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FIELD HEARING ON ADDRESSING THE NEEDS OF VETERANS IN RURAL AREAS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

JULY 21, 2007

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FIELD HEARING ON ADDRESSING THE NEEDS OF VETERANS IN RURAL AREAS

SATURDAY, JULY 21, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice at 12 p.m., at Montana State University, Great Falls College of Technology, Great Falls, Montana. Hon. Jon Tester, Member of the Senate Committee on Veterans' Affairs, presiding.

Present: Senators Tester, Baucus, and Salazar.

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

Senator TESTER. It's twelve o'clock noon. Will the hearing of the Senate Committee on Veterans' Affairs come to order. I want to thank each and every one of you who have come out today on such a beautiful day, a little warm, but that's the way it's been. I appreciate you taking time out of you folks' schedule to come here, and I want to thank everybody that has served in the military, I want to thank the spouses and families of those who have served in the military, whether you've served 40 years or 40 days. All three of us up here really appreciate your service to this country.

Over the last two years, I've been doing a lot of listening to Montana veterans. Today's session is going to be a little bit different. Max, Ken and myself hope to learn a lot from Montana veterans here today about what is going on on the ground so that we can take your suggestions and concerns back to Washington.

I might also add that the officials that are here today from the Guard, from the veterans' organizations will be also learning and listening as we speak. We are joined by several officials from the VA, both here and out from DC, and I hope that they will learn and listen to your concerns, as well. All of our panelists have come a long way to be here. I want to thank you for being here.

It is my pleasure to have some distinguished guests up here at the head table with me. Senator Max Baucus, Max really needs no introduction. He has been in public service to the State of Montana and the U.S. Senate for a good many years, and he is the Chairman of the powerful Senate Finance Committee.

Senator Salazar from Colorado is the lead author of the Rural Veterans Health Care Improvement Act, which is aimed at improving the lives of rural veterans. It's a piece of legislation that Max and I strongly support. Ken, I want to thank you very, very much

for coming and spending a little time in the beautiful State of Montana.

Exactly seven months ago, the President signed into legislation a bill creating a new Veterans Affairs Office and told the VA that it needed to use this new office to pay special attention to the issues that access the health care, mental health and long-term health care among rural veterans. Seven months later the two top positions to access the health care have not yet been filled, and we just don't have any indication at this point in time that the VA in Washington is going to take this new office seriously. It's an area that concerns all of us.

I hope that the folks at the VA will take note of the witnesses' testimony here today and take note of just how many folks have come out to this hearing. The number of people in this room who have given up their Saturday afternoon should send a clear message to the VA that the veterans in Montana expect and deserve the same quality and availability of health care that the veterans in Los Angeles, Seattle or any major metropolitan area are able to get. And so it will take a real commitment from the VA and Congress to be sure the VA has the resources; to do the right job.

Before I turn it over to Max and Ken for any opening statements that they may have, I just want to explain how this will work today.

After we hear from the witnesses, we have two panels of witnesses, we will open the hearing up to comments from the audience. We will have a microphone and you'll have to come up to the microphone. After the formal part of the hearing ends, I'll ask you to come up and get in line and you'll have an opportunity to speak.

I will say that you need to be concise. We're going to give you two minutes, and I'll probably be pretty right on that. So be concise and get right to the point so that the next person can speak and we can get in as many people as possible to testify. We do have other obligations today, so the time is limited. I don't want to cut any folks off, but I may have to do that. You are also encouraged, very, very much encouraged to submit written testimony, if you like, because that is also very, very helpful, as helpful as the spoken testimony, by the way.

Now, I would like to turn to Senator Baucus for any opening statement that he might have.

STATEMENT OF HON. MAX BAUCUS, U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Senator Tester.

First, I want to tell everybody just how proud I am to have Jon Tester serving with me and serving all of you in the U.S. Senate. We're very lucky to have Jon, especially on the Veterans' Affairs Committee. He has stood up to help veterans get all the care they deserve and need. Jon is a stand-up guy. He's very direct, makes things happen. And I just want to thank you, Jon, for having this hearing here in our state.

Second of all, I want to introduce Senator Salazar from down south, not too far south, in Colorado. When you get to know Ken Salazar, you'll know what I'm next going to say is true, that Ken is a real person. He is just a solid, solid westerner, he listens to

people, he's real, he's the real deal. And I'm just very, very honored, Ken, that you're here in our state. I know you have in Colorado some of the same issues we have, but it's an honor for us, especially as a Member of this Committee with the insight that you have to help us solve some problems. Thank you.

President George Washington, one of our most distinguished veterans quoted this, he said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars, how they were treated and appreciated by their country."

I believe Americans will always step up and serve our country, but I think President Washington's warning should not be ignored, it's really key, basically, to the degree with which young men and women do want to serve currently and in the future. We're very proud of our country, of our proud tradition of service.

We know our soldiers by far are the best in the world, they are the most brave, have the most strength, compassion, and our soldiers make just tremendous sacrifices. Our soldiers spend six to fifteen months away from their families at the time of deployment, they miss birthdays, Little League games, recitals, their spouses are forced to pick up the slack.

Montana currently has 7,000 men and women serving on active duty in Guard units. Half of Montana's 3,500 Guard personnel have been deployed to either Iraq or Afghanistan, leaving behind their jobs, businesses and families. Some of our soldiers may come home, some have been sacrificed to our country too, 3,900 killed in Iraq and Afghanistan since 2005, 29,000 injured. Twenty-two of those killed in Iraq and Afghanistan come from Montana.

Also, the nature of the problems we face has changed because of body armor and improved medical technology, thousands of soldiers are surviving blasts that in previous wars would have been deadly. Many of these survivors struggle to readjust to life back home. It's because of war that they are living with missing arms, legs, without peace of mind, their minds constantly return to the battlefield they left behind. It happens. Now, Vietnam vets are starting to reexperience some of the traumas they had with Iraq tragedies. And a few can see or understand these scars.

We all have met and know a lot of soldiers, men and women who return, many lost an arm, a leg. I go to Walter Reed often. I remember this one captain, he was from down around Columbus, he was going through such pain and struggle with such a terrific attitude, a real up-front, solid guy, and he's going through all kinds of therapy. He's fly fishing for himself personally and to teach other vets about fly fishing, anything that works. And I call him up from time to time to see how things are going. He's always upbeat, but, you know, there is an awful lot going through his head and mind, as well, that we still have to work on. It means so much to me.

The Nation, we're now only coming to terms with physical injuries from the war. Traumatic brain injuries, post-traumatic stress disorder, depression, injuries that linger on well after our soldiers have left the battlefield that require care for many years after they return home. The conflicts in Iraq and Afghanistan are producing tremendous strain on the services offered to the vets returning

from combat. Since 2001, the system has seen more than 25 percent increase in the number of patients it is serving. Personnel in these facilities are often dedicated, hardworking people, but the recently reported conditions, for example, the outpatient services of Walter Reed, project a support system under severe strain, at its very best.

Veterans can face a complicated maze of paperwork, appointments to secure basic health care benefits. In fact, in May of 2007, a study found that on average it takes the VA 127 days to process a disability compensation claim; 127 days, on average. That's up from an average of only 16 days in 2003. And appeals take an average of 657 days. Moreover, the accuracy of the VA compensation decisions is only 88 percent, meaning that thousands of vets will go without the benefits they deserve.

These challenges clearly are compounded in rural states like ours where vets are often forced to travel long distances for care. The vet living in Malta, the closest VA hospital is in Helena, a 600-mile round-trip drive, and with the gas prices such as they are, the drive can cost hundreds of dollars.

Today's hearing is focused on the challenges of providing veterans care in rural areas. As Senator Tester said, we have two excellent panels to help us get to the bottom of this and do all we possibly can to make sure our vets have clearly the best possible medical care that they deserve.

I want to especially thank General Mosley for coming today, I've read his report, for making improvements to the care soldiers are receiving after returning from combat top priority. Thank you for your efforts. I thought that was an excellent report, by the way. From what I can tell, it hit the nail on the head. I also want to really thank Travis Williams, sitting here in the front row. Thank you, Travis, for coming. We've all read your statement and we're all deeply moved by it. Your story is one of inspiration, and we're all very fortunate to have the opportunity to hear and learn from you today because you can help a lot of us folks by just explaining what you went through and helping us at this table to understand what we have to do. I can't thank you enough for what you're doing.

We owe a special debt to our vets, clearly, to do all we can. And let's make sure this hearing is one we can look back upon, and maybe not too many days, weeks, months from now, and say, Hey, we got some things done.

Thank you, again, Jon, for opening this hearing.

Senator TESTER. Senator Salazar.

STATEMENT OF HON. KEN SALAZAR, U.S. SENATOR FROM COLORADO

Senator SALAZAR. Thank you very much, Senator Tester. And let me just start out by, first of all, acknowledging both Senator Tester and Senator Baucus and your Senator from the south, not too far from here, a lot of times when I've been on the senate floor voting, Max and I will decide we're going to cast our votes the way the west would want us to cast our votes. That is, with a sense of independence and with a sense of wanting to transcend partisan poli-

tics and to make sure what we're doing is doing the best for our country, as well.

Senator BAUCUS. Not the south, but the west.

Senator SALAZAR. That's right, the west.

Truly, Senator Baucus is an incredible voice for Montana, and his chairmanship of the Finance Committee is something we're all very, very proud of. Senator Tester has made his presence known immediately in the U.S. Senate and his service on the Veterans' Affairs Committee, so we're all very, very proud of him.

Let me say that I want to thank, besides thanking my hosts here, who are Max and Jon, I want to say thank you to the veterans who are here. You are the ones we traveled here to hold this hearing to learn more from you, and we look forward to the testimony from the witnesses. And I want to thank the veterans service organizations, because I know you have provided so many services to the vets here in Montana and all around the country. So thank you for also being a part of this.

When I look at my job as a United States Senator, the reality of it is that we have a lot of things we have to work on. One of the highest of our priorities is making sure that the nearly 25 million veterans that we have in America are in fact taken care of. We can, in fact, walk the talk that George Washington said that we should walk and that Abraham Lincoln reinforced, that we, as a grateful Nation, are really standing up and saying that we're not only going to support you in the battlefield but we're also going to support you when you come back home.

So part of our mission today is to make sure that we're doing everything that we can as the United States of America and as the U.S. Senate in providing those services. For the 1.4 million veterans that served in Operation Iraqi Freedom and Operation Enduring Freedom, we also thank them for their sacrifice and for the duty that they have carried on on behalf of our Nation. It's incumbent upon us, with the new challenges that we're facing, to make sure that we're doing everything to address some of the challenges that our veterans are facing when they come back home.

The Congressional action that we have taken this year, I think, has been a direction, a good direction, a new direction and doing some good things for veterans. Let me say that for the first time the veterans service organizations here, I think, would be proud of the fact that the budget of the U.S. Congress, for the first time in its history, actually have fully funded the Independent Budget of the veterans service organizations. That's a major movement in the right direction.

And as I've studied that budget and looked at how we will move forward, it seems to me that some of our focus is, first of all, dealing with some of the mental health issues that we're facing when we recognize the fact that 35 percent of all of the returning veterans from Iraq and Afghanistan are facing some kind of PTSD, we need to make sure that the mental health services of our country are being delivered to those veterans who have served.

Second of all, Senator Baucus and Senator Tester and I were talking about the number of Iraqi war vets who are coming back with some form of TBI, traumatic brain injury. And the statistics

now is 17, 18 percent of all members who have served in Iraq are coming back with TBI. So we need to keep a focus on that.

Third, because of the kinds of injuries that the veterans are facing today in Iraq and Afghanistan, we need to make sure that the prosthetics programs of the vets are in fact working.

And, lastly, let me just say, this particular hearing is incredibly important to me because it's only when you come from a place like Montana or you come from a place like where I grew up in Colorado, 300 miles south of Denver, you realize there really are two Americas, there is the America of Los Angeles and Seattle and New York and New Orleans, and then there is the America which is really the rural America which has a whole set of challenges that are very different from those major communities.

And so it is with those thoughts in mind that two years ago I introduced legislation that created the Office of Rural Veterans Affairs. I know you'll hear some testimony about how that is going, that it is making significant progress, that that delivers on its mission, and the mission was to make sure that the disparity that existed between the health care delivered to veterans in rural areas and major metropolitan areas, that we address that disparity.

Dr. Jonathan Furlow did a study of some 700,000 vets across America several years ago. He found that there was a huge disparity. If you were in the metro areas, you got a higher quality of service than if you lived in the rural areas. So Senator Tester's efforts of trying to put a focus on what the challenges are for rural veterans is a very important agenda. And he and I and Senator Baucus have addressed some of that disparity.

At the end of the day, the people who we can learn from the most are the veterans who are actually in the system out in rural communities. And so this hearing today will help us figure out how we can move forward with this agenda so that we can address the needs of the rural veterans and we can also address the disparity that currently exists between the rural and metropolitan areas.

Thank you to all of you who have given up a good part of your Saturday to come and tell us what we ought to do. And, Travis, especially you, I spoke with you earlier, I read your testimony on the plane on the way from Washington. I was very moved by it. And I thank you, and I thank all of you who have served our country.

Senator TESTER. Thank you, Senator Salazar.

Before I introduce the witnesses, I want to mention just a couple of people who are very, very important to this Committee who I failed to mention earlier. The Chairman of the Veterans' Affairs Committee is Senator Akaka out of Hawaii, and he has sent his deputy staff director, Kim Lipsky. Would you stand up so they know who you are. And the reason it's important for you to get to know these folks is when this meeting is over with, I don't want to assign extra duty, but it's always good to bend their ears if you have questions.

Senator Craig out of Idaho is the Ranking Member, and he has been good enough to send a gentleman by the name of Jeff Gall to the Committee meeting. There is Jeff back there in the back.

So be sure and visit with these folks. You know what makes any government work well is the staff, so we really appreciate you folks coming down and your bosses sending you here.

Now the first panel, we've got a very distinguished first panel. I would ask the panelists to come up to the microphone when you speak so everybody can hear your testimony. Try to be concise. You don't need to read what you have there, try to summarize it, take four or five minutes would be great.

The panel consists of Mr. Alvy Chapman, Commander of the Disabled American Veterans of Montana. Alvy served from 1984 to 1990 in the U.S. Army. He has been involved with the DAV since 1993, holding both chapter and department level positions almost every year since 1993. He was voted Department Commander at the DAV's convention in June 2006 and was reelected to a second term in that position in June of 2007. Alvy, welcome to the hearing.

The second panelist is Mr. Ron Parmelee, Montana Liaison for the Paralyzed Veterans of America. Ron served in the U.S. Navy from 1961 to 1965, Chief of Prosthetics at Fort Harrison VA for nearly 20 years, 1977 to 1995. Montana Liaison to the Mountain States PVA since 1995.

Our third panelist, Dave McLean, Commander of the American Legion of Montana from Anaconda. Dave is a Naval Academy graduate, the year was 1958. Navy fighter pilot from 1959 to 1966, Vietnam vet. He's worked for Senator Mansfield in Washington, returned to Anaconda, practiced law, was elected vice-commander of the Montana Legion in 2006.

Fourth, we've got Keith Heavyrunner. He is the Director of Operation Glacier Warrior, a nonprofit, all-volunteer organization, Veterans Helping Veterans, Veterans with Disabilities and Gold Star Families. He is a member of the Blackfeet Nation. His oldest son is an active-duty soldier at Fort Bliss. Welcome, Keith.

John Burgess. John is a Vietnam vet, who served in the Marine Corps from 1966 to 1968. He's a lifelong Montanan and currently lives in Belt.

And the final presenter in this panel will be Lance Corporal Travis Williams, retired as a Marine Corps veteran from Missoula who served in Operation Iraqi Freedom in 2004 and 2005. He served four years in all, and Travis has a very enlightening story to tell.

Gentlemen, I want to thank you all for being here and your service to this country. And if you would come up to the podium, we'll get it underway. After the panelists speak, then there will be a short time for questions from Max and Ken and myself, and then we'll move to the next panel. So, Alvy, if you'll step up to the microphone.

STATEMENT OF ALVY CHAPMAN, COMMANDER, DEPARTMENT OF MONTANA, DISABLED AMERICAN VETERANS

Mr. CHAPMAN. Thank you, Senator Tester, and Max, welcome, Senator Salazar. The Department of Montana Disabled American Veterans has 5,500 members in the State of Montana. Our goal, of course, is to provide the best service that we can to Montana veterans and we do have some things that we'd like to talk about.

One is our DAV transportation system here in Montana. Right now, we're running 41 vans, we're logging about 760,000 miles a year. Right now, we have been as high as one million miles in one

year. To run this program takes two full-time employees, we have one for western Montana and one for eastern Montana, that one is located in Billings and one at the VA at Fort Harrison.

Underneath them, we have 22 local area coordinators. These are the people that actually take the call from the veterans and set them up with a ride on our van to get to a VA hospital. They're probably the most important people in our system, and they are all volunteers. Some of these people will do more than what we ask of them, they take calls at night and weekends, just do anything they can do to provide service to our veterans.

Underneath those 22 voluntary coordinators, locally we have about 250 drivers in the State of Montana. I didn't bring my hours, but I don't think the hours are even relevant because these people put in a lot more hours than is even reported in our own system. We have volunteers that drive 60 miles to even just get the van and go pick up a veteran and will drive 60 miles home. So it's quite a program. And it takes a lot of people to make it work.

The way the vans are bought by the DAV is through your DAV organization, through the local VFW and American Legion posts that help purchase vans, and then our national organization pays half of it. And starting last year, our Board of Montana Veterans Affairs here in Montana started giving us a grant to help purchase vans. And actually, we had quite a purchase last year of 12 vans and 5 this year, so we're increasing this program every year, and we suspect that we're probably going to continue to grow for at least the next three years.

Of course, the van program wouldn't be as successful as it is without the efforts of the VA itself. I know that we had some concerns about Walter Reed Medical Center, but it is our opinion of the DAV that we have the finest health care that the VA has to offer, which is under Joe Underkofler and his staff at Fort Harrison VA.

One of the issues that I know that we're watching right now is the travel pay issue, bringing the travel pay up to a Federal rate, is what we understand. Our concern there is that we would like to see it fully funded instead of just throwing that on top of what the VA already has to do. Our concern is that, especially in a rural state like Montana, it could cost Joe Underkofler and his staff far more money than it would cost someone back in the east because there are more VA hospitals, less distance to travel. So the burden for our rural states would be higher than those of on the east coast.

The other thing on the travel pay is we want to make sure that it doesn't do away with our van program. Yes, it is a lot of work for us to run that program, but it is very much needed. Even if you have travel pay out there, that's not going to diminish the need of the veteran that can't drive himself or the veteran that has an automobile that cannot travel the distance to get to that medical appointment. So there is always going to be a need for the van program, as far as we're concerned. So we would like that to be taken into consideration.

The amount of money that these volunteers and the DAV and the other service organizations save the VA by providing us a transportation network is a lot of money, and what we'd like to see

is maybe some more assistance in trying to keep that program together and keep it running for the veterans of Montana.

And with that, I guess I'll let everybody else come up and give their remarks.

[The prepared statement of Mr. Chapman follows:]

PREPARED STATEMENT OF ALVY A. CHAPMAN, COMMANDER, DEPARTMENT OF MONTANA, DISABLED AMERICAN VETERANS

Dear Chairman and Senators:

The Department of Montana of the Disabled American Veterans (DAV) with 5,500 members appreciates your concerns with the services being provided to the many men and women that have served this great Nation. Made up exclusively of men and women disabled in our Nation's defense, the DAV is dedicated to one, single purpose—building better lives for America's disabled veterans and their families. It is through this promise to our Nation's veterans that the DAV, Department of Montana has entered into a project with the Department of Veterans Affairs (DVA or VA) known as the Veterans Transportation Network (VTN).

The transportation network is filling a gap left by the closure of the Miles City Hospital in Eastern Montana and the lack of services across our great state. Many of our veterans that are depending on VA Medical Services are getting older and as you know the cost of fuel is rising sharply and leaving many veterans without the means to get to medical care. Because of the vast area that Fort Harrison is serving, some of our veterans are traveling two days to get to a medical appointment and then two days to return home. That is four to five days for a medical appointment. That is where the transportation network comes in as a much needed program for states such as Montana. Our Network consists of two full-time coordinators, 22 volunteer local coordinators and approximately 250 volunteer drivers.

The time and effort that these volunteers provide to the VA and DAV is outstanding to say the least. Many volunteers are putting in 12 hour days or more and driving as much as 500 miles per day. The burden of purchasing the 42 vans currently in service is being met through the many DAV, VFW and American Legion posts throughout the state along with many caring citizens that just want to help veterans get to their medical appointments. The State of Montana Veterans Affairs Board has stepped forward starting last year and has been assisting us with a grant to purchase more vans to cover more territory in the state. Without these resources the program would not be where it is today. The other half of van costs is met through the DAV National Office with grants through the Colorado Trust.

The two employees are paid through the Department of Montana DAV. We receive some grant dollars again from our National Organization. The rest is paid through our membership and fundraising efforts.

