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HEARING ON PENDING HEALTH CARE LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MAY 21, 2008

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HEARING ON PENDING HEALTH CARE LEGISLATION

WEDNESDAY, MAY 21, 2008

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

The Committee met, pursuant to notice, at 9:36 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Burr, and Craig.

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

Senator MURRAY [presiding]. Good morning. This committee hearing will come to order. Our Chairman, Senator Akaka, will be here shortly. He has asked me to go ahead and begin the hearing, so I want to welcome Senator Burr and other Senators who will be joining us today.

I think it is fitting that we are holding today's hearing so close to Memorial Day. Memorial Day is a day of remembrance and gratitude from a thankful Nation. Next week, we gather in communities throughout America among our friends and families and neighbors and all pause to give a quiet, humble thank you to those men and women who honorably gave themselves for a cause far greater than any one person.

And now, as America finds itself fighting two wars, it is our even greater duty to not only honor those who made the ultimate sacrifice, but to also do everything we can to care for those who are still with us. These men and women deserve the fulfilled promises of a grateful Nation, and as a country, we need to work to honor these veterans' sacrifices when they return home.

As everyone on this committee knows, we are charged with not only taking care of today's veterans, but also with preparing the VA for the needs of tomorrow, and one of the best ways I believe we can do that is to be proactive about the needs on the horizon, to pass the Women Veterans Health Care Improvement Act of 2008, which expands and improves health care services for women veterans in the VA system.

Women have always played a role in our military, going back to the founding of our Nation. However, as we all know, in today's conflicts, women are playing a far different and far greater role. Women now make up 14 percent of our current active duty Guard and Reserve forces. Some units, including Military Police, are using an increased number of females to fill jobs that were traditionally

held by male personnel. Because of the conflicts of today, we often have no clear front lines, but women, like all of our servicemembers, are always riding on dangerous patrols, guarding pivotal checkpoints, and witnessing the horrors of war firsthand.

However, while women's numbers are rising on the battlefield, up until now, women have remained a small minority at the VA. According to the VA, there are more than 1.7 million women veterans, but only 255,000 of those women actually use the VA health care services. For too long, the reasons for this discrepancy have been elusive. But today, we are getting a clearer picture.

In fact, when I first started holding roundtables around my home State of Washington to talk to veterans about their experiences with the VA, I heard almost exclusively from men. They would sit at the table with me. They would stand up. They would tell their stories and talk about their issues. But inevitably, as I was leaving the room, a woman would come up to me and whisper to me her experiences. Some told me they had been intimidated by the VA and viewed their local VA as a male-only facility. Others simply told me that they couldn't find someone to watch their kids so they could attend a counseling session or find time for other care.

But, as some Members of this Committee and those who will testify today know, the voices of women veterans are no longer whispers. Today, they are full-throated calls for equal access to care at the VA and I believe that now, as we sit on the brink of seeing more returning women veterans than ever before, it is time that we heed those calls. We simply cannot allow the attitudes of the past or the VA's lack of preparation for the influx of new women veterans to linger a minute longer.

As the Independent Budget has noted, the number of women using VA health care services will double in less than 5 years if women veterans from Iraq and Afghanistan continue to enroll at the current enrollment rates. We need to make sure now that the VA is prepared to care for the needs of these honorable veterans today, and that is exactly why Senator Hutchinson and I introduced the Women Veterans Health Care Improvement Act of 2008.

This important legislation will increase the number of women accessing care at the VA by increasing the VA's understanding of the needs of women veterans and the practices that will best help them. It will do so by requiring the VA to study the health care needs of women who are serving or who have served in Iraq and Afghanistan, study the effectiveness of current services being provided to women veterans, study barriers to care for women veterans who are not accessing the VA system, and it will also help provide child care for the newborn children of a woman veteran who is receiving maternity care at the VA.

This bill will implement a program to train, educate, and certify VA mental health professionals to care for women with military sexual trauma and Post Traumatic Stress Disorder. It will begin a pilot program that provides child care to women veterans that seek mental health care or other intensive health care services at the VA. It will begin a pilot program that provides readjustment counseling to women veterans in group retreat settings. It will make the position of Women Veterans Program Manager at all VA med-

ical centers a full-time position. And finally, it will include on VA advisory boards women that are recently separated from service.

Now, I know that the VA recognizes they need to improve service for our women veterans, and the Department has taken several steps to do that. But a lot more needs to be done if we are going to ensure that women get access to equal care at the VA for health care benefits and services, and that the VA health care system is tailored to meet the unique needs of our women veterans.

Planning for the wave of new women veterans is going to be a difficult and complex task, but the effort has to start today and it has to start with this bill.

Thank you very much. I see our Chairman has joined us, as well, and Mr. Chairman, I will turn to Senator Burr for his opening remarks and turn the gavel back over to you. Thank you very much.

Chairman AKAKA [presiding]. Thank you very much.

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

Senator BURR. I thank my colleague and aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Senator BURR. And aloha to our witnesses. We are grateful for your willingness to be here.

Before I get started on the subject of today's hearing, I would like to address a recent incident at the Temple, Texas, VA Medical Center. I and the Chairman, as well as other Members, were disappointed to learn that someone at the facility suggested, and I quote, "that we refrain from giving a diagnosis of Post Traumatic Stress Disorder straight out," unquote. Veterans trust the VA to give them the best care possible. Senator Akaka and I have called on the VA Inspector General to investigate this incident to make sure that no veteran was negatively impacted by this suggestion. I look forward to the IG's report and I look forward to hearing more from the VA in the coming weeks.

In light of the extensive agenda before us today, I will focus my remarks on one particular bill on today's agenda, S. 2573, the Veterans Mental Health Treatment First Act. I think everyone on this committee can agree that recovery and rehabilitation must be the focus of helping veterans with mental illness. Advances in proven therapies and medicines have given veterans more hope than ever that recovery is, in fact, possible. Our job is to figure out how we can best serve our veterans who are faced with the challenges of PTSD. The Treatment First Act is an effort to both provide early treatment and to put VA's emphasis where it belongs, on wellness and recovery.

Let me outline some facts that lead me to believe that a new approach to the care for veterans with service-related mental illness is absolutely essential. One, there has been a 150 percent increase in the number of veterans who are on disability for Post Traumatic Stress Disorder since the year 2000. Two, the evidence indicates that disability ratings for those with PTSD get progressively worse over time.

Three, the Veterans Disability Commission encouraged Congress to create a modern disability compensation system that used, and I quote, "a new holistic approach to PTSD, coupling PTSD treat-

ment, compensation, and vocational assessment," unquote. The Disability Commission also recommended that, and I quote, "treatment should be required and its effectiveness assessed to promote wellness of the veteran," unquote. In other words, the Commission recommended that disability compensation go hand-in-hand with treatment.

Research published in the American Journal of Public Health by Dr. Christopher Frueh from the University of Hawaii's Department of Psychology concluded, and I quote, "an accumulating body of empirical data suggests that current VA psychiatric disability and rehabilitation policies for combat-related Post Traumatic Stress Disorder are problematic. Current VA disability policies require fundamental reform to bring them into line with modern science and medicine." What a novel thing. That is a problem, Mr. Chairman. We have a system that results in our veterans who are diagnosed with service-related mental illness just getting worse and worse and never better.

In the last few years, we have been investing in the health care side of the VA's ledger to improve the mental health system. I would like the VA to start tracking how well its treatment programs are doing in terms of getting our veterans better and not worse. I believe that treatment can and should work.

Let me outline the promise that treatment holds. First, I will quote from a recently published RAND Corporation study on mental health, and I quote, "Ongoing advances in treatment provide hope for a new generation of servicemembers suffering the psychological effects of warfare. Medical science provides a better understanding than ever before of how to treat the psychological effects of combat," unquote.

Second, the RAND report also suggests that with evidence-based intervention, and I quote, "complete remission can be achieved in 30 to 50 percent of the cases of PTSD and partial improvement can be expected by most patients," clearly not the trend that we see within the system today. Moreover, the RAND report notes that there is a, and I quote, "hopeful possibility that PTSD may be reversible if patients can be helped to cope with the stresses in their current life."

Our challenge, then, is to focus on treatment, wellness, and recovery as a first priority and not sentence veterans to a lifetime of permanent disability. We really owe it to them to do better than we do today.

That is the concept behind Treatment First, S. 2573, which would allow veterans who have been diagnosed with service-related mental illness to enter into a mental health treatment program and provide them with a wellness stipend of up to $11,000. A wellness stipend is important so that veterans with mental health problems can still provide for their families while on the road to recovery. All the veterans would have to do is participate fully in the treatment program and agree to a short delay on filing disability until treatment has ended. The hope with my bill is that treatment will work and the veterans can then resume a full and productive life. VA disability payments will still be there at the end of the treatment for those who need it. And because it is a voluntary program, veterans can, at any time, file disability if that is, in fact, their desire.

Mr. Chairman, I said it on the floor when I introduced this bill, there is no catch to this legislation. I see a real problem when I see veterans who get steadily worse and not better. This is a horrible outcome for everybody, especially our veterans who are denied a full and productive life. That is why I think it is time that we look at new ideas for solving what I consider to be a real tragic problem.

Mr. Chairman, when I visit our men and women at Walter Reed and back home in North Carolina, I see the fierce determination they have to succeed in life, to overcome adversity, and not to be defined as disabled. I believe our veterans want an integrated system of health and benefits to help each one of them reach their goals. All this committee has to do is give them the tools to get there.

I thank my colleagues for once again hearing me passionately speak about this. I realize more than anybody that Veterans Service Organizations do not like change. This is real change. This committee cannot accept the status quo, and I don't believe the Department of Veterans Affairs wants to. But more importantly, our veterans don't want to. This is a real opportunity to change the lives of people who have different expectations than previous generations of veterans. Let us seize on this opportunity to do it.

I thank the Chair.

Chairman AKAKA. I thank you very, very much, Senator Burr, for your statement.

I am going to introduce Senator Dick Durbin from the State of Illinois—my distinguished colleague who has just arrived—and following him, I will ask for the remarks of Senator Craig. I will then make my statement.

Senator Durbin has asked to be here to make remarks on legislation that he has introduced. I am glad to have you here, Senator Durbin.

STATEMENT OF HON. RICHARD DURBIN, U.S. SENATOR FROM ILLINOIS

Senator DURBIN. Thank you very much, Mr. Chairman, Senator Burr, Senator Craig, and Senator Murray. Thank you for allowing me to make a few remarks here at this hearing.

This is the first time that I have appeared before the Senate Veterans' Affairs Committee and I come here today to speak to you about S. 2377, the Veterans Health Care Quality Improvement Act, which Senator Obama and I have introduced. We were drawn into this issue because of an extraordinary situation at one of our veterans facilities.

In Marion, Illinois, in Southern Illinois, there is a VA facility that has been there for many years and serves the veterans of Southern Illinois and Kentucky and Missouri who really treasure it. The men and women who go to the Marion VA love it and speak very highly of it. I would visit there from time to time and just thank goodness that we have, in a rural area of Illinois, such a great VA facility.

And then, in August of last year, there was a tragedy. Reports came out of the Marion VA facility that an extraordinary number of veterans were dying in surgery. Because of the number and be-

cause it was much larger than ever should have been anticipated, the Veterans Administration decided to suspend the surgery and surgical activities at the Marion VA to find out what was wrong.

Their investigation came up with some information that was very troubling—troubling in terms of Marion VA and its great reputation, troubling in terms of the veterans who counted on it, and troubling, as well, as we reflect on the new pressures and demands on our Veterans Administration with wars in Iraq and Afghanistan. As it turned out, there was at least one doctor, and maybe more, who should not have been practicing medicine at that facility.

Before I came to Congress, I was a practicing attorney. I used to defend doctors in medical malpractice cases and prosecute them, as well; so I have been on both sides of the table. And the VA came in and explained to me about this doctor, this controversial doctor, the surgeon who had been licensed to practice medicine in the State of Massachusetts. The VA said that they learned after he was on the VA staff that his license to practice medicine in Massachusetts had been surrendered by this doctor, and that the Massachusetts Medical Board told the VA there was no disciplinary action involved.

Well, I can tell you as a cynical lawyer, I didn't believe it. It was clear he had cooked a deal, a deal which said, I will give up my license to practice in your State if you will just drop whatever charges you have against me. And that is what happened.

This doctor had been involved in serious malpractice cases in Massachusetts. The VA didn't know it. They didn't know the circumstances for the surrender of his license. He then went to my State of Illinois and was involved in surgeries that took the lives of nine of our veterans. That is the reality. And the reality is that the surgical unit has not been fully restored—even as of today—at that Marion facility.

That is the reason why we introduced this bill. I want to make sure that we have the highest quality medical professionals—doctors and nurses and others—for our veterans. It is one thing to have a great building and to put in great technology, but we have to have the men and women there who can deliver the highest quality services. We failed in Marion. We failed with this doctor, and I don't want us to fail again.

Senator Obama and I introduced this legislation. There are several points that I will just raise with you and I hope you will consider, either in this bill or as part of another bill.

Vet the doctors who apply to work for the VA. We have to have a better vetting process. We make a recommendation in this bill that the VA doesn't like at all, which may be the reason they oppose it. It says that you have to be licensed in the State where you are practicing. If you are in a VA hospital in Illinois, you have to have medical privileges in Illinois. The reason is to make sure that there is a disciplinary board that is vetting each one of these doctors and looking closely at their backgrounds before they show up at a hospital in my State, North Carolina, Hawaii, Washington, or Idaho. I think that is the basics. That really is the minimum that we should expect.

Second, we expand quality control programs in the VA health care system to create new Quality Assurance Officers to give VA employees more opportunities to raise concerns, whistleblowers who can speak out. When we went back into this Marion VA facility after they had suspended surgical privileges. I had a young man on my staff who was a doctor. He started talking to the nurses—the surgical nurses—at the Marion VA who said, "We saw this coming. This man was doing things far beyond his expertise. He was performing surgeries which we have never performed at the Marion VA." The nurses knew it. They were afraid to speak out. That has to change.

Third, our legislation creates incentives to encourage high-quality doctors to practice at veterans hospitals. Doctors who agree to practice in hard-to-serve areas would benefit from student loan forgiveness and tuition reimbursement programs. They also have a chance to enroll in the Federal Employee Health Insurance Program.

Medical facilities in the VA should be required to establish affiliations with nearby medical schools. These partnerships would expose young medical students to a possible career in VA. In return, the VA would benefit from the energy of these young students working in these facilities.

Finally, the bill would instruct the VA to increase its recruitment of experienced doctors who are willing to practice part-time to care for our veterans.

I hope what happened to Senator Obama and me at the Marion VA never happens to you. We have a special obligation to make sure it doesn't. I hope you will consider this bill as part of the solution.

Thank you for allowing me to testify.

Chairman AKAKA. Thank you very much, Senator Durbin.

And now we will hear from Senator Craig.

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

Senator CRAIG. Thank you, Mr. Chairman. Senator Durbin, thank you for bringing us that message. This Committee has been and will always be focused on quality health care for our veterans, as is—and I have to say—as is the VA. That doesn't mean that it is perfect, and you have obviously found a glitch—a very critical one. Thank you.

Mr. Chairman and Ranking Member Burr, thank you again for holding this hearing on a broad panoply of issues. I come primarily this morning to speak of my cosponsorship to the legislation that Senator Burr spoke so passionately about a few moments ago, S. 2573, the Veterans Mental Health Treatment First Act. I am here in support of it because it would begin the coordination of care that is needed when it comes to treating mental health.

Currently—and I think the Senator has made this clear—there is a lack of coordination between the treatment provided by VHA and the disability payments made by VBA. S. 2673 does not stop a veteran from filing a disability claim for PTSD, it merely pauses this process so the veteran can focus on trying to get healthy. We are all about health and restoring people at the VA. And in today's

modern medicine, one trip to Walter Reed (as most of us have taken), we can clearly see that we are matching modern medicine with the desire of the modern veteran: to get whole, to get healthy, to go back to their communities, to be a part of their community in a full and productive way.

It is naive to think that disability ratings by VA and the payments that come with those ratings have no impact on a person's health, particularly when the willingness of the patient to get well plays a significant part in the success of their recovery. When you tell someone that has been living an active, healthy life that they are permanently disabled and give them a lifetime payment to reflect that, I believe, has a tremendous impact on their psyche. It makes it all the more difficult to get to the state of mind that is, at least in my opinion, necessary to tackle the mental health problems that they may be experiencing.

In the testimony submitted by VA, there are some valid concerns about S. 2573 that could be used to improve the legislation. But I do not agree with the VA's dismissal of the legislation because it is too difficult to implement. Mr. Chairman, there really isn't anything too difficult if it comes to bringing our veterans back to wholeness, both physically and mentally. Our focus needs to be on making veterans healthy again in all the ways we possibly can.

Unfortunately, it is clear that the current strategy to treat PTSD isn't working as well as we would want it to. According to disability ratings, veterans who are diagnosed with PTSD don't get better. They, in many instances, get worse. According to the 2005 review of the VA Inspector General, the rating evaluations typically increase over time until the disability rating reaches a full 100 percent.

VA is doing a tremendous job when it comes to treating the physical wounds of our veterans. While I don't pretend to have all the answers, I think VA needs to be willing to try new strategies when it comes to treating PTSD so that we can be as successful with the minds of our veterans as we are now with their bodies. That is the job of this Committee, to make sure that happens. I think the Senator has brought us a very instructive and creative piece of legislation that advances that; and, as he said and went into further detail, it takes nothing away from the veteran having what he or she deserves in the full process of time. But what they most deserve is our commitment to make them as whole as we possibly can for the work which they provided for this Nation.

Thank you.

Chairman AKAKA. Thank you very much, Senator Craig.

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

Let me add my welcome to the panel and to those who are here today.

We have another lengthy agenda that reflects the work and commitment of many members on both sides of the aisle on this Committee. The health care bills before us today address crucial issues which seek to improve services to veterans. I anticipate that from today's hearing, we will be able to develop another strong package

of veterans health legislation. I will briefly highlight a few of the bills on our agenda.

The Veterans Medical Personnel Recruitment and Retention Act of 2008 is based on extensive committee oversight, including our recent hearing on personnel issues. In the face of competition from other health care systems, VA frequently has difficulty recruiting and retaining personnel, particularly nurses and senior executives. To make matters worse, a significant portion of the VA nursing workforce will be eligible to retire within the next decade. This bill would provide the tools and flexibility for VA to attract the best personnel and deliver the best care for veterans.

Servicemembers and their families face many challenges as they return to civilian life. S. 2796 would establish pilot programs on the use of community-based organizations. The programs would assist transitioning veterans and their families as they access VA care and benefits and reintegrate into civilian life. VA has made significant strides in reaching out to provide these services; and I believe this legislation will provide further support to veterans.

Other bills before us seek to address a wide range of pressing needs. There are bills to prevent homelessness, assist family caregivers, and improve mental health services. It is this last topic, improving mental health care for veterans, which continues to get attention from this Committee, as you have heard. For the information of Members and others with an interest in the Committee's work, we have just scheduled a hearing on the current public perception of how mental health, and PTSD specifically, is dealt with by VA. While there has been much attention to an e-mail from one VA clinician which raised questions for many about the possible suppression of PTSD as a diagnosis, I am concerned that the suppression of PTSD both in terms of compensation and treatment may be, in fact, much more widespread.

The bipartisan veterans mental health care bill approved by this Committee last year, and now on the Senate calendar, is a comprehensive approach to improving PTSD and substance abuse care. Yet, there are objections to Senate action on this bill. Senator Burr and I are trying to address the pending objections now and hope this bill can pass the Senate before Memorial Day.

Finally, I am well aware that there are a substantial number of bills under consideration today and that several of them have been added to the agenda only recently. As a result, not all witnesses have had the opportunity to review them and formulate positions. Therefore, the Committee will hold the record of this hearing open for 2 weeks so that witnesses can submit supplemental views on any legislative item. It is important that we have your input well in advance of markup that is tentatively scheduled for June.

I thank the witnesses for being here today and look forward to hearing your testimony on legislation before the Committee.

I want to welcome our principal witness from the VA, Dr. Gerald Cross, Principal Deputy Under Secretary for Health. He is accompanied by Walter Hall, Assistant General Counsel, and by Kathryn Enchelmayer, Director of Quality Standards for the VHA's Office of Quality and Performance. Again, I thank you for being here. VA's full testimony will appear in the record.

Dr. Cross, will you begin.

STATEMENT OF GERALD M. CROSS, M.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND KATHRYN ENCHELMAYER, DIRECTOR, QUALITY STANDARDS, OFFICE OF QUALITY AND PERFORMANCE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Good morning, Mr. Chairman and Members of the Committee, and thank you for inviting me to present the administration's views on a number of bills that would affect the Department of Veterans Affairs' benefits and services. I would also like to thank you for introducing four bills on behalf of the Department. Those are S. 2273, S. 2797, S. 2889, and S. 2984. Among the other bills, the Department is pleased to support in part S. 2799 and S. 2937. We are unable to provide views, however, on S. 2926, S. 2963, and S. 2969 at this time, but we will submit them for the record.

Joining me today are Walt Hall, Assistant General Counsel, and Kathryn Enchelmayer, Director of Quality Standards from the Office of Quality and Performance; and sir, I would like to request that my written statement be submitted for the record.

Chairman AKAKA. It will be included in the record.

Dr. CROSS. Thank you, Mr. Chairman, for introducing S. 2797 on our behalf. Since our last communication on this proposal, VA has developed a more effective plan for Denver veterans. My prepared statement details our new vision. In addition to constructing a new state-of-the-art VA health care center, we propose to partner with the nearby University of Colorado Hospital by leasing inpatient space in the new tower that they intend to build there. VA would have its own building entrance, its own lobby, and the VA floors would be staffed by VA health care professionals. This model allows the VA to adjust to changing demographics and treatment methods. Our overall plan for serving Rocky Mountain veterans also includes a large new outpatient clinic in Colorado Springs.

VA strongly supports enhancements for the care of women veterans and we support several provisions of S. 2799, the Women Veterans Health Care Improvement Act of 2008. We generally support Section 201, which would permit us to care for newborns of women veterans under our maternity care. However, we believe that VA's obligation as a provider of neonatal or well baby care should be limited to care necessary immediately after delivery and until the mother and child are discharged, up to a maximum of 30 days.

We also support Section 206, which would require VA to staff each medical center with a full-time Women Veterans Program Manager. As to the other provisions of S. 2799, we already have many efforts underway that we think satisfy these requirements of the bill. We would be happy to discuss those during the course of this testimony.

S. 2377 shows the Committee's concern regarding the quality of care our veterans receive. We continually evaluate and improve our system to ensure VA standards for physician licensing not only meet, but also exceed, those in many outside health care organiza-

tions. VA, however, is a national health care system that uses progressive technology, such as telemedicine, to reach veterans in remote areas and across State boundaries. The requirement to mandate State licensure for physicians in a specific State of practice would have a serious negative impact on patient care. The bill would also severely limit VA's ability to respond during periods of emergency. VA's excellent performance during Hurricanes Katrina and Rita demonstrates the vital importance of flexibility during a crisis.

