for many veterans to use the hospital as their primary health-care provider. In a 2004 report, a government commission expressed concern that only 59 percent of Maine's veterans were living within its geographic guidelines for access to care, which ranged from 60 minutes for urban areas to 120 for very rural areas.

Furthermore, research by the National Rural Health Association underscores the problem. The association found that about 44 percent of service recruits come from rural areas whose population comprises 19 percent of Americans. The disparity was far less during World War II and the Vietnam War.

Of Maine's six CBOCs with two more planned under CARES, the closest CBOC is over 80 miles from its hub and the farthest is 260 miles. For primary care this is ok, but for specialty care services veterans have to travel to Togus or Boston. The distance a veteran may have to travel is more than 300 miles, which is clearly outside the 75-mile radius established by the VA. To make matters worse, most rural medical care providers, weary of the paperwork and long delays involved in the federal benefits system, often do not accept TRICARE, the military health insurance for active-duty soldiers and their families. The program offers a 180-day transitional benefit for soldiers after discharge.

There is evidence that the VA has known for some time about the need to focus more on rural care. A 2004 VA study of 750,000 veterans found that those living in rural areas tended to have more serious and costly health problems than their urban counterparts. Perhaps the VA could reach a lot of the veterans who live in rural Maine by expanding the use of fee-basis care, in which the VA contracts its services out to a third-party provider. Certainly, the myriad issues involved in pro-

viding healthcare for rural veterans must be addressed by the VA's new Office of Rural Health, which has been slow to get started.

Veterans Health Administration Office of Rural Health

In accordance with section 212 of the Public Law 109-461, VA established an Office of Rural Health. The mission of the office is to develop policies and identify and disseminate best practices and innovations to improve services to veterans who reside in rural areas. The law states:

- *Section 212c(3) "To designate in each Veterans Integrated Service Network (VISN) an individual who shall consult on and coordinate the discharge in such Network of programs and activities of the Office for veterans who reside in rural areas of the United States.*

Public Law 109-461—Sec. 822. Business Plans For Enhanced Access To Outpatient Care In Certain Rural Areas

(a) Requirement—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a business plan for enhanced access to outpatient care (as described in subsection (b)) for primary care, mental health care, and specialty care in each of the following areas:

- (1) The Lewiston-Auburn area of Maine.
- (2) The area of Houlton, Maine.
- (3) The area of Dover-Foxcroft, Maine.
- (4) Whiteside County, Illinois.

(b) Means of Enhanced Access—The means of enhanced access to outpatient care to be covered by the business plans under subsection (a) are, with respect to each area specified in that subsection, one or more of the following:

- (1) New sites of care.
- (2) Expansions at existing sites of care.
- (3) Use of existing authority and policies to contract for care where necessary.
- (4) Increased use of telemedicine.

Mr. Chairman, we are in an emergency situation in Maine, and VVA is seeking your help in Congress to expedite the provision stated in P.L. 109-461. Otherwise, our disabled veterans—both young and old—will be forced to continue their long-distance travel for care and treatment to the nearest VHA Medical Center, clinic, or hospital. We pioneered the first rural or rural-rural VA clinic as I like to call it, in the country. It covers an area bigger than the States of Connecticut and Rhode Island. It sits about 260 miles north of Togus VAMC. We quickly went from 1 day a week to 5 days a week with three providers and staff treating over three thousand veterans a month. There are also two mental health providers on board with telemedicine health 2 days a week. This was a great start to the VA's commitment to its veterans. But we veterans had to fight for this every step of the way. In the beginning we were told this would never happen.

If you travel into the farm towns of any State in the Union, you see lots of veterans who need help and are having difficulty finding it. Should we lose veterans who protected this Nation so honorably because our government was unwilling to look past politics? I think not!

Since 1982, Vietnam Veterans of America has been a leader in championing appropriate and quality health care for all women veterans. Additionally, although women veterans are authorized the same benefits, services and compensation as their male counterparts, many women do not know their rights as veterans, and they do not know how to access VA programs. Some concerns remain in the treatment, delivery, and monitoring of services to women veterans.