Of course the program was designed to fill a need because of the low pay veterans receive to travel to medical care. Raising the travel amounts will not diminish the need for the transportation network. Many of our passengers are from the greatest generation and are becoming unable to drive themselves. Other veterans own automobiles that cannot make the long trips to Fort Harrison. Therefore, we see a need for this program long into the future. We would like to see some assistance such as Federal grants for the specific purpose of running a program such as ours. Like I said there are 42 vans with almost 300 people involved in making the system work. That qualifies as a large business that runs on a shoestring budget. The money that these volunteers save the government is astronomical and we would like to see some of those savings be used to help support the program.

We would like to thank you for the opportunity to bring our concerns before you. We are always willing to come and talk about the transportation network. It is our belief that the network is the next best thing to the medical care itself.

Senator TESTER. Thank you, Alvy. I will probably have a few questions when we're done, for sure, and I'm sure Senator Baucus and Senator Salazar will have some questions.

Ron Parmelee.

STATEMENT OF RONALD PARMELEE, MONTANA LIAISON FOR THE MOUNTAIN STATES CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. PARMELEE. My name is Ronald Parmelee. I am the Paralyzed Veterans of America Liaison in Montana for the Mountain States Chapter in Denver, Colorado. I appreciate the opportunity to take a few minutes of your time.

Montana's VA healthcare system is good and helps many veterans. The outpatient clinic, along with the DAV transportation system helps many Montana veterans in the rural area. Like all systems, there are some veterans who get lost. This is true in the case of the spinal cord veterans in Montana. They have no one place to go in VISN 19. Montana spinal cord veterans have connections with the first spinal cord units where they received treatment, such as Woods, Palo Alto or Seattle. This is where they get their continuing treatment.

With the proposed spinal cord injury unit in the Denver VA Hospital at Fitzsimmons, there was to be a 30-bed acute care unit. The number jumps between 15, 20 to 30 acute care beds, depending on who you talk to. The number of spinal cord injured veterans in Wyoming, Colorado, Utah and Montana really need the use of a 30-bed acute care unit. We need the Montana Congressional delegation to support this program.

Other veterans in special categories also get lost. For instance, the VA doctor orders a heart cath and the VA cardiologist, just by looking at the veteran, says "no." The veteran is not stable enough to be transferred to another VA, but once stable, the transfer will take place. The veteran is concerned of the treatment he will receive at the other VA, being in a strange city and not knowing if he will be OK. What will the Denver doctors think when Fort Harrison says "no"? Ten days later he is in fair condition using his own health insurance, TRICARE, he has the procedure done at the community hospital and is told that he will have to pay what TRICARE does not pay. That just doesn't seem fair, especially when the community cardiologist finds there is a problem and has to put two stents in. The veteran returns to Fort Harrison for recovery. At the VA, no one says anything to him about the procedure, one way or the other. Thank goodness for the ward doctor who insisted that he have this procedure done.

Another problem is doctors' orders getting lost in the system. One example is a special floor-to-wall railing. There were specific specifications and these were given to Prosthetics by the doctor. The veteran has waited over two months. He called the VA and was told they would check into it and call him back. That was over a month ago. He still calls and no return calls. Answering machines are great.

Other areas of concerns are when the veteran's primary care physician is reassigned and the veteran is left with no one to turn to. Seriously ill veterans get to see a physician's assistant or a nurse practitioner.

Appointments that are supposed to be made for two-week follow-ups are sometimes taking six to eight weeks. Again, 90 percent of Montana veterans are taken care of with little or no problem. They are good doctors, nurses and staff; some bend over backwards to

help. I have seen patients waiting to see their provider and a staff worker comes by and takes them where they need to go ahead of schedule because of their condition.

Thank you for letting me take a few minutes of your time.

[The prepared statement of Mr. Parmelee follows:]

PREPARED STATEMENT OF RONALD PARMELEE, MONTANA LIAISON FOR THE MOUNTAIN STATES CHAPTER, PARALYZED VETERANS OF AMERICA

My name is Ronald Parmelee, and I am the Paralyzed Veterans of America Liaison in Montana for the Mountain States Chapter in Denver, Colorado. I appreciate the opportunity to take a few minutes of your time.

Montana VA Healthcare System is good and helps many veterans. The Outpatient Clinic along with the DAV Transportation Network helps Montana veterans in rural areas. Like all systems there are some veterans who get lost. This is true in the case of spinal cord veterans in Montana. They have no one place to go in VISN 19. Montana spinal cord veterans have connections with the first spinal cord units where they received treatment such as Woods, Palo Alto or Seattle. This is where they continue to receive treatment.

With the purposed spinal cord injury unit in the Denver VA Hospital, at Fitzsimmons, there was to be a 30-bed acute care unit. The numbers jumped between 15 to 20 to 30 acute care beds, depending on who you talk to. The number of spinal cord veterans in Wyoming, Colorado, Utah and Montana really need the use of this 30-bed acute care unit. We need the Montana Congressional delegates to support this program.

Other veterans in special categories also get lost. For instance, the VA doctor orders a heart cath and the VA cardiologist just by looking at the veteran says "no". The veteran is not stable enough to be transferred to another VA, but when stable the transfer will take place. The veteran is concerned of the treatment he will receive at the other VA. Being in a strange city and not knowing if he will be OK. What will Denver doctors think when Fort Harrison says no? Ten days later when he is in fair condition, using his own heath insurance (TRICARE) he has the procedure done at the Community Hospital and is told he will have to pay what TRICARE doesn't pay, that just does not seem fair. Especially when the community cardiologist finds there is a problem and has to put 2 stints in. The veteran is returned to Fort Harrison for recovery. At the VA no one says anything to him about the procedure one way or the other. Thank goodness his ward doctor insisted that he have the procedure done. Even when it was noted that this was a necessary thing to save this veterans life, the VA refused to pay for the procedure even though the veteran is 100 percent service connected. Part of this service connection is for his heart condition.

Another problem is doctor's orders getting lost in the system. One example is a special floor to wall railing. There were special specifications and this was given to Prosthetics by the doctor. The veteran has waited for over two months. He called the VA and was told they would check on it and call him back. That was over a month ago. He still calls and no return calls; answering machines are great.

Other areas of concern are when the veteran's primary care physician is reassigned and the veteran is left with no one to turn to. The seriously ill veterans get to see a Physician Assistant or a Nurse Practitioner.

Appointments that are supposed to be made for two-week follow-up visits sometimes take 6–8 weeks.

A lot of frustration is working with a Nurse Practitioner and waiting for who ever is pinch hitting for the transferred physician to make a decision and get back with the NP who gets back with the veteran.

When there is a problem the veterans does not know where to go, who to talk to. Also when the veterans want to put input in their cases they are ignored.

Again, 90 percent of the Montana veterans are taken care of with little problem. There are good doctors, nurses and staff. Some bend over backwards to help. I have seen patients waiting to see their provider and a staff worker comes and taken them where they need to be ahead of schedule because of their condition.

Thank you for letting me take a few minutes of your time.

Senator TESTER. Thank you very much, Ron. I appreciate your testimony.

And next we have Dave McLean.

STATEMENT OF DAVID McLEAN, COMMANDER, MONTANA DEPARTMENT, THE AMERICAN LEGION

Mr. McLEAN. Thank you, Senator Tester. I'm supposed to remind you that at the St. Patrick's parade in Anaconda you told the veterans you were going to get over and talk to them. They know you're busy, but they're looking forward to you making it.

Senator TESTER. I guess that's on the record.

Mr. McLEAN. Senator Baucus, Ray Cutler sends his best. He said, I knew "Max" when he was "Max."

Senator BAUCUS. I hope I still am "Max." But say hello to Ray. I have very fond memories of Ray, he's a great guy.

Mr. McLEAN. Senator Salazar, we have a mutual friend, Tom Bock, from Colorado, who is your National Commander of the American Legion, doing a very fine job, as a matter of fact. He is convinced the State of Montana, we should pass the legislation to have a national commander from Montana. We passed that in Kalispell two weeks ago. I'll be carrying that to Indianapolis soon to tell Tom. Thank you.

Ladies and Gentlemen, Veterans, I want to quickly hit on a point. If you think we like standing here in these silly hats and colored neckties and coats, let me tell you, there are a lot of other things I'd rather be doing today. But we have learned the lesson of why it is important to belong to veterans' organizations, and it's called political clout and it's called publicity. If any one of you wants to go to the VA or one of the senators' offices and individually try to get something done, having served on a Senate staff, I can tell you that they will pay attention to you and your request will probably lost. But when there are 13,000 members of the American Legion or 5,500 members of the DAV or whatever the number is, and the VFW speaking in a collective voice on your behalf, let me tell you, they listen. That is why it is important to belong to a veteran's organization. I realize it's an imposition to pay dues, but you have to take a look at what those dues do for you and try to understand that it is the many voices together. My grandmother said it best: "When more than one person prays together, God hears you better." The same thing comes with requests for VA funding, VA assistance.

First of all, I want to thank the VA for being there. We greatly appreciate the VA system and all that it has done. It is easy to come before committees such as this or go to the VA and say, We need this or we need that, but let's thank them for being there and doing what they have already done. Let's thank them for something else, that they are willing to listen to us. They're willing to admit they're not perfect, they're willing to say to us, Come and tell us what you need and let's try to get it for you.

This is the type of attitude that we need, this is the type of attitude that is going to cause our system to improve. This Senate Committee is interested in hearing about rural health care issues.

I remember the last time that the big wigs came to talk to us about rural health care issues, what we left with is that in Montana you don't even have rural health care, you have frontier health care. And that's not a joke, that's serious.

It's gotten better, but one of the reasons we're here today is to try to point out what we think is necessary to continue to make it

better. Remember, in 1993 the U.S. Congress indicated that they wanted the VA system open to all veterans. That was a congressional mandate. And to this point in time, 14 years later, that's unsuccessful. The VA system is not open to all veterans. If you think it is, be a Priority 8 veteran and try to get benefits. We're working on it.

Senator Tester came to Kalispell and addressed the convention. He's interested in it, they're working on it. We've got to continue to work together. We've got to open up the VA system to all veterans. There are studies that have been conducted by the VA and the DAV that indicate that veterans that reside in rural areas such as Montana will receive poorer health care than their urban components. Stands to reason.

What do we have in Montana? One major medical center where veterans can get their benefits. As a matter of fact, from Fort Harrison, Helena, Montana to Fargo, North Dakota, there are no major health care facilities available to veterans.

Now, I'll talk in a minute about community-based outpatient centers, and they're great. We used to have a major VA medical hospital in Miles City, Montana. I may be mistaken, and I'll be glad to be corrected if I am, but I think that's the only major VA hospital that has been closed in the United States of America. It's not there anymore. What do we have to fill the gap with?

I just mentioned it, community-based outpatient clinics. There are over 700 of these in the country. This is an attempt by the VA to bring health care closer to the veterans. We have nine, I think Theresa told me, in Montana, two new ones going to come, one to Cut Bank and one to Lewistown. That's great. But they're not major health centers. As a matter of fact, most of them are not staffed by physicians, they're staffed, the one in Anaconda is staffed by a nurse practitioner, and she's great. None of them, none of them, none of them take care of mental health issues. This is really important. I believe personally that every CBOC should have a physician on staff and at least every other one around the state should have mental health care available.

Everyone's acquainted with the care access program. The care access program wants to have more CBOCs, and that's fine. But, remember this, if we're talking about quality health care, you've also got to fund it. If you've got nine community health centers in the pot dividing up the health care, you get a certain level of health care. If you've got dividing up the same amount of money, you're getting less health care. So that's what we have to convince the VA and the Congress about, is help us fund these things.

Funding is extremely important. That's why I personally believe, and it is the position of the American Legion, we cannot continue to tolerate discretionary funding for the Veterans' Administration. We need to get to a system of mandatory funding. The problem in my mind with discretionary funding is that you get a bunch at the beginning of the year. Now, quite honestly, somewhere along the line, down the way, you're going to get emergency appropriations, as has happened for the last couple of years. A few months later, you may get a second or third one, but how does the VA plan for its staffing at the beginning of the year? They don't have enough money, they lay them off, so when the second set of funding comes

in, where is the staff? Mandatory funding is something we all have to work for and think about. This is extremely important.

We must also remember that the CBOCs are not the only avenue that is available for health care. We can enhance existing partnerships within the communities with other Federal agencies to provide health care. I'll give you an example, the Indian Health Service is an example. What are we going to hear? We're going to start talking about how the Federal Government cannot give you, one example, to use your Medicare because one Federal agency can't bill another one. They do it in the Indian Health Service. The Veterans' Administration is losing money on me now because I'm now on Medicare, but I can't use my Medicare to get my health care. What they'll lose, in addition to my Medicare payments, they're losing my supplement money. These are issues that we have to address. We've got to help the Congress understand how we can help finance the care that we feel that we need.

There was a Presidential Task Force formed to improve health care delivery to our Nation's veterans, and they made several recommendations to the DOD and the VA, and one of them said this: The VA and the DOD should declare that joint ventures are integral to the standard operations of both departments. This was recommendation No. 4.8 of the final report issued in May of 2003. And to this date, not a single one has materialized.

Yet, for example, there are military bases in many communities where veterans can get health care. Let's talk about a point that Senator Baucus brought up, and it's really important.

Senator TESTER. I have to ask you to wrap it up.

Mr. MCLEAN. Let's talk quickly about traumatic brain injury. OIF, Operation Iraqi Freedom, and OEF, Operation Enduring Freedom, veterans are returning home now, many have traumatic brain injuries, but there is no available care for them. We have to get something done for people coming back with these terrible problems.

During your questioning, please be sure and ask about what is going to be done with health care. Be sure and ask about what we can do to get doctors in every outpatient clinic. And be sure and ask about what we can do, as has been ably pointed out, to get an increase for mileage for veterans. We could probably go on and talk for hours today, but you all have things to say, too, so I will thank you for your time.

Thank you.

[The prepared statement of Mr. McLean follows:]

PREPARED STATEMENT OF DAVID MCLEAN, COMMANDER, MONTANA DEPARTMENT, THE AMERICAN LEGION

Thank you for this opportunity to present The American Legion's views on access to quality health care for veterans in general and veterans in rural communities in particular. Research conducted by the Department of Veterans Affairs (VA) indicated that veterans residing in rural areas are in poorer health than their urban counterparts. It was further reported that nationwide, one in five veterans who enrolled to receive VA health care lives in rural areas. Providing quality health care in a rural setting has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. Even more challenging will be VA's ability to provide treatment and rehabilitation to rural veterans who suffer from the signature ailments of the ongoing Global War on Terror—traumatic blast injuries and combat-related mental health conditions. VA's efforts need to be especially focused on these issues.

COMMUNITY BASED OUTPATIENT CLINICS (CBOC)

A vital element of VA's transformation in the 1990s, was the creation of CBOCs to move access closer to the veterans' community. A recent VA study noted that access to care might be a key factor in why rural veterans appear to be in poorer health. CBOCs were designed to bring health care closer to where veterans reside. Over the last several years, VA has opened up hundreds of CBOCs throughout the system and today there are over 700 that provide health care to the Nation's veterans. By and large, CBOCs have been pretty successful; however, of concern to The American Legion is that many of the CBOCs are at or near capacity and many still do not provide adequate mental health services to veterans in need.

One of the recommendations of the Capital Assets Realignment for Enhanced Services (CARES) recommendations was for more, not less, CBOCs across the Nation. The American Legion strongly supports this recommendation, especially those identified for rural areas; however, limited VA discretionary funding has limited the number of new CBOCs each fiscal year.

There is great difficulty serving veterans in rural areas. Veterans in states such as Nebraska, Iowa, North Dakota, South Dakota, Wyoming, and Montana face extremely long drives, a shortage of health care providers and bad weather. The Veterans Integrated Services Networks (VISNs) rely heavily upon CBOCs to close the gap.

The provision of mental health services in CBOCs is even more critical today with the ongoing wars in Iraq and Afghanistan. It has been estimated that nearly 30 percent of the veterans who are returning from combat suffer from some type of mental stress. Further, statistics show that mental health is one of the top three reasons a returning veteran seeks VA health care. The American Legion believes that VA needs to continue to emphasize to the facilities the importance of mental health services in CBOCs and we urge VA to ensure the adequate staffing of mental health providers in the CBOC setting.

CBOCs are not the only avenue with which VA can provide access to quality health care to rural veterans. Enhancing existing partnerships with communities and other Federal agencies, such as the Indian Health Service, will help to alleviate some of the barriers that exist such as the high cost of contracting for care in the rural setting. Coordinating services with Medicare or with other healthcare systems that are based in rural areas is another way to help provide quality care.

The Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans made several recommendations for DOD and VA, one of which: VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. (Recommendation 4.8) Since this Task Force's final report in May 2003, none have materialized—yet there are military bases in many rural communities.

TRAUMATIC BRAIN INJURY PATIENTS

In a July 2006 report entitled Health Status of and Services for Operation Enduring Freedom and Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation, the Department of Veterans Affairs' Office of Inspector General examined the Veterans Health Administration's ability to meet the needs of OIF/OEF veterans who suffered from traumatic brain injury (TBI). Fifty-two patients from around the country—including Montana, Colorado, North Dakota, and Washington state—were interviewed at least 1 year after completing inpatient rehabilitation from a Lead Center (Minneapolis, MN; Palo Alto, CA; Richmond, VA; and Tampa, FL) included those who lived in states with rural veteran populations.

Many of the obstacles for the TBI veterans and their family members were similar. Forty-eight percent of the patients indicated that there were few resources in the community for brain injury-related problems. Thirty-eight percent indicated that transportation was a major obstacle. Seventeen percent indicated that they did not have money to pay for medical, rehabilitation, and injury-related services.

Some of the challenges noted by family members who care for these veterans in rural settings include: the necessity for complicated special arrangements and the absence of VA rehabilitative care in their communities.

Case managers working at Lead Centers and several secondary centers noted limited ability to follow patients after discharge to rural areas and lack of adequate transportation.

These limitations place undue hardship on the veterans' families as well. Those contributing to the report, as well as veterans who have contacted The America Legion, have shared many examples of the manner in which families have been devastated by caring for TBI injured veterans. They have sacrificed financially, have lost jobs that provided the sole income for the family, and have endured extended

separations from children. It is The American Legion's belief that VA needs to continue to improve access to quality primary and specialty heath care services for veterans residing in rural and highly rural areas.

VET CENTERS

Vet Centers are another important resource, especially for combat veterans experiencing readjustment issues who do not live in close proximity to a VA medical facility. Because Vet Centers are community based and veterans are assessed the day they seek services, they receive timely care and are not subjected to wait lists. Some of the services provided include: individual and group counseling; family and marital counseling; military sexual trauma counseling; and, bereavement.

The American Legion believes veterans should not be penalized or forced to travel long distances to access quality health care because of where they choose to live. We urge VA to improve access to quality primary and specialty health care services, using all available means at their disposal, for veterans living in rural and highly 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 Committee to bring an end to the disparities that exist in access to quality health care in rural areas.

Senator TESTER. Next up is Keith Heavyrunner.

STATEMENT OF KEITH HEAVYRUNNER, DIRECTOR, OPERATION GLACIER WARRIOR

Mr. HEAVYRUNNER. Good afternoon, Senators, it's nice to meet you. The Blackfeet Tribe Old Person sends his regards and best wishes to you guys.

My name is Keith Heavyrunner. I am an enrolled member of the Blackfeet Nation, Browning, Montana. I have a son stationed at Fort Bliss, Texas, three-and-a-half years serving in the military. My youngest brother is currently serving in the military.

I grew up on the Blackfeet Tribal Reservation. I'm a member of the Montana Veterans Affairs Division, National American Indian Veterans, Inc., Operation Glacier Warrior and the National Native American Veterans' Memorial. I'm here to speak about Operation Glacier Warrior.

Operation Glacier Warrior is an annual three days of outdoor activities on the Blackfeet Reservation and in Glacier National Park. Operation Glacier Warrior is honoring all Montana families who are serving or have served in all branches of the service. Operation Glacier Warrior, most importantly, provides opportunity for veterans to speak with fellow veterans and families who have dealt with similar difficulties in their lives. Operation Glacier Warrior is also lifting the spirit of Gold Star Families who have lost a son, daughter, mother or father. We support our soldiers, marines, sailors and airmen returning home from the war by helping them in traditional ways in the transition from the military into civilian life. Resources range from counseling from accredited counselors to traditional healers. The volunteers consist of members of the Blackfeet Tribe, members of the Montana National Guard and members of the Northwest Montana Veterans Stand Down out of Kalispell.

As of June 30, 2007, from the State of Montana, there have been 201 wounded veterans from Iraq and 19 have been killed in action. It's unknown how many have been wounded in Afghanistan, two killed in Afghanistan.

Also, I brought the statistics from Colorado since we have a Senator from Colorado. As of June 30th of 2007, for the State of Colo-

rado, 440 wounded and 49 killed in Afghanistan. As of July 19th, 2007, 3,628 have been killed in Iraq. I don't know the statistics on how many have been killed in Afghanistan.

The Native American Indians who served in World War I, which at that time we weren't even recognized as citizens of the United States, approximately 6,000 Native American Indians served in World War I, and the original code talkers were the Choctaw Indians of Oklahoma during World War II. Minnie Spotted-Wolf is the first Native American Indian woman to serve in the Marine Corps. She is from Heart Butte, Montana. During World War II, 44,000 Native American Indians served their country.