VA strongly opposes S. 2824. The major provision of this bill would make direct patient care and the issues related to competence of health care providers subject to collective bargaining. Mr. Chairman, I do not exaggerate when I say this could jeopardize patient care. The Secretary and Under Secretary for Health are responsible for the care and safety of our veterans. They must be able to establish standards of professional conduct and competency. We believe the current restriction on collective bargaining rights is a sound compromise between VA's mission to serve America's veterans with the honor and care that they deserve and the interest of our Title 38 physicians, dentists, and nurses in bargaining over the conditions of their employment.

Mr. Chairman, I agree with S. 2573's emphasis on early treatment intervention. I stand ready to work closely with the Committee to explore the full impact of this complex proposal. In general, the bill would establish a program under which veterans would receive wellness stipends for complying with their treatment plans and for agreeing not to pursue the disability claims process for those conditions until treatment is completed. The bill, however, only authorizes VA to treat specific mental health conditions under this program. VA believes our veterans receive the best possible care when they receive comprehensive care addressing all of their medical needs. Moreover, the bill may place physicians in a "Catch–22" by requiring them to link the patient's clinical progress with the patient's financial interest.

The Department of Veterans Affairs considers suicide an issue of great importance and we are committed to doing everything we can to reduce the risk to our veterans and to better understand this complex phenomenon. However, because VA relies on multiple external sources of data to create a clearer picture of veterans' suicide, we believe S. 2899 may not achieve our mutual goal of a broader and more detailed view of this challenging issue. To arrive at accurate figures for the rate of suicide, multiple data sources have to be used, including national data sources. As an example, in one national database, a non-VA database, the most current data available is from 2005. VA continues to develop new methods for improving the quality and accuracy of the data. Our experts are among the Nation's leaders in the study of veteran suicide and our staffs stand ready to work closely with your staff to better measure and prevent suicide.

The Department appreciates the Committee's continued interest in the issues raised in the other bills under discussion today. We will welcome the opportunity to discuss VA's current efforts in these areas and proposals.

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

[The prepared statement of Dr. Cross follows:]

PREPARED STATEMENT OF GERALD M. CROSS, MD, FAAFP, PRINCIPAL DEPUTY, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Good Morning Mr. Chairman and Members of the Committee: Thank you for inviting me here today to present the Administration's views on a number of bills that would affect Department of Veterans Affairs (VA) programs of benefits and services. With me today are Walter A. Hall, Assistant General Counsel, and Kathryn Enchelmayer, Director, Quality Standards, Office of Quality and Performance. I am pleased to provide the Department's views on 14 of the 17 bills under consideration by the Committee. Unfortunately, we received S. 2963 too late to include in our written statement, but we will provide views and costs for the record. In addition, the Administration's position is currently under review for S. 2969. Therefore, it is not included in our written statement and we will forward those views as they are available. Similarly, the Administration is still developing its position on S. 2926 and we will provide those views for the record. I will now briefly describe the 14 bills, provide VA's comments on each measure and estimates of costs (to the extent cost information is available), and answer any questions you and the Committee members may have.

Mr. Chairman, today's agenda includes four bills that consist of legislative proposals the Administration submitted to the Congress: S. 2273; S. 2797; S. 2889, and S. 2984. Thank you for introducing these bills at our request. We believe each bill would significantly enhance the health care services we provide to veterans as well as our means of furnishing these benefits. I will begin my testimony by addressing the major health care related provisions in these important bills.

S. 2273 "ENHANCED OPPORTUNITIES FOR FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING ACT OF 2007"

S. 2273 would authorize VA to conduct two 5-year pilot grant programs under which public and non-profit organizations (including faith-based and community organizations) would receive funds for coordinating the provision of local supportive services for very low income, formerly homeless veterans who reside in permanent housing. Under one of the pilot programs, VA would provide grants to organizations assisting veterans residing in permanent housing located on military property that the Secretary of Defense closed or slated for closure as part of the 2005 Base Realignment and Closure program and ultimately designated for use in assisting the homeless. The other pilot program would provide grants to organizations assisting veterans residing in permanent housing on any property across the country. Both programs would require the Secretary to promulgate regulations establishing criteria for receiving grants and the scope of supportive services covered by the grant program.

In 1987, when VA began its specific assistance to veterans who were homeless, few recognized that long-term or permanent housing with supportive services was necessary to return these veterans to full function. It is now well understood that the provision of long-term housing coupled with needed supportive services is vital to enable them to lead independent lives in their communities. Although supportive services are widely available to these veterans through VA and local entities, most housing assistance that is available to them is limited to temporary or transitional housing. Generally sources of long-term housing for these veterans are lacking. Military facilities recently slated for closure or major mission changes may provide an excellent site for long-term or permanent housing for these vulnerable veterans who remain at risk of becoming homeless. Local redevelopment authorities could take these VA grant programs into account when designing their local plans to convert the property for use in assisting formerly homeless veterans. This would not only help the veterans but also enhance the community's efforts at economic revitalization. We estimate the costs associated with each of these pilots to be $375,000 in fiscal year (FY) 2009 and $11,251,000 over a 5-year period.

S. 2797 AUTHORIZATION OF FISCAL YEAR 2009 MAJOR MEDICAL FACILITY PROJECTS

Section 1 would authorize the following four major medical construction projects:

- Construction of an 80-bed replacement facility in Palo Alto, California, in an amount not to exceed $54,000,000;

• Construction of an Outpatient Clinic in Lee County, Florida to meet the increased demand for diagnostic procedures, ambulatory surgery, and specialty care, in an amount not to exceed $131,800,000;
• Seismic Corrections on Building 1 in San Juan, Puerto Rico, in an amount not to exceed $225,900,000; and
• Construction of a state-of-the-art poly-trauma health care and rehabilitation center in San Antonio, Texas, in an amount not to exceed $66,000,000.

Section 2 would authorize the following major medical facility projects:

• Replacement of the VA Medical Center in Denver, Colorado, in an amount not to exceed $769,200,000.
• Restoration, new construction or replacement of the medical center facility in New Orleans, Louisiana, in an amount not to exceed $625,000,000.

VA received authorization for lesser sums under Public Law 109–461 for these two major projects. In February 2008 we requested authorization in the amount of $769.2 million for the Denver-replacement project. However, the Department has identified an alternative option to purchase land and construct the new Denver VA facility while also leasing beds from the University of Colorado Hospital. Since our fiscal year 2009 major-facility-authorization request was submitted in February, we met with officials of the University of Colorado and the new University of Colorado Hospital (UCH) to discuss how best to replace the services and improve the access now being provided by the aging VA Medical Center in Denver. We are still finalizing the details of this approach, but our preliminary analysis shows that it would be better, for several reasons, to lease space in the inpatient unit that UCH plans to build and to have VA's new state-of-the-art health care facility focus on the provision of primary and specialty care, outpatient surgery, and nursing home care. This proposed and innovative VA partnership with UCH would also extend to the sharing of certain adjunct inpatient resources, such as laboratory and medical-imaging services, and include VA's leasing research space from the University of Colorado Denver. The leased inpatient space would be staffed by VA health-care professionals and accessed via a separate VA entrance and lobby. In all respects to our patients, it would be a VA facility. This change in construction plans would more effectively increase and improve veterans' access to care throughout the Rocky Mountain region. As part of this strategy, we would need to additionally seek authority to enter into a contract for a lease for an outpatient clinic in Colorado Springs, Colorado; the revised amount for this lease would exceed the current request. We will provide Committee the final authorization amounts needed for these projects shortly.

Section 3 would authorize VA to enter into leases for the following twelve facilities:

• Brandon, Florida, Outpatient Clinic, $4,326,000;
• Colorado Springs, Colorado, Community-Based Outpatient Clinic, $3,995,000; (the final amount needed for this project is pending)
• Eugene, Oregon, Outpatient Clinic, $5,826,000;
• Green Bay, Wisconsin, Expansion of Outpatient Clinic, $5,891,000;
• Greenville, South Carolina, Outpatient Clinic, $3,731,000;
• Mansfield, Ohio, Community-Based Outpatient Clinic, $2,212,000;
• Mayaguez, Puerto Rico, Satellite Outpatient Clinic, $6,276,000;
• Mesa, Arizona, Southeast Phoenix Community-Based Outpatient Clinic, $5,106,000;
• Palo Alto, California, Interim Research Space, $8,636,000;
• Savannah, Georgia, Expansion of Community-Based Outpatient Clinic, $3,168,000;
• Sun City, Arizona, Northwest Phoenix Community-Based Outpatient Clinic, $2,295,000; and
• Tampa, Florida, Primary Care Annex, $8,652,000.

Section 4 would authorize for appropriation the sum of $477,700,000 for fiscal year 2009 for construction of the four major medical projects listed in Section 1 and $1,394,200,000 for the two projects listed in Section 2. Section 4 would also authorize for appropriation for fiscal year 2009 $60,114,000 from the Medical Facilities account for the leases listed in Section 3. However, we will likely revise our request for both those Section 2 construction projects and the Section 3 leases. Our final recommendation on the amounts will be provided to the Committee shortly.

S. 2889 "VETERANS HEALTH CARE ACT OF 2008"

Mr. Chairman, you have asked us to testify on sections 2, 3, 4, 5, and 6, of S. 2889. Section 2 would authorize VA to contract for specialized residential care and rehabilitation services for veterans of Operation Enduring Freedom and Operation

Iraqi Freedom (OEF/OIF) who: (1) suffer from Traumatic Brain Injury, (2) have an accumulation of deficits in activities of daily living and instrumental activities of daily living that affects their ability to care for themselves, and (3) would otherwise receive their care and rehabilitation in a nursing home. These veterans do not require nursing home care, but they generally lack the resources to remain at home and live independently. This legislation would enable VA to provide them with long-term rehabilitation services in a far more appropriate treatment setting than we are currently authorized to provide. VA estimates the discretionary cost of section 2 to be $1,427,000 in fiscal year 2009 and $79,156,000 over a 10-year period.

Section 3 would require VA to provide full-time VA physicians and dentists the opportunity to continue their professional education through VA-sponsored continuing education programs. It would also authorize VA to reimburse these employees up to $1000 per year for continuing professional education that is not available through VA-sources. Currently, VA is required by statute to reimburse each of these individuals up to $1000 per year for expenses they incur in obtaining continuing education, even though VA has the capacity and resources to meet most of their professional continuing education needs in-house. Enactment of section 3 would result in cost-savings to VA, while serving as an effective recruitment and retention tool for the Veterans Health Administration. We estimate section 3 would result in discretionary savings of $8,700,000 in fiscal year 2009 and a total discretionary savings of $87,000,000 over a 10-year period.

Section 4 would eliminate co-payment requirements for veterans receiving VA hospice care either in a VA hospital or at home on an outpatient basis. In 2004, Congress amended the law to eliminate copayment requirements for hospice care furnished in a VA nursing home. Section 4 would result in all VA hospice care being exempt from copayment requirements, regardless of setting. Projected discretionary revenue loss is estimated to be $149,000 in fiscal year 2009 and $1,400,000 over 10 years.

Section 5 would repeal outdated statutory requirements that require VA to provide a veteran with pre-test counseling and to obtain the veteran's written informed consent prior to testing the veteran for HIV infection. Those requirements are not in line with current guidelines issued by the Centers for Disease Control and Prevention and other health care organizations, which, with respect to the issue of consent, consider HIV testing to be similar to other blood tests for which a patient need only give verbal informed consent. According to many VA providers, the requirements for pre-test counseling and prior written consent delay testing for HIV infection and, in turn, VA's ability to identify positive cases that would benefit from earlier medical intervention. As a result, many infected patients unknowingly spread the virus to their partners and are not even aware of the need to present for treatment until complications of the disease become clinically evident and, often, acute. Testing for HIV infection in routine clinical settings no longer merits extra measures that VA is now required by law to provide. Many providers now consider HIV to be a chronic disease for which continually improving therapies exist to manage it effectively. Repealing the 1988 statutory requirements would not erode the patient's rights, as VA would, just like with tests for all other serious conditions, still be legally required to obtain the patient's verbal informed consent prior to testing. VA estimates the discretionary costs associated with enactment of section 5 to be $73,680,000 for fiscal year 2009 and $301,401,000 over a 10-year period.

Section 6 would amend sections 5701 and 7332 of title 38, United States Code, to authorize VA to disclose individually-identifiable patient medical information without the prior written consent of a patient to a third-party health plan to collect reasonable charges under VA collections authority for care or services provided for a non-service-connected disability. The section 5701 amendment would specifically authorize disclosure of a patient's name and address information for this purpose. The section 7332 amendment would authorize disclosure of both individual identifier information and medical information for purposes of carrying out the Department's collection responsibilities. VA estimates that enactment of section 6 will result in net discretionary savings of $9,025,000 in fiscal year 2009 and $108,858,000 over 10 years.

S. 2984 "VETERANS BENEFITS ENHANCEMENT ACT OF 2008"

This bill includes several important program authority extensions, including VA's mandate to provide nursing home care to veterans with service-connected disabilities rated 70 percent or more and to veterans whose service-connected disabilities require such care; VA's authority to establish research corporations; and VA's mandate to conduct audits of payments made under fee basis agreements and other medical services contracts. We urge the Committee to take action on all of the expir-

ing authorities contained in the bill. Costs associated with these extensions will be paid from future discretionary appropriations. In the case of the audit-recovery program, we estimate discretionary recoveries in the amount of $9 million for fiscal year 2008 and a 10-year total in recoveries of $70 million.

A significant provision of S. 2984 would permit VA health care practitioners to disclose the relevant portions of VA records of the treatment of drug abuse, alcoholism and alcohol abuse, infection with the human immunodeficiency virus, and sickle cell anemia to surrogate decisionmakers who are authorized to make decisions on behalf of patients who lack decisionmaking capacity, but to whom the patient had not specifically authorized release of that legally protected information prior to losing decisionmaking capacity. It would, however, allow for such disclosure only under circumstances when the practitioner deems such content necessary for the representative to make an informed decision regarding the patient's treatment. This provision is critical to ensure that a patient's surrogate has all the clinically relevant information needed to provide full and informed consent with respect to the treatment decisions that the surrogate is being asked to make.

Another key provision would authorize VA to require that applicants for, and recipients of, VA medical care and services provide their health-plan contract information and social security numbers to the Secretary upon request. It would also authorize VA to require applicants for, or recipients of, VA medical care or services to provide their social security numbers and those of dependents or VA beneficiaries upon whom the applicant or recipient's eligibility is based. Recognizing that some individuals do not have social security numbers, the provision would not require an applicant or recipient to furnish the social security number of an individual for whom a social security number has not been issued. Under this provision, VA would deny the application for medical care or services, or terminate the provision of, medical care or services, to individuals who fail to provide the information requested under this section. However, the legislation provides for the Secretary to reconsider the application for, or reinstate the provision of, care or services once the information requested under this section has been provided. Of note, this provision makes clear that its terms may not be construed to deny medical care and treatment to an individual in a medical emergency.

Although VA has authority under 38 U.S.C. § 1729 to recover from health insurance carriers the reasonable charges for treatment of a veteran's nonservice-connected disabilities, there is no permanent provision in title 38 to require an applicant for, or recipient of, VA medical care to provide information concerning health insurance coverage. This provision would ensure that VA obtains the health-plan contract information from the applicant for, or recipient of, medical care or services.

Moreover, social security numbers enable VHA to make accurate and efficient medical care eligibility determinations and to instantaneously associate medical information with the correct patient by matching those social security numbers against records of other entities. Medical care eligibility determinations may be based on such factors as qualifying military service, service-connected disabilities, and household income. VHA may obtain or verify such information from internal VA components such as the Veterans Benefits Administration (VBA) which currently has authority to require social security numbers for compensation and pension benefits purposes, and outside sources, such as the Department of Defense (DOD), Internal Revenue Service and Social Security Administration. The availability of social security numbers ensures accurate matches of an individual's information with both internal and external sources. The income verification match programs are wholly dependent on social security numbers.

Be assured that VA will provide the same high degree of confidentiality for the beneficiaries' health plan information and social security numbers as it provides to patients' medical information in its records and information systems. There are no direct costs associated with this provision other than administrative costs associated with collecting revenue. Those costs will be paid from future discretionary appropriations.

Mr. Chairman, I now move to address the other bills on the agenda today.

S. 2377 "VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT"

S. 2377 is an excessively prescriptive bill that would impede the fundamental operations and structure of VHA. We have very recently provided the Committee with a copy of the Department's views on H.R. 4463, the identical House companion bill. Our views letter provides our detailed discussion of every provision. We would like to take this opportunity to discuss the provisions that cause us the most concern.

The requirement that within 1 year of appointment each physician practicing at a VA facility (whether through appointment or privileging) be licensed to practice

medicine in the State where the facility is located is particularly troubling and we believe harmful to the VA system. VA strongly objects to enactment of this provision. VHA is a nationwide health care system. By current statute, to practice in the VA system, VA practitioners may be licensed in any State. If this requirement were enacted, it would impede the provision of health care across State borders and reduce VA's flexibility to hire, assign and transfer physicians. This requirement also would significantly undermine VA's capacity and flexibility to provide telemedicine across State borders. VA makes extensive use of telemedicine. In addition, VA's ability to participate in partnership with our other Federal health care providers would be adversely impacted in times such as the aftermath of Hurricanes Katrina and Rita, where we are required to mobilize members of our medical staff in order to meet regional crises.

Currently, physicians who provide medical care elsewhere in the Federal sector (including the Army, Navy, Air Force, U.S. Public Health Service Commissioned Corps, U.S. Coast Guard, Federal Bureau of Prisons and Indian Health Service) need not be licensed where they actually practice, so long as they hold a valid State license. Requiring VA practitioners to be licensed in the State of practice would make VA's licensure requirements inconsistent with these other Federal health care providers and negatively impact VA's recruitment ability relative to those agencies. In addition, many VA physicians work in both hospitals and community-based outpatient clinics. Many of our physicians routinely provide care in both a hospital located in one State and a clinic located in another State. A requirement for multiple State licenses would place VA at a competitive disadvantage in recruitment of physicians relative to other health care providers.

Although the provision would allow physicians 1 year to obtain licensure in the State of practice, many States have licensing requirements that are cumbersome and require more than 1 year to meet. Such a requirement could disrupt the provision of patient care services while VA physicians try to obtain licensure in the State where they practice or transfer to VA facilities in States where they are licensed. The potential costs of this disruption are unknown at this time.

Further, we are not aware of any evidence of a link between differences in State licensing practices and quality of patient care. In 1999, the General Accounting Office reviewed the effect on VA's health care system that a requirement for licensure in the State of practice would have. The GAO report concluded, in part, that the potential costs to VA of requiring physicians to be licensed in the State where they practice would likely exceed any benefit, and that quality of care and differences in State licensing practices are not directly linked. See GAO/HEHS–99–106, "Veterans' Affairs Potential Costs of Changes in Licensing Requirement Outweigh Benefit" (May 1999).

Another provision would provide that physicians may not be appointed to VA unless they are board certified in the specialties of practice. However, this requirement could be waived (not to exceed 1 year) by the Regional Director for individuals who complete a residency program within the prior 2 year period and provide satisfactory evidence of an intent to become board certified. VA strongly opposes this provision of S. 2377. Current law does not require board certification as a basic eligibility qualification for employment as a VA physician. VA policy currently provides that board certification is only one means of demonstrating recognized professional attainment in clinical, administrative or research areas, for purposes of advancement. However, we actively encourage our physicians to obtain board certification. Facility directors and Chiefs of Staff must ensure that any non-board certified physician, or physician not eligible for board certification, is otherwise well qualified and fully capable of providing high quality care for veteran patients. VA should be given considerable flexibility regarding the standards of professional competence that it requires of its medical staff, including the requirement for specialty certification. Were this measure enacted, it could have a serious chilling effect on our ability to recruit very qualified physicians. At this point in time, VA has physician standards that are in keeping with those of the local medical communities.

Moreover, the bill would provide that the board certification and in-State licensure requirements would take effect 1 year after the date of the Act's enactment for physicians on VA rolls on the date of enactment. This would at least temporarily seriously disrupt VA's operations if physicians are unable to obtain board certification and in-State licensure within 1 year, or are unable to transfer to a State where they are licensed.

Mr. Chairman, we want to emphasize that we support the intent of several provisions of S. 2377 and have already been taking actions to achieve many of the same goals. We would welcome the opportunity to meet with the Committee to discuss recent actions we have undertaken to improve the quality of care across the system, including program oversight related measures.

S. 2383 PILOT PROGRAM PROVIDING MOBILE HEALTH CARE AND OTHER SERVICES

S. 2383 would require the Secretary, acting through the Director of the Office of Rural Health (DORH), to conduct a pilot program to furnish outreach and health care services to veterans residing in rural areas through the use of a mobile system equipped with appropriate program staff and supplies. The mobile system would have to be capable of furnishing the following services:

- counseling and education services on how to access VA health care, educational, pension, and other VA benefits;
- assistance to veterans in completing paperwork needed to enroll in VA's health care system;
- prescriptions for, and delivery of, medications;
- mental health screenings to identify potential mental health disorders, particularly for veterans returning from deployment overseas in OEF/OIF;
- job placement assistance and information on employment or training opportunities;
- substance abuse counseling; and
- bereavement counseling for families of active duty servicemembers who were killed in the line of duty while on active service.

Staffing for the mobile system would be required to include VA physicians; nurses; mental health specialists; casework officers; benefits counselors, and such other personnel deemed appropriate by the Secretary. To the extent practicable, personnel and resources from area community-based outpatient clinics could be used to assist in this effort. The bill sets forth a number of requirements related to the development and coordination of the pilot program as well as to the conduct of the mobile system (including the minimum frequency of visits to rural areas participating in the pilot programs).

S. 2383 would also mandate that the Secretary act jointly with the Secretary of Defense to identify veterans not enrolled in, or otherwise being cared for by, VA's health care system. VA would be further required to coordinate efforts with county and local veterans service officers to inform those veterans of upcoming visits by the mobile unit and the concomitant opportunity to complete paperwork for VA benefits. The bill would authorize $10 million to be appropriated for the mobile system each of FYs 2008 through 2010.

VA does not support S. 2383, because it is not necessary and is duplicative of ongoing efforts by the Department. VA's Office of Rural Health is already in the process of standing up a mobile system by which to provide medical care and services to veterans residing in rural areas, and VA's Vet Centers are already using mobile units to furnish readjustment counseling services. The Vet Centers and VBA also have in place extensive outreach program targeted at these veterans. VA has recently created a Task Force to review the adequacy of the assets and resources dedicated to these efforts thus far. Particularly with respect to the mobile system, we urge the Committee to refrain from taking action on the bill until we have sufficient experience with this model of delivery to ascertain its effectiveness and to identify and cure any deficiencies. We would be glad to brief the Committee on our activities to date.

As a technical matter, the duration of the pilot program is unclear, but we assume it is 3 years based on the terms of the bill's provision authorizing appropriations for FYs 2008–2010. Additionally, medications are currently mailed to these veterans and so it is not necessary to provide those benefits through a mobile system.