WOMEN VETERAN PROGRAM MANAGERS

The duties, responsibilities, advocacy, oversight and reporting of the VA Women Veteran Program Managers, as defined in their handbook (1330.2), are substantial. VVA calls for the VA to provide the Women Veteran Program Managers with a minimum of 20 hours per week to accomplish the responsibilities of the position. VVA believes that these significant duties and responsibilities are essential and should not be minimized in light of the collateral duties they usually must perform. Further, we believe that while each VISN must designate, support, and utilize one of its Medical Center Woman Veteran Program Managers as the VISN Women Veteran Program Manager, we believe additional time must be allocated for these increased duties and responsibilities.

PTSD AND SUBSTANCE ABUSE

The VA counts PTSD as the most prevalent mental health malady (and one of the top illnesses overall) to emerge from the wars in Iraq and Afghanistan, but the VA is facing a wave of returning veterans who are struggling with memories of a war where it's hard to distinguish civilians from enemy fighters and where the threat of suicide attacks and roadside bombs hovers over the most routine mission. Moreover, the return of so many veterans from Afghanistan and Iraq is squeezing the VA's ability to treat yesterdays' soldiers. Top VA officials have said that the agency is well-equipped to handle any onslaught of mental health issues and that it plans to continue beefing up mental health care and access under the administration's budget proposal released in mid-February.

Yet according to a Government Accountability Office (GAO) report issued in November 2006, the VA did not spend all of the extra \$300 million budgeted to increase mental health services and failed to keep track of how some of the money was used. The VA launched a plan in 2004 to improve its mental health services for veterans with PTSD and substance-abuse problems. To fill gaps in services, the department added \$100 million for mental health initiatives in 2005 and another \$200 million in 2006. That money was to be distributed to its regional networks of hospitals, medical centers, and clinics for new services. But the VA fell short of the spending by \$12 million in 2005 and about \$42 million in fiscal 2006, said the GAO report. It distributed \$35 million in 2005 to its 21 health care networks but did not inform the networks the money was supposed to be used for mental health initiatives. VA medical centers returned \$46 million to headquarters because they could not spend the money in FY'06.

More troubling, however, is the fact that the VA cannot determine to what extent about \$112 million was spent on mental health services improvements or new services in 2006. In September 2006, the VA said that it had increased funding for mental health services, hired 100 more counselors for the Vet Center program, and subsequently was not overwhelmed by the rising demand. That money is only a portion of what VA spends on mental health. The VA planned to spend about \$2 billion on mental health services in FY'06. But the additional spending from existing funds on what the VA dubbed its Mental Health Care Strategic Plan was trumpeted by VA officials as a way to eliminate gaps in recent and future mental health.

Furthermore, VVA believes there is a need for increased VA research specifically focused on women veterans' mental health issues. For example, as of August 2006 VA data showed that 25,960 of the 69,861 women separated from the military during fiscal years 2002-06 sought VA services. Of this number approximately 35.8 percent requested assistance for "mental disorders" (i.e., based on VA ICD-9 categories) of which 21 percent was for PTSD, with older female vets showing higher PTSD rates. Also, as of early May 2007, 14.5 percent of female OEF/OIF veterans reported having endured military sexual trauma (MST). Although all VA medical centers are to have MST clinicians, very few clinicians within the VA are prepared to treat co-occurring combat-induced PTSD and MST. These issues need to be addressed.

The VA will need to directly identify its ability and capacity to address these issues along with providing oversight and accountability to the delivery of their services. VVA believes that the VA has twelve programs that address PTSD in women veterans, but they are not exclusively for MST (some are general PTSD programs) and not all are gender-specific programs.

A concern for the environment of the delivery of services also exists in the residential programs of the VA. Most if not all residential programs are designed for treatment of mental health problems. The veterans of these programs are a very vulnerable population. This was particularly brought to our attention in regard to women veterans, who, in light of the high incidence of sexual trauma, rape, MST, and domestic violence find it difficult, if not impossible, to share residential programs with male veterans. They openly discuss their concern for a safe treatment setting, especially on units where the treatment unit layout does not provide them with a physically segregated, secured area. They also discuss the need for gender-specific group sessions, in light of the nature of some of their personal and trauma issues. VVA asks that all residential treatment areas be evaluated for the ability to provide this environment; that medical center facilities develop cost plans to address this accommodation; that these facilities report the findings for consideration to their respective VISN and to VA Central Office, Office of the Under Secretary for Health.

This submission points to the need for a well-conceived and well-implemented long-range plan for healthcare services and delivery for our women veterans. To VVA's knowledge no such plan exists. Although the VA has taken great strides in the past 15 years toward improvement of the quality of care for female veterans, there is always room for improvement. While it is fair to say that the quality of care

at most VA facilities is equal to that of any other medical system in the world, it does not help women veterans who cannot access that fine care because services aren't available.