The tradition has continued on with the Korean War, Vietnam, Desert Storm and Iraqi Operation Freedom. Many Native Americans have joined the military right after 9/11. The Vietnam veterans need to continue to be thanked for their service in the military. Like the Vietnam veterans, we do not want the new returning veterans to wait 30 years to file their claim for their VA benefits.

It's unknown how many Montana homeless veterans are out there, but I have heard there are now Iraq veterans that are homeless. Northwest Montana Veterans Stand Down in Kalispell, Montana provides help to about 40 families a month. On July 9, 2007, there were 12 families, and 7 of them were homeless. During the summer, there are more homeless veterans than in the winter. Mr. Allen Erickson has been working with the homeless veterans since 2000, providing assistance such as food and clothing. In addition, he is in need of more help and assistance with the utilities and trying to find jobs for them.

Thank you, Senators.

[The prepared statement of Mr. Heavyrunner follows:]

PREPARED STATEMENT OF KEITH HEAVYRUNNER, DIRECTOR, OPERATION GLACIER WARRIOR

Greetings, Senator Jon Tester, Senator Max Baucus and Senator Ken Salazar;

My name is Keith Heavyrunner I am an enrolled member of the Blackfeet Nation, Browning, Montana I am currently married to Bessie Heavyrunner, I have six children. My oldest son is station at Fort Bliss, Texas as United States Army, Signal Support Specialist.

I come from a family of 5 brothers and 3 sisters. My youngest brother is currently in the Montana National Guard as a Staff Sergeants. I have a nephew with the Marines station in Iraq and another nephew station in the army at Fort Leonard Wood Missouri I also have another nephew leaving in August for the Army.

I grew up on the Blackfeet reservation and attend the Browning public schools.

I listed into the United States Army in 1979 to 1983. After returning back home to Browning I did work such as carpenter work, farming, ranching, United States Postal Service as a contractor and in 2001 I was hired as the Veteran Tribal Representing for the Blackfeet Tribe.

My duties as Tribal Veterans Director is completing claims for veterans, transporting veterans to appointments through out Montana, working with the men and women currently in the military, hold special ceremonial for the men and women returning home from the military.

I serve on several boards; I am with the Montana Veterans Affairs Division, Native American Indian Veterans, Inc., Operation Glacier Warriors and the National Native American Indian Veterans Memorial.

Operation Glacier Warrior is an annual 3 days of outdoor activities on the Blackfeet Reservation and in Glacier National Park, Montana. Operation Glacier Warrior is honoring All Montana Families who are serving or have served in all branches of the military. Operation Glacier Warrior most importantly provides the opportunity for veterans to speak with fellow veterans and families who have dealt with similar difficulties in their lives. Operation Glacier warrior is also lifting the spirit of Gold Star families who have lost a son, daughter, mother or father. Additionally

we support our soldiers, Marines, Sailors and Airmen returning home from the war by helping them in the transition from the military into civilian life. Resources range from counseling from accredited counselors to traditional healers. The volunteers consist of member of the Blackfeet tribe, members of the Montana National Guard and members of the Northwest Montana Veterans Stand Down out of Kalispell, Mt As of June 30, 2007 for the state of Montana 201 wounded and 19 Killed in Action. Unknown how many wounded in Afghanistan, 2 killed in action in Afghanistan.

As of June 30, 2007 for the state of Colorado 440 wounded and 49 killed in action and as of July 19, 2007 3628 killed in Iraq.

Native American Indians who served in World War 1, which at that time Native Americans Indians were not recognized as US citizens. Approximately 6 thousand Native American Indians served in World War I and the original code talkers were the Choctaw Indians of Oklahoma, During World War II Minnie Spotted Wolf is the first native American Indian woman to serve in the marine's corp. she is from Heart Butte, Montana. During world war II 44, 000 native American Indians served.

The tradition has continue on with the Korean War, Vietnam, Desert Storm, and Iraqi Operation Freedom. This will continue on as future generations come of age. Native American Indians are one of the largest ethnic groups to volunteer for the military. The reason for volunteering is a family warrior traditions, poverty and the reason for native American Indian serving during world war II per the veterans did not want to see another invasion from other countries, like the one that now is here today.

Many Native American Indians has join the military after 9/11 to stop terrorism.

Vietnam veterans, needs to continue thanking them for their service in the military. Like the Vietnam veterans we do not want the new returning veterans to wait 30 years to file their claim for there VA benefits.

Unknown how many Montana homeless veterans there are but I have heard there are now Iraqi veteran that are homeless. Northwest Montana Veteran's Stand Down in Kalispell Montana provides help to about 40 families a month. July 9, 2007 there were 12 families and out of 7 of them were homeless. During the summer there are more homeless veterans then in the winter. Mr. Allen Erickson has been working with the homeless veterans since 2000 providing assistance such as food and clothing. In addition he is in need of more help and assistance such as food and providing assistance with the utilities as it is become a growing problem.

Senator TESTER. Thank you very much.

Appreciate it, Keith. John Burgess will be next.

STATEMENT OF JOHN BURGESS, VIETNAM VETERAN

Mr. BURGESS. Thank you, Senators, for having me here. We were discussing the situation on the mileage reimbursement, and I kind of figured it out, it's about 230 miles for me to drive to Helena from Belt, Montana, and that figures out to be 11 cents a mile, which comes to $25.30. And then, for some reason, the VA takes $6 off of that, so that comes up to $19.30.

When I go to gas up, my truck gets 17 miles per gallon of gas. For 230 miles divided by 17, it takes 13.5 gallons, and I figure that at $3 a gallon, at the time it was $3.30, and that comes up $41.50. So I'm kind of getting reimbursed about half of what it costs me, for the gas. And if they're going to raise it up, I'm wondering if they're going to raise up the price that they deduct off from it, too. Inflation.

These are supposed to be good guys. Well, anyway, I was diagnosed with lichen planus from Agent Orange. This happened about 41 years ago. They sent me to a couple of dermatologists and they checked it out and they gave me some salve, the first one didn't work, gave me some more, the second one didn't work. Now, I'm on the third and it's still not working. When I go to the clinic, they ask me on a scale of one to ten how bad my pain is. Well, I usually tell them it's about four because, really, you don't have a lot of pain

with it. But if you asked me what the itching was like, I'd tell you about a ten.

Now, that's about all I have. Thank you very much.

Senator TESTER. Thank you, John.

Next is Travis Williams.

STATEMENT OF TRAVIS WILLIAMS, OPERATION IRAQI FREEDOM VETERAN

Mr. WILLIAMS. Thank you, everyone, for coming today. My name is Travis Williams. I served in the Marine Corps from August 2002 to August 2006. And in 2005, I was deployed to Iraq with a unit out of Ohio, an infantry unit, Lima Company, 3rd Battalion 25th, to serve in the Al Anbar province. When we got there, it had been about a little over a year before any U.S. presence was known in that province, and they coined it the "Wild West of Iraq."

While we were there, we're more or less unprepared for what initially hit us, but we learned quick. For seven months, we cleared cities, villages and farmlands and we were engaged, not on a daily basis, but at least two or three times a week. Anyway, the main part of my story is, August 3, 2005, we were sent into the city of Barwanna, because six of our snipers had been killed, and one body was missing. The weapons were all captured by the enemy, so we were sent to find them. While making assault and entry into the city, one of our vehicles was blown up. In the vehicle were my whole squad and three other marines and an interpreter.

I guess that story sort of made me famous, I guess, or known, and for that I received fairly good care from the VA, and I appreciate everything they do for me. But I can only hope that someone doesn't have to go through something like that in order to get that quality of care, because I have numerous friends who were with me over there, but they just happened to be in a different squad in our platoon and lost the same friends, and haven't gone to seek help or haven't received the help they need yet.

I don't know too much about all the bills or any of legislation going on with VA funding or anything like that. The care I've received has been excellent. I do have my quips about having to set up appointments months out for the clinics, but my gratitude far outweighs those, so I just want to get the point across that it doesn't take some horrific incident to cause PTSD. It manifests in everyone differently. And I do agree with some of the points made that there needs to be more staff for mental health because the signs of battle not only show on the outside but on the inside, and I think that a lot of times they're only taken seriously when they show on the outside, and there is a lot more going on inside.

That's all I have. Thank you.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF TRAVIS WILLIAMS, OPERATION IRAQI FREEDOM VETERAN

My name is Travis Williams and this is my story . . .

I have lived in Montana since I was 6 years old. I graduated high school from Helena Capital in 2002 and shortly thereafter joined the Marine Corps. I guess I was attracted to the challenge, so I decided to test myself against their standards. I found I was able to adapt to the rigors of the Marine lifestyle quite readily. This was strange due to the fact that in high school I was completely opposite of every ideal they could throw my way. I found a sense of direction in the Marine Corps.

When I returned to Montana, I checked into my Reserve unit in Billings. In August of 2003 I enrolled at the University of Montana and attended classes between my monthly drills. In December of 2004, 9 Marines including myself received orders to activate with Lima Co. 3rd Battalion 25th Marines out of Columbus, Ohio.

We met up with our new unit in 29 Palms, California on January 5th 2005. We spent 2 months getting acquainted and training with Lima Co. before we left for Iraq. By the time we stepped on the plane, we were analogous to a family. We said our goodbyes and headed into the unknown.

Upon arrival in Kuwait we were informed that we were going to Iraq's now infamous Al Anbar province. Our home base was Haditha Dam which was guarded by the Azerbaijanis. They ran the security so that we would be able to conduct mobile operations throughout Iraq's largest province.

Our battle rhythm was demanding to say the least. We were 180 strong patrolling and clearing an area half the size of the country. My first major firefight was a two-hour siege of the town of New Ubaydi, Iraq. This town lies near the Syrian border where we were always sure to find resistance. During two hours of door to door fighting we had moved two blocks into the city. My platoon already had 5 casualties and the platoon adjacent had lost 8. This was my first taste of what war really was. It was most definitely unlike anything I had ever experienced, but it still felt exhilarating, never have I felt so alive and scared at the same time.

After experiencing the sights, smells, and sounds of battle and its aftermath, my emotions seemed to dull or shutdown. I later learned that this was a defense mechanism that allowed me to continue to operate in a combat zone. To the best of my knowledge, every marine seemed to experience this in one form or another.

By our two-month mark, we had all been engaged and fancied ourselves combat veterans. Everyone had either lost a friend or seen one carried away in a Medevac. We faced IEDs, mortar rounds, rockets, and small arms fire on a repetitive daily basis. Soon it was becoming hard to distinguish the real enemy, those we fought or those who made us fight. This double fronted battle only strengthened our small unit fraternity. Eventually, we recognized that someone on our side was continually putting us in harms way. We came to trust only each other and the outside world became irrelevant. We fought for each other not national policy or the ideals of democracy. Little did we know that this was only the beginning.

In August 2005, our Battalion lost 24 marines in about 10 days. Thirteen of them were from our company. On August 1st a team of our snipers were compromised and all 6 of them killed. On August 3rd we headed into the city of Barwanna, which was about 8 miles from our dam to recover the weapons of our fallen comrades. While entering the city, one of our troop transport vehicles or "tracks" as we call them was hit by a massive improvised explosive device (IED). To date it was the largest I had seen, I knew whoever was in that vehicle was probably dead. As I ran closer I realized that it was my squad that was in the track. In that moment, I truly understood the meaning of loneliness. In one fell swoop, the only family I had known for 6 months was taken from me. The bonds tempered by the fire of battle exceed those of any other. I felt alone and beached in a world I no longer wanted to be a part of.

After a couple hours we were ordered to continue with the mission as though nothing had happened. By noon you could already see the videos of the explosion on Al Jazeera. We stayed out for another week before they let us go back to the dam. I lost my appetite, and I most certainly did not sleep. It only got worse from there.

We still had another month of operations ahead of us. I had become very indifferent as to whether I lived or not. The battalion flew in a team of psychologists for us to speak with. During the middle of the first meeting, one doctor had fallen asleep. This only reiterated the belief that all we had was each other. That incident left me absolutely bitter to anyone that was not part of our unit.

When we arrived home it seemed surreal. I felt more out of place here than I did in Iraq. I isolated myself from friends and family and dwelled in my emptiness. In November of 2005 I went to Ohio to meet the families of those I called my brothers. The experience was second only in terms of difficulty to accepting the loss of my

best friends. I was drunk and angry and the only person I could blame was myself. I was certainly on the beaten path of destruction.

Upon my return to Missoula I received a phone call from Deb McBee, a veteran's service officer from the Military Order of the Purple Heart. She had read an article about what had happened to my squad and recommended I see someone at the VA clinic. I took her advice and enrolled for medical services. My VA physician referred me to David Anderson, the veteran's liaison for Western Montana Mental Health Clinic.

Dave made an immediate impression on me as someone who had experienced the atrocities of war firsthand. He served with 1st Battalion 9th Marines, the most engaged unit in the history of the Marine Corps. If I had a glimmer of hope it definitely came from this man. He only works with true combat vets so I was honored when he offered to help me out.

About 8 months later I received a disability rating of 50 percent for Post Traumatic Stress Disorder from the VA. Shortly thereafter I was discharged from the Marine Corps. With a rating of that size I was eligible for the VOC rehab program so I decided to pursue it. With Dave's help I changed my major to PRE MED and I am currently pursuing that field. I still see Dave on a weekly basis, and his wisdom has been paramount in terms of my recovery.

Senator TESTER. Thank you very much, Travis. Appreciate your service, and all of you folks' service to veterans and in the field. I'm just going to ask with a few questions real quick. Ron, I'll start with you. I can ask this question to some of the folks in the next panel, too, if you don't know.

But I was curious, you said that the spinal cord injury folks had no availability for health care in this region and that they were going to propose a 20- to 30-bed unit in Denver, Colorado. That's correct, right?

Mr. PARMELEE. That's correct. The thing is, spinal cord injury patients have to be handled differently than the normal patient. They have to be turned, they have to be taught how to do stuff. A lot of times the nurses can do more harm than what the patient came in with.

Senator TESTER. Where do these folks have to go now?

Mr. PARMELEE. They go to Seattle, they go to Woods, they go to Palo Alto, some go to New Mexico.

Senator TESTER. How long is this proposal—you said it's still a proposal, it's not a reality yet. Right?

Mr. PARMELEE. They're still working on some funding, is the last I heard.

Senator TESTER. How long has that been on the docket, how long have you been trying to get this done in Denver?

Mr. PARMELEE. We were trying to get a spinal cord unit there before they were going to move, and that's been a good 20 years. The ones who are in Denver were the majority of the spinal cord ones. They had to go to New Mexico. It's ridiculous.

Senator TESTER. Yes, it is ridiculous.

Mr. PARMELEE. Especially if you have an open decubiti and are trying to travel to go there.

Senator TESTER. Thank you very much.

Alvy, I wanted to ask you a couple of real quick questions. You said you had 41 vans in total, 760,000 miles this year. How many drivers do you have?

Mr. CHAPMAN. We have 250 drivers.

Senator TESTER. Is there a problem with being able to keep those folks? I mean, do you always have a driver, since it's a voluntary thing?

Mr. CHAPMAN. Not always. The local coordinators get their drivers, and it fluctuates from time to time.

Senator TESTER. So what happens if you can't get a driver? They just don't get to use the van, is that how that works?

Mr. CHAPMAN. Yes. The driver has to be qualified through the VA to drive a van; we just can't put anybody in that van. So there are cases where sometimes we don't have a volunteer to drive that van so it can't go.

Senator TESTER. Got you. OK. The Veterans Affairs' Committee recently approved a bill that would allow the VA to make transportation grants up to $50,000. It's not a huge amount of money but it could make a difference. If you were in a position that you could check off on a few things, what would you prioritize to make travel easier for vets, particularly in the rural frontier areas of the state? What would you do? Would it be—let me give you some examples that flip through my mind. With your program with the vans, should we look at ways to pay drivers or could you not pay them enough to do it, or should we be looking at more vans in the field, should we be looking at more regular runs to Fort Harrison or the clinics? Where would you put the priorities?

Mr. CHAPMAN. We're looking at this right now, and I think our priorities with our program right now is going to be to get more vans out there. Obviously, with as big a state as we have, 41 vans is not covering it. We have the entire area around Glasgow not being served at all, so we're going for Glasgow next and then Glendive.

What I think would help tremendously is we put all of our dollars into these two HSCs, the two employees that we have, but they're based in Billings and Helena. What I'd like to see is us having the ability, like the commander of the DAV or even a rapid-response team, to be able to go out to Glendive and actually set that up. But, see, there is travel cost and stuff associated with that, and right now we're so strapped on the dollars that we can't get out there.

Senator TESTER. Got you. Thank you very much.

Dave, and Max may, in fact, know this question, but I'm going to ask you. Why did they close the hospital in Miles City, since it's the only one closed in the U.S.? Why?

Mr. MCLEAN. I believe the answer that they gave is it wasn't being used regularly year-around.

Ruddy Riley is our department service officer, and he's an institution in veterans affairs from the veterans organizations.

Senator TESTER. Ruddy, why did they close the VA hospital?

Mr. RILEY. They closed it because there are seven patients a day, the average patients are seven patients a day. They couldn't justify a full hospital for that.

Senator TESTER. What do they need to justify a full hospital?

Mr. RILEY. I never did hear a figure.

Senator TESTER. I may ask somebody on the next panel in case they know. Thank you very much.

Dave, real quick, you said that most of the clinics are staffed by PAs, not physicians. Is that true across—is that all of them? Is that a Montana-specific thing or is that the way it is across the country?

Mr. MCLEAN. I'm afraid I can't answer that question. I think the VA can answer it. I do know—and they're working on it all the time. I think up in Kalispell, for example, there are three physicians available as compared to other areas like Anaconda where there are none. But the important thing, to me, is there are no health care practitioners, mental health care practitioners, and that is where we're seeing most of the veterans coming home really being let down right now.

Senator TESTER. Mr. Heavyrunner, real quick, the VA signed an agreement in 2003 with Indian Health Service to work on some pretty broad areas, five of them particularly on reservations, reservation specific. Those areas included communication access, target benefits awareness program, partnerships with native organizations and health promotion. Do you see the VA in Indian country working in any of those areas aggressively or even working in any of those areas?

Mr. HEAVYRUNNER. Not really right now, I've not seen it. I could be more informed about it when they come up and visit about it, but I know we're waiting for a TLC line, something like that, to come into IHS. We do have a lot of veterans on the reservations. From any other ethnic group, we are the highest enlisted in the military, the lowest to receive benefits or help from the VA. We have been working on that in the last couple of years with Buck Richardson who has been working with a TVR program, Travel Veterans Representative program. James Floyd out of the Salt Lake City area has been working very hard to get more people on the reservations to help the Native American veterans out there.

Senator TESTER. Good. John, real quick. You talked about the travel reimbursement, you talked about it being woefully inadequate, which it is, and we're working on getting that bumped up. But the question is, for me, you can't talk for anybody else, but when you're losing, when it's just for gasoline, by the way, not insurance, not tires, not anything else, wear and tear on the car, it's costing you money out of your pocket to get the health care, does that have an impact on your ability to—do you have to let some things go because of that, because you simply didn't have the money to get there on a personal basis?

Mr. BURGESS. Yes, I have.

Senator TESTER. So I would think if that's true with you, it's probably true with other veterans that live in places a long ways away from Fort Harrison?

Mr. BURGESS. I'm sure it's even worse.

Senator TESTER. Lastly, Travis, as was said earlier, I appreciate your service. In your written testimony, you didn't talk about it in the verbal, which was fine, but you talked about, in your written testimony, having a psychologist or a psychiatrist, I can't remember which, come in and do an assessment. I think you said the guy fell asleep and so it didn't do a lot of good. In fact, it made you a bit suspicious, which I think it would do to anybody.

I guess the question is, as you've transitioned out of active military into becoming a civilian veteran, was there any point in time in there where folks talked to you about your combat duty and what happened to you in the field to try to get to know exactly

what you had been through? Because it sounds like your engagements were more often than not.

Mr. WILLIAMS. Yes. Just for the record, the psychologist that fell asleep was not a VA doctor.

Senator TESTER. He was active military?

Mr. WILLIAMS. That's correct. When I got home, I didn't talk to anybody and I didn't seek any help. Actually——

Senator TESTER. Did anybody reach out to you?

Mr. WILLIAMS. Yes. Deb McBee from the Military Order of the Purple Heart, she read my article and gave me a call. And after I spoke with other people that I knew from Helena that worked in the VA and kind of, I guess I was more suspicious of her intentions, but they assured me that——

Senator TESTER. How about before that time, when you were still active military, was there any kind of debriefing as to what you went through?

Mr. WILLIAMS. The debriefing was where one of the doctors fell asleep. And then after that, we were offered—you know, they offer it to you if anybody needs to talk to somebody, you can go to a chaplain or the military doctors, but it's kind of a different—you know, it's kind of letting your guard down, I guess, to go speak with somebody then. And the way I felt, I guess, at the time, I felt the best way to handle it was just to bottle it up and wait until I got home.

Senator TESTER. Got you. I appreciate it. I have to point out that, before I turn it over to Senator Baucus, one of the big concerns we have had on the Veterans' Affairs Committee is the transition between active military to civilian life and making sure that those medical records make the transfer, making sure that you're debriefed appropriately and completely when you're still in the active military so that the VA can take those records and move forward in a way that makes sense to the individual.