S. 2573 "VETERANS MENTAL HEALTH TREATMENT FIRST ACT"

Mr. Chairman, S. 2573 is a very ambitious bill that would provide the Department with significant new tools to maximize and reward a veteran's therapeutic recovery from certain service-related mental health conditions, and, to the extent possible, reduce the veteran's level of permanent disability from any of the covered conditions. The goal of the legislation is to give the veteran the best opportunity to reintegrate successfully and productively into the civilian community.

Specifically, S. 2573 would require the Secretary to carry out a mental health and rehabilitation program for a veteran who has been diagnosed by a VA physician with any of the following conditions:

- Post Traumatic Stress Disorder (PTSD);
- depression; or
- anxiety disorder

that is service-related, as defined by the bill. The bill would also cover a diagnosis of a substance use disorder related to service-related PTSD, depression, or anxiety. For purposes of this program, a covered condition would be considered to be service-

related if: (1) VA has previously adjudicated the disability to be service-connected; or (2) the VA physician making the diagnosis finds the condition plausibly related to the veteran's active service. S. 2573 would also require the Secretary to promulgate regulations identifying the standards to be used by VA physicians when determining whether a condition is plausibly related to the veteran's active military, naval, or air service.

The bill sets forth conditions of participation for the veterans taking part in the program. If a veteran has not filed a VA claim for disability for the covered condition, the veteran would have to agree not to submit a VA claim for disability compensation for the covered condition for 1 year (beginning on the date the veteran starts the program) or until the date on which the veteran completes his or her treatment plan, whichever date is earlier.

If the veteran has filed a disability claim but it has not yet been adjudicated by the Department, the veteran could elect either to suspend adjudication of the claim until he or she completes treatment or to continue with the claims adjudication process. As discussed below, the stipend amounts payable to the veteran under the program will depend on which election the veteran makes.

If the veteran has a covered condition that has been adjudicated to be service-connected, then the individual would have to agree not to submit a claim for an increase in VA disability compensation for 1 year (beginning on the date the veteran starts the program) or until the date the veteran completes treatment, whichever is earlier.

S. 2573 would establish a financial incentive in the form of "wellness" stipends to encourage participating veterans to obtain VA care and rehabilitation before pursuing, or seeking additional, disability compensation for a covered condition. The amount of the stipend would depend on the status of the veteran's disability claim. If the veteran has not filed a VA disability claim, VA would pay the veteran $2000 upon commencement of the treatment plan, plus $1500 every 90 days thereafter upon certification by the VA clinician that the veteran is in substantial compliance with the plan. This recurring stipend would be capped at $6000. The veteran would receive an additional $3000 at the conclusion of treatment or 1 year after the veteran begins treatment, whichever is earlier.

If the veteran has filed a disability claim that has not yet been adjudicated, the participating veteran who elects to suspend adjudication of the claim until he or she completes treatment would receive "wellness" stipends in the same amounts payable to veterans who have not yet filed a disability claim. If the participating veteran elects instead to continue with the claims adjudication process, the veteran would receive "wellness" stipends in the same amounts payable to veterans whose covered disabilities have been adjudicated and found to be service-connected: $667 payable upon the veteran's commencement of treatment and $500 payable every 90 days thereafter upon certification by the veteran's clinician that the individual is in substantial compliance with the plan. Recurring payments would be capped at $2000, and the veteran would receive $1000 when treatment is completed or 1 year after beginning treatment, whichever is earlier.

If the Secretary determines that a veteran participating in the program has failed to comply substantially with the treatment plan or any other agreed-upon conditions of the program, the bill would require VA to cease payment of future "wellness" stipends to the veteran.

Finally, S. 2573 would limit a veteran's participation in this program to one time, unless the Secretary determines that additional participation in the program would assist in the remediation of the veteran's covered condition.

VA does not support S. 2573. While philosophically we discern and appreciate the aims of the bill, particularly the holistic and integrated approach to the receipt of VA benefits, this is a very complex proposal that requires further in-depth study of all of the bill's implications, including those related to cost. In addition, we have numerous concerns with the bill as currently drafted.

S. 2573 assumes that early treatment intervention by VA health care professionals for a covered condition would be effective in either reducing or stabilizing the veteran's level of permanent disability from the condition, thereby reducing the amount of VA disability benefits ultimately awarded for the condition. No data exist to support or refute that assumption.

With the exception of substance abuse disorders, we are likewise unaware of any data to support or refute the bill's underlying assumption that paying a veteran a "wellness stipend" will ensure the patient's compliance with his or her treatment program. Although there is a growing trend among health insurance carriers or employers to provide short-term financial incentives for their enrollees or employees to participate in preventive health care programs (e.g., reducing premiums for an enrollee who participate in a fitness program, loses weight, or quits smoking), we are

unaware of any data establishing that these and similar financial incentives produce long-term cost-savings to the carrier or employer. It would be extremely difficult, if not impossible, to quantify savings or offsets because there is no way to know whether a particular patient's health status would have worsened without VA's intervention and whether the intervention directly resulted in a certain or predictable total amount in health care expenditure savings. We would experience the same difficulties trying to identify what would have been the level of disability and costs of care for a particular veteran had he or she not participated in the early clinical intervention program established by S. 2573.

Providing these mental health care benefits independent of the medical benefits package provided to enrolled veterans gives rise to other concerns. A veteran's mental health and physical health are integral, and it would be very difficult to discern if certain conditions or physical manifestations that may result from or be related to a mental health condition are covered by S. 2573. As a provider, VA would need to assume that this bill would cover needed care for physical conditions that result from, or are associated with, the covered mental health condition under treatment. (Our approach would be similar to the approach taken under the Department's authority in 38 U.S.C. § 1720D to provide both counseling and care needed to treat psychological conditions resulting from sexual trauma.) For instance, recent scientific literature has linked heart disease to stress. Heart disease might at some point be linked to depression, PTSD and/or anxiety disorder. We believe that unless the scientific literature conclusively rules out an association between a covered mental health condition and the veteran's physical condition, the veteran should receive the benefit of the doubt. This could expand the scope of S. 2573 beyond the drafter's intent, because the types of physical conditions considered by the scientific community to be associated with mental health conditions could expand over time. Should this happen, S. 2573 could lead to VA essentially operating two different health care systems based on separate sets of eligibility criteria, undermining the accomplishments achieved under VA health care reform.

It is also troubling to us that S. 2573 would require VA to treat specific diseases and not the veteran as a whole. This approach places VA practitioners in the difficult and untenable position of being able to identify conditions they cannot treat. This creates a particularly serious ethical dilemma for the practitioner who knows that his or her veteran-patient has no other access to the needed health care services. In our view, authority to treat specific diseases—and not the person—is counter to the principles of patient-centered and holistic medicine.

The "wellness" stipends, themselves, raise several complex issues. None of VA's current benefits systems is equipped to administer such a novel benefit, and no current account appears to be an appropriate funding source from which to pay them. After much grappling with the issue, we have concluded that because the bill would amend only chapter 17 of title 38, United States Code, these stipends would have to be administered by VHA and paid from funds made available for medical care.

There would be significant indirect costs as well. VHA currently lacks the IT infrastructure, expertise, and staff to administer monetary benefits. Administering the easiest of monetary benefits would be challenging for VHA, but it is nearly insurmountable in connection with this bill, which calls for a very complex, nationwide patient tracking and monitoring system that also has the capacity to administer payments at different points in time for veterans participating in the program. The fact that the duration of each veteran's treatment plan is highly individualized only complicates the requirements of such a system-design, as does the fact that the bill would permit some veterans to receive treatment (and payment) extensions.

As a result, we do not believe that S. 2573 would be cost-effective as currently drafted. The maximum we could pay any veteran under the bill would be $11,000; however, it is reasonable to assume that the costs associated with designing, operating, and administering such a complex benefit program would far surpass the actual amounts we would pay out to the veterans (individually or collectively).

S. 2573 also places our physicians and practitioners in the difficult position of determining whether their patients will receive wellness stipends available under the program. It is quite atypical for a VA physician's clinical determination to have direct financial implications or consequences for his or her patients. VA physicians and practitioners seek to help their veteran-patients attain maximum functioning as quickly as clinically possible. S. 2573 would create potential conflict for our health care practitioners. They should focus solely on issues of health care and not feel pressure to grant requests for extensions of treatment in order to maximize the amount of money patients receive under the program.

It would also be difficult to define "substantial compliance," for purposes of S. 2573, in a way that is measurable and objective as well as not easily amenable to fraud or abuse. For instance, substantial compliance could be defined in part by

a veteran stating that he or she took prescribed medications as ordered by the physician and VA could confirm the veteran obtained refills in a timely manner. But that information does not actually verify that the patient in fact ingested the medication or did so as prescribed. There would unavoidably be some patients whose motivation for participating in this program is strictly financial, and they would invariably find ways to circumvent whatever criteria we establish in order to receive their stipends. Although these payments would not be sizable, they are sufficient to entice some patients who would not otherwise access VA's health care system to participate in the program. We fear these patients would cease their treatment and stop accessing needed VA services once their treatment and payments end.

Finally, if the use of "wellness" stipends were able to produce reliable, positive results in terms of patients' compliance or outcomes, there would then be a demand to extend this reward system to other VA treatment programs. And once a benefit is provided, it is difficult to ever repeal it. We say this only to point out that the cost implications in the out-years could be very difficult to estimate accurately.

Costing this bill is very complex, as there is no way for us to determine the total number of veterans who would participate in the pilot program, in which year they would enter the program, their ultimate disability status, and the amount of medical care they would each require. We estimate the increase in medical administrative costs for every 40,000 new veterans entering the VA system to be $280 million per year in addition to $293,340,000 per year in maximum stipend payments. The estimated one-time cost for eligible living veterans is $6,712,891,046. These costs do not factor in the costs of developing the IT infrastructure needed to administer the benefit. In light of these serious concerns and the bill's unknown total cost implications, we are unable to supports its enactment.

S. 2639 "ASSURED FUNDING FOR VETERANS HEALTH CARE ACT"

S. 2639 would establish, by formula, the annual level of funding for all VHA programs, activities, and functions (excluding the construction, acquisition, and alteration of VA medical facilities and provision of grants to assist States in the construction or alteration of State home facilities).

VHA funding for fiscal year 2008 (the first fiscal year covered by the bill) would be automatically established at 130 percent of the amounts obligated by VHA (for all its activities, programs, and functions) for fiscal year 2006. Thereafter, VHA funding would be automatically determined by a fixed formula. The formula would, generally speaking, be based on the number of enrollees each year and the number of other persons receiving VA care during the preceding year multiplied by a fixed per capita amount. The per capita amount would be adjusted annually in accordance with increases in the Consumer Price Index.

It has been VA's long-standing position that we do not support the concept of using a fixed formula to determine VHA funding. We believe that it is inappropriate and unworkable to apply an inflexible formula to a health care system that, by its very nature, is dynamic. The provision of care evolves continually to reflect advances in state-of-the-art technologies (including pharmaceuticals) and medical practices. It is not possible to estimate the concomitant costs or savings resulting from those evolving changes. Moreover, patients' health status, demographics, and usage rates are each subject to distinct trends that are difficult to predict. The proposed formula would not take into account any changes in these and other important trends. As such, there is no certainty that the amount of funding dictated by the proposed formula would be appropriate to the demands that will be placed on VA's health care system in the upcoming years.

Use of an automatic funding mechanism would also eliminate the valuable opportunity that Members of the Congress and the executive branch have to carry out their responsibility to identify and directly address the health care needs of veterans through the budget process. It could also depress the Department's incentive to improve its operations and be more efficient. It is important to note that S. 2639 would not ensure open enrollment, as the Department would still be required to make an annual enrollment decision. That decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula. Finally, references to "guaranteed funding" in the legislation may give the public the false impression that VA is being provided full funding for VA health care. It is not possible to determine whether the amount determined by the formula would be adequate. Because of S. 2639's potential for all of these unanticipated and unintended serious consequences, we continue to favor the current discretionary funding process that uses actuarially-based budget estimates to project the future health care needs of enrolled veterans.

S. 2796 PILOT PROGRAM USING COMMUNITY BASED ORGANIZATIONS TO INCREASE THE COORDINATION OF VA SERVICES TO TRANSITIONING VETERANS

S. 2796 would require the Secretary to carry out a 2-year pilot grant program (at five VA medical centers) to assess the feasibility of using community-based organizations to increase the coordination of VA benefits and services to veterans transitioning from military service to civilian life, to increase the availability of medical services available to these veterans, and to provide their families with their own readjustment services. Specifically, grantees could use grant funds to operate local telephone hotlines; organize veterans for networking purposes; assist veterans in preparing applications for VA benefits; provide readjustment assistance to families of veterans transitioning from military life to civilian life; provide outreach to veterans and their families about VA benefits; and coordinate the provision of health care and other benefits being furnished to transitioning veterans.

VA does not support S. 2796, because it is duplicative of the Department's ongoing efforts. Vet Centers are already providing much of the outreach, readjustment counseling services, and family support services that would be required by this bill. Additionally, VA case managers and Federal recovery coordinators already coordinate the delivery of health care and other VA services available to veterans transitioning from military service to civilian life, including supportive services for their families. VA is committing ever increasing resources to these ends. Use of grant funds to establish local hotlines would duplicate and dilute the effectiveness of VA's central hotlines. The duplicated efforts required by the bill would likely create significant confusion for the beneficiary. Further, funding family readjustment services wholly unrelated to the veteran's readjustment needs would divert medical care funds needed for veterans' health care.

To the extent the Secretary determines external resources are necessary to provide the services described in the bill, VA already has the necessary authority to contract for them. We favor using contracts instead of grants, as the former allow VA to respond to changing local needs. That approach also gives us an accurate way to project the cost of the services. S. 2796, on the other hand, would not. It would also not be cost-effective as it is likely that a grant awarded under the program would be for an amount significantly less than the cost VA incurs in administering the grant. We also note the bill would not include authority for VA to recapture unused grant funds in the event a grantee fails to provide the services described in the grant.

We note further that when selecting pilot sites the Secretary would have to consider medical centers that have "a high proportion of minority groups and individuals who have experienced significant disparities in the receipt of health care." We are uncertain what this language means and on what basis such a determination would be based.

Although the proposed pilot project is limited to five VA medical centers, the scope of the uses for the grant funds is very broad, and the bill does not specify the number and amount of the grants to be awarded. We are unable to estimate the cost estimate of S. 2796 due to the bill's lack of specificity.

S. 2799 "WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2008"

In general, title I of S. 2799 would require VA to conduct a number of studies related to health care benefits for women veterans. Section 101 would require VA, in collaboration with VHA's War-Related Injury and Illness Study Centers, to contract for an epidemiologic cohort (longitudinal) study on the health consequences of combat service of women veterans who served in OEF/OIF. The study would need to include information on their general, mental, and reproductive health and mortality and include the provision of physical examinations and diagnostic testing to a representative sample of the cohort.

The bill would require VA to use a sufficiently large cohort of women veterans and require a minimum follow-up period of 10 years. The bill also would require VA to enter into arrangements with the Department of Defense (DOD) for purposes of carrying out this study. For its part, DOD would be required to provide VA with relevant health care data, including pre-deployment health and health risk assessments, and to provide VA access to the cohort while they are serving in the Armed Forces.

Mr. Chairman, we do not support section 101. It is not needed. A longitudinal study is already underway. In 2007, VA initiated its own 10-year study, the "Longitudinal Epidemiologic Surveillance on the Mortality and Morbidity of OEF/OIF Veterans including Women Veterans." Several portions of the study mandated by section 101 are already incorporated into this project and planning for the actual conduct of the study is underway. The study has already been approved to include

12,000 women veterans. However, section 101 would require us to expand our study to include women active duty servicemembers. We estimate the additional cost of including these individuals in the study sample to be $1 million each year and $3 million over a 10-year period.

Section 102 would require VA to conduct a comprehensive assessment of the barriers to the receipt of comprehensive VA health care faced by women veterans, particularly those experienced by veterans of OEF/OIF. The study would have to research the effects of 9 specified factors set forth in the bill that could prove to be barriers to access to care, such as the availability of child care and women veterans' perception of personal safety and comfort provided in VA facilities.

Neither do we support section 102. It is not necessary because a similar comprehensive study is already underway. VA contracted for a "National Survey of Women veterans in FY 2007–2008," which is a structured survey based on a pilot survey conducted in VISN 21. This study is examining barriers to care (including access) and includes women veterans of all eras of service. Additionally, it includes women veterans who never used VA for their care and those who no longer continue to use VA for their health care needs. We estimate no additional costs for section 102 because VA's own comparable study is underway, with $975,000 in funding committed for fiscal years 2007 and 2008.

Section 103 would require VA to conduct, either directly or by contract, a comprehensive assessment of all VA programs intended to address the health of women veterans, including those related to PTSD, homelessness, substance abuse and mental health, and pregnancy care. As part of the study, the Secretary would have to determine whether the following programs are readily available and easily accessed by women veterans: health promotion programs, disease prevention programs, reproductive health programs, and such other programs the Secretary specifies. VA would also have to identify the frequency such services are provided; the demographics of the women veteran population seeking such services; the sites where the services are provided; and whether waiting lists, geographic distance, and other factors obstructed their receipt of any of these services.

In response to the comprehensive assessment, section 103 would further require VA to develop a program to improve the provision of health care services to women veterans and to project their future health care needs. In so doing, VA would have to identify the services available under each program at each VA medical center and the projected resource and staffing requirements needed to meet the projected workload demands.

Section 103 would require a very complex and costly study. While we maintain data on veteran populations receiving VA health care services that account for the types of clinical services offered by gender, VA's Strategic Health Care Group for Women Veterans already studies and uses available data and analyses to assess and project the needs of women veterans for the Under Secretary for Health. Furthermore, we lack current resources to carry out such a comprehensive study within the 18-month time-frame. We would therefore have to contract for such a study with an entity having, among other things, significant expertise in evaluating large health care systems. This is not to say that further assessment is not needed. We recognize there may well be gaps in services for women veterans, especially given that VA designed its clinics and services based on data when women comprised a much smaller percentage of those serving in the Armed Forces. However, the study required by section 103 would unacceptably divert significant funding from direct medical care. Section 103 would have a cost of $4,354,000 in fiscal year 2008.

Section 104 would require VA to contract with the Institute of Medicine (IOM) for a study on the health consequences of women veterans' service in OEF/OIF. The study would need to include a review and analysis of the relevant scientific literature to ascertain environmental and occupational exposure experienced by women who served on active duty in OEF/OIF. It would then have to address whether any associations exist between those environmental and occupational exposures and the women veterans' general health, mental health, or reproductive health.

We do not object to section 104. We suggest the language be modified to allow VA to decide which organization is best situated to carry out this study (taking into account the best contract bid). While IOM has done similar studies in the past, this provision would unnecessarily foreclose the possibility of using other organizations. We estimate the one-time cost of section 104 to be $1,250,000, which can be funded from existing resources.

Section 201 would authorize VA to furnish care to a newborn child of a woman veteran who is receiving VA maternity care for up to 30 days after the birth of the child in a VA facility or a facility under contract for the delivery services. We can support this provision with modifications. As drafted, the provision is too broadly

worded. We believe this section should be modified so that it applies only to cases where a covered newborn requires neonatal care services immediately after delivery. The bill language should also make clear that this authority would not extend to routine baby well-baby services.

We are currently unable to estimate the costs associated with section 201 without data on projected health care workload demands and future utilization requirements. We have contracted for that data and we will forward the estimated costs for this section as soon as they are available.

Section 202 would require the Secretary to establish a program for education, training, certification and continuing medical education for VA mental health professionals furnishing care and counseling services for military sexual trauma (MST). VA would also be required to determine the minimum qualifications necessary for mental health professionals certified under the program to provide evidence-based treatment. The provision would establish extremely detailed reporting requirements. VA would also have to establish education, training, certification, and staffing standards for VA health care facilities for full-time equivalent employees who are trained to provide MST services.

We do not support the training-related requirements of section 202 because they are duplicative of existing programs. In fiscal year 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related training and education opportunities nationwide. VA also hosts an annual 4-day-long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. VA has recently unveiled the MST Resource Homepage, a web page that serves as a clearinghouse for MST-related resources such as patient education materials, sample power point trainings, provider educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. It also hosts discussion forums for providers. In addition, VA primary care providers screen their veteran-patients, particularly recently returning veterans, for MST, using a screening tool developed by the Department. We are currently revising our training program to further underscore the importance of effective screening by primary care providers who provide clinical care for MST within primary care settings.

We object strongly to the requirement for staffing standards. Staffing-related determinations must be made at the local level based on the identified needs of the facility's patient population, workload, staffing, and other capacity issues. Retaining this flexibility is essential to permit VA and individual facilities to respond to changing needs and available resources. Imposition of national staffing standards would be an utterly inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 203 would require the Secretary to establish, through the National Center for PTSD, a similar education, training, and certification program for health care professionals providing evidence-based treatment of PTSD and other co-morbid conditions associated with MST to women veterans. It would require VA to provide these professionals with continuing medical education, regular competency evaluations, and mentoring.

VA does not support section 203 because it is duplicative of, and would divert resources from, activities already underway by the Department. VA is strongly committed to making state-of-the-art, evidence-based psychological treatments widely available to veterans and this is a key component of VA's Mental Health Strategic Plan. We are currently working to disseminate evidence-based psychotherapies for a variety of mental health conditions throughout our health care system. There are also two programs underway to provide clinical training to VA mental health staff in the delivery of certain therapies shown to be effective for PTSD, which are also recommended in the VA/DOD Clinical Practice Guidelines for PTSD. Each training program includes a component to train the professional who will train others in this area, to promote wider dissemination and sustainability over time.

Section 204 would require the Secretary, commencing not later than 6 months after the date of enactment, to carry out a 2-year pilot program, at no fewer than three VISN sites, to pay veterans the costs of child care they incur to travel to and from VA facilities for regular mental health services, intensive mental health services, or other intensive health care services specified by the Secretary. The provision is gender-neutral. Any veteran who is a child's primary caretaker and who is receiving covered health care services would be eligible to participate in the pilot program. VA does not support this provision. Although the inability to secure child care may be a barrier to access to care for some veterans, funding such care would divert

those funds from direct patient care. We estimate the cost of section 204 to be $3 million.

Section 205 would require VA, not later than 6 months after the date of enactment, to conduct a pilot program to evaluate the feasibility of providing reintegration and readjustment services in a group retreat setting to women veterans recently separated from service after a prolonged deployment. Participation in the pilot would be at the election of the veteran. Services provided under the pilot would include, for instance, traditional VA readjustment counseling services, financial counseling, information on stress reduction, and information and counseling on conflict resolution.

VA has no objection to section 205; however, we are unclear as to the purpose of and need for the bill. We note the term "group retreat setting" is not defined. We would not interpret that term to include a VA medical facility, as we do not believe that would meet the intent of the bill. We also assume this term would not include Vet Centers as we could not limit Vet Center access to any one group of veterans. Moreover, many Vet Centers, such as the one in Alexandria, Virginia, are already well designed to meet the individual and group needs of women veterans. Section 205 would have no costs.