In closing, VVA would like your support of H.R. 4107, Women Veterans Health Care Improvement Act, introduced by Rep. Stephanie Herseth Sandlin (D-SD) and S. 2799 Women Veterans Health Care Improvement Act of 2008, introduced by Senator Patty Murray (D-WA).

Mr. Chairman and members of the Subcommittee, on behalf of Vietnam Veterans of America, and the Veterans in Maine, I thank you for your continued hard work and dedication to this issue. I will be happy to answer your questions.

Prepared Statement of Joseph E. Wafford, Supervisory National Service Officer, Department of Maine, Disabled American Veterans

Chairman Michaud and other Members of the Subcommittee:

Thank you for requesting the testimony of the Disabled American Veterans (DAV), Department of Maine, at today's field hearing of the Subcommittee. DAV is a national veterans service organization of 1.3 million members, and is dedicated to rebuilding the lives of disabled veterans and their families.

The topics before the Subcommittee—women, rural and special needs veterans—are of acute interest to DAV in Maine and nationwide. Maine, with an adult population of 970,000, is home to 155,000 veterans, who constitute 16 percent of our adult population, among the highest proportion of veterans in any State. Also, with so many members of the National Guard and Reserve forces fighting the wars in Iraq and Afghanistan, including the Maine National Guard, and with nearly half of those serving coming from rural, remote and frontier areas, access to Department of Veterans Affairs health care and other VA services in rural areas is perhaps VA's most pressing challenge today, and is an exceedingly important issue in this State. Within that set of challenges, we are encouraging VA to do a better job of addressing the needs of women veterans, who are playing such an important role in these war deployments, and because of that exposure, are suffering a degree of disability and combat-related illnesses that we have never seen before in American military expeditions. In that regard, we urge the Subcommittee to swiftly consider and approve a bill, H.R. 4107, the Women Veterans Health Care Improvement Act, offered by Representatives Herseth Sandlin and Brown-Waite, two Members of your Committee. We are seeing a large number of rural veterans, both men and women, coming home from these wars with severe injuries and illnesses. Therefore, we are very pleased that the Subcommittee is turning its attention to these issues, and urge that you maintain that strong focus.

As you know, VA operates a major regional medical center in Togus, near Augusta. Opened in 1866, the Togus facility was the first national home for disabled volunteer soldiers. Today, Maine's only VA medical center plays a major role in the community and State, providing medical, surgical, psychiatric and nursing home care. It is also a significant employer in the Augusta community.

VA also operates community-based outpatient clinics (CBOC) in Bangor, Calais, Caribou, Rumford and Saco, and there is a part-time outpatient clinic in Lincoln. Also the VA's Readjustment Counseling Service has established "Vet Centers" in Bangor, Lewiston, Caribou, Portland and Springvale, and VA provides a mental health clinic in Portland. Given the vast distances, severe weather and geographical barriers of our beautiful State, coordination of health care and patient referrals for subspecialty services are major, continuing challenges, both within the VA and in the State's private sector as well. In an effort to provide more effective health care to Maine's veterans, the Togus Center operates a home tele-health program that currently aids 116 veterans, and uses VA's video "Help Buddy" system to monitor the health status of outpatient veterans who live at a distance from the Medical Center.

Mr. Chairman, as you know, VA had planned to open a CBOC in Dover Foxcroft, but those plans were shelved due to an insufficient veteran population base to support a full time VA clinic. DAV believes that area still needs VA's attention, and we highly recommend that Togus provide a "satellite van" or a portable physician office to serve veterans in that area. Once veterans in the Dover Foxcroft area become aware that VA has established a health care presence for them, even on a part time basis, this may help justify a full time clinic later on in that community. We would appreciate the Subcommittee's making that recommendation to the VA.

According to VA, in 2006 (latest information available), inpatient admissions to VA health care facilities in Maine totaled 1,696, while outpatient visits reached 325,718. Also, 17,474 veterans 65 years of age and older received health care from

VA in 2006. VA makes a wide range of geriatric, rehabilitation and extended care services available and offers expanded programs to meet the growing needs of this elderly population. The Togus VA Medical Center offers elderly veterans geriatric primary care, geriatric and gero-psychiatric consultations, geriatric evaluation, nursing home and dementia care, as well as palliative and respite care.