With that said, Senator Baucus?

Senator BAUCUS. I'd like to follow up a little bit with what Senator Tester was asking you, Travis. Again, reading your statement, I picked this up from other veterans, there is a certain sense that your real support group are your buddies, the people that you trained with, that you fought with. And also reading your statement, you get the sense that, particularly on Iraq, you're leaving active duty, this guy kind of fell asleep, and you're kind of looking for a support system, the only support system you really have are your buddies. So when you come home, it's a real problem because you lose that support system because when you come back home, it's kind of alien to you. I know you said in your statement, "I almost felt more comfortable in Iraq" than you did when you came home.

Mr. WILLIAMS. The main reason for that was the unit we were with was from Ohio, right, two weeks before leaving the country we got separated from that unit, all the reservists that were from the RD Battalion got separated from the infantry units and we got thrown in the mix with people we didn't know for our decompression time. And then when we got sent home—so, you know, all my friends got sent home with the Ohio unit and I came out here. They had their support unit and they had doctors on hand. They

had everything ready when they got home. When we got home, it was almost like they almost forgot we were coming home that day.

Senator BAUCUS. Right. And I guess some units get broken up like that, too, that's not uncommon to experience?

Mr. WILLIAMS. No.

Senator BAUCUS. So one potential solution is to try to address the breaking up of units, it seems to me. Would that help or not?

Mr. WILLIAMS. In theory, it's a good idea, but it can't happen that way all the time.

Senator BAUCUS. I have no idea if this works at all, but what suggestions do you have for training? I can see that you've had training on how to deal with potential PTSD and so forth. I mean, when you went through training, was there any part of the training program that would help you and others to deal with that potential problem after you come back home?

Mr. WILLIAMS. We had, you know, hip-pocket classes on PTSD and symptoms, battle stress, things like that, but I don't think it's a problem in the training. I think it's more a fact of life that when you're at war with a bunch of guys, you know, who is going to be the first one to admit they're having problems dealing with seeing things. It comes with the job.

Senator BAUCUS. Right. When you're over there, that's true. But before going over there, is there a role or a place for people like you who have gone through this experience to help those now in basic training, a role that would help not only you but help them?

Mr. WILLIAMS. I definitely think so. I believe I tried to get toward that with my comments about my psychologist in that when we come home it's hard to trust somebody who has little knowledge about the realities of war. And I think that prior veterans, prior combat veterans are a huge asset in helping us get back. I mean, myself, when I came home, I didn't trust anybody, I was drinking.

Senator BAUCUS. But you found a fellow you trusted in, David somebody.

Mr. WILLIAMS. Yes, David Anderson.

Senator BAUCUS. He's a marine, he's seen wars and battle, therefore, there is a guy you kind of relate to?

Mr. WILLIAMS. Yes, sir.

Senator BAUCUS. Is that sort of common, do you think, is your experience pretty common? I know you were split up from your Ohio group.

Mr. WILLIAMS. I don't know if it's that common. I wish it was, I mean, I've tried to tell all my friends, and Dave's opened himself up to talk to me, I mean he's given his number out to plenty of my friends in Ohio, if they need to talk to him, ever. But I think that also it's not just a matter of having those people on hand, it's a matter of the veteran himself actually going to get the help, if he can. I guess you can't really expect to be spoon-fed everything.

Senator BAUCUS. Clearly. But still it's important to anticipate potential problems, do the best you can to get prepared, as with training. I guess what I'm trying to figure out here is how we, in rural areas, get not just proportionate care but almost more than proportionate care. I mean, what bothers me, and Miles City is the example, I remember that we tried everything under the sun to keep that hospital open. I brought, just for the sake of my col-

leagues here and some of you here, Majority Leader George Mitchell to Montana to highlight to keeping that Miles City Hospital open. We got in an airplane, I think it was in Lewistown and flew, going over to Miles City. He turned and said, Max, haven't we crossed Montana already.

So, no, we have a ways to go. We've got the folks from Miles City, and then we've got the folks from Billings, we put him in a van and we turned off the air conditioning so he realized how far it is. We did all we could, but we just couldn't prevail, frankly, to keep the hospital open. Basically the argument is what you just heard, well, there are only seven beds there. And I say, so what, there are seven bodies, those are seven Montanans and those are seven vets. You know, you're a vet in a bigger city, you have facilities there, it's there.

But in our state, there isn't very much in this state. We need some kind of mandate that gives proportionate dollars for rural communities because of the cost of travel that we just talked about, because of the cost of no support system, because you don't have many buddies when you get to a small town. You get to a big town, there are a lot of buddies and people who have seen combat, a support system. There is where we get caught because it's a tyranny of the averages, it doesn't pay for itself, therefore, you have to cut it. It's the wrong question to ask, does it pay for itself. The question is, should the care be given, I think it should. There has to be some way to bump it up, not just an average. Dave touched on that a little bit about mandates. It's not quite the same point, but something along the lines. Maybe Dave can expand a little bit on the idea or your thoughts about some kind of mandate dollars.

Mr. MCLEAN. Let me read you a letter:

> Dear Sir,
>
> I'm a World War II veteran, two years in the Southwest Pacific. I came home without a scratch mentally or physically and, believe me, my true feelings are that my Uncle Sam owes me nothing for doing what we had to do.
>
> Here is where the Legion can help. Several months ago, I received a letter from the VA that it was time for my annual physical exam, I should call the Bozeman, Montana office, which is a CBOC, to set up an appointment. Sounds great. I called at 8 a.m. Monday morning, the line was busy. OK. I waited 15 minutes and called again. The phone rang but no answer. I called three more times that Monday, the phone would ring but no answer.
>
> I went through the same procedure for the next 14 working days, 8 a.m. in the morning, the line was busy, and from there on the phone would ring and no one would answer. Finally, I got to make my appointment. When I met with the doctor, I asked her about the difficulty I had getting an appointment. She told me they were so busy and so shorthanded, they couldn't answer the phone most of the time.
>
> I cannot say enough good things about the doctor and her staff. They are great. But they are really overworked. I have my own doctor in Livingston and I go to the VA once a year to keep my record clean. My heart breaks

> when I see veterans that really need medical help and need to wait just to get a phone call through to get an appointment. Our government treats them like heroes overseas and then treats them like second-class citizens when they get home. Please don't throw this in the garbage. Raise hell in the proper places. By the way, I've been in the Legion for 41 years.
>
> Thank you.
>
> *Walter W. O'Hara.*

Senator BAUCUS. That says it all. I gave the statistics, I'm told there is about 25 percent additional sort of pressure on the system now because of vets coming home from Iraq and Afghanistan, so forth, which puts more strain on the system. Any of you who might want to address that, do you experience that at home, kind of the point made by that letter that Dave read, give us your feelings. Everybody's trying to do a good job, the VA wants to do a good job with you. If there are a lot more vets coming home, it's kind of tough. But you can shed a light on what you've experienced with some of that.

When we first got involved in the invasion of Iraq, the second time the American Legion went before the Veterans' Affairs Committee, we did everything we could to try and get the VA to gear up for these people who are coming back. Unfortunately, it fell on deaf ears at that time. Now, we are into the problem and it's just an overwhelming problem, so we're trying to close the barn door afterwards.

We're going to ask that question to the second panel so that the second panel can hear what you and others are saying.

One quick additional point, we, in the Congress, are in the process of expending an extra $3 billion more for vets, and Senator Salazar mentioned this point, that it seems like that is going to make a big difference. It's not just for next year, Fiscal Year 2008, it's because it's our hope, frankly, that will deal with a lot of additional pressures that are being put on the system.

One final point, Dave, it's my understanding, it's a good one, jurisdictional Medicare. You were saying that maybe we ought to get some benefit out of the Medicare dollars that are spent. I didn't quite understand your point.

Mr. MCLEAN. There are many in the room that can answer this better than I can. My understanding, when you're on Medicare, the VA says they can't bill Medicare for help because one government agency cannot bill another government agency. They're losing billions of dollars. Behind every Medicare recipient is the secondary policy. If the VA provides the care to somebody and can bill Medicare, the supplemental policy, that's part of the bill they don't have to foot.

Senator BAUCUS. That's a good point. As you all know, the slight problem is the Medicare system is about to go belly up in about 6, 8, 10 years from now.

Mr. MCLEAN. It better last longer than that. I have a life expectancy of 20 years.

Senator BAUCUS. Thank you very much.

Senator TESTER. Senator Salazar.

Senator SALAZAR. Thanks, Senator Tester.

Let me ask you a couple of questions, first, to you, Travis. You tell a story which is an incredible story and a true story, and I would encourage, not only you, but others to make sure that your story is told so that the people who are making policy know what that story is.

Senator BAUCUS. If I might add on that, I suggest that statement get published widely. It will make a big difference.

Senator SALAZAR. It seems to me you went to Iraq. You came back and you went through this period of being very, very lost, very, very lost. Describe for us, short, in a couple of paragraphs, what kind of transition occurred from the time you came back from Iraq, you were debriefed. I'm sure you probably got some health care and then you were let go and you were lost for a very long time. What did the DOD do and where did the VA pick up? Did they do anything to help you?

Mr. WILLIAMS. The transition coming back, basically what happened was we flew out of Kuwait after we had been split up during our decompression time, which is the last two weeks in Iraq, is where you go back to a major, bigger base where you're less likely to be engaged, and it's more or less exactly what it says, decompression time. You get split up according to the states that you're going to fly back into the country to, and that's pretty much the two weeks. That's your next group that you're stuck with.

So you go through, you have these classes about when you're coming home, signs of PTSD and battle stress, stuff like that, just to kind of make you aware.

And then they bring you through, quickly, kind of a shakedown class of the benefits offered by the VA. And from what I know now as compared to what I knew then, they far exceed what they told us when we were coming back.

And so I was released from my unit that night that I got home, told to come back in in about a week. Went and checked back in, turned in my gear, and they just kind of cut you loose. I mean, you talk with the medical staff on hand, which was a Navy Corpsman, Seaman Chief, and then you just kind of get cutoff and let go. And you have pay, you get paid vacation when you get off, so you've got 2 months of getting paid to where you don't have to do anything, you don't have to work and you're getting paid. So usually, I mean, not to speak for everyone, in my case, it ended up being 4 weeks of just going and getting drunk and thinking about everything that happened, and doing all this stuff in my own head with alcohol was not a good mixture.

And to top that off, when we got back, we had a month before the Marine Corps Ball, the Birthday Ball, and I was planning on going to Ohio to meet the families of my friends. And so when I got there, I stayed there for a week visiting the grave sites and family members and trying to answer as many questions as I could for them. And it was nice to get it over with, but it was also one of the hardest things I've had to deal with. It was pretty terrible. I can't describe it any other way.

After that, I came home and then that's when I received a call from the Military Order of the Purple Heart, and my whole problem is, without that call, I probably wouldn't have gone to seek

help or known about any of the benefits that the VA has to offer. And I know that's the case with a lot of my friends because——

Senator SALAZAR. In those two or three months, did the VA contact you?

Mr. WILLIAMS. No. I contacted the VA.

Senator SALAZAR. You contacted the VA after the Military Order of the Purple Heart contacted you?

Mr. WILLIAMS. Yes.

Senator SALAZAR. Although you were here and this whole issue of the transition from DOD over to the VA is a keystone issue focused on by Jon Tester, by Senator Baucus and caring about veterans' problems, there is a lot of attention being placed on what is happening with the returning veterans from Iraq and from Afghanistan, so obviously we would welcome your comments on that.

Very quickly, Jon, you talked to John Burgess, you talked about the reimbursement, half the gas is basically what you get? Senator Tester has legislation that Senator Baucus and I are supporting, we're going to get it done to increase some mileage reimbursement, 28 cents per mile is what the legislation proposes. Would that help?

Mr. BURGESS. Yes, it sure would. Twenty-two cents would help at least break even.

Senator SALAZAR. Eleven cents just doesn't do it?

Mr. BURGESS. That's right. Just tell them, don't mess with that $6.

Senator SALAZAR. If I can, Mr. Heavyrunner, in terms of the Native American issues and services, is there a difference in terms of how the VA—let me ask this question. We're here dealing with the disparity that we frankly know from a scientific point of view exists between what happens in urban communities and what happens in rural communities. Is there that same kind of disparity with respect to Native Americans who have served and their treatment from the VA and the general population?

Mr. HEAVYRUNNER. I think so. It's pretty much the same.

Senator SALAZAR. Would you say it would be important for us in the U.S. Senate to at least put some attention with respect to Native Americans and VA services to Native Americans?

Mr. HEAVYRUNNER. Yes, sir. I know that right now we're dealing with a lot of PTSD with Native Americans returning from Iraq, and we're also using a lot of our traditional healing to help these young men when they come back from Iraq, but the more combat veterans we put in Operation Glacier Warrior, the more help they'll get. What I'm saying is, there is a need. The more we can help these young men and women as older veterans, the better off we are.

Senator SALAZAR. Thank you.

Mr. Chapman, to you, the legislation, again, that all of us are supporting would create a program and make available like $50,000. Would that help with some of the transportation challenges here in Montana if your organization were to get a $50,000 grant a year?

Mr. CHAPMAN. It would help quite a bit. We buy our vans through donations and whatnot. We don't have the ability to get up to this area and work with people, so we could get a van in that area and then provide service to them.

Senator SALAZAR. Speaking of the Native Americans?

Mr. CHAPMAN. That's where the grant monies help out tremendously. It would then give us more opportunity to help us work with the hardest-to-serve regions.

Senator SALAZAR. If I could ask you, Dave, in terms of the Independent Budget, you obviously are very familiar with veterans' issues, the funding by the Congress, that we can get this done. We have a lot of struggle ahead of us before we get there, if we do fund the Independent Budget, and the VSO comes up with it, is that a step in the right direction?

Mr. MCLEAN. It's definitely a step in the right direction, yes.

Senator SALAZAR. We need your help. You know, we're out of time, but we've learned a lot from all of you.

Senator TESTER. Thank you, panelists, and Senator Baucus and Senator Salazar. It's not easy, but I appreciate your input and very, very much respect your point of view and it's very, very helpful.

Our second panel consists of some, once again, some very, very fine individuals from the VA in Washington, Dr. Richard Hartman, joined by the Undersecretary for Health for Operations and Management, Mr. Feeley, is the chief operations officer responsible for the Veterans Integrated Service Network. We're also pleased to have, and I had the opportunity to meet for the first time the head of the VISN here for Montana and Colorado, Dr. Glen Grippen. Dr. Grippen is joined by the head of the VA Hospital in Helena, Dr. Joe Underkofler. Joe Foster is here representing the State of Montana Veterans Affairs Division. I've had an opportunity to work with Joe on several occasions, he's a good man. General Randy Mosley, who also is a fine man in his own right.

Thank you very much for your service to the State. We're going to start out with Dr. Hartman. I'm going to ask you folks to be very brief. We've got very limited time, and I know there are a lot of questions to be asked of you fellows, so rock and fire.

STATEMENT OF RICHARD HARTMAN, PH.D., DIRECTOR FOR POLICY, ANALYSIS, AND FORECASTING, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM FEELEY, M.S.W., FACHE, UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Dr. HARTMAN. Good afternoon, Mr. Chairman, Members of the Committee and people of Montana and panelists. Thank you for the opportunity to discuss the VA's ongoing efforts to provide safe, effective, efficient and compassionate health care to veterans residing in rural areas. I'm accompanied by Mr. William Feeley, the VA's Deputy Undersecretary for Health Operations and Management.

My remarks will briefly review the national challenge presented by rural health care and the VA's strategic direction and initiatives that are underway. While I'm here to present the VA's national overview and direction for addressing the needs of our rural veterans, Mr. Grippen, Mr. Floyd and Mr. Underkofler are here to give you the firsthand account of their implementation and experience as it is happening here in Montana and in Network 19 with our veteran population.

Among the entire enrolled VA population, 39 percent were classified as rural veterans at the end of Fiscal Year 2006. And among the entire enrolled VA population, 2 percent were classified as "highly rural." Highly rural refers to counties with less than seven citizens per square mile.

Researchers have studied the rural health care experience, including a number of articles that looked at VA health care. Three studies have found that veterans living in rural areas tend to be slightly older and have slightly more physical health problems but fewer mental health conditions, as compared to suburban and urban veterans.

VA's strategic direction is to enhance non-institutional care with less dependence on large institutions. We provide home-based primary care as well as home-based programs. We're using telemedicine and tele-mental health to reach into the veterans' homes and into community clinics, including tribal clinics. This allows us to evaluate and follow patients without them having to travel to large medical centers. We're also using a special Internet site, providing information to veterans in their own home, including up-to-date research information, access to portions of their medical records and the ability to refill medications online.

To further increase access to care, the VA has over 880 outpatient clinics, of which over 700 are Community-Based Outpatient Clinics, or CBOCs, located around the country. Forty-five percent of our CBOCs are located in rural or highly rural areas. In addition, we are expanding these efforts with the establishment of outreach clinics, such as the one announced by the Secretary that will be opening in Craig, Colorado. There are currently 12 open outreach clinics.

VA is focusing additional attention on the special needs of veterans who reside in rural areas. In accordance with Section 212 of the Public Law 109–146, VA has 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 office is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VHA is working to incorporate the unique needs of rural veterans as new programs are implemented.

In addition to our internal efforts, VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of health care for rural veterans. We have partnerships with Health and Human Services, including the Indian Health Service, IHS, and HHS's Office of Rural Health Policy, collaborating in the delivery of health care in rural communities.

Thank you for your continuing support of our veterans. The VA recognizes the importance and the challenge of service in rural areas, and we believe our current and planned efforts are addressing these concerns for your current and emerging veterans. I'll be happy to answer any questions you may have.

[The prepared statement of Dr. Hartman follows:]

PREPARED STATEMENT OF RICHARD HARTMAN, PH.D., DIRECTOR FOR POLICY, ANALYSIS AND FORECASTING, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Mr. Chairman, Members of the Committee and visiting members. Thank you for the opportunity to discuss VA's ongoing efforts to provide safe, effective, efficient and compassionate health care to veterans residing in rural areas. I am accompanied today by Mr. William Feeley, VA's Deputy Under Secretary for Health for Operations and Management.

My remarks will briefly review the national challenge presented by rural health care and VA's strategic direction and initiatives that are underway. While I am here to present VA's national overview and direction for addressing the needs of our rural veterans, Mr. Grippen, Mr. Floyd and Mr. Underkofler are here to give you the firsthand account of their implementation and experience as it is happening here in Montana and Network 19 with our veteran population.

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Thank you for your continuing support of our veterans. VA recognizes the importance and the challenge of service in rural areas, and we believe our current and planned efforts are addressing these concerns for our current and emerging veterans. I will be happy to answer any questions you may have.

Senator TESTER. Thank you very much, Dr. Hartman. Do you have a flight to catch, Dr. Grippen?

Dr. GRIPPEN. All three of us do.

Senator TESTER. Dr. Grippen, you're up to bat next.

STATEMENT OF GLEN GRIPPEN, M.D., NETWORK DIRECTOR, VISN 19, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOE M. UNDERKOFLER, DIRECTOR, VA MONTANA HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS

Dr. GRIPPEN. Good afternoon, Mr. Chairman. Thank you for the opportunity to discuss VISN 19 and the health care services we offer to the veterans it's our privilege to serve. My remarks will primarily talk about the current programs and collaborative efforts in Network 19.

The VA Rocky Mountain Network 19 covers a geographic area of 470,000 square miles across nine states and principally serves the states of Colorado, Montana, Utah, and Wyoming. Our service area also extends into portions of Idaho, Kansas, Nebraska, Nevada and North Dakota. We are the second largest VA Network in terms of geographic area and deliver health care services to urban, rural and frontier locales. Distances between our medical centers, severe weather, secondary roads, and high mountain passes are significant factors to veterans' access to care.

Network 19 is constantly focused on providing care closer to veterans, both in their homes and in their communities. We have established Community Based Outpatient Clinics or Outreach Clinics as sites of the care to provide high quality primary care and mental health care to veterans. Network 19 currently has 32 CBOCs and one Outreach Clinic. Ten CBOCs are located in Colorado, five in Wyoming, nine in Montana, five in Utah, two in Nevada, one of which is an Outreach Clinic, one in Idaho, and one in Nebraska.

Most of these CBOCs are located in rural areas. Network 19 will open six additional sites of care in 2007 and 2008. These new sites are planned for the West Valley of Salt Lake City; Lewistown, Montana; Cut Bank, Montana; Craig, Colorado; Burlington, Colorado; and Elko, Nevada.

Network 19 is a national leader in Care Coordination and Telehealth. We serve more than 1,000 veterans in Care Coordination Home Telehealth programs. Fourteen care coordinators use disease management protocols and home telehealth technologies such as the Health Buddy. The Health Buddy is an in-home messaging device that serves as a connection between patients at home and care providers.

We have 26 other telehealth programs across the Network, including primary care, home care, cardiology, dermatology, retinal screening, radiology, rehab and polytrauma. We are using telemental health to reach into the veterans' homes and into community clinics. This allows us to evaluate and follow patients without them having to travel long distances.