Section 206 would require the Secretary to ensure there is at least one full-time employee at each VA medical center serving as a women veterans program manager. We strongly support this provision. The position of the women veterans program manager has evolved from an overseer of local programs to ensure access to care for women veterans to a position requiring sophisticated management and administrative skills necessary to execute comprehensive planning for women's health issues and to ensure these veterans receive quality care as evidenced, in part, by performance measures and outcome measurements. The duties of this position will only continue to grow as we strive to expand services to women veterans. Thus, we believe there is support for the dedication of a full-time employee equivalent at every VA medical center. We estimate section 206 would result in additional costs of $7,131,975 for fiscal year 2010 and $86,025,382 over a 10-year period.

Next, section 207 would require the Department's Advisory Committee on Women Veterans, created by statute, to include women veterans who are recently separated veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated veterans who are minority group members. These requirements would apply to committee appointments made on or after the bill's enactment. We support section 207. Given the expanded role of women and minority veterans serving in the Armed Forces, the Committees should address the needs of these cohorts in carrying out their reviews and making their recommendations to the Secretary. Having their perspective may help project both immediate and future needs.

S. 2824 COLLECTIVE BARGAINING RIGHTS FOR REVIEW OF ADVERSE ACTIONS

The major provision of S. 2824 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. It would repeal the current restriction on collective bargaining, arbitrations, and grievances over matters that the Secretary determines concern the professional conduct or competence, peer review, or compensation of Title 38 employees. The Secretary would also be required to bargain over direct patient care and clinical competency issues, the processes VA uses to assess Title 38 professionals' clinical skills, and the discretionary aspects of Title 38 compensation, including performance pay, locality pay, and market pay. Because they would be negotiable these matters would also be subject to nonclinical, non-VA third party review.

VA strongly opposes this provision. Prior to 1991, Title 38 professionals did not have the right to engage in collective bargaining at all. The current restriction on collective bargaining rights is a sound compromise between VA's mission—best serving the needs of our Nation's veterans—and the interest of Title 38 physicians, nurses, and other professionals in engaging in collective bargaining. Importantly, Congress recognized that the Secretary, as the head of the VA health care system, would be in the best position to decide when a particular proposal or grievance falls within one of the statutory areas excluded from bargaining. Such determinations should not be legislated. Neither should they be made by a non-clinical third party who is not accountable for assuring the health and safety of the veterans the Department is responsible for. If the Secretary and the Under Secretary for Health are going to be responsible and accountable for the quality of care provided to and the safety of veterans, they must be able to determine which matters affect that care. They must be able to establish standards of professional conduct by and competency of our clinical providers based on what is best for our veterans rather than what

is the best that can be negotiated or what an arbitrator decides is appropriate. The Under Secretary for Health has been delegated the authority to make these discretionary determinations. VA has not abused this discretionary authority. Since 1992, there have been no more than 13 decisions issued in a 1-year period and, in most cases, even far fewer decisions than that. This is particularly striking given the number of VA health care facilities and bargaining unit employees at those facilities. We are therefore at a loss to understand the need for this provision.

S. 2824 would also transfer VA's Title 38 specific authorities, namely the right to make direct patient care and clinical competency decisions, assess Title 38 professionals' clinical skills, and determine discretionary compensation for Title 38 professionals, to independent third-party arbitrators and other non-VA non clinical labor third parties who lack clinical training and understanding of health care management to make such determinations. For instance, labor grievance arbitrators and the Federal Service Impasses Panel would have considerable discretion to impose a clinical or patient care resolution on the parties. VA would have limited, if any, recourse if such an external party erred in its consideration of the clinical or patient care issue. The exceptions to collective bargaining rights for Title 38 employees identify areas that directly impact VA's ability to manage its health care facilities and monitor the professional conduct and competence of its employees; management actions concerning these areas must be reserved for VA professionals.

This bill would allow unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under Title 5, including the manner by which an employee is disciplined and the determination of the amount of an employee's compensation. That would be unprecedented in the Federal Government. Such a significant change in VA's collective bargaining obligations would adversely impact VA's budget and management rights; it would also skew the current balance maintained between providing beneficial working conditions for Title 38 professionals and meeting patient care needs, jeopardizing the lives of our veterans. There would be no costs associated with this provision.

S. 2921 CARING FOR WOUNDED WARRIORS ACT OF 2008

Section 2 would require the Secretary to conduct up to three pilot programs, in collaboration with the Secretary of Defense, to assess the feasibility of training and certifying family caregivers to be personal care attendants for veterans and members of the of the Armed Forces suffering from TBI. VA would be required to determine the eligibility of a family member to participate in the pilot programs, and such a determination would have to be based on the needs of the veteran or servicemember as determined by the patient's physician. The training curricula would be developed by VA and include applicable standards and protocols used by certification programs of national brain injury care specialist organizations and best practices recognized by caregiver organizations. Training costs would be borne by VA, with DOD required to reimburse VA at TRICARE rates for the costs of training family members of servicemembers. Family caregivers certified under this program shall be eligible for VA compensation and may receive assessments of their needs in the role of caregiver and referrals to community resources to obtain needed services.

VA does not support section 2. Currently, we are able to contract for caregiver services with home health and similar public and private agencies. The contractor trains and pays them, affords them liability protection, and oversees the quality of their care. This remains the preferable arrangement as it does not divert VA from its primary mission of treating veterans and training clinicians.

Section 3 would require VA, in collaboration with DOD, to carry out a pilot program to assess the feasibility of providing respite care to family caregivers of servicemembers and veterans diagnosed with TBI, through the use of students enrolled in graduate education programs in the fields of mental health or rehabilitation. Students participating in the program would, in exchange for graduate course credit, provide respite relief to the servicemember's or veteran's family caregiver, while also providing socialization and cognitive skill development to the servicemember or veteran. VA would be required to recruit these students, train them in the provision of respite care, and work with the heads of their graduate programs to determine the amount of training and experience needed to participate in the pilot program.

We do not support section 3, which we recognize is an effort to compel VA to use existing arrangements with affiliated academic institutions as a novel means of providing respite care to family caregivers of TBI patients. Individuals providing respite care do not require advanced degrees, only appropriate training. Respite care is an unskilled type of service that does not qualify for academic credit or serve to

meet any curricula objectives in the graduate degree programs related to mental health or rehabilitation. Further, section 3 would require VA to use graduate students in roles that are not permissible under academic affiliation agreements, and we have serious doubts this proposal would be acceptable to graduate schools.

Moreover, VA has a comprehensive respite care program. We also have specialized initiatives underway for TBI patients to reduce the strain on their caregivers, which overlap with this bill. Plus we provide respite care by placing the veteran in a local VA facility for the duration of the respite period. Veterans may receive up to 30 days of respite care per year. We estimate the costs of S. 2921 to be $39,929,000 for fiscal year 2010 and $790,374,000 over a 10-year period.

S. 2899 "VETERANS SUICIDE STUDY ACT"

S. 2899 would require the Secretary to conduct a study to determine the number of veterans who have committed suicide between January 1, 1997, and the date of the bill's enactment. The study would have to be carried out in coordination with the Secretary of Defense, Veterans Service Organizations, the Centers for Disease Control and Prevention, and State public health offices and veterans agencies. The bill would require the Secretary to submit a report to Congress on his findings within 180 days of the bill's enactment.

VA understands the intent of the Senate in proposing S. 2899. However, we would like to make the Senate aware of the difficulties in accomplishing the legislation's intent—and what VA is doing, and intends to do, to improve our ability to obtain and report on suicide numbers.

At present, determining suicide rates among veterans is a challenging puzzle. Multiple data sources must be used, and data must be carefully checked and rechecked. Each system helps obtain a piece of the complicated puzzle that constitutes the process of accurately estimating rates of veteran suicides. These are time-consuming processes—but they are the best ways VA knows to obtain aggregate data on suicide.

VA relies on multiple sources of information to identify deaths that are potentially due to suicide. This includes VA's own Beneficiary Identification and Records Locator Subsystem, called BIRLS; records from the Social Security Administration; and data compiled by the National Center for Health Statistics in its National Death Index (NDI).

Calculating suicide rates specifically for veterans is made even more difficult by the fact that the National Death Index does not include information about whether a deceased individual is a veteran or not. NDI is simply a central computerized index of death record information on file in the vital statistics offices of every State. The Index is compiled from computer files submitted by State vital statistics offices. Death records are added to the file annually, about twelve months after the end of a calendar year.

Given that the NDI does not indicate veteran status, VA regularly submits requests for information to NDI. VA sends NDI a list of all patients who have not been treated at any VA medical centers in the past twelve months and before, to see if they are still among the living. NDI checks this list against their records, and tells VA which veterans have died, and the cause of their death as listed on the veterans' death certificates. From this information, VA is able to learn the approximate number of veterans under its care who have died of suicide, and to use that information to make comparisons on rates of suicide among those veterans and all other Americans.

This information tells VA about the suicide rates among veterans under its care, but says nothing about the rates of suicide among veterans who are not currently in the system. For those veterans, an even more complicated process has to be followed in order to estimate rates. VA obtains regular updates from the Department of Defense's Defense Manpower Data Center on soldiers separating from the military. Those new veterans immediately become part of total population and suicide calculations.

Additionally, the Department will, among other things, also systematically assess its efforts to inform funeral directors about the importance of determining whether or not a person who has died of suicide is or is not a veteran, and what sorts of information to consider in making that determination. Finally, VA will investigate working directly with State vital records offices, as the NDI does, to obtain information on veteran suicides directly from them.

VA asks that the Senate give us time to complete these actions before requiring any study of the numbers of suicides among veterans. We are "pushing the envelope" to get the most accurate data available on suicides in the shortest possible

timeframe, and we commit to sharing that data with Congress as soon as it becomes available.

We estimate the cost of this bill to be $1,580,006 in fiscal year 2008 and $2,078,667 over a 10-year period.

S. 2937 PERMANENT TREATMENT AUTHORITY FOR VETERANS WHO PARTICIPATED IN CERTAIN DOD TESTING

Section 1 would make permanent the Secretary's authority to provide needed inpatient, outpatient, and nursing home care to a veteran who participated in a test conducted by the Department of Defense (DOD) Deseret Test Center as part of its chemical and biological warfare testing program conducted from 1962–1973, for any condition or illness possibly associated with such testing at no cost to the veteran. This authority will expire after December 31, 2008.

VA supports section 1, which we note is identical to our own proposal in S. 2984. We estimate the discretionary cost of this provision to be $4,458,000 in fiscal year 2009 and $144,434,000 over a 10-year period.

Section 2 would require the Secretary, not later than 90 days after the date of the Act's enactment, to enter into a contract with IOM to conduct an expanded study on the health impact of participation in Project Shipboard Hazard and Defense (Project SHAD). Such a study should include, to the extent practicable, all veterans who participated in Project SHAD. VA does not support this provision, as we doubt that an expanded study could be conducted by IOM or any other organization because IOM has already thoroughly studied the health of SHAD veterans and made a concerted attempt to identify all involved veterans for its study.

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

WRITTEN VIEWS SUBMITTED AFTER THE HEARING BY JAMES B. PEAKE, M.D., SECRETARY OF THE DEPARTMENT OF VETERANS AFFAIRS

U.S. DEPARTMENT OF VETERANS AFFAIRS,
Washington, DC, July 8, 2008.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: We are pleased to provide the Department of Veterans Affairs' (VA) views on S. 2969, the "Veterans' Medical Personnel Recruitment and Retention Act of 2008." We stated at the Committee's hearing on May 21, 2008, that VA would provide written views for the record.

S. 2969 contains several provisions intended to enhance VA's ability to recruit and retain nurses and other health-care professionals. Many of these provisions would be helpful, and we can support them. However, several of the provisions would not be helpful or are otherwise flawed. We appreciate the opportunity to work with Committee staff on this bill and to provide technical comments and operational observations.

SECTION 2. ENHANCEMENT OF AUTHORITIES FOR RETENTION OF MEDICAL PROFESSIONALS.

Authority to Extend Hybrid Status to Additional Occupations

Subsection (a) would amend section 7401(3) to add "nurse assistants" to the list of so-called hybrid occupations for which the Secretary is authorized to appoint and to determine qualifications and rates of pay under title 38. In addition, it would authorize the Secretary to extend hybrid status to "such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department" subject to a requirement to provide 45 days' advance notice to the Veterans' Affairs Committees and OMB. Before providing such notice, VA would be required to solicit comments from unions representing employees in such occupations.

VA favors such a provision. Nursing Assistants are critical to the Veterans Health Administration's (VHA) ability to provide care for a growing population of older veterans, who are high-acuity patients and/or frail elderly requiring 24-hour nursing care. Turnover data, 10.5 percent for 2006 and 11.1 percent for 2007, illustrate the great difficulty VA experiences in retaining this occupation. It is increasingly critical for VHA to be able to quickly and easily employ these nurse extenders. The same

holds true for other hard-to-recruit health care occupations. This bill would give the Secretary the ability to react quickly when it is determined that these authorities would be useful in helping in recruiting and retaining a critical occupation without seeking additional legislative authority. However, the bill language should be modified to specifically apply to occupations that clearly involve the delivery of health care. In addition, because this authority involves the conversion of title 5 occupations to title 38 hybrid, the 45-day notice requirement should be modified to add OPM. Thus, we recommend modifying subsection 2(a) of the bill to read:

(a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.—

(1) IN GENERAL.—Paragraph (3) of section 7401 of title 38, United States Code, is amended by striking "and blind rehabilitation outpatient specialists." and inserting in its place the following: "blind rehabilitation outpatient specialists, and such other classes of health care occupations who

(A) are employed in the Administration (other than administrative, clerical, and physical plant maintenance and protective services employees);

(B) are paid under the General Schedule pursuant to section 5332 of title 5;

(C) are determined by the Secretary to be providing either direct patient-care services or services incident to direct patient-care services; and

(D) would not otherwise be available to provide medical care and treatment for veterans;

(E) as the Secretary considers necessary for the recruitment and retention needs of the Department.

(2) The Secretary's authority provided in paragraph (1) is subject to the following requirements:

"(A) Not later than 45 days before the Secretary appoints any personnel for a class of health care occupations that is not specifically listed in this paragraph, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, the Office of Management and Budget and the Office of Personnel Management notice of such appointment.

"(B) Before submitting notice under subparagraph (A), the Secretary shall solicit comments from any labor organization representing employees in such class and include such comments in such notice."

Probationary Periods for Part-Time Nurses

Subsection (b) provides for probationary periods for part-time (PT) Registered Nurses (RN) and revises the probationary period for RNs, both full-time (FT) and PT, from 2 years to its equivalency in hours, 4180. It also provides that a PT appointment of a person who previously served on a FT basis in a "pure" title 38 position (7401(1)), and completed a probationary period in the FT position would not have to serve a probationary period in the PT "pure" title 38 position. VA opposes this provision. We believe this provision is technically flawed and would not be helpful.

Part-time title 38 employees, including RNs, do not serve probationary periods. Probationary periods apply to full-time, permanent employees. We see no benefit to creating a probationary period for part-time nurses. Moreover, a probationary period for PT RNs would not make them the equivalent of tenured employees, for example for purposes of discipline or discharge.

Prohibition on Temporary Part-Time Nurse Appointments In Excess of 4,180 Hours

Subsection (c) would amend section 7405(f)(2) to limit temporary part-time appointments of hybrid (Licensed Practical Nurse (LPN) and Licensed Vocational Nurse (LVN)) nurses to no more than 4180 hours. VA opposes this provision. Currently, all part-time hybrid appointments may be for periods exceeding 1 year. The purpose of this restriction on LPNs and LVNs is not apparent. Operationally, it could hamstring VHA when it determines that part-time LPNs and LVNs best serve patient care needs. The result could be to deprive VA of highly qualified LPNs and LVNs wishing to work only on a part-time basis, for example, for personal and family reasons.

Reemployed Annuitant Offset Waiver

Subsection (d) generally provides that annuitants may be temporarily reemployed in a title 38 position without being subject to having their salary offset by the amount of their annuity.

VA instead favors a Government-wide policy on waivers of this offset. Under current law, VA must obtain a waiver for individuals on a case-by-case basis, or obtain delegated waiver authority from the Office of Personnel Management (OPM). VA

has done so for some critical occupations. The Administration has submitted a bill, which VA favors, to provide agencies with the authority to grant offset waivers to facilitate the temporary part-time reemployment of annuitants, which has been introduced as S. 2003. With many VA employees at or near retirement eligibility the potential for significant losses of mission-critical leaders and technical experts is a significant threat to VA's capability to deliver high quality health care to our Nation's veterans. VA access to retired title 38 health care providers, without financial penalty, would enhance our ability to meet these challenges and maintain the continuity of quality patient care, including support in times of disaster. As explained by OPM, S. 2003 "would allow Federal agencies to rehire recently retired employees to assist with short-term projects, fill critical skill gaps and train the next generation of Federal employees."

Minimum Rate of Basic Pay for Section 7306 Appointees Set to Lowest Rate of Basic Pay for SES

Subsection (e) would amend section 7404(a) to add a provision setting the basic pay of non-physician/dentist section 7306 employees at not less than the lowest rate of basic pay for the Senior Executive Service (SES). This amendment would be effective the first pay period that is 180 days after enactment.

VA supports the principle of pay equity with SES rates for its section 7306 non-physician/dentist executives as a tool needed to meet the challenge of recruitment and retention. However, we recommend some modifications in the bill's language.

Equity in pay for executive level managers and consultants is essential to attracting and retaining candidates for key positions. The pay schedule for 38 U.S.C. § 7306 appointees is capped at the pay rate for Level V of the Executive Schedule (currently $139,600). Locality pay is paid up to the rate for Level III (currently $158,500).

Individuals appointed under 38 U.S.C. § 7306 serve in executive level positions that are equivalent in scope and responsibility to positions in the SES. By comparison, employees in the SES receive a significantly higher rate of basic pay. The maximum SES pay limitation is the rate for Level II (currently $172,200) pending OPM certification that the agency meets all regulatory criteria for certified performance appraisal systems, including the employing agency makes meaningful distinctions based on performance. We estimate the costs of this provision to be $225,290 in fiscal year 2009 and $2,466,862 over a 10-year period.

We recommend modifying this proposal to state that the basic pay of non-physician/dentist section 7306 employees be set at the rates of pay for SES employees under section 5382 of title 5. This modification would allow VA executive pay to track the full range of SES pay. The SES pay system conditions pay up to EL II on OPM certification that an agency's SES rating system meets all regulatory criteria for certified performance appraisal systems. In this regard we note that VHA uses the same rating system for its section 7306 executives as it uses for its SES members. OPM has certified this system in the past, and is finalizing certification for this year. For consistency, we also recommend that the bill be modified to require that the Secretary make the same certification for the rating system covering section 7306 employees. Thus, we suggest that section 2(e)(3) be modified to read as follows:

> "(3) Positions to which an Executive order applies under paragraph (1) and are not described by paragraph (2) shall be paid basic rates of pay in accordance with section 5382 of title 5 for Senior Executive Service positions and not greater than the rate of basic pay payable for level III of the Executive Schedule; or if the Secretary certifies that the employees are covered by a performance appraisal system meeting the certification criteria established by regulation under section 5307(d), level II of the Executive Schedule."

Comparability Pay Program for Section 7306 Appointees

Subsection (f) would amend section 7410 to add a new subsection to establish "comparability pay" for non-physician/dentist section 7306 employees of not more than $100,000 per employee in order to achieve annual pay levels comparable to the private sector. Similar to provisions for RN Executive Pay in section 7452(g), it would provide that "comparability pay" would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

VA supports the concept of comparability pay for its non-physician/dentist executives. However, at this time we cannot support this proposal because it is a potentially precedent-setting departure from the unitary approach to government-wide

SES pay. The Department is evaluating alternative proposals that may be more appropriate in addressing the comparability pay issues of these executives.

VA is working on a cost estimate for this provision and will provide it at a later time.

Special Incentive Pay for Department Pharmacist Executives

Subsection (g) would further amend section 7410 to authorize recruitment and retention special incentive pay for pharmacist executives of up to $40,000. VA's determination of whether to provide and the amount of such incentive pay would be based on: grade and step, scope and complexity of the position, personal qualifications, characteristics of the labor market concerned, and such other factors as the Secretary considers appropriate. As with RN Executive Pay and comparability pay added by subsection (f), it would provide that "comparability pay" would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

This provision will provide a retention incentive to about 40 positions: pharmacy benefit managers (PBM), consolidated mail outpatient pharmacy (CMOP) directors and VISN formulary leaders (VFL). While VA is facing worsening pay compression issues within the ranks of senior pharmacy program managers in the VHA, we cannot support this provision because it will not address the Department's retention needs in the long-term. The Department is evaluating alternative proposals that will be more appropriate in addressing the recruitment and retention needs of our pharmacy executives.

We estimate the cost of this provision to be $1,391,500 for fiscal year 2009 and $16,324,220 over a 10-year period.

Physician/Dentist Pay

Subsection (h) concerns physician/dentist pay. VA supports this provision.

Paragraph (1) would provide that the title 5 non-foreign cost of living adjustment allowance for physicians and dentists would be determined as a percentage of base pay only. This would clarify the application of the title 5 non-foreign cost of living adjustment allowance to VHA physicians and dentists. The VA physician/dentist pay statute, 38 U.S.C. § 7431, does not address how the allowance is determined for physicians and dentists. We recommend that this provision be amended to clarify that it is applicable only to these physicians and dentists employed at Department facilities in Alaska, Hawaii, and Puerto Rico. These are the only Department facilities to which the title 5 non-foreign cost of living adjustment allowance is applicable.

Paragraph (2) would amend section 7431(c)(4)(B)(i) to exempt physicians and dentists in executive leadership provisions from the panel process in determining the amount of market pay and tiers for such physicians and dentists. In situations where physicians or dentists occupy executive leadership positions such as chief officers, network directors, and medical center directors, the consultation of a panel has some limitations. The small number of physicians and dentists who would qualify as peers for the executive leaders results in their serving on each other's compensation panels and, in some cases, on their supervisor's panel. Providing the Secretary with discretion to identify executive physician/dentists positions that do not require that panel process would resolve these issues.

Paragraph (3) would provide an exception to the prohibition on the reduction of market pay for changes in board certification or reduction of privileges correcting an oversight in the recent revision of the physician/dentist pay statute. This modification would allow VA to address situations where there is a loss of board certification or an adverse reduction in clinical privileges. No costs are associated with this provision.

RN and CRNA Pay

Subsections (i) and (j), relate to RN and Certified Registered Nurse Anesthetist (CRNA) Pay

Subsection (i) would amend the cap for registered nurse to maximum rate of EL V or GS–15, whichever is greater. The current cap is the rate for EL V. Subsection (j) would amend section 7451(c)(2) to exempt CRNAs from the current cap of EL V.

It is important for pay caps to be both fiscally responsible and sufficient to promote employee recruitment and retention. These proposals are not consistent with these principles. We note the alternative GS–15 cap would be meaningless inasmuch as it already is lower than the existing cap that is set at EL V, with a difference of about $15,000. Moreover, it is unclear whether this alternative cap would be at the GS–15 rate before locality pay or after locality pay. The CRNA cap would leave CRNA pay rates completely uncapped, which would allow rates to potentially

exceed those of physicians and dentists, the title Executive Schedule (Levels I–V), or the VA 7306 Schedule.