Mr. Chairman, in Maine, more than 1,400 active duty service members and veterans of the Global War on Terror have sought VA health care. Many veterans from the conflicts in Iraq and Afghanistan have visited Vet Centers. These community-based Vet Centers serve as an important resource for veterans who, once home, often seek out fellow veterans for advice to help them transition back to civilian life.

The State of Maine operates six State veterans homes supported by VA subsidies. They are located in Augusta (120-bed skilled care and 30-bed residential care); Bangor (120-bed skilled care); Caribou (40-bed skilled care and 30-bed residential care); Scarborough (120-bed skilled care and 30-bed residential care); South Paris (62-bed skilled care and 30-bed residential care) and Machias (30-bed residential care). We are very fortunate in Maine to have these homes available to the State's war veterans as a continuing source of care and comfort in their elderly period. One difficulty, however, that concerns us is that our State Homes do not provide a rehabilitation or convalescence capability. Given our elderly veteran population's needs, the State Homes could offer veterans a great new service if they embraced a rehabilitation/convalescence mission in partnership with the Togus Medical Center. Many veterans in inpatient care at the Togus VA Center live in Bangor, Caribou and other communities at great distance from Togus. Following surgery or other invasive care in Togus, if they had a local residential provider available to help them with rehabilitation, these veterans could be placed closer to home. The State Homes are available but do not offer rehabilitation, so often these veterans are admitted to community nursing homes at higher cost to the VA. I encourage VA to consider exploring such an arrangement with the Maine Veterans Homes to see whether such a referral partnership for post-hospital convalescence is feasible.

In general, current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when a medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support any broad VA contracting for populations of veterans.

The *Independent Budget* (IB) veterans service organizations (Disabled American Veterans, Veterans of Foreign Wars of the United States, AMVETS and Paralyzed Veterans of America) agree that VA contract care for eligible veterans should be used judiciously and only in the specific circumstances described above so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human and technical resources to promote effective, high quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, spinal cord injury or chronic mental health problems. We are concerned that in an open environment of mixed government and private providers with tight budgets, the contracted element (particularly if it were focused on acute and primary care to large populations) would inevitably grow over time, and place at risk VA's well-recognized qualities as a renowned and comprehensive provider. We believe such a distributed program would not only become prohibitively expensive, but also could damage VA's health professions affiliations—the bedrock of VA quality care.

We believe the best course for most enrolled veterans in VA health care is for VA to provide continuity of care in facilities under the direct jurisdiction of the Secretary of Veterans Affairs. For the past twenty-five years or more all major veterans service organizations have consistently opposed a series of proposals seeking to contract out or to "privatize" VA health care to non-VA providers on a broad or general basis. Specific incidences of such proposals have occurred in the States of Maryland, Minnesota, Oregon and Florida. Ultimately, these ideas were rejected by Congress or the Federal courts. We believe such proposals—ostensibly seeking to expand VA health care services into broader areas serving additional veteran populations at less cost, or providing health care vouchers enabling veterans to choose private providers in lieu of VA programs, in the end only dilute the quality and quantity of VA services for all veteran patients. Given the dire financial straits VA has experienced over several recent fiscal years, this is an important policy to sick and disabled veterans, and to those who represent their interests.

Mr. Chairman, aside from these concerns, we know that VA's contract workloads have grown significantly. VA currently spends more than \$2 billion annually on contract health care services, from all sources. Unfortunately, VA does not adequately monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most veterans under the care of contract providers. VA has no systematic process for contract care services to ensure the care is safe and delivered by certified, licensed, credentialed providers. Also, VA does not monitor continuity of contract care or ensure that these veterans are properly referred back to the VA health care system following private care. Records of veterans' contract care are inadequate in documenting the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care, nor does VA know if the care received is consistent with a continuum of VA care.

Several times the *Independent Budget* has recommended that VA implement a program of community contract care coordination that includes integrated clinical and claims information for veterans currently cared for by community-based providers. VA is yet to take these actions.

In order to meet the needs of our newest generation of veterans with access challenges and special needs, particularly in a State such as Maine, it will be crucial for VA to develop an effective care coordination model that achieves VA's responsibilities to these veterans. Developing an effective care coordination model would improve patient care quality, optimize use of VA's limited resources, and prevent overpayments when eligible veterans utilize contract community care.