Network 19 serves a large Native American population and through our Tribal Veterans Representative program, we have been successful in our outreach to the sovereign nations of Nevada, Idaho, Colorado, Wyoming and Montana. Agreements with the Indian Health Service have allowed us to expand our tele-mental health to the nations of the Crow, and Northern Cheyenne of Montana and the Eastern Shoshone and Northern Arapaho of Wyoming. We plan to expand tele-mental services to three reservations in Montana, Rocky Boy, Fort Belknap and Fort Peck in the next

six months. These agreements also open the door to establish referral patterns from IHS clinics to VA medical centers.

Access to mental health resources is one of the concerns facing veterans in rural areas. Therefore, comprehensive mental health care is one of the top priorities of VISN 19. We have added 140 mental health positions over the last 4 years. Some of these positions have been placed in CBOCs to add resources and greater mental health expertise in primary care sites. Each medical center has a designated Suicide Prevention Coordinator. These activities include identification of veterans at high risk for suicide and education of providers, veterans and families and members of the community. The Network has added staff to improve the coordination and delivery of care to the following programs: Post-Traumatic Stress Disorder, Substance Abuse, Mental Health/Primary Care Integration, Homeless programs, and for the re-entry of incarcerated veterans.

Network 19 is being called upon to deliver 21st century health care to 21st century combat veterans. They are young. Many have young families. Some have suffered traumatic injury on the battlefield. Our mission is to ensure continuity and improved coordination of health care for seriously injured veterans.

We have been aggressive with our outreach efforts to these soldiers by participating in the out-briefings for returning soldiers, and we make individual contact with soldiers identified by DOD as being injured. Our medical centers actively collaborate with state National Guard and Reserve components to ensure that no returning soldier slips through the cracks.

Network 19 has enhanced their Operation Enduring Freedom/Operation Iraqi Freedom program staff to provide intensive case management in every state for seriously injured soldiers. Transition Patient Advocates serve as personal advocates for seriously injured returning veterans by traveling to Walter Reed, meeting with the families, and helping the veteran navigate the VA system.

We have established a Polytrauma System of Care for veterans across the country. This system of care consists of teams of doctors, therapists, nurses, case workers and other health care experts who work closely with our patients and their families to provide top-quality individualized care. Our goal is to help veterans and service members achieve their highest potential level of recovery and functioning.

The Denver VA Medical Center has been designated as the VISN 19 Polytrauma Site, which works directly with the Palo Alto VAMC as our Polytrauma Rehabilitation Center. The Grand Junction VAMC and the Salt Lake City Medical Center have Polytrauma Support Clinics, and the Sheridan, Cheyenne and Montana VA Medical Centers have designated polytrauma points of contact. The goal of this system of care is to ensure that important specialty care can still be provided to veterans as close as possible to their homes.

Senator TESTER. Could I just get the rest of your testimony just to put in the record, and then we'll have some time for questions. Appreciate your participation very much. Thank you.

Dr. GRIPPEN. Senators, thank you.

[The prepared statement of Dr. Grippen follows:]

PREPARED STATEMENT OF GLEN GRIPPEN, NETWORK DIRECTOR, VISN 19, DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Mr. Chairman and Members of the Senate Committee on Veterans' Affairs. Thank you for the opportunity to discuss the VA Rocky Mountain Network 19 and the health care services we offer to the veterans it is our privilege to serve. My remarks will briefly review current programs and collaborative efforts in Network 19 and our plans to increase services and access to care.

The VA Rocky Mountain Network 19 covers a geographic area of 470,000 square miles across nine states and principally serves the states of Colorado, Montana, Utah, and Wyoming. Our service area also extends into portions of Idaho, Kansas, Nebraska, Nevada, and North Dakota. We are the second largest VA Network in terms of geographic area and deliver health care services to urban, rural and frontier locales. Distances between our medical centers, severe weather, secondary roads, and high mountain passes are significant factors to veterans' access to care.

Network 19 has consequently focused on providing care closer to veterans both in their homes and in their communities. We have established Community Based Outpatient Clinics (CBOCs) or Outreach Clinics as sites of care to provide high quality primary care and mental health care to veterans. Network 19 currently has 32 CBOCs and one Outreach Clinic: ten CBOCs are located in Colorado, five in Wyoming, nine in Montana, five in Utah, two in Nevada—one of which is an outreach clinic—one in Idaho, and one in Nebraska. Most of these CBOCs are located in rural areas. Network 19 will open six additional sites of care in FY 2007 and FY 2008. These new sites are planned for the West Valley of Salt Lake City; Lewistown, Montana; Cut Bank, Montana; Craig, Colorado; Burlington, Colorado; and Elko, Nevada.

Network 19 is a national leader in Care Coordination and Telehealth. We serve more than 1,000 veterans in Care Coordination Home Telehealth programs. Fourteen care coordinators use disease management protocols and home telehealth technologies such as the Health Buddy. The Health Buddy is an in home messaging device that serves as a connection between patients at home and care providers, facilitating patient education and monitoring of chronic diseases. We have 26 other telehealth programs across the Network including primary care, home care, cardiology, dermatology, retinal screening, radiology, rehabilitation and polytrauma. We are also using tele-mental health to reach into the veterans' homes and into community clinics. This allows us to evaluate and follow patients without them having to travel long distances.

Network 19 serves a large Native American population and through our Tribal Veterans Representative program, we have been successful in our outreach to the sovereign nations of Nevada, Idaho, Colorado, Wyoming, and Montana. Agreements with the Indian Health Service (IHS) have allowed us to expand our tele-mental health program to the nations of the Crow, and Northern Cheyenne of Montana, and the Eastern Shoshone and Northern Arapahoe of Wyoming. We plan to bring tele-mental services to three reservations in Montana (Rocky Boy, Fort Belknap and Fort Peck) in the next 6 months. These agreements also open the door to establish referral patterns from IHS clinics to VA medical centers, and improve sharing of medical information.

Access to mental health resources is one of the concerns facing veterans in rural areas. Therefore, comprehensive mental health care is one of the top priorities for Network 19. We have added 140 mental health positions. Some of these positions have been placed in CBOCs to add resources and greater mental health expertise in primary care clinics. Each medical center has a designated Suicide Prevention Coordinator. Their activities include identification of veterans at high risk for suicide and education of providers, veterans and families and members of the community. The Network has added staff to improve the coordination and delivery of care to the following programs: Post Traumatic Stress Disorder; Substance Abuse; Mental Health/Primary Care Integration; Homeless programs; and for the re-entry of incarcerated veterans.

Network 19 is being called upon to deliver 21st century health care to 21st century combat veterans. They are young. Many have young families. Some have suffered traumatic injury on the battlefield. Our mission is to ensure continuity and improved coordination of healthcare for seriously injured or ill servicemembers returning from theaters of combat as they transition from DOD to VA.

We have been aggressive with our outreach efforts to these soldiers by participating in out-briefings for returning soldiers and we make individual contact with soldiers identified by DOD as having an injury. Our medical centers actively collaborate with state national Guard and Reserve components to ensure that no returning soldier slips through the cracks.

Network 19 has enhanced their Operation Enduring Freedom/Operation Iraqi Freedom program staff to provide intensive case management in every state for seriously injured soldiers. Transition Patient Advocates serve as personal advocates for seriously injured returning veterans by traveling to Walter Reed, meeting with the families, and helping the veteran navigate the VA system.

We have established a Polytrauma System of Care for veterans and active duty personnel with lasting disabilities due to Polytrauma and Traumatic Brain Injury. This system of care consists of teams of doctors, therapists, nurses, case workers and other health care experts who work closely with our patients and their families to provide top-quality individualized care. Our goal is to help veterans and servicemembers achieve their highest possible level of recovery and functioning. The Denver VA Medical Center has been designated as the VISN 19 Polytrauma Site working directly with the Palo Alto VAMC as our Polytrauma Rehabilitation Center. The Grand Junction VAMC and the Salt Lake City Medical Center have Polytrauma Support Clinics and the Sheridan, Cheyenne and Montana VA Medical Centers have designated Polytrauma points of contact. The goal of this system of care is to ensure that important specialty care can still be provided to veterans as close to home as possible.

Also, the Vet Center program provides quality readjustment counseling and community outreach to combat veterans and their families. There are several Vet Center sites throughout VISN 19's geographical area.

The demand for Long Term Care has greatly increased due to the aging veteran population. Network 19 has developed an array of home and community based care services. We have five Home Based Primary Care Programs in our VISN. In addition, VISN 19 has a unique program for non-VA, or fee basis care which includes a nurse-managed system of care authorization and review. Through this system we have supported home based care and community based outpatient care—devoting more than $28.5 million to this program in FY 2007 to date, and almost $61 million to care in the community.

Contracts with community care providers also serve to improve access. As an example, in Montana, where advanced practice mental health providers have traditionally been scarce, we contract with three community mental health systems across the state to augment VA staff and provide treatment of severe mental illness, medication management, psychotherapy, and case management for veterans in their local communities.

Transportation in the Rocky Mountain States is an unremitting challenge. Assistance from the Disabled American Veterans Transportation Network makes the journey to secondary care much easier for our patients. DAV has established a responsive, professional network and we cannot thank them enough. In the last 6 months in Montana alone, DAV has operated 46 vans, utilizing 246 volunteer drivers who have driven almost 400,000 miles and transported almost 9,000 veterans for VA care.

Network 19 is committed to providing quality health care to veterans, regardless of where they live. New technologies allow us to provide that quality care in any location. We remain keenly aware of the importance and challenges of service in rural areas, and believe our current and planned efforts are addressing these concerns for our current and emerging veterans.

This concludes my statement. At this time I would be pleased to answer any questions you may have.

Senator TESTER. Joe Foster is next.

STATEMENT OF JOE FOSTER, ADMINISTRATOR, MONTANA VETERANS AFFAIRS DIVISION

MR. FOSTER. Thank you for taking your time to be with us here today.

The Montana Veterans Affairs Division does not provide health services to veterans. However, we are instrumental in the process by which all our veterans, particularly those in Montana's rural areas, attain Federal VA health services and benefits. We currently operate 10 veterans service offices located throughout the state; and it is through these offices that the great majority of Montana's veterans attain Federal VA disability compensation, pension and burial benefits, and have the opportunity to enroll into the VA Montana Healthcare System, either by completing the VA Form

10–10 EZ or through the process of being rated with some level of service-connected disability.

Outside of a community-based veterans service office in Hamilton, my agency's service offices are the only ones located outside of the Fort Harrison VA Center near Helena, and it is through these State of Montana offices that the great majority of our veterans attain the benefits to which they are entitled. In fact, within two months, we will be establishing our 11th veterans service office, which will be located in Wolf Point, and its outreach area will include the northeastern corner of the state.

According to the 2000 census, Montana has the third lowest population density in the Nation, with 46 percent living in what is officially termed "Rural Areas." As it happens, Montana has the Nation's second-highest veteran per capita population. So, obviously, we have veterans outreach service challenges in regards to the provision of veteran health and benefits access and services.

Before I make my lone recommendation which would assist the Montana Veterans Affairs Division in providing greater services to its rural veterans, I will share three statistics with you that reflect how good a job the VA-Montana Healthcare System, the VA Montana's Veterans' Benefits Regional Office, the state's veterans service organizations, and the Montana Veterans Affairs Division does in the outreach of its services to your veterans, both rural and nonrural.

These statistics are part of an analysis I conducted in 2005 and presented to the Montana Legislature's State Administration and Veterans Affairs Interim Committee, and each directly reflects how well VA health and benefit services are provided in our extremely rural state compared to nationally and to our western region.

First, in 2004, almost 25 percent of Montana's vets were enrolled in the VA Healthcare System. This percentage was the 9th highest nationally and 2nd highest in the 11 Western States I compared—Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming.

Second, in 2004, 12.1 percent of Montana's veterans were receiving Federal VA disability compensation. This percentage was 15th highest nationally and 4th highest in the 11 western states.

And, last, Power of Attorney representation. This is a document a veteran signs which authorizes my Division or one of the national veterans service organizations to represent him or her in developing a disability compensation claim and serving as that veteran's advocate throughout the claims development, rating and, as necessary, appeals process. Essentially,a it is the authorizing document whereby a veteran attains professional veterans benefits services. In 2004, 76.3 percent of Montana's veterans had power of attorney representation. This percentage was second highest nationally and number one of the 11 Western States.

To summarize, despite the challenges inherent in such a large and rural state, Montana has a veterans services program that works very well and continues to improve and, in fact, is a national leader and model to be emulated. With continued support from Congress and from Montana's Governor and legislature, we will continue to improve, which takes me to my lone recommendation.

Various bills have been introduced in Congress intended to provide Federal grants to the states for rural veterans service outreach programs. This kind of financial support is needed and would be appreciated. I believe that the grants should be made available strictly at the state organizational level and at the Tribal Nation level, and the grant's usage should be left entirely up to the state of the Tribal Nation, no strings attached, just performance measures.

[The prepared statement of Mr. Foster follows:]

PREPARED STATEMENT OF JOE FOSTER, ADMINISTRATOR, MONTANA VETERANS AFFAIRS DIVISION

Senator Tester, Senator Baucus and Senator Salazar, thank you for investing your valuable time to being with us in Montana, and asking me to participate in this hearing, which is to focus on veteran health care and services in rural areas.

While the Montana Veterans Affairs Division does not provide health services to veterans, we are instrumental in the process by which all our veterans—particularly those in Montana's rural areas—attain Federal VA health services and benefits. We currently operate 10 veterans service offices located throughout the state; and it is through these offices that the great majority of Montana's veterans attain Federal VA disability compensation, pension and burial benefits; and have the opportunity to enroll into the VA-Montana Healthcare System—either by completing the VA Form 10–10 EZ or through the process of being rated with some level of service-connected disability.

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To summarize, despite the challenges inherent in such a large and rural state, Montana has a veterans services program that works very well and continues to improve, and—in fact—is a national leader and model to be emulated. With continued

support from Congress, and from Montana's Governor and legislature, we will continue to improve—which takes me to my lone recommendation:

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Thank you for this opportunity to speak, and thank you, Sen. Tester, for bringing this hearing to Montana.

Senator TESTER. Thank you very much. Appreciate it.

General Mosley, unfortunately, we're about out of time, so you have to make it brief.

STATEMENT OF MAJOR GENERAL RANDALL MOSLEY, ADJUTANT GENERAL, MONTANA NATIONAL GUARD

General MOSLEY. Mr. Chairman and Members of the Committee, you have a report I have given you. I thank you for the opportunity to partner with you. Senator Baucus, you made the comment that you wanted to be able to look back after this hearing and say that we were able to get things done. The last time I had an opportunity to partner with Montana's delegation was during BRAC. And during BRAC, under the leadership of the Montana senators, we were able to convince the Air Force that they were wrong. And with the help of Montana State Government, the citizens and the people of the community, we changed the outcome of BRAC. I think the opportunity is today just like as it was then, we have the opportunity in this particular issue to partner together to change how we are going to treat Montana veterans.

As I say, in my packet, you have the information, I'll point out a couple things that are there besides the report. The first is a map of Montana overlaid on the Eastern seaboard. One end of Montana is at Washington, DC, and the other is at Bangor, Maine. You would not convince anyone living in Washington, DC, that they would have to drive to Bangor, Maine to get any type of health care. This is not like anywhere else.

My second point in there, again, is a map of Montana, the counties where all the Montana Guardsmen reside and where the VA health care centers are located. My testimony was to be pretty much in support of the report that was put together to assess the Montana National Guard, the Reserve components, post-deployment health reassessment program. It was brought to the forefront when one of our own members, almost 18 months after returning, tragically committed suicide. This sad fact is occurring across the Nation. This is an examination of our program as well as the partnership between DOD and the Federal VA, and there are areas where all of us need to change our practices and improve. I think that with your help and assistance, that we can do that.

That's pretty much, in the time allowed, what I would make the statement on. Please take time to go through the report, and I'll be glad to work with your staff. My staff is analyzing every recommendation made, and we will be working with your staffs on that. There are three authors of this report, State Representative Julie French, Mr. Joe Foster, and Mr. Joe Underkofler, who are here today.

I think State Representative, Julie French, would say the issue was really brought up because it was families that contacted her. Our soldiers don't necessarily contact the chain of command and tell them anything. It's the family members who contact our family readiness programs and others, say, Hey, I've got a problem with my spouse and you need to help me with it. It's a partnership all the way through that we've got to strengthen.

Thank you.

[The prepared statement of General Mosley follows:]

PREPARED STATEMENT OF MAJOR GENERAL RANDALL D. MOSLEY, ADJUTANT GENERAL, MONTANA NATIONAL GUARD

Dear Comittee Members:

Thank you for the opportunity to present testimony to the field hearing of the U.S. Senate Committee on Veterans' Affairs in Great Falls, Montana concerning the Needs of Veterans in Rural Areas. I am the Commanding General of the Montana National Guard, the Director of the Montana Department of Military Affairs, and a member of the Governor's cabinet. As the Commanding General, I am responsible for the medical readiness of the state's National Guard. As Director of the Montana Department of Military Affairs, I am a member of the Montana Board of Veterans Affairs which is responsible for statewide service to veterans.

The Montana National Guard consists of over 3,700 members who live in virtually every corner of the state. Since 2001, over 80 percent have been mobilized for Federal active duty; and since release from this duty are now eligible for enrollment in the VA health care system.

The medical readiness and health care of our post-deployment Guardsmen are of extreme importance to both the Governor and me. Recently, the Montana National Guard's Post-Deployment Health Reassessment (PDHRA) program's scope, execution and adequacy were brought to the forefront when Montana Army National Guard member, Specialist Christopher Dana, tragically committed suicide on March 4, 2007. Specialist Dana was federally activated as part of the Montana-based 1–163rd Infantry Battalion, and deployed to Iraq where he served honorably in an intense combat environment.

When the battalion's tour of duty ended in late 2005—after 18 months away from home—Specialist Dana was rapidly processed through Department of Defense demobilization facilities to expedite both his return home and reintegration into the civilian environment. This expedited approach is standard operational procedure for Reserve Component (National Guard and Reserve) units whose tour of duty supporting Operation Iraqi Freedom or Operation Enduring Freedom has ended.

However, Chris Dana's suicide—as well as the many others that have occurred nationwide in the aftermath of National Guard and Reserve combat veterans' return to mainstream civilian life—has prompted Montana's critical assessment of the PDHRA program's effectiveness in reintegrating combat veterans into civilian society. Active component military members that return to a base or fort can readily access the installation's mental and physical health services infrastructure. On the other hand, Reserve component combat veterans are transitioned very rapidly into the civilian environment—an environment that does not necessarily understand what the veteran has been through, and does not necessarily have readily identifiable or available mental health services.

A task force of mental health professionals, state and Federal healthcare personnel, state legislators, and veterans service organizations representatives were assembled to review the PDHRA process (as mandated by the Department of Defense) and provide recommendations to use in improving the overall reintegration and reconstitution process of the state's Reserve component military members. Their findings and recommendations, contained within the attached report, envision a statewide network of education, support services, and resources that will meaningfully assist Montana's veterans cope with the emotional and mental health issues resulting from serving in combat; and who—once home—are expected to smoothly reintegrate into a civilian lifestyle.

The Task Force report validated that the Montana National Guard is following the established Department of Defense (DOD) guidance and standards for Post Deployment Health Reassessment. However, the report points out that the DOD guidance is inadequate to sufficiently support Soldiers and Airmen returning from theater operations. Specifically, the report lists 10 findings with 16 recommendations suggesting corrective action. Listed below are some of the findings and recommenda-

tions from the report which the Task Force determined impact the National Guard, as well as Reserve and Active Component combat veterans, in their successful reintegration into the mainstream, civilian environment. I have borrowed liberally the verbiage contained in the report, especially as it pertains to veteran healthcare.

A Significant finding found the Post-Deployment Process for returning veterans to be failing in many areas, noting that it has not been suitably effective nor conducted in an environment that facilitates attaining needed information from veterans who may have or are developing Post-Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI) conditions. The Task Force noted a number of deficiencies. Demobilization station and home station processing is ineffective in identifying mental health issues, except for those who self-report, or have already been identified during military service. Identification of a veteran's need for mental health services is ultimately based upon self-reporting. Query and counseling processes supporting self-reporting are not mandatory, and existing query and health assessment processes are not effective in proactively identifying veterans who may need assistance. The query and health assessment events are conducted only for a finite time frame. When conducted, they are not done in an environment that provides sufficient confidentiality—while mitigating any stigmatizing impact. Further, the personnel conducting the query or health assessment do not necessarily have the type of professional or technical training, education or experience needed to adequately recognize a Guardsman's emotional or mental health status. Also at issue is the effectiveness and suitability of the query or health assessment instruments used.

The onset of emotional or mental health disability symptoms is variable and unpredictable. Symptoms may manifest immediately or take years, which is problematic for Guardsmen (and other combat veterans) who have been discharged and are no longer a member of a military organization. Veteran enrollment into the Federal VA healthcare system is not automatic, with insufficient command emphasis to ensure this action takes place.