We would support this provision if the bill were amended to modify section 7451(c)(2) to read: "The maximum rate of basic pay for any grade for a covered position may not exceed the rate of basic pay established for positions in level IV of the Executive Schedule under section 5315 of title 5." This would increase the cap from level V to level IV for both RNs and CRNAs, consistent with the pay cap that applies to the GS locality pay system. We estimate the cost of this provision to be $4,803,964 for fiscal year 2009 and $56,357,188 over a 10-year period.

Subsection (k) would make amendments to the RN locality pay system (LPS). These provisions are not helpful and unnecessary. No costs are associated with this provision.

Paragraph (1) would require the Under Secretary for Health to provide education, training, and support to VAMC directors in the "conduct and use" of LPS surveys. We are concerned that this provision's focus on facility-conducted surveys is at odds with Public Law 106–419, which enabled VAMCs to use third-party salary surveys whenever possible rather than VA-conducted surveys. The use of third-party surveys is in fact the preference of the Department. We recommend modifying this provision to read: "The Under Secretary for Health shall ensure appropriate education and training are available with regard to the conduct and use of surveys, including third-party surveys, under this paragraph." This would cover both types of surveys. Paragraph (2) would require the annual report VAMCs must provide to VA Central Office to include the methodology for every schedule adjustment. These reports form the basis for the annual VA report to Congress. We are concerned that this provision, especially in conjunction with proposed paragraph 3, could result in the inappropriate disclosure of confidential salary survey data, contrary to current section 7451(d)(5). It also would impose an onerous burden inasmuch as VHA has nearly 800 nurse locality pay schedules. We do note that VA policy does provide for how these surveys are to be obtained or conducted.

Paragraph (3) would require the most recent VAMC report on nurse staffing to be provided to any covered employee or employee's union representative upon request. This provision should be modified to specify at what point the report must be provided. It would not be appropriate to provide an individual a copy of the VAMC report before Congress receives the VA report.

Subsection (l) would increase the maximum payable for nurse executive special pay to $100,000. This provision would make the amount of nurse executive pay consistent with the Executive Comparability Pay in section 2f. We do not support this proposal. We estimate the cost of this provision to be $316,250 for fiscal year 2009 and $3,710,053 over a 10-year period.

The caption for subsection (m) suggests it provides for eligibility of part-time nurses for certain nurse premium pay. However, many of the substantive amendments are not limited to part-time nurses, or to all registered nurses.

VA opposes subsection (m) as seriously flawed, unnecessary, and costly.

Subparagraph (1)(A) would amend section 7453(a) to make part-time nurses eligible for premium pay under that section. However, part-time nurses already are eligible for section 7453 premium pay where they meet the criteria for such pay.

Subparagraphs (1)(B) and (1)(C) would require evening tour differential to be paid to all nurses performing any service between 6 pm and 6 am, and any service on a weekend, instead of just those performing service on a tour of duty established for those times to meet on-going patient care needs. Under current law, these differentials are limited to the RN's normal tour of duty and any additional time worked on an established tour.

The "tour of duty" in the current law reflects the requirement of ensuring adequate professional care and treatment to patients during off and undesirable tours. The limitation of tour differential and weekend pay only for service on a "tour of duty" rewards those employees who are subject to regular and recurring night and weekend work requirements. If that is changed to "period of service," any employees performing night or weekend work on an occasional or ad-hoc basis would also be entitled to this premium pay in addition to overtime pay, providing an inappropriate windfall for performing occasional work.

Subparagraph (2) would authorize title 5 VHA employees to receive 25 percent premium pay for performing weekend work on Saturday and Sunday. We understand the purpose of this provision is to limit the expansion of week-end premium pay to non-tour hours to registered nurses. However, it does not fully achieve that purpose. Pursuant to section 7454(a) and (b)(2), physician assistants, expanded-function dental auxiliaries, and hybrids are also entitled to week-end pay under section 7453. The expansion of week-end pay would apply to them as well. In addition, because physician assistants and expanded-function dental auxiliaries are entitled to

all forms of registered nurse premium pay under section 7453, the expansion of the night differential premium pay would also apply to them. Furthermore, where VA has authorized section 7453 night differential for hybrids, the expansion of the night differential premium pay would apply to them as well.

Subsection (n) would add additional occupations to the exemption to the 28th step cap on title 38 special salary rates: LPNs, LVNs, and unspecified "other nursing positions otherwise covered by title 5." Notwithstanding the exemption, under current statute, title 38 special salary rates cannot exceed the rate for EL V. The language "nursing positions otherwise covered by title 5" is unclear as to what positions it would include. RNs are appointed under title 38, LPNs/LVNs are hybrids, and section 2(a)(2) of the bill would convert nursing assistants to hybrid. Moreover, it is not apparent why only these positions and not all positions authorized title 38 special rates would be exempted. Using the same formula for the cap on title 5 special rates would afford VA the most flexibility in establishing maximum rates for title 38 special rates. Adopting the title 5 fixed percentage formula would render the section 7455(c)(2) report for exceeding 94 percent of the grade maximum unnecessary, so we propose deleting it. Thus we recommend amending section 7455 to read as follows:

> (a)(1) Subject to subsections (b), (c), and (d), when the Secretary determines it to be necessary in order to obtain or retain the services of persons described in paragraph (2), the Secretary may increase the minimum rates of basic pay authorized under applicable statutes and regulations, and may make corresponding increases in all rates of the pay range for each grade. Any increase in such rates of basic pay—
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> (c) The amount of any increase under subsection (a) in the minimum rate for any grade may not exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent, and no rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.

Section 3(a)(1) would add new section 7459, imposing restrictions on nurse overtime.

Section 7459 generally would prohibit mandatory overtime for nurses (RNs, LPNs, LVNs, nursing assistants, and any other nurse position designated by the Secretary). It would permit mandatory overtime by nurses under certain conditions: an emergency that could not have been reasonably anticipated; the emergency is nonrecurring and not due to inattention or lack of reasonable contingency planning; VA exhausted all good faith, reasonable attempts to obtain voluntary workers; the affected nurses have critical skills and expertise; and the patient work requires continuity of care through completion of a case, treatment, or procedure. VA could not penalize nurses for refusing to work prohibited mandatory overtime. Section 7459 provides that nurses may work overtime hours on a voluntary basis.

VA favors this mandatory overtime restriction with the caveat that first and foremost, VA needs to be able to mandate overtime where issues of patient safety are identified by facility leadership. We note VAMCs currently have policies preventing RNs from working more than 12 consecutive hours and 60 hours in a 7-day period pursuant to section 4(b) of Pub. L. 108–445.

Section 3(b) would amend 38 U.S.C. 7456 (the "Baylor Plan"), which authorizes VA to allow nurses who perform two 12-hour regularly scheduled tours of duty on a weekend to be paid for 40 hours. This work-scheduling practice typically would be used when facilities encounter significant staffing difficulties caused by similar work scheduling practices in the local community. Currently, VA has no nurses working on the Baylor Plan. The proposed revision would substitute scheduled "periods of service" for "regularly scheduled 12-hour tour of duty." The purpose and effect of this amendment are unclear. VA would oppose a revision of this authority if it were to mandate that all work on 12 hour regular weekend tours of duty automatically be considered Baylor Plan tours such that it would mandate that any nurse who works two 12-hour shifts on a weekend in addition to their regular tour of duty to get paid for 40 hours, in addition to premium pay for the extra work, such as overtime; and to mandate that nurses are not on the Baylor Plan but who routinely work 12-hour shifts under compressed work schedules that fall on weekends are entitled to 40 hours of pay for the 24 hours worked on the weekend in addition to pay for the remaining 16 hours.

Section 3(b)(2)(A), in eliminating the requirement that service be on a "tour of duty" appears to make the Baylor 1,248 hourly rate divisor apply to all service on

the weekend instead of just non-overtime hours. It is not appropriate for non-Baylor weekend work hours, and VA opposes this provision.

Section 3(b)(3) would delete section 7456(c), the current Baylor Plan requirement, which provides for a 5-hour leave charge for each 3 hours of absence that reflects the relative value of the truncated Baylor tour, in effect increasing the value of leave for affected employees. VA opposes this provision as providing an unwarranted windfall.

Section 3(c) would amend section 7456A to change the 36/40 alternate work schedule to a 72/80 alternate work schedule, so that under the schedule six 12-hour "periods of service" anytime in a pay period would substitute for three "12-hour tours of duty" in each week of the pay period. Similar changes would be made to section 7456A's overtime, premium pay and leave provisions.

VA is experiencing planning problems with the use of the current 36/40 schedule. That problem stems from the 36/40 language requiring three 12-hour tours in a work week and because VA defines "work week" as Sunday–Saturday. Changing "work week" to "pay period" only makes the problem occur every 2 weeks instead of every week, so we do not view that as helpful. We do support changing the 36/40 alternate work schedule to a 72/80 alternate work schedule, so that the six 12-hour tours can occur anytime in a pay period, providing more work scheduling/planning flexibility. VA will soon undertake a pilot in which all hours worked on tours of duty that begin in a work week (even if they end in the following work week) will be considered part of the work week for the purpose of the 36/40 alternate work schedule. We think this may help resolve the problem.

Section 4 would make amendments to VA's Education Assistance Programs. VA supports these proposals.

Section 4(a) would amend section 7618 to reinstate the Health Professionals Educational Assistance Scholarship Program through the end of 2013. The program expired in 1998. The Health Professional Scholarship Program would help reduce the nursing shortage in VA by obligating scholarship recipients to work for 2 years at a VA health care facility after graduation and licensure.

This proposal would also expand eligibility for the scholarship program to all hybrid occupations. This would be helpful in recruiting and retaining employees in the several hard-to-fill hybrid occupations. We estimate the cost of this provision to be $725,000 in fiscal year 2010 with a 5-year total of $21,380,000.

Section 4(b) would make certain amendments to the Education Debt Reduction Program. It would amend section 7681(a)(2) to add retention as a purpose of the program and amend section 7682(a)(1) to make it available to "an" employee, in lieu of "recently appointed." It would also increase the authorized statutory amounts in section 7683 to $60,000 and $12,000, respectively.

The "recently appointed" requirement limits eligibility to employees who have been appointed within 6 months. VA's experience has been that this is not a sufficient period. In several instances, employees applying just missed the 6-month deadline. In many cases it takes more than 6 months for employees to become aware of this very helpful recruitment and retention program. VA also supports the increased amounts in light of increased education costs since the program was enacted. We estimate the cost of this provision to be $5,400,000 for fiscal year 2010 and $77,352,000 over a 10-year period.

Section 4(c) would authorize VA researchers from "disadvantaged backgrounds" to use authorities in the Public Health Service Loan Repayment Program (LRP). This program presently is not available to Federal employees other than those working for the National Institutes of Health (NIH). Clinicians with medical specialization and research interests who might otherwise consider career clinical care or clinical research opportunities with VHA are therefore less likely to do so because VA employees are not eligible for the LRP. These same research-focused, entry-level professionals have historically been the highest caliber and most sought-after candidates. VA researchers should be able to participate in this much sought-after program. VHA's Education Debt Reduction Program (EDRP) is only available for employees hired for permanent title 38 positions. Those in time-limited clinical research training positions such as the Research Career Development Awards (which historically have served as entryways to VA careers in clinical care and research) are not eligible. There are no costs associated with this proposal; it would not increase the funding of this program, but simply authorize VA researchers to participate in it.

The Office of Management and Budget advises that there is no objection to the submission of this report from the standpoint of the Administration's programs.

Sincerely yours,

JAMES B. PEAKE, M.D.,
Secretary.

U.S. DEPARTMENT OF VETERANS AFFAIRS,
Washington, DC, July 21, 2008.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: On May 21, 2008, you chaired a hearing to receive comments on 17 health care-related bills that were before the Committee. At the hearing, the Department testified on 14 of the bills. We stated that we needed additional time to coordinate the Administration's positions on S. 2926, S. 2963, and S. 2969. With this letter, we are providing views for the record on S. 2926 and S. 2963. The Administration's views on S. 2969 are being transmitted to you by separate letter.

S. 2926, VETERANS RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT OF 2008

S. 2926 contains many clarifying and technical provisions; however, we will discuss only the substantive provisions of the bill. The most important change to be accomplished by S. 2926 is contained in Section 2. It would amend 38 U.S.C. § 7361 to allow two or more medical centers, with the concurrence of the Secretary, to form a Multi-Medical Center Research Corporation (MMCRC). The MMCRC would be authorized to support research and education projects at the two or more medical centers that had formed it. This section would also allow an existing non-profit research corporation (NPC), with the approval of the medical centers involved and the Secretary, to expand into a MMCRC. Under current law, a VA medical center may establish an NPC that is authorized to facilitate approved research and education projects at that medical center.

This provision of section 2 would not change the requirement that four members of senior management of one medical center, the Director, the Chief of Staff and, as appropriate, the Assistant Chiefs of Staff for Research and for Education, will serve on the board of the NPC. Rather, it would provide that this core group be augmented by the medical center director from each of the other facilities to be served by that NPC. This would provide VA with one official from each facility served by the MMCRC who may be held accountable by VA. It would require the NPC boards to decide whether their NPCs should evolve into MMCRCs and require them to obtain VA approval. This would ensure that the board has accepted the responsibilities that an MMCRC entails and that VA has considered whether the arrangement is reasonable and in the best interests of the Department.

Section 2(c) would make clear that NPCs are subject to VA oversight and regulation, but not under the direct control of the Department. It would also expressly provide that the NPCs are not "owned or controlled by the United States" or "an agency or instrumentality of the United States." This is currently made clear only in the legislative history of the statute.

Section 3 would clarify that NPCs may support VA research and education generally. More specifically, it would amend 38 U.S.C. § 7362 to state that NPCs may support "functions related to the conduct of" VA research and education—but still only VA research and education—not just administer approved research or education projects. Currently, the corporations may facilitate only VA-approved research and education projects.

Section 4 would broaden the qualifications for the non-VA board members to include business, legal and financial backgrounds, thus allowing NPCs to use these board positions to acquire the legal and financial expertise needed to ensure sound governance and financial management. Currently, the law requires that there be members of the board of directors of an NPC who are not Federal employees and who "are familiar with issues involving medical and scientific research or education."

Section 4 would also update the conflict of interest provision currently in section 7363(c) of title 38, United States Code, which prevents individuals from serving on the board if they are "affiliated with, employed by, or have any other financial relationship with" a for-profit entity that is a source of funding for VA research.

Section 5 would enhance several powers of the NPCs. Section 5(a) collects in one place all discussion of NPC powers and makes several important clarifications. First, it would provide NPCs with authority to retain fees charged to non-VA attendees for educational programs in order to cover the costs of attendance by such participants. Current law authorizes NPCs to facilitate education, but does not authorize them to retain fees charged to non-VA attendees for educational programs they administer.

Second, it would permit the NPCs to reimburse the VA Office of General Counsel (OGC) for resources necessary for prompt review of Cooperative Research and Development Agreements (CRADAs). This would permit Regional Counsel offices to address the growing volume of CRADAs, the form of agreement mandated by VA to establish terms and conditions for industry-sponsored studies performed at VA medical centers and administered by NPCs. Under the bill, any such reimbursements would be used by OGC for only staffing and training in connection with such legal services.

Third, section 5(a) of the bill would permit NPCs to expend funds for necessary planning purposes, prior to approval of a research project or education program by VA, such as the expenses of preparing a grant proposal. Currently, the NPCs can assist VA with funding only for research or education projects that have already been approved by VA.

Section 5(b) would continue the proscription on VA transfer of appropriated funds to NPCs, but would make explicit the authority of a medical center to "reimburse the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 5." This would codify that reimbursements from VA to NPCs pursuant to Intergovernmental Personnel Act (IPA) assignments are allowable.

Section 7 would increase NPC reporting requirements to include IRS Form 990, which contains a wealth of information about revenues and expenditures as well as major programmatic accomplishments. Section 8 would eliminate the sunset clause on establishing new NPCs.

We support the provision in section 2 of S. 2926 that would authorize the establishment of new multi-center non-profit research corporations (NPCs) and the consolidation of existing single facility NPCs into multi-facility NPCs. This would offer the prospect of NPC-assistance in funding research projects to VA medical centers (VAMCs) that are unable to support their own dedicated corporation. This provision would also provide the system with the tools needed to consolidate or close NPCs that are too small to institute proper internal controls without the loss of the funding support for VA research and education programs that the NPCs provide. By requiring the Director of all VAMCs supported by an NPC to sit on its board of directors, the provision would provide this beneficial increased flexibility without sacrificing VA oversight.

With respect to the draft bill's remaining provisions, however, we ask the Committee to defer further action on this draft bill in order to give the Department an opportunity to address underlying structural issues and to formulate policy related to the governance and finance of the VA affiliated non-profit research corporations. A steering committee has been chartered by the Veterans Health Administration Office of Research and Development to provide recommendations regarding governance, oversight, and finance issues related to the corporations by the end of the fiscal year. We will be happy to provide you with a copy of their final report and recommendations.

S. 2963, VA MENTAL HEALTH AND OTHER BENEFITS EXTENDED TO MEMBERS OF THE ARMED FORCES

Section 1 of the bill would require the Secretary of the Department of Veterans Affairs (VA), acting through the Under Secretary for Health, to carry out a program to provide scholarships to individuals pursuing education or training in behavioral health care specialties critical to the operations of the Department's Vet Centers. Individuals eligible for the program would include those pursing education or training leading to licensure or certification in behavioral health care specialties, which the Secretary deems are critical to the operation of the Vet Centers and who otherwise meet other criteria or requirements established by the Secretary. The amount of any scholarship provided under the program would be determined by the Secretary; however, the total amount available for all the scholarships provided under the program in any fiscal year could not exceed $2 million.

In exchange for the scholarship, an individual participating in the program would be required to enter into an agreement with the Secretary and fulfill a service obligation in a Vet Center, as specified in the agreement. Section 1 would also require these agreements to include repayment provisions in the event the individual does not fulfill the service obligation. The bill would also specify that these scholarships are to be paid from amounts made available to VA for the provision of readjustment benefits.

VA supports the concept of using scholarships for this purpose; however, this provision is unnecessary. Under existing authority, we could establish by regulation a

special scholarship program for individuals pursuing degrees in mental health specialties and require those individuals to agree to serve for a specified period in VA's Vet Centers. The current program is used very successfully to recruit individuals for difficult-to-recruit and difficult-to-retain health care positions throughout the country. We believe it is essential to target scholarships to difficult-to-recruit and difficult-to-retain occupations across the Veterans Health Administration system, rather than limiting scholarships to specific facilities.

We note that current law provides express terms governing a participant's service obligation and liability if a breach occurs at any phase in the program. These statutory provisions help ensure that VA is able to reap the benefits of tangible and intangible investments made by the Department. In addition, current law imposes treble damages for a scholarship participant who fails to complete the service obligation. In sharp contrast, section 1 would require VA to promulgate regulations relating to repayment of the amount of a scholarship provided under this section. Imposing significant penalties for those who breach their service obligations helps VA to deter individuals from using VA as an interest-free, tax-free educational loan program. Section 1 provides no effective means of ensuring that VA will receive the benefit of the participants' professional services as VA employees. Finally, because Vet Centers are currently funded through the medical care appropriations we believe the cost of such scholarship program shall be funded from the same appropriations, rather than the readjustment benefits program.

We estimate the cost of section 1 to be $2,313,938 for fiscal year 2009 and $24,483,918 over a 10-year period.

Section 2 of S. 2963 would extend eligibility for VA's readjustment counseling and related services provided through the Department's Vet Centers to members of the Armed Forces, including members of the National Guard or Reserve, who serve on active duty in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF). Servicemembers would be eligible for the readjustment counseling services even if they are on active duty at the time they receive them. They would have to also meet eligibility requirements prescribed jointly by the Secretary of Veterans Affairs and the Secretary of Defense.

VA supports section 2. We can most effectively address the readjustment needs of former combat-theater servicemembers who are still on active duty through early intervention—even before they are discharged. With our expertise, we can help prepare them for many of the common readjustment problems experienced by veterans with combat service. Extending readjustment counseling and related services to this population may also help to resolve problems that otherwise might prevent some of them from pursuing long-term military careers. We note that VA provides these services in a confidential setting and in a manner that helps to reduce any concern that an active-duty military member may have about any stigma related to seeking counseling or other mental health services. Thus, we see significant benefits to this section.

We also note that, by operation of law, these servicemembers' immediate family members would remain eligible for certain family-support services while the servicemember is on active duty. These services would be provided only to the extent that they are needed for, or in furtherance of, the active-duty member's successful readjustment to civilian life.

The Department estimates the cost of section 2 to be $14,791,000 for fiscal year 2009 and $178,418,309 over a 10-year period. The increased fiscal year 2009 workload resulting from this proposal can be absorbed within the fiscal year 2009 President's Budget request, which includes funding for the establishment of 39 new Vet Centers.

Section 3 would require the Secretary to provide referral services at Vet Centers to individuals who have been discharged or released from active military, naval, or air service but who are not eligible to receive readjustment counseling and related services. It would also require VA to advise these individuals of their right to apply to the appropriate military, naval, or air service for review and upgrade of their discharge status.

VA does not support section 3. Vet Centers provide readjustment counseling and related services to veterans who: (1) meet the title 38 definition of veteran (i.e., "a person who served in the active military, naval, or air service, and who was discharged or released therefore under conditions other than dishonorable"); and (2) served in a combat theater. It is unclear whether this provision is intended to address all of those with "less than honorable" discharges. If so, the language of this section is exceptionally broad and would broaden eligibility for these referral services to non-combat veterans. These clarifications need to be made before VA can develop a position and cost estimate for the provision.

Section 4 would require that the suicide by certain former members of the Armed Forces that occurs during the 2-year period beginning on the date of separation or retirement from the Armed Forces be treated as a death in the line of duty for purposes of survivors' eligibility for certain benefits. The former Armed Forces members who would be covered are those "with a medical history of a combat-related mental health condition or Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI)." The benefits that would be covered under section 4 are "[b]urial benefits," Survivor Benefit Plan benefits under title 10, United States Code, "[b]enefits under the laws administered by the Secretary of Veterans Affairs," and Social Security Act benefits. Furthermore, for purposes of benefits under section 4, the date of death would be considered to be the date of separation or retirement from the Armed Forces, except that, for purposes of determining "the scope and nature of the entitlement," the date of death would be considered to be the date of the suicide. We believe this last provision would provide the date of death for purposes of determining the effective date of an award or amount of benefits, although this is not clear from the bill's language. Essentially, under section 4, the suicide of a covered individual would be treated as a service-connected death for VA benefit purposes.

Although VA supports the concept of section 4 and recognizes its compassionate intent, we cannot support this provision because it may have a negative impact. In some cases, the veterans' combat-related mental health conditions may make them susceptible to considering suicide. Knowing survivor benefits would be awarded to their spouses and children might exacerbate their conditions, making them even more susceptible to acting on their suicide ideations. Their illnesses may cause them to reject any opportunity to obtain medical assistance, believing instead that their families will benefit more from their suicide. This might especially be the case for those who feel overwhelmed by their obligation to provide for their families.