Mr. Chairman, the information expressed above is the basis for the IB recommendation on coordination of community care. Based on our current knowledge of VA's ongoing demonstration called "Project HERO (Healthcare Effectiveness and Resource Optimization)," VA is not fully employing our recommended model in that demonstration, which has been put in place in Veterans Integrated Service Networks (VISNs) 8, 16, 20 and 23. While this demonstration does not directly affect VA programs in the State of Maine, it is of rising concern among veterans and organizations that represent them in the States that are a part of this demonstration. The *Independent Budget* veterans organizations are united that whatever emerges from that demonstration, we believe as representatives of millions of enrolled, sick and disabled veterans, that the Veterans Health Administration (VHA) needs to closely coordinate with our community any proposed expansion of the Project HERO initiative.

We appreciate the recent change in VA policy on beneficiary travel reimbursement, increasing the rate of reimbursement from eleven cents per mile to 28.5 cents. This increase, made after over 30 years of stagnancy, helped to ease rural veterans' ability to access VA facilities for their care. We thank you for supporting that change, and for providing the new funding essential to enable VA to adopt the new policy. Unfortunately, recent dramatic gasoline price increases have wiped out most of that improvement, but we are grateful nevertheless.

Mr. Chairman, we appreciate your Subcommittee's work in establishing the VA Office of Rural Health (ORH) in legislation enacted in 2006, Public Law 109-461. Veterans in Maine and elsewhere have high expectations for that office to establish creative and effective policies in meeting veterans' healthcare needs in rural America. The *Independent Budget* for Fiscal Year 2009 made a series of recommendations dealing with the responsibilities of this new office, including the following:

- VA must ensure that the distance veterans travel, as well as other hardships they face be considered in VA's policies in determining the appropriate location and setting for providing VA health care services;
- VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized VA medical programs needed for the care of sick and disabled veterans;
- VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the Office of Rural Health;
- Mobile Vet Centers should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and highly rural areas;
- Through its affiliations with schools of health professions, VA should develop a policy to help supply health professions clinical personnel to rural VA facilities and practitioners to rural areas in general. The VHA Office of Academic Affiliations, in conjunction with Office of Rural Health, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations;
- The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee under the Federal Advisory Committee Act, to include

membership by veterans service organizations (including those that offered the *Independent Budget*). Mr. Chairman, we understand the Secretary is now considering taking steps to establish this advisory Committee, and we applaud that decision;

- Recognizing that in areas of particularly sparse veteran population and absence of VA facilities, the Office of Rural Health should sponsor and establish demonstration projects with available providers of mental health and other health care services for enrolled veterans, taking care to observe and protect VA's role as coordinator of care. The projects should be reviewed and monitored by the Rural Veterans Advisory Committee. Funding should be made available to the Office of Rural Health to conduct these demonstration and pilot projects outside of VERA, and VA should report the results of these projects to the Committees on Veterans' Affairs;
- At highly rural VA CBOCs, VA should establish a staff function of rural outreach worker to collaborate with rural and frontier non-VA providers to establish referral mechanisms to ease referrals by these providers to direct VA health care when available, or VA-authorized care by other agencies;
- Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide public transportation vouchers and other mechanisms to promote rural veterans' access to VA health care facilities that are distant to their rural residences. This travel program should be inaugurated as a pilot program, in a small number of facilities. If successful as an effective access tool for rural, remote and frontier veterans who need access to direct VA care and services, it should be expanded into other rural areas; and
- The ORH should seek and coordinate the implementation of novel methods and means of communication, including use of the worldwide web and other forms of telecommunication and telemetry, to connect rural, remote and frontier veterans to VA health care facilities, providers, technologies and therapies, including greater access to their personal health records, prescription medications, and primary and specialty appointments.

Mr. Chairman, most of these recommendations are clearly applicable in our State. On behalf of the *Independent Budget*, we hope the Subcommittee will address these recommendations with oversight and further legislation if needed, to ensure they are implemented. Rural veterans, whether in the State of Maine or elsewhere, deserve access to VA health care, despite the obvious challenges we face in providing it.

Mr. Chairman, this concludes my testimony, and I will be pleased to consider your questions on these important topics.

**Prepared Statement of Brian G. Stiller, Center Director,
Togus Veterans Affairs Medical Center, Veterans Health Administration,
U.S. Department of Veterans Affairs**

Mr. Chairman and members of the Subcommittee, on behalf of the 1300 employees and 400 volunteers at the Togus Veterans Affairs Medical Center (Togus) in Maine, I thank you for this opportunity to discuss the care and services we provide to veterans in Maine.