Another finding addresses the fact that veterans are reluctant to disclose mental health issues. Several factors lead to this finding; to include concern about negative impacts on their employment and career (both in the military and civilian sectors), a perceived social stigma attached to emotional or mental health conditions or disorders, and a lack of knowledge about or sufficient confidence in available mental health services. A veteran's reluctance to disclose mental health issues is further impacted by a lack of awareness by the general public, employers, and veterans' family members regarding the nature of mental health conditions; as well as access to and treatment of these types of conditions.

The report also noted a lack of statewide availability of counseling resources, particularly in rural areas. Montana is the fourth largest state but with fewer than 1 million residents. Many parts of the state are without a robust size community capable of sustaining medical or mental health professions. The availability of these services may not be timely enough or available in needed frequency or proximity. Additionally, a specific centralized coordination and referral capability does not exist. Counseling services that are or may be available do not necessarily know about each other. These services include health services offered by the Federal VA, Montana Department of Public Health and Human Services, and the communities.

The Task Force also found that National Guard commanders lack education on mental health issues, and the organization lacks an effective and well-publicized operational standard and policy that would support and maximally retain in military service a Guardsman who has a diagnosed emotional or mental health condition. In addition, veterans service organizations (e.g., American Legion, Disabled American Veterans, Veterans of Foreign Wars, Vietnam Veterans of America) have posts/chapters located throughout the state and are not consistently utilized as a resource to assist in the post-deployment needs. The number of Federal VA Vet Centers is limited and needs to be expanded to cover rural areas of Montana.

The Task Force developed sixteen recommendations that would markedly improve the post-deployment health of our returning veterans. Expanding and enhancing the PDHRA process was viewed as a critical component; leading off with completion of an initial PDHRA for Guardsmen within 90 days after discharge from active-duty status or during the first scheduled National Guard drill period—whichever is earlier. Subsequent PDHRAs need to be scheduled and conducted every 6 months after the initial query or assessment until a two-year time span has elapsed. After the 2–year period, the PDHRA process will accompany the required Periodic Health Assessment action. This process needs to be accomplished for as long as the Soldier or Airman is in the military. Expanding the PDHRA process is currently outside the scope and provided resources of the DOD program. Providing additional resources to the existing program would ensure program enhancements such as the use of

more comprehensive and effective mental health assessment instruments in the PDHRA process, e.g., VA screening templates, or other survey instruments such as the Mississippi Scale or the Beck Inventory. Two additional enhancements needed are the inclusion of a "face to face" educational component in the PDHRA process during which issues related to mental illness stigma and self-reporting of mental health symptoms are discussed and a referral of Guardsmen who are identified as having mental health issues to appropriate mental health professionals.

Other recommendations included: Mandate and monitor Guardsmen enrollment in the VA healthcare system through completion and submission of the VA Form 10–10EZ immediately after redeployment. Develop and implement a comprehensive training program for command leadership and unit personnel that provides information on mental health issues such as combat stress, anxiety, depression and traumatic brain injury; leadership also needs to be educated on treatment methods for these conditions and educated as to available resources. Develop, publish and distribute to all National Guard units and individual Guardsmen an information guide that contains—at a minimum—civilian and Federal VA resources for medical and mental health services and care. Provide information to the National Guard chain-of-command and all members regarding programs, resources and contact information to be used when a unit member self-reports or is identified as needing assistance for emotional or mental health conditions; which would also be posted in the Montana National Guard's web site. Actively participate in the newly authorized Suicide Prevention Program to be administered by the Montana Department of Public Health and Human Services. Facilitate the development and implementation of increased "informal" support systems such as the "Vet to Vet" peer support program; and encourage—at both state and unit command levels—a more active and mutually supportive relationship with the state's veterans service organizations.

I have tasked my staff to immediately review the Task Force Report and develop a strategy which addresses the above outlined findings. Some of the corrective actions necessary to better support our veterans and to satisfy the Task Force recommendations can be accomplished within my authority as Adjutant General. However, some of the corrective measures need assistance from your level. I have directed my staff to contact and work closely with Montana's Congressional Delegation to begin collaborating on effective solutions to better serve our Montana Soldiers and Airmen.

Your continued support of the Nation's veterans is truly appreciated.

[The PDHRA Task Force Report follows:]

POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA) PROGRAM

PDHRA TASK FORCE REPORT

ASSESSMENT AND RECOMMENDATIONS

Submitted To:
Randall D. Mosley
Major General, Montana National Guard
The Adjutant General

June 2007

PDHRA TASK FORCE MEMBERSHIP

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Department of Military Affairs

♦ ***Larry Winslow***
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♦ ***Joyce DeCunzo***
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Montana Senate
Senate District 2

♦ ***Brian Garrity***
Interim Mental Health Ombudsman
Governor's Office

June 29, 2007

Major General Randall D. Mosley:

As directed by you, the Post-Deployment Health Reassessment Program (PDHRA) Task Force was convened in April 2007 to critically analyze the Montana National Guard's PDHRA program and generate recommendations to enhance its effectiveness. This report of our findings and recommendations is provided for your review and consideration.

We thank you for the opportunity to participate in this important process, and believe that the recommendations – if implemented – will markedly improve the PDHRA program.

Sincerely,

Joe Foster
Chairman

POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA) PROGRAM

GOAL AND TASK FORCE GUIDANCE

PDHRA GOAL

The goal of the Post Deployment Health Reassessment Program is to educate Soldiers and Airmen about the normal reactions to abnormal situations that they may have experienced, to encourage honest and full disclosure, to try to provide the healthcare that each Soldier and Airman needs and deserves, and to ensure the physical and mental readiness of the force.

ISSUE

Does the Montana National Guard PDHRA program adequately identify both medical and behavioral health issues that arise from deployment in a manner that provides for effective and efficient follow-up and treatment?

DIRECTED OUTCOME

Using Task Force expertise, review the PDHRA program to identify needed changes and confirm its adequacy. Prepare a report listing recommendations on how the Montana National Guard can better meet the stated goal of the PDHRA program.

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OVERVIEW STATEMENT

The Montana National Guard's Post-Deployment Health Reassessment (PDHRA) program's scope, execution and adequacy were brought to the forefront when Montana Army National Guard member, Specialist Christopher Dana tragically committed suicide March 4, 2007. Specialist Dana was federally activated as part of the Montana-based 1-163rd Infantry Battalion and deployed to Iraq where he served honorably in an intense combat environment.

When the battalion's tour of duty ended in late 2005 after 18 months away from home, Specialist Dana was rapidly processed through Department of Defense demobilization facilities to expedite his return home and reintegration into the civilian environment. This expedited approach is standard operational procedure for Reserve Component (National Guard and Reserve) units whose tour of duty supporting Operation Iraqi Freedom or Operation Enduring Freedom has ended.

However, Chris Dana's suicide – as well as the many others that have occurred nationwide in the aftermath of National Guard and Reserve combat veterans' return to mainstream civilian life – has prompted Montana's critical assessment of the PDHRA program's effectiveness in reintegrating combat veterans into civilian society.

To the Montana National Guard's credit, a reintegration program was established and implemented well before the PDHRA program was mandated by the Department of Defense; and once mandated, the Guard followed the directives, provided the resources, and – though not included in the "official" PDHRA process – continued to conduct reintegration informational briefings. Painfully obvious, however, is that the citizen-soldier, now a combat veteran, oftentimes needs services and support resources that extend far beyond what the Montana National Guard or the PDHRA program currently offer.

This report, as directed, provides recommendations for the Montana National Guard to use in improving the overall reintegration and reconstitution process of its Soldiers and Airmen. This report also recognizes that the Montana National Guard's combat veterans are but a microcosm of those who reside in our large state – which includes those still serving, those discharged from the Guard or Reserve units, and those discharged from active military service.

Therefore, recommendations in this report envision a statewide network of education, support services, and resources that will meaningfully assist Montana's veterans cope with the emotional and mental health issues resulting from serving in combat; and who – once home – are expected to smoothly reintegrate into a civilian lifestyle.

The recommendations presented in this report are considered attainable and pertinent, and are based upon a process that began with the groups first meeting on April 10, 2007, and meeting every week – but one – until the report's completion. The general public and military members were also invited to participate in the process. On April 24, 2007, the Task Force hosted a public hearing where concerned citizens and Guardsmen provided important, heart-felt testimony and suggestions, many of which are reflected in this report.

Further, a web-based survey was made available to Montana National Guardsmen as a way to obtain their thoughts on the PDHRA program. This 10-question survey was conducted over a two-month period, and yielded 308 complete responses. These also provided the Task Force with valuable information and insights.

The personal anguish that Specialist Dana endured is shared by many other combat veterans, their families and friends. It is our collective duty to recognize the inadequacies of the PDHRA program and thoughtfully identify and implement programs and processes that can truly serve those who served so honorably and selflessly on our behalf. These brave men and women lived in constant mortal danger a half a world away. Now, at home where they should feel safe and at peace, many shoulder a burden only a few can truly appreciate.

To all those who have stepped forward to offer assistance and provide information, personal insight and perspective – the Task Force thanks you. You all have directly contributed to an important vision of assistance and support for our Montana veterans and their families.

Sincerely and on behalf of the PDHRA Task Force,

Joe Foster
Chairman

INTRODUCTION

This report takes into account the enhancements the Montana National Guard incorporated into its implementation of the PDHRA program, which was designed and mandated by the Department of Defense. However, after listening to those the program is intended to serve and evaluating the PDHRA process in depth, the Task Force considers the program falls short in fulfilling its intended mission, which is to reintegrate combat veterans into the civilian environment.

Before branching out to other related topics, Task Force discussion began with this question: Does the Montana National Guard PDHRA program adequately identify both medical and behavioral health issues that arise from deployment in a manner that provides for effective and efficient follow-up and treatment?

After careful study, the Task Force's assessment is: No, it does not.

However, further clarification is in order. The PDHRA program and its content originated from the Department of Defense and was mandated through the National Guard Bureau (the national authority over state National Guard organizations) to the Montana National Guard. The Task Force finds that the Montana National Guard conducted its PDHRA program "by the book." In fact, it supplemented the PDHRA program with additional and pertinent informational briefings.

However, the Task Force considers the PDHRA program deficient. It does not provide the vision, operational conduct, or resources necessary to adequately identify medical or behavioral health issues that arise from deployment, or provide for proper follow-up and treatment either upon a Guardsman's return from deployment or in the aftermath when emotional or mental health issues often begin to emerge.

As a matter of organization, this report first identifies the Task Force's *Findings*. The *Findings* specify the PDHRA program's shortfalls, as well as other issues that, in varying degrees, impede a combat veteran's successful reintegration. Many *Findings* are quite inclusive in scope and are further defined with related areas of concern.

The report then provides *Recommendations* to the National Guard that the Task Force believes will significantly improve the PDHRA program and processes, as well as other aspects of the reintegration challenge. The *Recommendations*, while predominately directed to the Montana National Guard, also include initiatives for other agencies in an effort to comprehensively address reintegration issues.

The report includes additional, pertinent information provided in three appendices. The first provides a report of the PDHRA program's current content and its implementation in Montana. The second provides the results of the Guardsmen survey, and the third appendix provides a list of available resources that National Guard members can access for assistance if dealing with mental health issues.

FINDINGS

Listed are issues the Task Force determined impact National Guard, as well as Reserve and active component combat veterans, in their successful reintegration into the mainstream, civilian environment.

Finding #1
Post-Deployment Process Failing in Many Areas

Military post-deployment personnel reintegration processes, policies, query or assessment instruments have not been suitably effective nor conducted in an environment that facilitates attaining needed information from veterans who may have or are developing post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI) conditions.

a. Demobilization station identification processes are ineffective for identifying mental health issues, except for those who self-report, or have already been identified during military service.

b. Home station processing is "endured," soldier and family attention span is limited, and information provided is overwhelming. The most important and pertinent information is not succinctly provided; rather, the veteran and veteran family members are inundated with paperwork and materials.

c. Existing query and health assessment processes are not effective in proactively identifying veterans who may need assistance. The query and health assessment events are conducted only for a finite timeframe. When conducted, they are not done in an environment that provides sufficient confidentiality – while mitigating any stigmatizing impact. Further, the personnel conducting the query or health assessment do not necessarily have the type of professional or technical training, education or experience needed to adequately recognize a Guardsman's emotional or mental health status. Also at issue is the effectiveness and suitability of the query or health assessment instruments used.

d. Onset of emotional or mental health disability symptoms is variable and unpredictable. Symptoms may manifest immediately or take years, which is problematic for Guardsmen (and other combat veterans) who have been discharged and are no longer a member of a military organization.

e. Veteran enrollment into the federal VA healthcare system is not automatic, with insufficient command emphasis to ensure this action takes place.

f. Identification of a veteran's need for mental health services is ultimately based upon self-reporting. Query and counseling processes supporting self-reporting are not mandatory, except for the National Guard's Periodic Health Assessment.

Finding #2
Problems Created When Combat Teams Are Separated

Montana's infantry battalion was deployed to Iraq and functioned as "combat teams." Upon demobilization and return to Montana, the combat teams, which provide a level of mutual support and understanding, were broken up due to mandated unit reorganizations (e.g., units disbanded or new units formed) or Guardsman reassignments to other units. The break-up of the combat team has caused unintended and unanticipated consequences.

a. Active component combat teams that return to a base or fort relatively intact can readily access the installation's mental health services infrastructure. On the other hand, reserve component combat veterans are transitioned very rapidly into the civilian environment – an environment that does not necessarily understand what the veteran has been through and does not necessarily have readily identifiable or available mental health services.

b. Montana National Guard combat team break-ups and the National Guard Bureau policy of no mandated drill for three months after the combat veteran's return can isolate soldiers from those who can provide mutual support and understanding.

Finding #3
Delays in Attaining Awards, Medals and Badges Impact Morale

The perception exists that Montana state government and National Guard leadership doesn't care.

a. There are delays in processing campaign awards, medals and badges, including, notably, the Combat Action Badge (CAB) and Combat Infantry Badge (CIB). Delays in receiving these and other awards negatively impact the veteran's morale and confidence in military leadership. In addition, the CAB and CIB are two awards that represent a veteran's combat experience and may have a direct impact on a combat veteran receiving significant federal VA benefits. Without the CAB or CIB award, the veteran can experience significant delays in obtaining certain federal VA entitlements and medical services.

b. Regulatory discharge processes and nature of the discharge ("less than honorable") for Guardsmen not attending drill periods do not take into account the affected persons emotional or mental health conditions.

c. Unit-level information regarding resources and processes to assist its members in attaining needed mental health services is not sufficiently available.

d. There is a perceived lack of recognition from the Governor's Office due to Guardsmen not receiving a "Governor's coin."

Finding #4
Veterans Reluctance to Disclose Mental Health Issues

Veterans are hesitant to come forward with emotional or mental health issues.

a. Guardsmen are concerned about negative impacts on their employment and career, both in the military and civilian sectors.

b. There is a perceived social stigma attached to emotional or mental health conditions or disorders.

c. In general, there is a lack of knowledge about or sufficient confidence in available mental health services.

d. Returning Guardsmen have personal pride and may struggle to admit that "something is wrong." The veteran doesn't want to be seen as "weak," be it personally or by family, friends, or work colleagues.

Finding #5
Inadequate Public Awareness on Veteran Mental Health Issues

There is a lack of awareness by the general public, employers, veterans, and veterans' family members regarding the nature, access to and treatment of mental health conditions.

Finding #6
Lack of Counseling Resources in Some Locations

Statewide availability of counseling resources is limited, particularly in rural areas. The availability of these services may not be timely enough or available in needed frequency or proximity.

Finding #7
Counseling Services Lack Coordination

A specific centralized coordination and referral capability does not exist at the State or National Guard level. Counseling services that are or may be available do not necessarily

know about each other. These services include federal VA, Montana Department of Public Health and Human Services, community health services, or more types of services, such as those provided in various support groups (e.g. "Vet to Vet" concept).

Finding #8
Guard Commanders Lack Education on Mental Health Issues

The National Guard unit-level command structure lacks an education program where its members can learn to recognize and understand emotional or mental health conditions and symptoms, and the resources available to assist with these types of conditions. Further, the National Guard lacks effective and well-publicized operational standards and policies that would support and maximally retain in military service a Guardsman who has a diagnosed emotional or mental health condition.

Finding #9
Family Readiness Program Lacks Resources

The National Guard's family readiness program is required by regulation to serve all Montana reserve component military organizations before, during, and after any activation into federal military duty. The existing organizational structure, resources, scope of services, and mission-focus all lack the ability to fulfill its regulatory intent and consistent role in military member and family care issues.

Finding #10
Veterans Service Organizations Are Underutilized

Veterans service organizations (e.g., American Legion, Disabled American Veterans, Veterans of Foreign Wars, Vietnam Veterans of America) have posts/chapters located throughout the state and are not consistently utilized as a resource to National Guard units and family programs.

RECOMMENDATIONS for MONTANA NATIONAL GUARD

In response to the *Findings* previously discussed, the Task Force submits the following *Recommendations* directed to the Montana National Guard.

Recommendation #1
Evaluate Medical Status Before Discharge

Do not initiate discharge processes for an Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) Guardsman for "failure to perform" (e.g., nonattendance at drill periods) until his or her physical or mental health status has been assessed.

Recommendation #2
Allow Guardsmen to Request Honorable Discharge

Provide an opportunity for OEF/OIF Guardsmen to request an honorable discharge based on physical or mental health reasons.

Recommendation #3
Thoroughly Review All Guard PDHRA Personnel Files

Thoroughly review all OEF/OIF Guardsmen's personnel records to identify those who have not been through the PDHRA process. Ensure that these personnel are immediately scheduled to complete this process.

Recommendation #4
Expand the PDHRA Process

Plan and implement a long-term, enhanced PDHRA process that ensures:

a. Completion of an initial PDHRA for Guardsmen within 90 days after discharge from active-duty status or during the first scheduled National Guard drill period – whichever is earlier. Subsequent PDHRAs will be scheduled and conducted every six months after the initial query or assessment until a two-year timespan has elapsed. After the two-year period, the PDHRA process will accompany the required Periodic Health Assessment action. This process will be accomplished for as long as the Soldier or Airman is in the Montana National Guard.

b. Use of more comprehensive and effective mental health assessment instruments in the PDHRA process, e.g., VA screening templates, or other survey instruments such as the Mississippi Scale (screens for PTSD conditions) or the Beck Inventory (screens for depression).

c. Inclusion of a "face to face" educational component in the PDHRA process during which issues related to mental illness stigma and self-reporting of mental health symptoms are discussed.

d. Referral of Guardsmen who are identified as having mental health issues to appropriate mental health professionals. The National Guard will monitor referral actions and request reports of care.

Recommendation #5
Mandate Enrollment in the VA Healthcare System

Mandate and monitor Guardsmen enrollment in the VA healthcare system through completion and submission of the VA Form 10-10EZ.

Recommendation #6
Guardsmen Receive Awards and Medals within 90 Days

Thoroughly review all OEF/OIF veteran Guardsmen's personnel records to identify those who have not received authorized awards and medals. Ensure that all authorized awards and medals that can be approved at the Montana National Guard level be issued within 90 days.

Recommendation #7
Send Badge Information to Department of Defense within 90 Days

Thoroughly review all OEF/OIF veteran Guardsmen's personnel records to identify those who have not received authorized badges or other recognitions that must be approved at Department of Defense level (e.g., Combat Infantry Badge, Combat Action Badge). Ensure that requests and all supporting documentation are forwarded to the Department of Army or Department of Air Force within 90 days. Ensure that the badge or other recognition is notated in the Guardsman's discharge document.

Recommendation #8
Include Mental Health Focus in Training

Develop and implement a comprehensive training program for command leadership and unit personnel that provides information on mental health issues such as combat stress, anxiety, depression and traumatic brain injury. Leadership also needs to be educated on treatment methods for these conditions and made aware of available resources. The training program should be incorporated into the Training Management System and scheduled into each unit's Annual Training Calendar. It should be conducted by qualified mental health providers.

Recommendation #9
Increase Awareness of Available Resources

Develop, publish and distribute to all National Guard units and individual Guardsmen an information guide that contains – at a minimum – civilian and federal VA resources for medical and mental health services and care.

a. Provide information to the National Guard chain-of-command and all members regarding programs, resources and contact information to be used when a unit member self-reports or is identified as needing assistance for emotional or mental health conditions. Additionally, post the information guide on the Montana National Guard's website.

b. Actively participate in the newly authorized Suicide Prevention Program to be administered by the Montana Department of Public Health and Human Services.

Recommendation #10
Create Crisis Response Team for At-Risk Guardsmen

The team's purpose would be to personally contact OEF/OIF veteran unit members who do not attend drill periods, or whose wellness status is undetermined. The team will consist of, at minimum, a member from the Guardsman's combat team and a person with mental health training. The team is responsible for appropriate follow-up actions.

Recommendation #11
Allow Guardsmen to Attend Drill Immediately Upon Returning Home

Allow deactivating Guardsmen to attend drill periods during the three-month "no-drill" timeframe after the return to Home Station. Activities could include providing the Guardsman with needed or additional information, the opportunity to reconnect with

"battle buddies," and provide opportunities for more confidential physical or mental health assessments.

Recommendation #12
Increase Informal Support Systems

Facilitate the development and implementation of increased "informal" support systems such as the "Vet to Vet" peer support program.