We also have several technical concerns with section 4. Subsection (b) identifies the covered former Armed Forces members as those "with a medical history of a combat-related mental health condition or [PTSD] or [TBI]." It is unclear from the language whether the adjective "combat-related" is meant to modify PTSD and TBI as well as mental health condition. The statement of the bill's sponsor upon introducing the bill suggests so. "This legislation guarantees benefits . . . provided they have a documented medical history of a combat-related mental-health condition, including PTSD or TBI." 154 Cong. Rec. S3716 (daily ed. May 1, 2008). However, the bill language should be clarified.

Subsection (c)(1) identifies "[b]urial benefits" as one of the covered benefits, but fails to specify from which Federal department or agency. We note that subsection (c)(3) identifies as covered benefits "[b]enefits under the laws administered by [VA]," which would cover VA burial benefits and therefore implies that subsection (c)(1) refers to another agency. Again, the introductory statement of the bill's sponsor suggests a solution to this interpretive question. "The Service Member's survivor will be entitled to the same . . . active duty burial benefits that they would have received" had the former servicemember died on active duty, id., but clarification of the bill language may be in order.

VA is still in the process of developing costs for section 4.

Section 5 would require DOD to carry out a grant program for non-profit organizations furnishing support services to survivors of deceased servicemembers and veterans. As to this section, VA defers to the views of the Secretary of Defense.

The Office of Management and Budget advises that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely yours,

JAMES B. PEAKE, M.D.,
Secretary.

Chairman AKAKA. Thank you very much, Dr. Cross.

I would like to ask for questions, first, from Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman. Thank you all for your testimony.

Dr. Cross, let me start with a subject all of us have referenced here today. Secretary Peake, speaking at the National Press Club yesterday, said that trust and confidence is important and that we need to earn them. I couldn't agree more. But, time and time again, actions taken by senior VA officials have undermined that trust, as you know, and last week we learned about the e-mail that has been referenced, sent by a VA mental health professional in Texas which

suggested that the VA staff should stop diagnosing veterans with PTSD in order to save time and money.

Well, thankfully, Secretary Peake strongly condemned that e-mail and I thank him for that. He said that it was an isolated case, however, by a single practitioner, which leads me to my question. How do we know that this is an isolated case?

Dr. CROSS. Well, thank you for mentioning that. First of all, the individual in question was not a senior VA employee but a new employee—relatively new—without supervisory responsibility. But let me say this very, very clearly: the contents of that e-mail—the e-mail in question—were absolutely contrary to VA policy. The VA is committed to absolute accuracy in all of our diagnoses, including those for PTSD.

Now, we treat about 400,000 patients a year as of 2007 for PTSD. The message that I must get out today and that we must—I need your help with is this—to veterans and their families, we are concerned. We are the experts on this. Treatment is available and treatment works. Please come and see us if this is a problem. We are ready to help.

Senator MURRAY. Well, I appreciate that statement from you and I appreciate what Dr. Peake said, but I would like to know what mechanism you have in place to ensure that the policies that you do establish in the central office are being followed out in the field. Do you have any classes or additional training or periodic assessments of how these policies are implemented so that we won't hear about this again?

Dr. CROSS. Yes, Senator, we absolutely do. Not only do we put out policies, we pursue the policies to see that they are being implemented. Our staff at that facility—our staff at the VISN—support the policy, and do not support this e-mail, and do not think it applies elsewhere within the organization. We will continue to pursue this and to make sure that it does not carry further.

Senator MURRAY. OK, and I am sure this Committee will follow up on that, so thank you. I appreciate that and I hope that you keep sending that message through every mechanism that you have.

Dr. CROSS. Thank you.

Senator MURRAY. Dr. Cross, in your testimony, you recognize that the inability to get child care is a barrier to some of our veterans, so I was surprised that you opposed Section 204 of the women veterans bill that I have introduced, which would require the VA to simply conduct a pilot program to pay for the cost of child care for veterans receiving care at our VA facilities for mental health or for other intensive services. So, you identify the lack of child care as a barrier to care for these women, yet you are unwilling to do anything about it. So, why are you even looking at barriers for veterans if once you assess that they are barriers you are not willing to do what needs to be done to decrease those barriers?

Dr. CROSS. Senator, there is so much in your bill that we really appreciate and support and so many things that we have to work together on that we are exactly on the same sheet of music. It was only in regard to Section 204 that we found that the funding—our concern was that the funding would simply divert funds from direct patient care.

Senator MURRAY. It would divert funds from——

Dr. CROSS. Direct patient care.

Senator MURRAY. Well, if——

Dr. CROSS. Also, we have other means in place where we supplement individuals driving some distance, but——

Senator MURRAY. Well, I find it troubling that that is the opinion—the way you look at it—because what we are finding is that women are not getting care, particularly mental health care, because they can't get child care. So, if we want to encourage these women to get in and to get the mental health care they need and not sit at home, reducing that barrier is a critical part of their care.

Dr. CROSS. We agree, too, that we want to make sure if there are any barriers that we can reduce, we do so. I think the only real objection we had to this was it would come out of direct patient care and we have other mechanisms in place to help supplement people for their travel——

Senator MURRAY. Well, it is certainly not our intent to divert care. It certainly is our intent to make sure they get access to care, so I disagree on the premise, but we will keep working.

In your testimony, you also stated that the VA is opposed to the longitudinal study on the health consequences for women veterans who have served in Iraq and Afghanistan because, you say, a similar study involving 12,000 women veterans has already been approved. Can you tell me what approved means?

Dr. CROSS. Underway.

Senator MURRAY. Underway?

Dr. CROSS. Beginning.

Senator MURRAY. Is it funded?

Dr. CROSS. In 2007, the VA initiated its own 10-year study—a longitudinal epidemiological surveillance on the mortality and morbidity of OEF/OIF veterans, including women veterans.

Senator MURRAY. Including women veterans, but not particular to women veterans.

Dr. CROSS. Yes, Senator, including. And the staff, looking at both parts of the bill and what we are doing, felt that we certainly met that requirement.

May I say something else about research?

Senator MURRAY. Yes.

Dr. CROSS. This is very important to us and there is a point that very few people know. Over the past 7 years, we have published 46,000 articles in the medical literature—the VA, VA providers—896 of those were in *Science*,the *New England Journal of Medicine*, or *JAMA*. Many of those were related to women's health. I have a number here that I can share with you——

Senator MURRAY. I actually would like it if you could, for the record, give me a list of all of the studies that you have ongoing for women veterans right now; conclusions; how long they are going to take; and what the process is.

But in my time, let me ask you, I am also having trouble understanding why you are opposed to including active duty women servicemembers as part of the longitudinal study on health consequences. I would think that the VA would want to know what the needs are for current as well as future patients. So, if you exclude

current active duty women, are you not going to lose some of the information that you need?

Dr. CROSS. I believe that the only objection that we would have in that regard is the logistics of trying to work with that group along with the veteran group. Of course, our focus as the VA is on the veterans, and so that is why we directed our study in that direction.

Senator MURRAY. Well, OK. We will have further discussions about that. But you also object to assessing the existing health care programs for women veterans and reporting those findings to Congress. In your statement, you recognize that there are gaps in the care for women veterans—you say that to us—especially since the system was obviously designed when there weren't as many women in the VA. But, you oppose the assessment, and I find that very troubling.

Dr. CROSS. There is so much we can talk about on this and I think it is very important. I think there have been gaps, and continue to be, that we are addressing right now with a number of initiatives we have underway: everything from training to equipping, to the location of treatment, and to the way that women are welcomed into our system. We are absolutely committed to making them welcome. They make up 6 percent of our enrollees at this time and they are about 5.2 percent——

Senator MURRAY. Well, making them welcome and making sure that they have the services available are two different ways of looking at it.

Let me ask you particularly about the military sexual trauma (MST) provisions, because those are especially important to women today. It is a difficult topic and one that we believe we have got to address much stronger. In your testimony, you say you are strongly opposed to the MST staffing standards that we are putting in place. There has got to be today some sort of accepted norm for providing care for veterans who have MST. Can you tell me what the appropriate patient workload for an MST provider is today?

Dr. CROSS. I don't have that information, Senator. I will be happy to get it for you, but I can explain why——

Senator MURRAY. Before you do that, can you tell me what acceptable time a provider should spend with someone who has MST?

Dr. CROSS. As much time as necessary.

Senator MURRAY. OK. You wanted to respond further. I mean, it seems to me that we need to put in place norms, particularly for military sexual trauma, that we don't know much about. It is an issue that women are reluctant to talk about, and establishing some staffing standards is a realistic way of making sure that we are dealing with that issue adequately.

Dr. CROSS. We support the focus on MST. It is, in fact, very important and that is why we made it a screening test, to make sure that even if the patient themselves don't bring it up, that we raise the issue and ask them directly about this, and that if there is a positive screen, that we get them in treatment. What we are doing is developing a number of outpatient/inpatient capabilities to provide the best treatment in the United States for these individuals.

Senator MURRAY. Do you believe that you have an adequate number of people today to train and educate people—your clinicians—about MST within the VA today?

Dr. CROSS. I think that we are doing an adequate job on training our primary care providers and also our specialty providers. That doesn't mean I am satisfied.

I have a group called the Strategic Health Group for Women Veterans that reports to me and has to inform me how we are doing; and I rely on them to keep me informed and to modify our programs as time goes along.

I think our concern about staffing standards was the "cookie cutter" approach, that we don't accept, really, on any of our programs. We think that they have to be individually tailored at the facility. Our facilities have different organizations and different places and different capabilities and providers, different patient populations. We tailor our approach in those places to put together our resources in the most effective way possible.

Senator MURRAY. Well, I would just say, Mr. Chairman—and my time is way over—that because this issue is so important, because there are so many women not accessing the VA today, because there is an increasing number of veterans, I think it is imperative that we focus like a laser on this and really show that we are following a set standard and have very explicit policies in place to make sure these women do get in; because just hoping it is going to happen or saying it is there today is not making it happen.

But thank you, Dr. Cross. We will look forward to working with you on this.

Dr. CROSS. Thank you, Senator.

[The response from VA follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO DEPARTMENT OF VETERANS AFFAIRS REGARDING WOMEN'S HEALTH RESEARCH PROJECTS

Request: Please provide a list of all active and recently completed women's health research studies, along with a short description of the studies, the number of women veterans involved in the studies, the expected completion dates of studies still underway and the amount of funding either requested or provided for each study during its duration. Also, provide a list of proposals that have been made for women veterans' health research studies since January 1, 2003, that were not approved for awards, with a short description of the reason for disapproval, and the estimated cost of those proposed studies. In addition, please provide a description of how the Department of Veterans Affairs (VA) selects research projects.

Response: Attached is a list of active and recently completed women's health research projects supported by VA's Office of Research and Development (ORD). VA's women's health research includes studies on diseases prevalent solely or predominantly in women, such as certain types of cancer (e.g., breast, cervical, ovarian), lupus, human papillomavirus (HPV), and hormonal effects on diseases in post-menopausal women; studies focusing on women subjects, for example, Post Traumatic Stress Disorder (PTSD) in women, osteoporosis in women, and multiple sclerosis in women; and studies on the health care needs and service utilization of women at VA, as well as the structures and organizations for the delivery of quality care. Current research examines the complex interaction of physical and mental health; the unique risks and outcomes of military service, particularly related to sexual and combat trauma and PTSD; and the impact of VA's organization and structures of health care delivery for women veterans on access, barriers to care, service availability, utilization, satisfaction, and quality of care. Reflecting the increasing numbers of women in the military, research is also directed at analyzing the needs and experiences of the new generation of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) women veterans. In some of these OEF/OIF studies, such as the women veterans' cohort study, potential gender disparities in utilization and

outcomes are being assessed. Studies are also aimed at better understanding special concerns of reintegration for women veteran mothers.

The broad scope of VA women's health research is also mirrored in recent research findings. Recent research has identified possible factors affecting treatment decisions such as hormone therapy discontinuation; explored gender differences in health care use and costs, health-related quality-of-life, VA health care utilization and mortality, and colorectal cancer screening barriers and information needs; suggested that gender is a factor explaining the use of mental health and substance abuse services among at-risk drinkers; and evaluated strategies to increase regular mammography screening among women veterans. Women veterans' perceptions about and experiences with VA health care have been documented, and VA and non-VA health care outcomes for vascular surgery operations in women have been compared. VA's efforts to identify and treat military sexual trauma have also been evaluated, and knowledge about the impacts of military trauma on women veterans—sexual and combat—has been reviewed in order to inform future research and treatment. In the largest randomized clinical trial to date involving women veterans with PTSD, VA investigators and colleagues found that prolonged exposure therapy, a type of cognitive behavioral therapy, was an effective treatment for PTSD in female veterans and active-duty military personnel (Journal of the American Medical Association. 2007;297(8):820–830).

ORD does not systematically collect enrollment data centrally and, therefore, the number of participants is not included on the attached list. VA assures adequate representation of study participants through its scientific merit review process, which all studies undergo. It is important to note that nearly all studies funded by ORD that involve human subjects include women, except for obvious male relevant issues such as prostate or testicular cancer.

Regarding the list of projects that were not funded, every year, nearly 2,000 letters of intent or research proposals are sent to ORD. Of these, only about 20 percent are selected for funding, based on rigorous peer review for scientific merit and administrative review for relevance to the veteran-centric health care mission of VA. In order to protect intellectual rights of investigators who may still be pursuing funding for their proposals through VA or other sources, ORD does not release information about such proposals. It is also important to note that from feedback provided to researchers through the review process, many of these studies are improved and ultimately funded.

Regarding the process for selecting research projects, VA scientists submit research proposals through their local VA research office, which provides oversight and guidance for the local research program, using a standard format that describes the scientific question, the proposed method to answer the question, and its relevance to veterans' health. VA convenes scientific peer review committees, comprised of VA and non-VA scientists, to review proposals for scientific merit and appropriateness. The review committees assign a priority score based on merit.

The next level of approval occurs within ORD, where ORD staff ensures relevance to veteran needs and checks with other ongoing projects funded by VA or others to ensure there is no duplication of effort. Proposals are then funded in order of merit and appropriateness/need based on the two-tier review described above. For the project to start, additional approvals are needed, which are done through review at the site where research is conducted (e.g., Institutional Review Board approval). This ensures local accountability for compliance with applicable regulations. In regards to women's health, ORD is routinely reviewing and funding new studies.

Office of Research and Development
Active Women's Health Research Projects

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration (est.)
2	Indianapolis, IN	Antony, Asok C.	10/1/2006	9/30/2010	Folate Receptor-Targeted Therapy for Cervical Cancer	$547,200
3	White River Junction, VT	Asin, Susana N.	4/1/2007	3/31/2010	HIV-1 Replication and Transmission in the Female Reproductive Tract	$833,711
4	Detroit, MI	Badr, M. Safwan	7/1/2004	6/30/2009	Breathing Instability and Upper Airway Obstruction During Sleep	$754,000
5	Kansas City, MO	Banerjee, Snigdha	10/1/2007	9/30/2010	Cell-Cell Interactions During Breast Tumor Angiogenesis: Role of NRP-1	$816,939
6	East Orange, NJ	Beck, Kevin	10/1/2005	9/30/2008	Ovarian Hormone Regulation of Behavior Following Traumatic Stress	$592,658
7	Milwaukee, WI	Chen, Guan	4/1/2006	3/31/2009	Estrogen Receptor Regulates c-Jun Activity in Breast Cancer Cells	$649,196
8	Baltimore, MD	Cole, John W	10/1/2007	9/30/2010	Stroke and the Genetics of Thrombomodulin	$694,528
9	Omaha, NE	Davis, John S.	10/1/2005	9/30/2009	Role of Egr-1 in the Function and Fate of the Corpus Luteum	$585,000
10	Omaha, NE	Davis, John S.	4/1/2004	3/31/2009	Research Career Scientist Award	$380,778
11	San Diego, CA	Deftos, Leonard J.	10/1/2004	9/30/2009	Neuroendocrine Cancer: Regulation of Tumor Progression	$788,420
12	West Los Angeles, CA	Farias-Eisner, Robin	4/1/2006	3/31/2009	Role for Atherogenic HDL and Oxidative Stress in Ovarian Cancer	$471,789
13	Portland, OR	Finn, Deborah A.	10/1/2004	9/30/2008	Neurosteroid Modulation of Ethanol Drinking Behavior in Mice	$859,811
14	San Antonio, TX	Frazer, Alan	10/1/2006	9/30/2009	5-HT Transporter Function: Interaction of Hormones and Antidepressants	$870,599
15	Charleston, SC	Gilkeson, Gary S.	10/1/2005	9/30/2009	Role of Estrogen Receptors in Lupus-Modulators of the Inflammatory Response	$571,000
16	Oklahoma City, OK	Greenwood, Beverley	10/1/2007	9/30/2010	Understanding Pain of Gastrointestinal Origin in Women that Serve in OEF/OIF	$311,400

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Office of Research and Development
Active Women's Health Research Projects

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration (est.)
17	Oklahoma City, OK	Harley, John B.	4/1/2008	3/31/2012	Lupus Association with Signal Transducer and Activator of Transcription 4	$597,500
18	White River Junction, VT	Howell, Alexandra L.	7/1/2004	6/30/2009	Mucosal Immunity to HIV-1	$1,482,141
19	Oklahoma City, OK	Kaufman, Kenneth M	4/1/2007	3/31/2010	Susceptibility Genes in Systemic Lupus Erythematosus	$715,522
20	Detroit, MI	Kosir, Mary A.	10/1/2004	9/30/2008	Targeting Breast Cancer Metastases: Role of Chemokine Heparanase	$609,514
21	West Los Angeles, CA	Lee, Cathy C.	1/1/2005	6/30/2008	Metabolic Effects of Androgenicity in Aging Men and Women	$621,981
22	Long Beach, CA	Levin, Ellis R.	10/1/2005	9/30/2009	Estrogen Receptor and Cardiovascular Function	$571,200
23	Indianapolis, IN	Matei, Daniela	10/1/2007	9/30/2010	Role of Tissue Transglutaminase in Ovarian Cancer	$441,000
24	Brockton, MA	McGlinchey, Regina	4/1/2005	3/31/2009	Classical Associative Learning in Male and Female Detoxified Veterans	$603,375
25	Decatur, GA	Nanes, Mark S.	10/1/2006	9/30/2010	Cytokine Induced Resistance to Vitamin D	$590,000
26	Charleston, SC	Oates, James C.	10/1/2006	9/30/2009	Urine Biomarkers of Lupus Nephritis in Aspreva Lupus Management Study	$382,800
27	Boston, MA	Pineles, Suzanne	7/1/2008	6/30/2013	The psychophysiology and neurobiology of PTSD across the menstrual cycle	$766,259
28	Hines, IL	Rana, Ajay	4/1/2005	9/30/2008	Regulation of Breast Cancer Growth by MLK-3	$544,891
29	Ann Arbor, MI	Richardson, Bruce C.	10/1/2006	9/30/2010	Does Demethylation of the Inactive X Predispose Women to Lupus?	$515,000
30	Detroit, MI	Rishi, Arun	10/1/2004	12/31/2011	CARP-1: A Potential Therapeutic Agent for Breast Cancer	$1,548,654
31	Chicago, IL	Rubinstein, Israel	4/1/2006	3/31/2010	ActivelyTargeted Nanoparticulate Paclitaxel to Treat Breast Cancer	$530,000

Office of Research and Development
Active Women's Health Research Projects

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration (est.)
32	San Francisco, CA	Scalapino, Kenneth J.	6/1/2006	5/31/2009	The role of regulatory T-cells in Murine Lupus	$575,963
33	San Diego, CA	Stein, Murray B.	10/1/2005	9/30/2010	Neurobiology of Severe Psychological Trauma in Women	$750,000
34	West Los Angeles, CA	Sugawara, Masahiro	10/1/2005	9/30/2008	Human Epidiymal Protein 1 for Papillae Formation and Papillary Prolifera	$325,700
35	West Los Angeles, CA	Taylor, Anna N.	4/1/2002	3/31/2009	Senior Research Career Scientist Award	$1,148,722
36	Houston, TX	Thiagarajan, Perumal	10/1/2005	9/30/2009	Antibodies with Prothrombin Specificity in Lupus	$560,000
37	Portland, OR	Van Winkle, Donna M.	10/1/2004	9/30/2008	Opioid Mediated Cardiac Adaptation to Stress	$1,233,028
38	Sepulveda, CA	Weisbart, Richard	10/1/2004	9/30/2008	Antibody-based Transport Systems for Intracellular p53 Restoration	$639,000
39	Portland, OR	Wiren, Kristine M.	4/1/2007	3/31/2011	Neurotoxic Effects of Alcohol: Effects of Gender	$709,500
40	Portland, OR	Wiren, Kristine M.	4/1/2008	3/31/2013	Research Career Scientist Award	$687,000
41	Iowa City, IA	Sadler, Anne	7/1/2006	6/30/2009	Physical and Sexual Assault in Deployed Women: Risks, Outcomes and Services	$763,328
42	East Orange, NJ	Banerjea, Ranjana	9/1/2006	8/30/2009	Chronic and Physical Mental Illness Care in Women Veterans	$573,000
43	West Los Angeles, CA	Washington, Donna	9/1/2006	8/30/2008	Women Veterans Ambulatory Care Use - Phase II	$285,058
44	West Los Angeles, CA	Washington, Donna	7/1/2002	6/30/2008	Improving VA Access and Quality of Care for Women	$1,114,974
45	Sepulveda, CA	Yano, Elizabeth	4/1/2008	9/30/2009	Impact of Practice Structure on Quality of Care for Women Veterans (Phase 2)	$258,500
46	Boston, MA	Shipherd, Jillian	9/1/2006	8/30/2009	MST Effect on PTSD and Health Behavior: A Longitudinal Study of Marines	$710,165

Office of Research and Development
Active Women's Health Research Projects

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration (est.)
47	Palo Alto, CA	Kimerling, Rachel	2/1/2006	1/31/2009	Evaluation of Military Sexual Trauma Screening and Treatment	$390,600
48	Palo Alto, CA	Kimerling, Rachel	4/1/2008	9/30/2008	Gender and Medical Needs of OIF/OEF Veterans with PTSD and Comorbid Substance Abuse	$41,400
49	Palo Alto, CA	Kimerling, Rachel	4/1/2008	9/30/2008	Examining the Diagnostic and Clinical Utility of the PTSD Checklist	$35,500
50	Bedford, MA	Eisen, Susan	10/1/2007	9/30/2009	Predicting Post-Deployment Mental Health Substance Abuse and Service Needs	$66,800
51	Seattle, WA	Gerlock, April	7/1/2007	6/30/2011	Detection of Intimate Partner Violence: Implications for Intervention	$710,009
52	Seattle, WA	Bradley, Katharine	9/1/2006	8/31/2008	Alcohol Misuse and the Risk of Post-Surgical Complications and Mortality	$402,237
53	Tampa, FL	Luther, Stephen	7/1/2007	8/31/2009	The Quality of Locoregional Breast Cancer Treatment for Breast Cancer in the VHA	$279,800
54	White River Junction, VT	Schnurr, Paula	3/1/2007	2/28/2011	Re-engineering Systems for the Primary Care Treatment of PTSD	$742,675
55	New Haven, CT	Brandt, Cynthia	10/1/2007	10/30/2012	Women Veterans Cohort Study	$1,100,569
56	East Orange, NJ	Lange, Gudrun	5/1/2008	9/30/2008	Pilot Study of Re-Integration and Service Needs for Women Veteran Mothers	$69,100
57	Sepulveda, CA	Bean-Mayberry, Bevanne	1/1/2004	7/30/2009	Assessment of Preventative and Chronic Disease Measures in Women	$573,113
58	Dallas, TX	Suris, Alina	4/1/2007	3/31/2009	Manualized Treatment for Veterans with Sexual Trauma	$721,000
59	Palo Alto, CA	Phibbs, Ciaran	6/1/2008	9/30/2008	Pregnancy Outcomes of Veterans (PROVE) Feasibility Study	$50,200
60	Boston, MA	Taft, Casey	5/15/2008	9/30/2008	PTSD-Focused Cognitive Behavior Therapy for Partner Violence: A Pilot Study	$92,673