Togus has experienced many positive changes in the delivery of healthcare services to veterans in Maine. One of the most significant changes has been an increase in numbers of enrolled veterans selecting Togus as their preferred choice for healthcare services and support. In 1999, total enrollment for healthcare was 19,000. Currently, 52,000 veterans are enrolled. Of those enrolled, 38,500 have received healthcare services.

I want to focus my remarks today on three key factors in the delivery of healthcare in Maine. First, I will speak on the challenge of providing access to care in a largely rural setting. Next, I want to share our progress in meeting the demands in the mental health area. Finally, I will conclude with remarks on our current efforts in serving the expanding female veteran population.

Community Based Outpatient Clinics. During the last two decades, Maine has experienced a remarkable and sustained shift in the delivery of healthcare services, particularly access to rural healthcare. Today, there are six full-service Community-Based Outpatient Clinics (CBOC) in Maine. Five of six CBOCs have expanded more than once to meet increased demand. Our CBOCs are located in Bangor, Calais, Caribou, Lincoln, Rumford and Saco.

The new Bangor CBOC includes physical therapy, dental, optometry, radiology, part-time and limited specialty services as well as Compensation & Pension rating

exams. Four of our six CBOCs now offer on-site phlebotomy services and all CBOCs have contracted locally for X-rays and immediate lab services. To minimize travel, teleretinal imaging services are available at Caribou. VA recently changed the reimbursement rate from 11 cents to 28.5 cents per mile to help offset some of the travel cost.

CBOCs are an essential part of primary care and they provide preventive health services, health promotion and disease prevention programs, as well as mental health services. A part-time primary care access point is located in Fort Kent. To further provide care in rural or residential settings, Home-Based Primary Care (HBPC) teams operate out of Togus and Portland. These teams provide primary care and support services to veterans requiring short term care, as well as veterans seeking to maintain an independent living situation. New HBPC teams are authorized for Caribou and Lincoln. Recruitment for these new positions is ongoing.

Rural Health. VA recently instituted the Office of Rural Healthcare (ORH) to specifically identify and address the needs and challenges of providing healthcare to veterans living in rural areas. ORH is leveraging rural health expertise from the public and private sectors and is currently working on several initiatives such as the Veterans Rural Health Advisory Committee, Veterans Integrated Service Network (VISN) Rural Consultant Program and Rural Health Resource Centers. ORH recently completed an analysis of outreach clinics and a Mental Health and Long Term Care Plan. These initiatives are a few of the additional mechanisms to enhance effectiveness and efficiency of healthcare delivery to rural areas including Maine.

Affiliations. Togus continues to enhance existing affiliations with State and national medical education facilities as well as establishing new affiliations. We see the need to help grow and nurture the medical education of students in Maine, to encourage them to stay and to practice rural healthcare. To that end, Togus is working with the Maine Medical Center (MMC), a private facility in Portland to provide clinical positions for Maine medical students attending Tufts University for their rotations or residency. Similarly, Togus is working with the University of Southern Maine for nurse practitioner students and the University of New England for physician assistant and pharmacist students. As Husson College institutes its new pharmacist program, Togus will offer training opportunities to those students. Similar training opportunities are currently available for other clinical disciplines such as dental, psychology, social work, and nursing. In October 2008, we plan to host a "Medical Education and Research" symposium for medical education, healthcare and research organizations.

Additional Initiatives. Togus continues to be a leader in health care by identifying and employing new technologies such as the latest improvements in home healthcare monitoring. Maine recently received a \$25 million Federal Communications Commission grant to develop telemedicine services throughout Maine. Togus is coordinating with other Maine healthcare organizations to determine how best to further deploy and utilize this healthcare technology.

Currently, over 150 veterans receive adjunct care via home telehealth using a variety of devices. VA staff use these devices to review medications, assess wounds, complete psychosocial assessments, conduct follow-up reviews for medication changes and determine if there are changes in health status when medications are changed. Areas of focus are primary care, Spinal Cord Injury, specialty or acute care and patients discharged from inpatient medical or mental health units. These devices provide timely, accurate data to allow providers to provide some healthcare remotely while minimizing veteran travel.