Recommendation #13
Enhance Family Readiness Program

Expand the family readiness program to ensure that National Guard and Reserve unit families have access to support services at all times, including the pre-mobilization, mobilization and post-mobilization time periods.

a. Consider changing "readiness" in program titles to "resource," which better conveys the spectrum of services and information envisioned of a comprehensive and active family program.

b. Strategically establish Family Resource Centers throughout the state. Center locations should be based upon high densities of National Guard and Reserve personnel, as well as geographic considerations. Family Resource Center staffing could be by volunteer and/or part-time paid personnel.

c. Incorporate veterans service organizations, including the auxiliaries, into Family Resource Center operations, various training events, information distribution and unit activities.

d. Educate all family program personnel of the symptoms and characteristics of emotional and mental health conditions, the resources available to treat the conditions, and the processes by which the resources are accessed.

e. Develop and distribute to all unit personnel, a succinct, one-page critical resource referral listing, to include at a minimum: federal VA medical facilities, federal VA Vets Centers, crisis hotline contact information, Montana Veterans Affairs Division field offices, and pertinent National Guard resources (e.g., the state chaplain).

Recommendation #14
Form a Partnership with State Veterans Organizations

Encourage at both state and unit command levels a more active and mutually supportive relationship with the state's veterans service organizations. Based upon mutual interest and appropriate personnel involvement, potential cooperative relationships may include:

a. Unit "adoption" programs, which would establish formal relationships between National Guard units and nearby veterans service organization posts or chapters.

b. Jointly facilitated informal support activities between Guard units and veterans service organizations' combat veterans.

c. Active participation in and resource augmentation for unit family programs and activities.

d. Establishment of a state-level council that includes veterans service organizations and National Guard leadership. The council would provide command emphasis and guidance to facilitate accomplishment of mutually approved initiatives and relationships with state-level programs (e.g., the family program and employer support program).

RECOMMENDATIONS for GOVERNOR'S OFFICE

The Governor's Office is recognized as a key resource in improving mental health care for Veterans.

Recommendation #1
Governor's Office Can Take a Lead Role in Public Education

The Governor's Office can serve as a lead entity in developing public education initiatives supporting veteran mental health awareness, and available services and resources through public service announcements that would:

a. Encourage veterans to seek assistance through federal VA healthcare services, federal VA Vets Center counseling services, and the Montana Veterans Affairs Division for federal VA healthcare system enrollment and federal VA disability claim services.

b. Educate the public that veteran emotional and mental health issues are treatable, and should not stigmatized as they are no different than other medical conditions. Different public service announcements could target different groups, e.g., employers, friends, workmates and families.

c. Advertise the statewide suicide hotline.

d. Incorporate other mental health advocacy groups in public education efforts, e.g., Montana Mental Health Association.

Recommendation #2
Work with Montana Congressional Delegation

Montana's Congressional Delegation can support initiatives that augment VA-provided services and influence Department of Defense officials' support for Montana National Guard initiatives and provision of needed documentation for awarding authorized Guardsmen combat badges and other recognitions. The delegations could:

a. Work to expand Vet Center locations in Montana.

b. Work with the Department of Defense to ensure that the Montana National Guard is provided documentation necessary to authorize the award of military service badges (CIB/CAB) or other medals/recognitions that exceed the Montana National Guard's authority to issue.

c. Assist the Montana National Guard in obtaining support for its envisioned PDHRA program and for significantly enhanced family program staffing and services.

APPENDICES

Appendix 1
PDHRA Program and Implementation in Montana

Background
The Post-Deployment Health Reassessment (PDHRA) program was designed to screen active and reserve component service members between 90 and 180 days after returning from certain deployments. Information from field research indicated that health concerns, particularly those involving mental health, are more frequently identified several months following return from operational deployment. The goal of the PDHRA program is to increase the opportunity for early identification and treatment of emerging mental health and other deployment-related health concerns.

The PDHRA program was launched on March 10, 2005, by the Assistant Secretary of Defense for Health Affairs, who directed an extension of the then current Post Deployment Health Assessment (PDHA) program to provide follow-on through a Post-Deployment Health Reassessment (PDHRA) process. The program was extended on an Army-wide basis on January 16, 2006 and then to the National Guard on April 21, 2006.

Eligibility Criteria
The PDHRA screening is mandatory and is completed three to six months post deployment for all active duty and reserve component service members who redeployed from a combat zone since March 10, 2005. Those service members who redeployed between September 11, 2001 and March 9, 2005, are to be afforded the opportunity to complete the PDHRA if they desire. However, completion is voluntary.

PDHRA Process
Three to six months after returning from deployment, service members are directed to complete the Post Deployment Health Reassessment (PDHRA).

Service members complete a DD Form 2900 Post Deployment Health Reassessment in one of three ways: on a tablet PC during a drill period, through the service member's Army Knowledge Online (AKO) login, or by speaking to a member of the PDHRA Call Center (1-888-PDHRA-99).

Once the DD Form 2900 has been completed, the service member then completes the PDHRA screening. Screenings are done on site by a DOD PDHRA Team (minimum of 60 soldiers required to support this team request) or by telephone through a provider with the PDHRA Call Center. Providers are physicians or mid-level practitioners.

If health concerns are indicated during any part of this process that require further evaluation, the healthcare provider ensures that the service member receives the contact information for the most convenient VA facility, Military Treatment facility, or TRICARE provider. A PDHRA-specific Line of Duty (LOD) DA Form 2173 is completed to ensure that the service member is not billed for the evaluation appointment.

Once the PDHRA assessment is completed, the service member is provided with a copy of the DD Form 2900 and DA Form 2173 if one was generated. Copies of these documents are also placed in the service member's Medical Record.

Timeline

Army Announces PDHRA Implementation Plan (Pilots)	Army Announces FULL PDHRA Implementation	NG Announces FULL PDHRA Implementation	MTNG PDHRA Implementation Announced
March 10 2005	January 16, 2006	21 April 2006	1 June 2006

2006

- Jun — Onsite PDHRA (INF/AVN)
  - Missoula, Belgrade, Fort Harrison, Billings, Great Falls, Butte, Helena
- Aug — Phone Call to Soldiers
  - Soldiers who attended onsite event and received referrals
- Sep/Oct — First follow-up memos
  - Incomplete PDHRA per MEDPROS
- Nov/Dec — First partial follow-up memo
  - Online portion complete: provider contact not done

2007

- Feb 07 — Second follow-up memo
  - Incomplete PDHRA per MEDPROS
- Mar 07 — Phone call to Soldiers
  - Incomplete or partially incomplete

Periodic Health Assessment

On October 12, 2006, the Department of the Army announced that the Army-wide implementation of the Periodic Health Assessment (PHA) would be effective on November 1, 2006. The PHA was designed to improve and maintain the medical readiness of the Army by closely monitoring the health status of all Soldiers to provide timely evidence-based preventive health care, information, counseling, treatment or testing as appropriate.

A PHA includes a self-reported health status, a review of current medical issues, a symptom-directed physical exam as appropriate, and clinical preventive services (counseling and interventions) recommended by age and gender.

The annual PHA replaces the routine physical exams that were previously done every 5 years between the ages of 30 and 60 and annually after age 60. It also replaces the requirement of Soldiers to complete an Annual Medical Certificate that outlined self-reported medical issues and/or concerns.

The PHA is conducted in two parts including a self-reported health status and a health status review and physical examination.

Part 1 – Self-Reported Health Status
Primary Care Provider Review of Medical Issues
Focused Physical Exam
Preventive Education Based on Age and Gender
Preventive Discussions
Conducted/Coordinated by Non-Credentialed Provider
Pre-DHA, Post-DHA, PDHRA, AMC
Health Assessment Review Tool (HART)

Part 2 - Health Status Review/Physical Exam
Conducted by Credentialed Provider
Physician, Physician's Assistant, Nurse Practitioner

Issues Identified on Self Reported
Focused Physical Exam

In addition to the medical focus, the Montana National Guard is also incorporating a questionnaire and review of the Soldier's mental wellness. This will allow us to continue to identify those Soldiers who may be at greater risk due to issues that may arise from a previous deployment.

The Montana National Guard implemented the PHA on June 1, 2007 in a manual format and will adopt the Health Assessment Review Tool (HART) when it becomes available. This electronic system will further increase the efficiencies of this annual requirement.

Appendix 2
Montana National Guard PDHRA Survey

Deployment Survey - PDHRA Task Force Input

zoomerang

Results Overview

Date: 8/27/2007 6:41 AM PST
Responses: Completes
Filter: No filter applied

1. In what phase of the deployment process do you think it is MOST CRITICAL to include training and education on medical and mental health resources?

Pre-Mobilization Phase	98	32%
Mobilization Phase	34	11%
Post-Mobilization Phase	73	24%
Reintegration/Reconstitution Phase	78	25%
Comment	27	9%
Total	310	100%

2. Do you think that the information and/or education provided through the Montana National Guard was sufficient to inform you of the medical and mental healthcare resources and/or benefits available to you after deployment?

Yes	183	59%
No	127	41%
Total	310	100%

61 Responses

3. Current DOD policy discourages units from conducting monthly drills during the first 90-days following deployment. If the Montana National Guard were to implement drill assemblies during the first 90 days after returning from deployment, what would you like to see incorporated during this time? Please check all that apply.

Open Discussions regarding deployment experiences	84	27%
Reunion/Reintegration Training	94	30%
Regular Drill	54	17%
Prefer to have no assemblies or drills during this time	161	52%
Other, please specify	54	17%

4. How satisfied are or were you with the services provided to you through the Federal and State Veteran's Affairs programs?

Very Satisfied	58	19%
Satisfied	166	54%
Unsatisfied	52	17%
Extremely Unsatisfied	10	3%
Comment	52	17%

5. If you were or are currently concerned about your post deployment physical or mental health, what would prevent you from seeking care? Please check all that apply.

Embarrassment	66	21%
Fear of being treated differently	68	22%
My unit would have less confidence in me	60	19%
I would be blamed for the problem	35	11%
It would harm my career	106	34%
Availability of health care providers in my area	56	18%
Loss of military membership or civilian employment	90	29%
Other, please specify	99	32%

6. What could be done to reduce or eliminate these concerns and allow you to be more comfortable in seeking services from a physical or mental health care provider?

View 209 Responses

7. Do you believe that the Post Deployment Health Assessment (PDHA) conducted in theatre was beneficial in identifying your medical and/or mental healthcare needs?

Yes	151	49%
No	159	51%
Total	310	100%

104 Responses

8. Do you believe that the Post Deployment Health Reassessment (PDHRA), targeted for conduct within the first 180 days after returning from theatre, was beneficial in identifying your medical and/or mental healthcare needs?

Yes	190	61%
No	120	39%
Total	310	100%

95 Responses

9. What more should the Montana National Guard do to better address both physical and mental health care needs of their returning combat veterans once they return from deployment? Please check all that apply.

Provide additional information on medical/mental health care benefits & resources	154	50%
Conduct annual health assessments at unit using medical providers	133	43%
Facilitate the establishment of additional VET Centers in the state	87	28%
Establish a Montana National Guard toll-free PDHRA resource hotline	99	32%
Conduct mandatory counseling sessions for all returning soldiers and airmen	124	40%
Conduct a PDHRA program for 2 years after returning from deployment	136	44%
Provide additional resources and training for family members	142	46%
Other, please specify	58	19%

10. Do you or your familiy members have other comments that you would like to share with the Task Force?

Yes	64	21%
No	246	79%
Total	310	100%

64 Responses

Thank you for your comments. The information you submit is entirely confidential and is an extremely important piece in our evaluation process. Your input will be considered by the PDHRA Task Force in their review of the PDHRA process.

Appendix 3
Mental Health Services Resource Listing

VA Montana Healthcare System Hospitals and Clinics

VA Medical Center
1892 Williams Street
Fort Harrison, MT 59636
(406) 442-6410

Anaconda Primary Care Clinic
118 E. 7th St.
Anaconda MT 59711
(406) 563-6090

Billings Community Based Clinic
2345 King Avenue West
Billings MT 59102
(406) 651-5670

Bozeman Primary Care Clinic
300 N. Willson, Suite 703G
Bozeman MT 59715
(406) 522-8923

Glendive Primary Care Clinic
2000 Montana Avenue
Glendive, MT 59330
(406)377-4755

Great Falls Primary Care Clinic
1417 9th St. South
Suite 200 (Clinic)
Suite 301 (Voc Rehab)
Great Falls, MT 59405
1-877-468-8387

Kalispell Primary Care Clinic
31 Three Mile Drive, Suite 102
Kalispell, MT 59901
(406)751-5980

Miles City Primary Care Clinic and Nursing Home
210 S. Winchester
Miles City MT 59301
(406) 874-5600

Mental Health Service Plan Providers
Licensed Mental Health Centers

Eastern Montana CMHC
Frank Lane Executive Director
P.O. Box 1530
2508 Wilson
Miles City MT 59301
(406) 234-0234
(406) 234-0235
email: flanemhc@mcn.net

Center for Mental Health
Mike McLaughlin Executive Director
PO Box 3089
915 1st Ave South
Great Falls, MT 59403
(406) 771-8648 ext. 1603
email: mikem@center4mh.org

Western Montana Mental Health Center
Paul Meyer Executive Director
Building T-9 Fort Missoula
Missoula MT 59804
(406) 728-6870
(406) 543-4536
email: pmeyer@wmmhc.org

Mental Health Center
Bob Ross Exe Director
P.O. Box 219
1245 North 29th Street
Billings, MT 59103
(406) 252-5658
email: rross@scmrmhc.org

Other Contacts

Roger Trumper
OEF/OIF Patient Advocate
VA Montana Healthcare System
406-447-7832

Web Sites

United States Department of Veterans Affairs
www.seamlesstransition.va.gov/index.asp

Montana Department of Public Health and Human Services
Addictive and Mental Disorders Division
www.dphhs.mt.gov/amdd/index.shtml

Montana Veterans Affairs' Division
www.mt.gov/dma/mvad

Senator TESTER. With that suggestion, I'd like to put the entire packet in the record of General Mosley.

Real quickly, and I don't know who can best answer this, so I'm just going to let whoever answers, answer it. Dave McLean talked about the fact that there were no mental health services provided in any of the clinics. Can you tell me why and can you tell me when that may change?

Dr. HARTMAN. What we have provided in Montana is we use contracts through Southeastern Mental Health, what was called Golden Triangle and Southwestern Mental Health to provide primary mental health care throughout the state of Montana, realizing we could never provide providers all over. Their notes are entered into our system so that we can monitor the progress of those vets being seen from our mental health section in Fort Harrison and, if need be, to bring those people in for more intensive care.

We also use tele-medicine in two forms.

One, we use it for mental health into all of our CBOCs with our providers in Helena. Second, there is a program operated out of Denver, Colorado, University of Colorado that's currently operating in the Lame Deer and Crow reservations, soon to operate in Fort Peck, Fort Benton and Rocky Boy, which provides tele-mental health counseling.

Senator TESTER. So what you're saying is there is mental health services offered at these clinics?

Dr. HARTMAN. It's offered through tele-mental health, yes. And then also the local health is done with the contract providers.

Senator TESTER. OK. Tele-mental health means you're talking to somebody over the TV screen; right?

Dr. HARTMAN. That's correct.

Senator TESTER. I appreciate that; I don't want to minimize that. But when you're talking about somebody who is, as Senator Salazar talked about, 17 to 18 percent are coming back with TBI, you have 35 percent coming back with PTSD from these current conflicts that we're in, we have a situation that Travis delineated somewhat that he went through when he came back because of the engagements he was in.

I honestly, my perspective, I'm not an M.D., like I told you before, I'm a farmer, so I don't know this stuff. The fact is, though, I think you need somebody you can look in the eye and develop that personal relationship. And when might that happen, what needs to happen to make that happen? And I don't mean to minimize the work you're doing. You're doing great work.

Dr. HARTMAN. I understand that. Let me try to answer that. First off is, before anybody is put out on a contract, they are evaluated through our mental health program to evaluate to see just where they are, because we don't just put anybody into the contract program. And so, therefore, that is the first phase. Second is that contract program does provide that face-to-face relationship with these providers, in addition to, if they need tele-mental health. That is in addition to the direct——

Senator TESTER. How does that get initiated?

Dr. HARTMAN. That gets initiated by the identification of that person needing that care at Fort Harrison, and then they are put into the contract program, and they're identified with the provider.

We, in turn, get the progress notes from that provider and we review those on a regular basis to make sure there is progress being made.

Senator TESTER. I don't want to work this over too much, I just want to tell you that one of the big concerns that I think is out there in Congress, as well as with the veterans organizations, and I don't want to speak for the VSOs at all, but I will just tell you, it's the concern of folks coming back, and the transition between active military and the civilian isn't being made properly, and we end up with some people that need help, either we don't know they need help or, you know, they can't get help.

Dr. HARTMAN. I agree. And I also would mention that each person returning that's identified that comes to us is put through a mental health screening when they come back, so we try to do that identification.

Senator TESTER. Thank you very much. I will just tell you just one thing, and then I'll turn it over, because we do have a lack of time here, and I do want to turn it over to Senator Baucus. We're going to see if we can get the six bucks written off so that doesn't happen.

Senator BAUCUS. That six bucks stuck in my mind, too.

What is the difference between—you mentioned rural and highly rural. Is that correct?

Dr. HARTMAN. Yes.

Senator BAUCUS. What is the effect of that designation, what about those counties, what happens to those counties that are rural?

Dr. HARTMAN. What we try to do——

Senator BAUCUS. Very briefly.

Dr. HARTMAN. What we try to do for those areas where we have the highly rural is we try to utilize all the services within the VA's capacity, that is mental tele-health——

Senator BAUCUS. Next question, what more is done in highly rural counties compared with rural counties?

Dr. HARTMAN. It would be the same. The health care that's provided is the same, it doesn't matter if you're highly rural or rural.

Senator BAUCUS. Do you know our entire state is highly rural? We have six people per square mile in Montana, our whole state is highly rural, and I just urge you to think of Montana as being highly rural. And so what is the relevance of being defined as highly rural from the VA perspective? So what?

Dr. HARTMAN. From the VA perspective, it goes into the fact of capacity and what kinds of services we can buy. I think when we talk about the issue of rural health, it's not just a VA issue, it's a national issue. When we look at trying to provide services to veterans——

Senator BAUCUS. I'm trying to understand what is the effect of being designated highly rural, if any?

Dr. HARTMAN. The effect of the designation of highly rural goes by distance——

Senator BAUCUS. I'm talking about the VISN services that VA provides because a county is rural.

Dr. HARTMAN. It doesn't change——

Senator BAUCUS. So it's irrelevant. I don't think it should be irrelevant. I think it should be very relevant, and I think it needs to be figured out how to provide the extra services highly rural areas like Montana need.

Dr. HARTMAN. We'll definitely take that into consideration.

Senator BAUCUS. No. Not take into consideration. Do something about it. That's a bureaucratic phrase, "take into consideration." We want results. Senator Tester and I wrote the VA a letter two months ago and got no response, I have it in front of me, basically asking about the consequences of closing down the Sidney operations and moving to Glendive. And I have the letter right here, dated May 15. No response. I just frankly find that not good practice when two senators write the VA a letter and there is still no response 2 months later.

Mr. Hartman, I expect a response next week.

Dr. HARTMAN. We'll respond next week.

Senator BAUCUS. Thank you very much. I

appreciate that.

I want to thank General Mosley for all you're doing. I read your report, and I think it's really on target. I'm glad you explained to us about the BRAC collaboration. There was such teamwork in our BRAC presentation, we got it down to the exact number of minutes that I had and General Mosley had, and we really practiced it, and it made a big, big difference.

Thank you, General, thank you for being here.

I know you in the VA are trying. I don't want to be self-righteous about this. But the point is you, Mr. Hartman, and myself, all of us, we're the hired hands, we're the employees, we're working, they're our employers, the veterans are. It's up to us to go the extra mile to do everything we possibly can do to get the job done. I know you agree with that and believe in doing that. I'm asking you to, and me, to remind ourselves that's why we're here.

Senator SALAZAR. I'm just going to make a brief comment, in the interest of time, you move forward with VISN 19 and your responsibilities there, I just want to remind you that the rural issues that we are talking about here have been central to us. We worked with your predecessor, Larry Burrough, to try to put a focus on the rural issues. And these three senators sitting up here are not going to forget at all the importance of rural communities. We have three people that have known the reality of farming and ranching in rural America. You'll have three senators here that are going to be on you all the way to make sure we're taking care of the needs of rural vets.

Dr. Hartman, I enjoyed our conversation on the plane and I enjoyed and look forward to working with you. But what I would like to do is ask you, I would ask you to provide us an update on the implementation efforts with respect to the Office of Rural Veterans Affairs. I was talking to Senator Tester this morning, and one of the concerns he raised was the fact that the office was created by us, signed into law by the President some eight months ago, and we haven't yet made the hiring decision with respect to who is going to run the office and what exactly it is going to do. I know you've talked about it. I want you to go deeper, and as you go deeper, I want you to, this is a directive, as well, I want you to address

the central questions that we're talking about here, how is it that we can make sure that these vets that are in the highly rural areas are in fact receiving the health care that they ought to be receiving, including mental health care.