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Office of Research and Development
Active Women's Health Research Projects

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration (est.)
61	Iowa City, IA	Sadler, Anne	7/1/2008	6/30/2011	Combat, Sexual Assault, and Post-Traumatic Stress in OIF/OEF Military Women	$298,669
62	Boston, MA	Vogt, Dawne	9/1/2008	8/31/2011	Stigma, Gender and Other Barriers to VHA Use for OIF/OEF Veterans	$520,900

Office of Research and Development
Recently Completed Women's Health Research Projects (FY06 - present)

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration
2	Kansas City, MO	Banerjee, Sushanta K.	4/1/2005	3/31/2008	The Roles of WISP-2/CCN5 Signaling in Breast Cancer Development	$593,933
3	Brockton, MA	Brady, Christopher B.	4/1/2005	3/31/2008	The Cognition and Stroke Risk Project: Gender and Cognitive Decline	$737,053
4	Denver, CO	Janoff, Edward N.	4/1/2003	3/31/2008	Cellular Determinants of Mucosal HIV-1 Infection	$629,523
5	Nashville, TN	Mundy, Gregory R.	4/1/2003	3/31/2008	Mechanisms of Action of Statins on Bone Formation	$675,000
6	Columbia, MO	Smith, C. Jeffrey	4/1/2005	3/31/2008	Preparation of Low-Valent Tc/Re(I) Imaging/Therapeutic Agents	$687,948
7	West Los Angeles, CA	Srivatsan, Eri S.	4/1/2003	3/31/2008	Isolation of a Cervical Cancer Tumor Suppressor Gene	$700,000
8	Iowa City, IA	Sadler, Anne	4/12005	3/31/2008	Sexual Violence and Women Veterans Gynecological Health	$786,901
9	Boston, MA	Vogt, Dawne	4/1/2007	3/31/2008	Further Development and Validation of the DRRI	$148,100
10	Minneapolis, MN	Sayer, Nina	10/1/2007	4/30/2008	Community Re-Integration Problems and Treatment Preference Among OIF/OEF Veterans	$253,662
11	Portland, OR	Anderson, Sharon	4/1/2003	3/31/2008	Pathophysiology of Diabetic Nephropathy	$589,500
12	Ann Arbor, MI	Krein, Sarah	10/1/2007	4/30/2008	Study of Women Veterans in Menopause	$9,000
13	Pittsburgh, PA	Eagon, Patricia K.	10/1/2002	9/30/2007	Alcohol-Induced Liver Injury: Effects of Gender and Sex Hormones	$1,372,755
14	Minneapolis, MN	Sayer, Nina	5/1/2006	12/30/2007	Barriers & Facilitators to PTSD Treatment Seeking	$362,117
15	Sepulveda, CA	Yano, Elizabeth	4/1/2005	3/31/2007	Impact of Practice Structure on the Quality of Care for Women Veterans	$261,500
16	Palo Alto, CA	Kimerling, Rachel	7/1/2007	10/30/2007	Gender and Medical Needs of OIF/OEF Veterans with PTSD	$28,700
17	Madison, WI	Atwood, Craig S.	10/1/2004	9/30/2007	Pituitary Hormone-Lowering Drugs Suppress Alzheimer's Neurodegeneration	$495,900
18	Philadelphia, PA	Cohen, Philip L.	10/1/2004	9/30/2007	C-Mer Deficiency - a New Model of Systemic Autoimmune Disease	$450,000
19	Oklahoma City, OK	Harley, John B.	10/1/2002	9/30/2007	Anti-Ro Autoimmunity	$675,000

June 2008

Office of Research and Development
Recently Completed Women's Health Research Projects (FY06 - present)

	A	B	C	D	E	F
1	Facility	Principal Investigator	Start Date	End Date	Description	Total Funding Over Duration
20	Birmingham, AL	Johnson, Victoria A.	10/1/2004	9/30/2007	Drug Resistance in Genital Tract Viruses Derived from HIV-Infected Women	$450,000
21	Iowa City, IA	Lee, John H.	10/1/2004	9/30/2007	Therapeutic Potential of HPV-16 E6 and E7 Inhibition	$465,600
22	White River Junction, VT	Friedman, Matthew J.	6/1/2001	3/30/2007	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	$7,032,556
23	Minneapolis, MN	Murdoch, Maureen	10/1/2003	9/30/2006	Does PTSD Service Connection Affect Disease Course and Functioning	$893,286
24	Ann Arbor, MI	Richardson, Bruce C.	4/1/2001	3/31/2006	LFA-1 Overexpression, T Cell Autoreactivity, and Lupus	$672,300
25	West Los Angeles, CA	Taylor, Anna N.	10/1/2001	9/30/2006	Alcoholism and Neuro-Endocrine-Immune Interactions	$692,800
26	Denver, CO	Wierman, Margaret E.	10/1/2001	9/30/2006	Repression of GnRH by Liganded Steroid Receptors	$675,000
27	Baltimore, MD	Cole, John W	7/1/2003	6/30/2006	Stroke and the Genetics of Thrombomodulin	$462,660
28	Omaha, NE	Gorby, Gary L.	4/1/2002	3/31/2006	Gonococcal Opas: Role in Invasion of Human Fallopian Tube Epithelium	$464,400
29	Columbia, SC	Hrushesky, William J.M.	10/1/2002	9/30/2006	Biologic Discrimination of Key Molecular Targets to Prevent Metastasis	$555,000
30	Little Rock, AR	Klimberg, V. Suzanne	4/1/2001	3/31/2006	Prevention of Breast Cancer: Role of Dietary Glutamine	$672,300
31	Decatur, GA	Nanes, Mark S.	10/1/2001	9/30/2006	Cytokine Induced Resistance to Vitamin D	$613,820
32	Ann Arbor, MI	Duvernoy, Claire S.	10/1/2003	3/31/2006	Estrogen Alternatives and Vascular function in Post-Menopausal Women	$342,550
33	St. Louis, MO	Eisen, Seth A.	10/1/2004	9/30/2006	Pain Among Gulf War Veterans: Secondary Analysis of CSP#458 Data	$129,000
34	West Los Angeles, CA	Washington, Donna	10/1/2001	11/30/2005	Women Veterans Ambulatory Care Use: Patterns, Barriers, and Influences	$748,400
35	Boston, MA	Vogt, Dawne	10/2/2002	9/30/2005	Toward Gender Aware VA Health Care: Development and Evaluation of an Intervention	$582,300

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Chairman AKAKA. Thank you, Senator Murray.

I will call on our Ranking Member, Senator Burr, for his questions.

Senator BURR. Thank you, Mr. Chairman, and again, thank you, Dr. Cross.

I don't have enough time to go through just the testimony on S. 2573, but let me pick apart a few places and help me to understand exactly the mindset of the Department of Veterans Affairs. Quoting your testimony, "S. 2573 assumes that early treatment

intervention by VA health care professionals for a covered condition would be effective in either reducing or stabilizing a veteran's level of permanent disability from the condition, thereby reducing the amount of VA disability benefits ultimately awarded for the condition. No data exists to support or refute that assumption."

Let me make it perfectly clear. My motive here in introducing this legislation is not about reducing the amount of VA disability benefits. It is about treatment. It is about a different outcome. So, I am going to ask you real specifically, what data exists to support what VA is currently doing in our mental health treatment—given that we see the percentages on the outcome side continue to go up—meaning what we are doing is not working. Tell me what data you have that I haven't seen that says what you are doing is working.

Dr. CROSS. The best data that exists comes from the Institute of Medicine and their report that we paid for and came out about 6 months or a year ago on what is the standard of care for PTSD in the world today. They listed off those treatment types of programs that should be included—the best possible treatment program. We are doing those. The exposure therapy, and cognitive therapy were the things that they recommended; and so, we are aligned with what the Institute of Medicine recommended.

Senator BURR. And the assumption that you are making to come to the outcome that you have, is that every servicemember who has PTSD participates in these programs that you offer. And my point is, it is not good enough for us to offer programs if people don't participate in them. If people have to drop out of the treatment stream because of the financial burdens that exist with the family and they don't get the treatment, what is the outcome? The outcome is they continue to get worse.

Every medical journal, every study that has been done says an intense up-front treatment for mental health conditions is absolutely essential to the outcome. Yet, we believe that just because we offer it—we offer a tremendous amount of benefits for disabilities. They are scattered all over the country. And the fact is that if you enter in Richmond, Virginia, with a Traumatic Brain Injury, but don't find out about a state-of-the-art facility in San Antonio, Texas, and you never get there, the likelihood is your outcome is different.

And we are reliant on being able to say, well, it exists. But there's no attempt to try to communicate this throughout. And then we wonder why we have hearings where family members come in where they have voluntarily taken somebody out of the VA system because of their determination of the outcome and put them in a private facility to try to get a different outcome. Am I blowing this out of proportion?

Dr. CROSS. Sir, I agree, and let me say something. We are intrigued by this bill——

Senator BURR. It is not good enough, Dr. Cross, to be intrigued.

Dr. CROSS [continuing]. And we agree——

Senator BURR. I want you to be passionate about changing the outcome——

Dr. CROSS. Can I say——

Senator BURR [continuing]. Of the future for these kids.

Dr. CROSS. Let me tell you a couple of the things that we are doing that relate to this. You say some folks have not come in. We agree with that. We are very concerned about that. At this very moment, we are contacting 550,000 OEF/OIF veterans who have not yet come to see us, calling them on the phone saying, "How are you doing? Having any problems? Can you come see us?" And we put a screening program in place so that even if the patient doesn't ask about symptoms related to PTSD, we ask about them—made it part of our Electronic Health Record. We are taking these concerns very seriously——

Senator BURR. Let me go back to your testimony just real quick. "Costing this bill is very complex as there are no ways for us to determine the total number of veterans who would participate in a pilot program, in which year they would enter the program, their ultimate disability status, and the amount of the medical care that each require. We estimate the increase in medical administration costs for every 400,000 new veterans entering the VA system to be $280 million per year in addition to the $293 million per year in maximum stipend payments."

My point is that the entire testimony goes back to, one, we can't figure out what this costs. I am not questioning what it costs. I am questioning whether what we do works. You are not focused on whether what you do today works. You are focused on justifying what you spend on it.

Dr. CROSS. Some of the concerns that we have about patient care are very significant. Forget the cost. For instance, substantial compliance—what does that mean? Does that put the treatment provider, the physician, in place of a judge in a way that is going to impact their financial status? That is a concern to us, because in our C&P programs, we tried to keep those separate. Why just mental health? There are other conditions that we could use the same thought in regard to. And why just provide treatment for mental health and not other conditions, even though I say there are other medical conditions that very much influence mental health?

Those are some of the concerns that we would like to work out with you and your staff, because we think that there is a great deal of interest in this; but there are some concerns that we have that we think need to be addressed to make this better.

Senator BURR. Well, it is not my MO to come in and to raise issues at the level that I have with this, but it significantly disappoints me when we have a delivery system that is so good that will not think out of the box, that will not recognize the fact that we have a problem.

Now, Senator Murray and I, we are both passionate about mental health treatment. We may have very different approaches and where we find commonality, I think we work together. Where we don't, we are very passionate about our differences. But both of us agree on one thing. This is about the outcome of these servicemembers. This is about, do they get better.

And I would only tell you that when you challenge whether this bill works or not based upon the lack of data, let me suggest to you that when I look at the data on the outcomes that we currently get, we would all opt to go somewhere else and not to the Department of Veterans Affairs to get mental health treatment because, as Sen-

ator Craig said, this is spiraling down to where everybody is disabled—and eventually 100 percent—and I would just suggest to my colleagues, that is not the expectation of today's warriors. Their expectation is to get well. And if we have a system that is designed only to manage getting sicker, then we have made a huge mistake.

I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Dr. Cross, in your written testimony, you described the likely impact of the proposed requirement that every VA physician be licensed in the State which they practice. In your best estimation, what percentage of VA physicians would be forced to be relicensed or relocate and what impact would this have on VA's ability to care for veterans?

Dr. CROSS. Thank you, Mr. Chairman. Eighty-three percent of VA physicians are board certified at this time. In the Nation, the number is approximately 85 percent, so very similar numbers for the VA and the Nation. Among VA surgeons, by the way, about 93.4 percent of VA surgeons are board certified, whereas only about 90 percent of those across the Nation outside the VA are board certified. So, that is the percentage in terms of board certification that would make a difference for us.

I support board certification. I think it is—I am board certified. I think it is very important. I think that we should promote it. Requiring it becomes problematic in terms of hiring and retention at times, but I think we should move forward to make sure that as many as possible, even all of our physicians are board certified.

Chairman AKAKA. I am glad to hear that from you, Doctor.

Your testimony notes that views on S. 2963 are not available, yet I understand that there are several accounts that the Department does, in fact, support the legislation. This legislation would have a significant impact on Vet Centers. Does the Department support this legislation, and if so, how will Vet Centers and staff not become overwhelmed by additional veterans?

Dr. CROSS. Sir, I don't think we have developed our views on that yet. That is one of the ones that we are still working on.

Chairman AKAKA. Dr. Cross, at the Committee's hearing on personnel issues on April 9, we heard about a range of staffing issues facing VA facilities. Nursing positions stood out as particularly challenging to fill. How can VA better use the various alternative work schedules frequently used outside of VA to improve recruitment and retention of nurses?

Dr. CROSS. Recruitment and retention of nurses is something that is of great interest to the VA and we are quite willing to use flexible scheduling or whatever other techniques that we can come by to make their practice with us—you know, help them to retain those very important staff members.

I do want to say that we have been thinking outside the box. We have been doing innovative things. Our nursing academy proposal, for instance, that has already been started—working with civilian universities to expand the capacity to train more nurses nationwide, and then, of course, in this situation bring them into the VA—is already underway. And we have made grants with—we made arrangements with—four universities, and I understand that

we are looking to expand that this year. We are looking at ways to be more innovative—provide more innovative support for nurses.

Chairman AKAKA. Dr. Cross, you oppose the mobile health bill, which is S. 2383, in part because it is duplicative of existing programs and ongoing efforts. I believe mobile units would have significant value in rural areas and would like to see their deployment accelerated. What resources or tools does VA require to speed the implementation of mobile health units?

Dr. CROSS. Our Office of Rural Health is putting together a package for more outreach, including mobile assets that we can send out into the rural environment. Particularly, it might include things like preventive health and primary care assessments. Our Vet Centers have a proposal that I have already accepted to buy a number of vans to reach out to locations where counseling might be made available in more remote areas.

The challenge that we had with the bill is this: the bill was phrased in such a way and was so specific in terms of how often we would go out, who would be on the van—it had so many people in the van that I was trying to envision how large it would have to be—because it included everything from employment counselors, to financial counselors, to PTSD, to mental health, to medical care. That was going to be difficult for us. So, we are aligned with you in support of the concept. Some of the details in the bill do cause us some problems.

Chairman AKAKA. Before I move on, Dr. Cross, nonprofit research corporations, NPCs, are providing important support to VA research and I know you think it is very important to your work. How would the function of NPCs be strengthened if multiple facilities were permitted to consolidate research corporations to form multi-medical center NPCs?

Dr. CROSS. I will ask Mr. Hall to help me on this, but I do want to say that we are doing more large-scale studies that go across many boundaries that currently exist, and to try to put these large studies together, I think this is one thing that might help us in that direction.

Walt?

Mr. HALL. The other part of it, Mr. Chairman, is we have a number of corporations out there at some of our smaller facilities that don't have the critical mass. They don't have the funding necessary to pay for all the overhead that is necessary to appropriately run the corporations. By allowing some of these smaller corporations to combine, to merge into large units, they would be better able to fund their overhead and fulfill their oversight responsibilities.

Chairman AKAKA. Let me ask a final question. Dr. Cross, I am concerned about the potential conflict that would arise for health care practitioners if S. 2573 is adopted. What is the health care practitioner's primary mission—care for the veteran's mental health or for the financial implications of a wellness stipend determination? Does leaving the decision in the hands of a practitioner create an inherent conflict between practitioner and patient?

Dr. CROSS. The primary purpose, Mr. Chairman, of a health care provider in the VA is to address the well-being of the patient that they are taking care of. In our C&P programs—our compensation and pension programs—where we do examinations, we do our best

to try and separate those examinations for compensation from the ongoing treatment that we provide for the individual over a period of years. That can get very complicated for a physician—having to address treatment needs of an individual at the same time as trying to address something that has financial implications for that same patient at the same time. I think sometimes it can get in the way of treatment, and that is why we try to keep it separate.

Chairman AKAKA. I want to thank you for your responses and your colleagues, as well, for being here.

Dr. CROSS. Well, thank you, sir. I appreciate it.

Chairman AKAKA. Thank you. I want to excuse the first panel.

I would like to call the second panel up. I welcome our witnesses from Veterans Service Organizations to the second panel. I appreciate your being here today and look forward to your testimony.

First, I want to welcome Carl Blake, National Legislative Director for Paralyzed Veterans of America. Next, I welcome Joseph Wilson, Assistant Director for Health Policy for the Veterans Affairs and Rehabilitation Commission of the American Legion. I also welcome Joy Ilem, Assistant National Legislative Director for Disabled American Veterans. And finally, I welcome Chris Needham, Senior Legislative Associate of the National Legislative Service of Veterans of Foreign Wars.

I thank all of you for joining us today. Your full statements will appear in the record of the Committee.

Mr. Blake, will you please begin with your testimony.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Chairman Akaka. On behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today on the proposed health care legislation. Due to the number of bills on the agenda, I will limit my comments to just a few issues.

While PVA appreciates the concepts outlined in S. 2573, the Veterans Mental Health Treatment First Act, we oppose this proposed legislation. We believe that this legislation draws attention to a concept that the VA ought to be focused primarily on already—the health and wellness of sick and disabled veterans. But, this focus should not be at the expense of the veteran.

We cannot argue with the importance of proper and effective treatment to address the mental health issues that veterans may face. However, we are concerned with the fact that the legislation requires the veteran to delay his or her right to file a claim while participating in the program. While we can certainly see the benefit of a veteran participating in a comprehensive treatment program, we see no reason why he or she should not still be able to file a claim concurrently. Otherwise, the process simply is delayed a year. And while we understand the argument that a veteran would receive a stipend under this program, we do not believe that this is an acceptable method of offsetting the broad range of benefits along with compensation associated with an adjudicated claim.

PVA supports the provisions of S. 2797 that establish funding authorizations for construction projects in fiscal year 2009. We were pleased to see that significant dollars are being authorized to fi-

nally address the problems with the health care facility in Puerto Rico. PVA has been particularly involved with this project to ensure that a quality spinal cord injury center is maintained at this medical facility.

We are also particularly pleased to see that funding is authorized for the replacement hospital in Denver, Colorado. Since the inception of the CARES process a number of years ago, we have advocated for this replacement facility and a co-located SCI center to serve the veterans of the Trans-Mountain Region. Our architects have been working with VA staff in developing the design and construction plans for this new facility, which will obviate the needs of veterans with spinal cord injury having to travel to Seattle, Washington, Albuquerque, New Mexico, and Milwaukee, Wisconsin, to receive specialty care.

We ask that the Committee pay particular attention to this project in light of Secretary Peake's press release of April 24, 2008, and the VA's comments here today announcing a reversal of VA's longstanding position to build a new facility on the Fitzsimmons Campus and replace it with leased and shared space in a new tower to be constructed by the University of Colorado and the University of Colorado Hospital. A similar proposal was rejected by then-Secretary Anthony Principi a number of years ago, who found that a freestanding, exclusive VA facility was the most appropriate approach to meeting the health care needs of veterans in this region.

We ask the Committee to ensure that this project moves forward as planned as a unique, freestanding, tertiary care VA replacement hospital. Allowing the VA to move forward in the manner that Secretary Peake outlined recently could prove detrimental to all veterans in the Trans-Mountain Region, particularly those with specialty health care needs.

PVA strongly supports S. 2926, the Veterans Nonprofit Research and Education Corporations Enhancement Act. The purpose of this legislation is to modernize and clarify the existing statutory authority for VA-affiliated nonprofit research and education corporations, NPCs. This bill will allow the NPCs to fulfill their full potential in supporting VA research and education, which ultimately results in improved treatments and high-quality care for veterans while ensuring VA and Congressional confidence in NPC management.

PVA has been a strong supporter of the NPCs since their inception, recognizing that they benefit veterans by increasing the resources available to support the VA research program and to educate VA health care professionals. We urge expeditious passage of S. 2926 so that veterans may benefit even more from the enhancements and operational capabilities and oversight that this bill provides.

Mr. Chairman, I would like to thank you again for the opportunity to testify. I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Chairman Akaka, Ranking Member Burr, and Members of the Committee, on behalf of Paralyzed Veterans of America (PVA) I would like to thank you for the opportunity to testify today on the proposed health care legislation. The scope of health care issues being considered here today is very broad. We appreciate the Committee taking the time to address these many issues, and we hope that out of this process meaningful legislation will be approved to ensure veterans receive the best health care available from the VA.

S. 2273, THE "ENHANCED OPPORTUNITIES FOR FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING ACT"

PVA supports S. 2273, the "Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act." Homelessness has proven to be a major problem among the men and women who have served in uniform. While estimates vary, it is believed that as many as 250,000 veterans are on the street in any given night. This fact seems incomprehensible in light of the sacrifices that these men and women have made.

The proposed legislation establishes a pilot program to provide grants to up to ten qualifying entities for a period of 5 years. These grants will be awarded to public and non-profit organizations to coordinate the provision of supportive services that exist in the local community. The target within the veteran population for this program will be those veterans that have previously participated in the Homeless Providers Grant and Per Diem Program. When a veteran achieves the goals within the program, he or she is ready to move into a more permanent living environment. However, in many situations the veteran will still need supportive services to accompany their housing needs as they progress toward a goal of self-sufficiency. These entities can then coordinate supportive services such as continued case management, counseling, job training, transportation, and child care services. By addressing each of these issues, the veteran stands a better chance of getting off of the street and living a productive life once again.