Mental Health. I'd now like to share with you some of our accomplishments and successes in the mental health area. Togus Mental Health Service saw sustained growth in the number of unique veterans served from 4,230 to 5,854—a 38-percent increase from FY 04 to FY 07. Through the VA Mental Health Initiative process, during the same period, our mental health staff grew from 54 to 74, an increase of 39 percent. With additional staffing, we are able to care for the increased number of veterans and develop new programs and areas of treatment. New services include an opiate substitution (buprenorphine) treatment program, a Suicide Prevention program, a recovery program, our first Grant and Per Diem homeless facility, an integrated mental health and primary care team located in the primary care area at the Togus campus, three new clinicians for our Post Traumatic Stress Disorder (PTSD) Clinical Team and a vocational rehabilitation staffer for a supported employment program. Care for veterans in rural Maine improved with all of our northern CBOCs having telemental health connectivity and many having in-home video phone connections. All Maine CBOCs now have on-site specialized mental health providers. There are two VA mental health clinics located in Bangor and Portland.

To better serve combat veterans returning from Iraq or Afghanistan, Togus reorganized its PTSD program into a one week intensive outpatient program that uses a new evidenced based treatment approach: Acceptance and Commitment Therapy (ACT). With clinical experience in that area, we were asked to be consultants to the national roll-out of ACT for VA. This program focuses on the needs of new veterans who have careers, families and cannot attend a longer program. This program provides the basis for follow-on care in another PTSD class and individual or group treatment as well as a dual diagnosis treatment. This new program has been very well received by Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans with favorable feedback. Moreover, two programs were conducted solely for women veterans to appropriately support their needs.

We are striving to provide more intensive or specialized mental healthcare and residential support for veterans in rural areas, particularly veterans who are homeless, who are in extended treatment for PTSD, or who have substance abuse problems.

Partnership with Vet Centers. PTSD treatment is readily available at Togus VAMC, six CBOCs, two mental health clinics and all five Vet Centers located in Bangor, Caribou, Lewiston, Portland and Sanford. Togus works in partnership with the five Vet Centers to provide mental health services to combat veterans throughout the State. Maine's Vet Centers have outreach locations to provide mental health services to more rural locations.

Special Need Population. Design is nearly complete and construction will begin this fall on the relocation and expansion of our 16 bed inpatient psychiatry unit. The new unit will have 24 beds, with special care areas for geriatric veterans and those more acutely ill. These improvements will ensure care is provided in accordance with latest industry standards to minimize risk and ensure safety for this vulnerable patient population.

Women Veterans. Women comprise about 14 percent of active duty Guard and Reserve forces. The ratio of enrollment for female to male veterans has increased over the last decade. In FY 2007, women comprised 5.2 percent of all veteran users nationwide and it is projected the percentage will increase to 8.1 percent of all veteran users by 2011. Approximately 42 percent of OEF/OIF women veterans are enrolled for VA healthcare services and 28.5 percent used VA healthcare services in 2007. Of these, 78.5 percent were under the age of 40, which presents new challenges in addressing their unique healthcare needs. In Maine, there are approximately 1700 women veterans receiving VA healthcare.

VA is committed to identifying and meeting the various needs of women veterans of all ages and at all levels. Togus' women's clinic provides primary care, gynecology and mental health services and a bone densitometer to screen for osteoporosis. Maternity care is provided via Fee-Basis by a community provider of the veteran's choice. Mammography is provided via Fee-Basis at any FDA-approved site near the veteran's home. VA has two Performance Measures which are specific to women's health: breast cancer screening and cervical cancer screening. In both of these measures, Togus exceeded the national benchmark. All veterans are surveyed with a clinical reminder regarding Military Sexual Trauma and dedicated treatment services are available through Togus and its various clinics, Vet Centers or Fee-Basis as appropriate.

We plan to purchase additional equipment to expand care to women veterans this year. VISN 1 primary care is evaluating women's healthcare educational and equipment needs at CBOCs with the goal of providing increased access to routine healthcare that is gender specific. Togus has a dedicated Women Veterans Program Manager (WVPM) who is also the Lead MVPM for VISN 1. To enhance outreach efforts, Togus hosts an annual Women Veterans Information Fair and provides a site for Women Veterans of America meetings.

Mr. Chairman, to better serve Maine veterans, we must continue to closely monitor and meet their needs. America's veterans have earned the best care we can possibly provide and it is our privilege to provide them with the highest levels of customer service. We appreciate your interest and support in helping VA to successfully accomplish our mission of providing world-class care to all those who have so honorably served our great country.