In response to Senator Baucus's questions, it seemed that the distinction between rural and highly rural essentially are irrelevant from the perspective that you have. That's our point. We can imagine in some of our very rural communities where somebody is trying to access mental health, that that mental health may not be there. What I want you to do, you're relatively new on the job, I want the VA to give us responses with respect to how we make this office get up and functioning and what it is that we can try to do to improve services.

Mr. FEELEY. I'd like to comment, if I could, for a minute. I'd like to see if we could clear up the demographic issue. Forty-five percent of the CBOCs are in a defined rural community. I think your point is related to the 2 percent or 6 citizens per square mile, is the frontier component that we heard mentioned earlier. I think that's going to be used as a criteria to elevate the importance of rural health care, because the travel time for six citizens per square mile is going to mean they've got a tougher job of getting health care. I think we're going to commit to that.

I want to let you know that the position has been posted for rural health care leader. And that, of, course is going to shed light—it was posted yesterday. I'm not defending the fact that it took 8 months for it to get posted, but it is posted. I can say, when that position is hired, it's going to shed light on this issue in a very bright way, drive the attention forward.

I think many of the things going on in Network 19 are a role model for many areas of the country, and we're going to accelerate that effort.

I also want to raise the question that Senator Tester asked about, that I do understand the hands-on element related to mental health, but the future of providing a similar standard of care for everyone is going to be this technology revolution where we'll be sitting at our television set interfacing with our physician 300 hundred miles away, talking to the doctor, the nurse and the specialist with us all on the same screen.

And that may sound very "Star Wars'ish," but it's actually going on in some places now. And I believe James Floyd and I discussed that last night, that there is a laboratory at Salt Lake where they're doing these types of things. This is the way we're going to manage chronic illness, in particular.

Senator SALAZAR. I would ask, we're going to have a new Secretary on aboard, but all these issues that we're talking about in rural America, the reason this panel is meeting here, the reason I'm here this Saturday in Montana as opposed to being some 800 miles to the south, is because I care about these issues.

The reason that Senator Baucus and Senator Tester flew essentially through all night to be here is because we care about these rural issues. So the message we want to give the VA is that, for us, these issues are going to be issues that we're going to continue to work on, and we want the best results, we want results for the rural areas.

The mental issues, picking up on Senator Tester's point of view, Senator Baucus is one of the people in the forefront in terms of health care reform for our country. Mental health, I think, is harder. Jon Tester is right, you have to be able to look people in the eye. I think Travis will tell you that in terms of the people he's dealt with.

Mr. FEELEY. I would like to mention there are 4,000 mental health recruitments in the VA in the past 15 months because we, too, are committed to the same thing you are, which is making sure that these veterans returning are getting good care. It's an important assignment.

Senator BAUCUS. Briefly, too, you know, this term "rural" is bandied a lot in the Congress and so forth, but I know you understand, I want to reinforce the point that there is rural and there is rural. I remember a doctor who came before us, he said, "I'm a rural doc." He's from Indiana. I did a calculation, Indiana is 22 times more dense than Montana, but he thought he was a rural doctor. He was not a rural doctor. Indiana is very populated.

We've got special problems here, and I want to drill that into you and ask that you address them.

Thank you.

Senator TESTER. Real quick, and then we'll take a few comments. I think tele-medicine has its potential, but I think if you throw out tele-medicine and say, we have that area taken care of because we have tele-medicine, that's not the way to do business.

We sent people to war, we have to take care of them when they get back. I'm not saying you are not taking care of them, but I think it has to be a priority; I don't think it's a priority now.

We can now take comments from the audience. It has to be quick and concise. I've been to a lot of veterans hearings, I know there are stories that can take days. Very well, quickly go ahead.

Mr. FORMAZ. There is no inpatient mental health as far as drug and alcohol treatment in the state of Montana. There are 107,000 veterans here and no drug or alcohol treatment. You can wait 6 months to go out of state. That just is substandard.

Ms. FRENCH. I am Julie French. I am from a county that has 1.5 persons per square mile. It is our county and my house district that you are not being able to serve by van service. Hopefully, Glasgow will be considered for a service center. We are very, very concerned about the lack of mental health and care for our vets. I will say, I believe there is not even a psychologist or psychiatrist east of Billings for eastern Montana. When you talk about mental health services, we do not have a community center, as they talked about, anywhere near us, so it is a huge issue. Our vets will not travel 120 to 200 miles simply to get care. I remind you, it's almost a thousand miles from Scobey, Montana roundtrip to Helena, Montana and back. It's almost closer to go to Fargo, North Dakota for treatment.

Mr. BREWER. David Brewer. I'm retired military, and the comments that I want to throw out at you, the big thing that I saw, like Mr. Williams, when I got off active duty, I had in my retirement as well as my separation, it was like they were just checking me off the books, it wasn't that in-depth. I was told, because my last physical was within 5 years of my separation and my retire-

ment, I didn't need anything more, so I wasn't asked questions either, just like this gentleman over here.

The other thing I'd like to point out, my medical records were sent, I understood, to St. Louis to be transcribed or photocopied or whatever. I don't know what happened to the original copy, but I kept copies of mine, and when I made my attempt to get something processed through the VA, they basically told me, send us a copy of your records. And then when I did, they lost them, and it took them 6 months or 9 months, whatever it was, to try and find those records to decide whether or not they were going to do anything. Anyway, they sent me a comments form within the first 4 months of when I first applied. I should have not filled that out because I told them how great it was, and I never heard from them again.

But I guess that would be my comment, that I think the vets should be getting the original copy of their VA medical files back after they're photocopied. Why throw them away? Mail them to the veterans.

Another thing I want to throw out, there is, use Amtrak.

AUDIENCE MEMBER. I would like to introduce you to Mr. Tome, 83 years old yesterday. He has a star, he was on Normandy Beach. He has post-traumatic stress disorder. I'm his neighbor. I've helped these elderly neighbors, friends of mine, try to get the medicines that they need. It's ridiculous. He has suffered and I've seen his wife suffer, neither one of them can drive to Fort Harrison. They're told that it's in the mail. He was told a week ago. His wife can explain all this, that his medicine would have been there if it was sent Monday. Today is Saturday, it's still not there. He needs this daily several times a day. This has gone on now since I've known them, 10 years. This has to be fixed. I'd like you to just speak to his wife one second. She can explain a little bit about how she's doing. It needs to be addressed.

Senator TESTER. We've got it. We'll deal with it. You've got decisionmakers here that are going to deal with it. And the bottom line is if we can get them the medicine, the problem is solved, at least this problem.

AUDIENCE MEMBER. Travis here has gone through a lot. Rick, my brother, passed away from Vietnam post-traumatic stress. Families are suffering, too.

AUDIENCE MEMBER. The only thing I have to say, I've been a disabled vet for 10 years, I will say that the VA is great but they're understaffed, no doctors, lack of doctors. In Great Falls, the doctor sees 1,800 patients.

AUDIENCE MEMBER. I'd like to address the mental health issue. The VA has had a new program, they're training peer counselors. It's a program called Vet-to-Vet, and they're at work on it right now. It's not perfect but, like Travis says, it's vets talking to other combat vets, talking about things in a language that you understand, and it does provide help.

Senator TESTER. Thank you. Right there.

AUDIENCE MEMBER. The transit providers in this state have a deep desire and the expertise and the capital resources to help and assist our veterans with vehicles, lift vehicles. The only thing we are lacking is the collaborative working relationships with local

VSOs. I would hope that you would help us foster those relationships.

Senator TESTER. Have you made the offer to the VSOs to see if they would be willing to work with you?

AUDIENCE MEMBER. We have been trying and have met basically with a stone wall.

Senator TESTER. Go ahead.

Mr. HARRISON. Gabriel Harrison from Montana, and I have two issues. They give us a phone number to call them, and I'm from the northern part of Montana, I called and they said, this phone number is not a working number. The second one, I have physical health care provided by local hospitals. I am in what they call debt collection right now since it's been 2 years since they billed me.

AUDIENCE MEMBER. I want to say something about the mental health. One, I have been going to the mental health clinic since 1992, I have been sober 24 years and I have not had suicidal thoughts for 4½ years now. The mental health care that I have been getting from the VA is excellent, I cannot say anything more. But I do agree that we are understaffed, the doctors that I get usually have me put on back order, waiting for a doctor, because the doctor I had is no longer there.

AUDIENCE MEMBER. I've got nothing but good to say about the health care system that we're having here in Montana, but as a Native American from Browning, I've been turned down for services up there, and I don't think that's right. I know there are more Native Americans here that do get turned down.

Senator TESTER. Were you turned down because you're a Priority 8; is that why you were turned down?

AUDIENCE MEMBER. They said I had a residence down here and up there and I could probably afford it myself, and they were trying to send me to the VA system.

Senator TESTER. Back here in the corner.

AUDIENCE MEMBER. Thank you for the opportunity to address you today. I hail from Alaska, and I'm here to ask you for your help. In Alaska they don't use comprehensive planning or assessment in looking at how they even get to a regional center, and these regional centers are being addressed administratively. I also want to say that sociologically a lot of factors have changed, a lot of the role of the spouse in helping the vet has changed through divorce laws and whatnot, and so I am asking you to make a finding today of whether this is a national issue of national security or if this is just assisting the districts, because I feel that Congress should address the states and tell the states that this is not a state issue, this is a Federal issue.

Senator TESTER. Thank you.

Mr. KUNTZ. My name is Matt Kuntz. I'm an Army veteran who is also the stepbrother of the soldier who killed himself due to PTSD in our treatment of him a couple months ago. And I have two points. One is we need to provide PTSD and traumatic brain injury care, regardless of whether or not these guys have service-connected status. If you're asking for PTSD care or traumatic brain injury care, you're injured. And I'm a service-connected vet myself, and I know firsthand that it's horrible going through that process, and I can't imagine doing it for PTSD. It's painful, like it was my

ankle that was torn away in ranger school, it was a rough, bad process. And trying to deal with PTSD, we can't have these guys wait for care.

My other point is I understand the contract counselors, I have a lot of vets call me and ask for help, for whatever reason, and we need to train these counselors better, legitimately train these people because right now we've got them, just like was mentioned, that fall asleep, we've also got counselors, these guys tell them what happened to them, and the things that they did, and the revulsion shows on their face and the guys don't go back to counseling after the counselor looks at them in that manner. And I wouldn't go back either. So you've finally got them in the door to a counselor, so we need to make sure these counselors are trained.

Mr. COVENT. I'm Gerry Covent, and I'm a retired military member. I want to hit briefly on the closer-to-home clinic care. In Great Falls, when they opened up, it was fabulous. I didn't have to travel to Helena for health care. When I'd go to an appointment, the doctor wanted to see me in 2 months, I'd have that appointment. Nowadays, when I go there to get an appointment, they send me a letter to tell me when my appointment is going to be. If I have 2 months' worth of medicine, just like last week, I'm out of medication and still haven't received my letter for an appointment.

I know here in Great Falls they've lost three providers in the past year. Now, you have three people instead of five giving care. When I go in to see them, I want to mention that, but they're really overworked and understaffed.

Mr. RICCIO. My name is Ray Riccio from Molese, Montana. I'd like to make a comment about TBI or traumatic brain injury. In 1990, I received the first state license to operate an adult day care center in Missoula. All of my clients were Medicaid clients. I was licensed for eight; my full case load was nearly a couple dozen people. Ninety percent of my clients were young adults with traumatic brain injury. Traumatic brain injury is incredible, what I see happening in a country with all of these survivors of conflict coming back with PTSD and traumatic brain injury, having cared for most of these people for a number of years, I was a member of the Montana Brain Injury Association and also the National Traumatic Brain Injury Association, there is an overwhelming tidal wave that is going to hit us in this country, and I really fear for these survivors that are returning.

Senator TESTER. Thank you. This will be the last one.

Mr. FLETCHER. I'm Joe Fletcher, and I have the greatest job in the world. I am able to work with vets every day of the year. One of the greatest problems that we have sometimes is working with vets, especially those who have the mental health problems.

Travis, you're a young Iraq veteran, and I'm beginning to see them all the time coming back. But one of the biggest problems is around 4 o'clock, no phone rings in the Great Falls clinic. The only avenue for that vet that is in a crisis situation is the local emergency room. Folks, that needs to be fixed.

Senator TESTER. Just real quick, I want to thank everybody on the panel, I want to thank everyone who came today. Those of you folks who did not have an opportunity to speak, write down the problem on a piece of paper and fax it to one of my staff members.

Senator BAUCUS. I want to thank the panelists for being here, thank the people from the agencies for being here. There is only one way we solve the problem, and that's if we work together. Thank you very much.

(Whereupon, at 2:30 p.m., the Committee was adjourned.)

A P P E N D I X

PREPARED STATEMENT OF PETE FORMAZ, NCAC–II, LAC, PRESIDENT, MONTANA ASSOCIATION OF ALCOHOL AND DRUG ABUSE COUNSELORS, ON BEHALF OF NAADAC, THE ASSOCIATION FOR ADDICTION PROFESSIONALS

Senator Baucus and Senator Tester, thank you for accepting my testimony on this critical challenge facing our Nation. Access to addiction treatment for returning veterans is not merely of political or professional interest to me; it is deeply personal as well. After serving from 1966–1968 for the U.S. Marine Corps in Vietnam, I returned home with post-traumatic stress disorder (PTSD) and alcohol and other drug addiction. When I asked for help in 1979 at the Veterans Administration (VA) hospital in Long Beach, California, I was told my addictions were self-inflicted injuries, and I could deal with them on my own. PTSD was unknown/unacknowledged by the VA at that time. I continued struggling with my addictions, eventually resulting in my homelessness. I achieved sobriety, without help from the VA, in 1981 and so remain today.

For the last eight years I have been a certified addiction counselor, helping treat those with addictions. In 2006, I became president of the Montana affiliate of NAADAC, The Association for Addiction Professionals, and I currently chair the recently formed NAADAC Task Force on Veterans Policy, which will track issues related to veterans' access to addiction treatment and make policy recommendations. I am submitting this testimony on behalf of NAADAC.

Both war and the transition home can be traumatic experiences for soldiers and veterans. Trauma has been demonstrated to be a significant risk factor in substance use. Although anyone can be at risk of addiction, veterans with post-traumatic stress disorders are at special risk of substance use disorders as many try to "self-medicate" with alcohol and other drugs. About 75 percent of Vietnam-era veterans with PTSD also had diagnosable substance use disorders. Estimates among today's veterans are even higher.

It is important to note that neither PTSD, PTSD-caused substance use nor treatment for those recovering from trauma is limited to veterans. In New York City after 9/11, civilians and emergency workers diagnosed with PTSD were five times more likely to increase their use of cigarettes or marijuana compared to those without the diagnosis. In Oklahoma City after the 1995 bombing, over 60 percent of people with PTSD reported consuming alcohol to help cope. New research continues to help us better understand the physiological effects of trauma on the brain as it relates to addiction and PTSD.

Certified addiction services professionals throughout the United States are the frontline health care workers who address these trauma-related substance use disorders. When there is a sudden, increased need for counseling, the addiction services workforce rises to the challenge. For example, after Hurricanes Katrina and Rita, there were increases in substance use. Working with the Substance Abuse and Mental Health Services Administration (SAMHSA), NAADAC recruited certified addiction professionals to deploy to the Gulf Coast to help compensate for the reduced health care infrastructure and increased demand for treatment. Over 200 addiction professionals served in the Gulf Coast region in the 6 months following the hurricanes. All were certified in the latest evidence-based treatment practices, post-traumatic counseling and family systems. Some of those counselors are still in New Orleans today.

Today, the population of high-need veterans is not geographically concentrated like the displaced citizens of New Orleans. Our Nation must reach out to veterans wherever they are. Many areas—including rural Montana—do not have anywhere near the VA treatment facilities required to meet the need.

Fortunately, there are already civilian systems in place to provide high-quality, evidence-based treatment. There is a national system of treatment providers, qualified by state agencies. Veterans and their families who are not able to access the

VA system for whatever reason should be allowed and encouraged to access treatment from civilian treatment providers. Our veterans do not have time to wait for a parallel VA system to be built up, and there is no reason to expend the overhead and startup costs to replicate a system already in place. The VA should collaborate with these existing treatment centers and professionals whenever possible to fill unmet needs now. The VA should eliminate barriers to this common-sense cooperation whenever possible.

Increased collaboration with existing treatment providers would drastically expand veterans' access to treatment. The U.S. military, the VA and Congress should consider expanding access to and quality of care in other ways as well:

- When screening for PTSD and substance use disorders, the military should wait 45–60 days after the servicemen and women have returned home. When screenings occur in the field, there is the motivation for servicemen and women to minimize their symptoms for fear that a finding of PTSD or substance use disorder would require treatment in-theater and delay their return home. Whenever possible (by cooperating with existing treatment providers), veterans should be able to receive treatment in their own communities.
- Everyone providing addiction treatment services should be certified in the latest evidence-based practices to ensure the best outcomes for clients.
- The psychological effects of rapid troop re-deployment should be investigated.
- Health care available to returning National Guardsmen and women must be of the same high quality available to other combat forces.
- Female soldiers are also on the frontlines more than in previous wars, and health care providers must be sensitive to gender-dependent warning signs and treatment strategies.

In closing, I want to remind everyone that creating a more efficient and effective system of addiction treatment for veterans not only affects (or saves) the lives of veterans themselves, but its effect ripples out to their spouses, children, employers and communities. This should be a national priority.

This testimony is submitted on behalf of NAADAC, The Association for Addiction Professionals. NAADAC is the largest membership association serving treatment and prevention counselors, educators and other health care professionals specializing in addiction. NAADAC was founded in 1972 as the National Association for Alcohol and Drug Abuse Counselors and today has 46 state affiliates and 11,000 members around the world.

MONTANA MENTAL HEALTH ASSOCIATION,
July 19, 2007.

Hon. JON TESTER
204 Russell Senate Office Building,
Washington, DC.

DEAR SENATOR TESTER: Thank you for calling Saturday's field hearing in Montana on veterans' health. This is a vitally important issue, and the Montana Mental Health Association applauds your desire to learn more about the healthcare needs of veterans—particularly in the area of mental health.

You will hear firsthand from a number of veterans and their families on Saturday who will share with you their struggles to access care for themselves and their loved ones. My office has been involved with some of these cases, since we have a toll-free resource and referral number. It is a challenge for our office to help Montanans—veterans or not—get the mental health care they need. Fifty out of Montana's fifty-six counties are federally designated mental health professional shortage areas. A scarcity of providers and the high cost of medication and services limit access for all Montanans. For veterans and guardsmen, it can be even tougher, due to requirements to use in-network providers. Montana has the second highest rate of suicide in the country, and as National Guardsman Chris Dana's death this spring demonstrated, combat-related mental health problems, the difficulty that many still have in talking about mental health problems (their own or those of their loved ones) and the challenges of negotiating the system are contributing to this grim statistic.

As a former state senator, you would have been proud of the efforts made by the Montana legislature to increase funding for mental health care for low income Montanans and suicide prevention. The legislature also increased funding for mental health services for those returning to the community from Montana's prisons. It is time for the Federal Government to step up to the plate by improving mental health

services for those returning to their communities after serving our country in wartime, and their families.

There are a number of ways the Federal Government can do this. Here are a few:

• Increase the number of providers who can care for our vets and the guardsmen who served in Iraq and Afghanistan. In a frontier state like Montana, this is especially important since providers can be few and far between.

• Increase funding for both crisis and ongoing mental health services so that vets don't face waiting lists or have their numbers of visits limited.

• Admit that the experience of going to war can and often does result in serious emotional and mental health problems, and help make the general public aware of this, too, so that we all can better help these returning heroes. Misunderstandings about the biological nature of mental health problems and that people can and do recover from them; the mistaken belief that depression and other mental illnesses mean you have "weak character" and the misconception that you can just "tough it out" or "act happy to be happy," are barriers to people getting the services they need. The Montana Mental Health Association ran over $20,000 worth of radio ads in the past year aimed at military families and returning veterans, and we plan to continue our outreach efforts. But a broader effort, supported by the Federal Government and the military itself, is also needed.

• Increase funding for research on post traumatic stress disorder and other mental health issues. There's a lot we still don't know about why some individuals are more prone to develop PTSD, depression or substance abuse disorders. Without this knowledge our ability to develop medications and other treatment therapies, or to effectively reduce the numbers who become affected, is limited. Increase in funding to national research institutes is critical to our successfully treating and preventing mental health and substance abuse problems.

• Recognize and support the role of military families. Spouses, parents and children left behind when soldiers are deployed often experience high levels of stress, which can result in depression, anxiety, and substance abuse. When a deployed soldier returns, his or her family may find the readjustment equally or even more stressful, particularly if the veteran has developed health problems that might include PTSD, a traumatic brain injury, or disabling injury. If these families are to survive to help support our vets, they must be provided more services as well.

Once again, thank you, Senator Tester, for shining a light on this very important issue. And thanks also to Senators Baucus and Salazar for attending the hearing and lending their support for improved health services for our veterans. The Montana Mental Health Association stands ready to partner with you and others to improve the mental health of our veterans and their families. Please contact me at 406–587–7774 or *tracy@montanamentalhealth.org* if you would like further information on mental health, our activities in Montana, and how we might assist in this critically important effort.

All best wishes,

TRACY VELAZQUEZ,
Executive Director.

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