S. 2377, THE "VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT"

PVA supports S. 2377, the "Veterans Health Care Quality Improvement Act." We certainly appreciate the underlying intent of this bill which is to ensure that the health care provided by the VA is the very best available. Section 2 of the legislation defines standards that must be met for physicians to practice in the VA. It requires the disclosure of certain information pertaining to the past performance of a physician and requires the Director of each Veterans Integrated Service Network (VISN) to investigate any past disciplinary or medical incompetence issues of physicians to be hired.

PVA supports Section 3 of S. 2377 that requires the Under Secretary for Health to designate a national quality assurance officer and a quality assurance officer for each VISN. This establishes a quality-assurance program for the health care system and provides a method for VA health care workers to report incidents of inconsistency. We believe that one of the keys to high quality health care services is an affective quality assurance program. This program could be beneficial for improving accountability within the health care system.

We likewise support Section 4 of the legislation that offers incentives to attract physicians to work in the VA health care system. It also encourages the VA to recruit part time physicians from local medical schools. PVA has expressed concern in the past that the VA is struggling to attract high quality physicians, particularly to specialized services like spinal cord injury care, blind rehabilitation, and mental health.

S. 2383

PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas. These veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through community-based outpatient clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings.

PVA has no objection to the proposal for a pilot program to use mobile systems in not less than three VISNs. However, the one caution we would offer is that services provided in this manner tend to be more expensive and less cost-effective. We believe that mobile services tend to be much more cost-effective in areas where a

large segment of the target population can be served because it drives down the overall cost-per-patient. In other words, the VA could potentially get more "bang for its buck" by having a mobile clinic set up in the downtown area of a major city where an existing medical facility may be beyond capacity.

Furthermore, we are concerned about how these mobile centers will be staffed. The legislation calls for VA physicians, nurses, and mental health specialists, case workers, benefits counselors, and any other personnel deemed appropriate to staff the mobile clinic. While we fully agree with these staffing guidelines, given the difficulty in hiring many of these professionals already, particularly nurses and mental health professionals, we remain skeptical about the ability of the VA to meet this requirement. We are also concerned about the ability of these clinics to meet the needs of women veterans—a segment of the veteran population that is rapidly growing, particularly in rural areas where National Guard and Reserve units are returning.

Finally, one last suggestion that we would like to offer is that each of these mobile clinics should be accessible for persons with disabilities. There are many disabled veterans who might like to take advantage of these mobile services, and it would be a real disservice to them if they are unable to visit one of these clinics because it is inaccessible.

S. 2573, THE "VETERANS MENTAL HEALTH TREATMENT FIRST ACT"

While PVA understands the concepts outlined in S. 2573, the "Veterans Mental Health Treatment First Act," we oppose this proposed legislation. We believe that this legislation tries to draw attention to a concept that the VA ought to be focused on already—the health and wellness of sick and disabled veterans. But this focus should not be at the expense of the veteran. We cannot argue with the importance of proper and effective treatment to address the mental health issues that veterans may face. However, we believe this legislation would simply force near term treatment on veterans in order to save the VA, and by extension the Federal Government, money paid out in compensation in the long term.

First, we would point out that the legislation calls for a "pre-evaluation" of the veteran exhibiting symptoms of Post Traumatic Stress Disorder (PTSD) to determine if the condition might be related to his or her service. This implies a step not unlike the disability claims process should already be taking. Furthermore, it calls for the Secretary to prescribe regulations dictating what constitutes a relationship to military service—a concept already addressed in Title 38 U.S.C. and the Code of Federal Regulations.

Second, the legislation requires the veteran to delay his or her right to file a claim while participating in the program. While we can certainly see the benefit of a veteran participating in a comprehensive treatment program, we see no reason why he or she should not still be able to file a claim concurrently. Otherwise, the process simply is delayed a year. And while we understand the argument that a veteran would receive a stipend under this program, we do not believe that this is an acceptable method of offsetting the broad range of benefits, along with compensation, associated with adjudication of a claim. Furthermore, depriving a veteran of his or her entitlement to compensation may actually have the unintended effect of providing a financial disincentive to participate in rehabilitation and treatment.

S. 2639, THE "ASSURED FUNDING FOR VETERANS HEALTH CARE ACT"

PVA supports S. 2639, the "Assured Funding for Veterans Health Care Act," introduced by Senator Tim Johnson. Despite the fact that Congress has taken significant steps in the last couple of years to address the funding needs of the VA, the appropriations process still puts the VA at a significant disadvantage each year. For 13 of the past 14 years, the VA appropriations bill was not passed before the start of the new fiscal year on October 1. In fact, on several occasions, the VA appropriations bill was not passed before the start of the new calendar year, leaving the VA to react accordingly. We certainly appreciate the efforts Congress has made recently to provide adequate funding for the VA. However, the current process has only met one of the goals we have established for funding the VA health care system—sufficiency, timeliness, and predictability.

We believe that it is time for Congress to truly debate alternative funding mechanisms to provide for the needs of the VA health care system. As such, S. 2639, is one of those alternatives that we believe can be effective. Unfortunately, some members in both the Senate and House have opposed mandatory funding because it would be too costly; however, a Congressional Research Service report provided to Congress last year detailing the running expenditures for the Global War on Terror

since September 11, 2001, revealed that Veterans Affairs-related spending constitutes 1 percent of the government's total expenditure since that date.

Without question, there is a high cost for war, and caring for our Nation's sick and disabled veterans is part of that continued cost. A report by a researcher at Harvard's Kennedy School of Government predicted that Federal outlays for veterans of the wars in Afghanistan and Iraq would arc between $350 billion and $700 billion over their life expectancies following military service—an amount in addition to what the Nation already spends for previous generations of veterans. Thus, it is clear the government will be spending vast sums in the future to care for veterans, to compensate them for their service and sacrifice, but these funds will still only constitute a minute fraction of total homeland security and war spending.

Moreover, too much of the opposition to assured funding legislation revolves around myths that simply are not true. Outside of cost, one of the chief complaints about assured funding is that Congress would lose oversight over the VA health care system. This idea is nonsensical at best. Most importantly, funding would be removed from the direct politics and uncertainties of the annual budget-appropriations process, and Congress would still retain oversight of VA programs and health care services—as it does with other Federal mandatory programs.

Some Members of Congress also fear that assured funding would open the VA health care system to all veterans. In fact, the Health Care Eligibility Reform Act of 1996 theoretically opened the VA health care system to all 25 million veterans; however, it was never anticipated that all veterans would seek or need VA health care. Current enrollment figures do not support the notion that veterans will flood the VA health care system. Moreover, the Secretary is required by law to make an annual enrollment decision based on available resources—a fact that has left the VA health care system closed to eligible Category 8 veterans for more than 5 years. This bill would not affect the Secretary's authority to manage enrollment, but would only ensure the Secretary has sufficient funds to treat those veterans enrolled for VA health care.

Finally, as you know, the whole community of national veterans' service organizations strongly supports an improved funding mechanism for VA health care. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

The Partnership for Veterans Health Care Budget Reform is currently working on a proposal for Congress that would change VA's medical care appropriation to an advance appropriation which would provide approval 1 year in advance, thereby guaranteeing its timeliness. Furthermore, by adding transparency to VA's health care enrollee projection model, we can focus the debate on the most actuarially-sound projection of veterans' health care costs to ensure sufficiency. Under this proposal, Congress would retain its discretion to approve appropriations; retain all of its oversight authority; and most importantly, there would be no PAYGO problems.

S. 2796

PVA supports S. 2796, a bill that establishes a pilot program to facilitate the use of community-based organizations to ensure that veterans receive the care and benefits that they have earned and deserve. The program will be carried out in five selected locations by providing grants to community-based organizations with the goal of providing information and outreach in rural areas and areas that have a high proportion of minority veterans. This offers an excellent opportunity for the VA to ensure that current information pertaining to available benefits for the veterans and their families is available in previously underserved geographic areas.

S. 2797, CONSTRUCTION AUTHORIZATION

PVA supports the provisions of S. 2797 that establishes funding authorizations for construction projects in fiscal year 2009. We are pleased to see that significant dollars are being authorized to finally address the problems with the health care facility in Puerto Rico. PVA has been particularly involved with this project to ensure that a quality spinal cord injury (SCI) center is maintained at this medical facility.

We are also particularly pleased to see that funding is authorized for the replacement hospital in Denver, Colorado. Since the inception of the CARES process a number of years ago we have advocated for this replacement facility and a co-located SCI center to serve the veterans of the trans-mountain region. Our architects have been working with VA staff in developing the design and construction plans for this new facility which will obviate the need of veterans with spinal cord injury having to travel to Seattle, WA, Albuquerque, NM or Milwaukee, WI to receive needed care.

We ask that the Committee pay particular attention to this project in light of Secretary Peake's press release of April 24, 2008, announcing a reversal of VA's longstanding position to build a new facility on the Fitzsimmons campus and replace it with leased and shared space in a new tower to be constructed by the University of Colorado and the University of Colorado Hospital. A similar proposal was rejected by then-Secretary Anthony Principi a number of years ago who found that a free-standing, exclusive VA facility was the most appropriate approach to meeting the health care needs of veterans in this region. We ask the Committee to ensure that this project moves forward, as planned as a unique, free-standing tertiary care VA replacement hospital. Allowing the VA to move forward in the manner that Secretary Peake outlined recently could prove detrimental to all veterans in the transmountain region, particularly those with specialized health care needs.

S. 2799, THE "WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT"

PVA supports S. 2799, the "Women Veterans Health Care Improvement Act." This legislation is meant to expand and improve health care services available in the Department of Veterans Affairs (VA) to women veterans, particularly those who have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). More women are currently serving in combat theaters than at any other time in history. As such, it is important that the VA be properly prepared to address the needs of what is otherwise a unique segment of the veteran population.

Title I of the bill would authorize a study that would evaluate the health care needs of women veterans and the services that are currently available to women veterans through the VA. Furthermore, it would also authorize a study to identify barriers and challenges that women veterans face when seeking health care from the VA. We believe each of these studies and assessments can only lead to higher quality care for women veterans in the VA. They will allow the VA to dedicate resources in areas that it must improve upon.

Title II of the bill would target special care needs that women veterans might have. Specifically, it would ensure that VA health care professionals are adequately trained to deal with the complex needs of women veterans who have experienced sexual trauma. Furthermore, it would require the VA to develop and implement a program of education, training, and certification for health care professionals for the treatment, including evidence-based treatment, of Post Traumatic Stress Disorder (PTSD) and other co-morbid conditions that are proven effective for women veterans. While many veterans returning from OEF/OIF are experiencing symptoms consistent with PTSD, women veterans are experiencing unique symptoms also consistent with PTSD. It is important that the VA understand these potential differences and be prepared to provide care.

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

S. 2824

PVA generally supports the provisions of S. 2824, a bill that would improve the collective bargaining rights and procedures for review of adverse actions for certain health care professionals in the VA. These changes would be a positive step in addressing the recruitment and retention challenges the VA faces to hire key health care professionals, particularly registered nurses (RN), physicians, physician assistants, and other selected specialists.

As we understand current practice, certain specific positions (including those mentioned previously) do not have particular rights to grieve or arbitrate over basic workplace disputes. This includes weekend pay, floating nurse assignments, mandatory nurse overtime, mandatory physician weekend and evening duty, access to survey data for setting nurse locality pay and physicians' market pay, exclusion from groups setting physicians' market pay, and similar concerns. This would seem to allow VA managers to undermine Congressional intent from law passed in recent years to ensure that nurse and physician pay are competitive with the private sector and to ensure nurse work schedules are competitive with local markets.

Interestingly, given the VA's interpretation of current laws, these specific health care professionals are not afforded the same rights as employees who they work side-by-side with everyday. For instance, Licensed Practicing Nurses (LPN) and Nursing Assistants (NA) can challenge pay and scheduling policies, while RN's cannot. This simply makes no sense to us.

S. 2889, THE "VETERANS HEALTH CARE ACT"

PVA generally supports the provisions of Section 2 of the proposed S. 2889, the "Veterans Health Care Act." This new section is consistent with the other authorities granted under Section 1720 of Title 38. It is important that if the VA chooses to use this authority, then appropriate facilities are chosen to reflect the age and complexity of the issues being faced by Operation Enduring Freedom and Operation Iraqi Freedom veterans.

Likewise, we support Section 4 of the proposed bill that would prohibit the VA from collecting co-payments from veterans receiving hospice care whether in an inpatient or outpatient setting. As we recall, the VA actually supported similar legislation during the 109th Congress. This legislation only makes sense as it will align with current statute that prevents VA from collecting co-payments from veterans receiving hospice care in a nursing home setting.

S. 2899, THE "VETERANS SUICIDE STUDY ACT"

The incidence of suicide among veterans, particularly Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans, is a serious concern that needs to be addressed. Any measure that may help reduce the incidence of suicide among veterans is certainly a good thing. As such, PVA supports this legislation. This bill would require the VA to conduct a study to determine the number of veterans who have committed suicide since January 1, 1997.

It is important to note that VA has made suicide prevention a major priority. VA has developed a broad program based on increasing awareness, prevention, and training of health care staff to recognize suicide risk. A national suicide prevention hotline has been established and suicide prevention coordinators have been hired in each VA medical center. Research into the risk factors associated with suicide in veterans and prevention strategies is underway.

However, it is equally important to point out that suicide prevention is something that can be addressed early on in the mental health process. With access to quality psychiatric care and other mental health professionals, many of the symptoms experienced early on can be addressed in order to reduce the risk of suicide down the road. This extends to proper screening and treatment for veterans who deal with substance abuse problems as well.

S. 2921, THE "CARING FOR WOUNDED WARRIORS ACT"

PVA fully supports the provisions of S. 2921, the "Caring for Wounded Warriors Act." The provisions of this legislation are consistent with recommendations included in *The Independent Budget* for fiscal year 2009. The difficulties being faced by caregivers—whether family, friend, or professional caregiver—have been documented in recent years as more men and women return from Operation Enduring Freedom and Operation Iraqi Freedom severely injured. Perhaps, no organization understands the importance of caregiver assistance more than Paralyzed Veterans of America. A substantial number of our members rely on caregivers to function daily.

A certification and training program for caregivers, as outlined in Section 2 of the bill, could be a vital tool for ensuring severely injured veterans receive the care they need. It will help them learn to cope with the tremendous stress that they, as caregivers, must deal with while simultaneously providing care. This is why PVA, in conjunction with *The Independent Budget*, has previously called on Congress to formally authorize, and for VA to provide, a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans. Moreover, *The Independent Budget* calls for the VA to "establish a pilot program immediately for providing severely disabled veterans and family members residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans." We particularly appreciate the specific provision that allows for compensation of caregivers who take part in the training program.

We would like to make a couple of suggestions as it relates to the pilot program authorized in Section 2 of the legislation. First, these services should not be limited only to caregivers who assist veterans who have experienced Traumatic Brain Injury. There are many veterans of the current conflict, and previous conflicts, who have experienced equally severe injuries and diseases. Second, the certification program should not be limited to families as defined by the legislation. There are many willing caregivers and paid personal care attendants out there who do not necessarily meet the strict criteria of the definition in the bill, but who could equally benefit from this legislation.

PVA likewise supports the authorization of a pilot program for respite care as outlined in Section 3 of the proposed bill. As with Section 2, we do not believe that the provisions of Section 3 should be limited to veterans who have incurred a Traumatic Brain Injury. Moreover, we do not believe that the relationship established by this legislation should be limited to graduate-level students. As stated in *The Independent Budget* for fiscal year 2009.

> The *IBVSO*s believe VA should establish a new national program to make periodic respite services available to all severely injured veterans. This program should be designed to meet the needs of younger severely injured or ill veterans, in contrast to the generally older veteran population now served by VA programs. Where appropriate VHA services are not available because of geographic barriers, the VHA should develop contractual relations with appropriate, qualified private or other public facilities to provide respite services tailored to this population's needs.

Finally, as this Committee moves forward with deliberations on how best to provide services to the caregivers and families of severely injured veterans it may be worth reviewing VA progress regarding Section 214 of Public Law 109–461. Section 214 required VA to implement a pilot program to assess and improve caregiver assistance services. Public Law 109–461 required the VA Secretary to carry out the pilot over a 2-year period within 120 days following enactment of Public Law 109–461. Caregiver assistance referred to VA services that would assist caregivers such as:

- Adult-day care.
- Coordination of services needed by veterans, including services for readjustment and rehabilitation.
- Transportation services.
- Caregiver support services, including education, training, and certification of family members in caregiver activities.
- Home care services.
- Respite care.
- Hospice services and other modalities of non-institutional VA long-term care.

S. 2926, THE "VETERANS NONPROFIT RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT"

PVA strongly supports S. 2926, the "Veterans Nonprofit Research and Education Corporations Enhancement Act." The purpose of this legislation is to modernize and clarify the existing statutory authority for VA-affiliated nonprofit research and education corporations (NPCs). This bill will allow the NPCs to fulfill their full potential in supporting VA research and education, which ultimately results in improved treatments and high quality care for veterans, while ensuring VA and congressional confidence in NPC management.

Since passage of Public Law 100–322 in 1988 (codified at 38 U.S.C. § 7361–7368), the NPCs have served as an effective "flexible funding mechanism for the conduct of approved research and education" performed at VA medical centers across the Nation. NPCs provide VA medical centers with the advantages of on-site administration of research by nonprofit organizations entirely dedicated to serving VA researchers and educators, but with the reassurance of VA oversight and regulation. During 2007, 85 NPCs received nearly $230 million and expended funds on behalf of approximately 5,000 research and education programs, all of which are subject to VA approval and are conducted in accordance with VA requirements.

NPCs provide a full range of on-site research support services to VA investigators, including assistance preparing and submitting their research proposals; hiring lab technicians and study coordinators to work on projects; procuring supplies and equipment; monitoring the VA approvals; and a host of other services so the principal investigators can focus on their research and their veteran patients.

Beyond administering research projects and education activities, when funds permit, these nonprofits also support a variety of VA research infrastructure expenses. For example, NPCs have renovated labs, purchased major pieces of equipment, staffed animal care facilities, funded recruitment of clinician-researchers, provided seed and bridge funding for investigators, and paid for training for compliance personnel.

Although the authors of the original statute were remarkably successful in crafting a unique authority for VA medical centers, differing interpretations of the wording and the intent of Congress, gaps in NPC authorities that curtail their ability to fully support VA research and education, and evolution of VA health care delivery systems have made revision of the statute increasingly necessary in recent

years. S. 2926 contains revisions that will resolve all of these and will allow the NPCs to better serve VA research and education programs while maintaining the high degree of oversight applied to these nonprofits.

The legislation reinforces the idea of "multi-medical center research corporations" which provides for voluntary sharing of one NPC among two or more VA medical centers, while still preserving their fundamental nature as medical center-based organizations. Moreover, accountability will be ensured by requiring that at a minimum, the medical center director from each facility must serve on the NPC board. This authority will allow smaller NPCs to pool their administrative resources and to improve their ability to achieve the level of internal controls now required of nonprofit organizations.

The legislation also clarifies the legal status of the NPCs as private sector, tax exempt organizations, subject to VA oversight and regulation. It also modernizes NPC funds acceptance and retention authorities as well as the ethics requirements applicable to officers, directors and employees and the qualifications for board membership. Moreover, it clarifies and broadens the VA's authority to guide expenditures.

PVA has been a strong supporter of the NPCs since their inception, recognizing that they benefit veterans by increasing the resources available to support the VA research program and to educate VA health care professionals. We urge expeditious passage of S. 2926 so that veterans may benefit even more from the enhancements in operational capabilities and oversight that this bill provides.

S. 2937

PVA fully supports the provisions of S. 2937, a bill that provides permanent treatment authority for participants in Department of Defense chemical and biological testing conducted by Deseret Test Center and an expanded study of the health impact of Project Shipboard Hazard and Defense (SHAD). The impact of these tests conducted during World War II and subsequent years has only become more evident in recent years. Given the hardships that these men endured then, it is only appropriate that they receive adequate care now.

S. 2963

PVA generally supports the provisions of S. 2963, a bill to enhance mental health services for servicemembers and veterans. We believe that the scholarship program outlined in Section 1 of the bill is an innovative way for the VA to fill important professional positions in behavioral specialties. With growing demand on the VA to be able to meet the behavioral health needs of the men and women returning from Iraq and Afghanistan, this scholarship program can help the VA better address that demand.

PVA has no objection to allowing servicemembers who served in Operation Enduring Freedom or Operation Iraqi Freedom to receive readjustment counseling and mental health services at Vet Centers as called for in Section 2 of the legislation. Vets Centers are the frontline access point for these men and women to seek care in the VA. It only makes sense to afford these men and women this opportunity. Furthermore, this provision continues the move to open certain benefits and services to servicemembers who have not become veterans yet.

Likewise, PVA has no objection to Section 4 of the legislation that would allow for suicide of a former member of the Armed Forces that occurs during the 2-year period beginning on the date of the separation or retirement from the military to be treated as a death in the line of duty. This consideration is contingent upon the requirement that the servicemember have a medical history of combat-related mental illness, Post Traumatic Stress Disorder (PTSD), or Traumatic Brain Injury. Our only caution is that for the purposes of this legislation, medical history should be defined as having a clinical diagnosis. With the considerations of this provision, the surviving spouse or beneficiary of the servicemember would then be eligible for certain benefits. This legislation is extremely important in light of the ever-increasing incidence of suicide, particularly among OEF/OIF veterans.

S. 2969, THE "VETERANS' MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT"

Overall, PVA is extremely supportive of the Committee's efforts to enhance VA's ability to recruit and retain valuable health-care professionals through the provisions of S. 2969, the "Veterans' Medical Personnel Recruitment and Retention Act." As you are aware, the Nation is experiencing critical shortages of invaluable health care professionals, particularly registered nurses (RN), registered nurse anesthetists, physical and occupational therapists, speech pathologists, pharmacists and physicians.

We particularly appreciate the focus on enhancement of VA's ability to recruit and retain RN's. However, we would like to ask the Committee to consider extending the specialty pay provisions of S. 2969 to include nurses providing care in VA's specialized service programs, such as spinal cord injury/disease (SCI/D), blind rehabilitation, mental health and brain injury.

Veterans who suffer spinal cord injury and disease require a cadre of specialty trained registered nurses to meet their complex initial rehabilitation and life-long sustaining medical care needs. PVA's data reveals a critical shortage of registered nurses who are providing care in VA's SCI/D system of care. The complex medical and acuity needs of these veterans makes providing care for them extremely difficult and demanding. These care conditions become barriers to quality registered nurse recruitment and retention. Many of VA's SCI/D nurses are often forced onto light duty status because of injuries they sustain in their daily tasks. This situation has become a significant problem because it puts additional strain on those SCI/D nurses without medical problems to meet patient needs. PVA believes SCI/D specialty pay is absolutely necessary if nurse shortages are to be overcome in this VA critical care area. We are eager to assist the Committee staff in developing legislative language that will create specialty pay for VA nurses working in these critical care areas.

With regards to specific provisions of the legislation, PVA supports the provision to eliminate a duplicative probationary period for a part-time VA nurse who previously completed the required probationary period when in a full-time status. We also support the exemption for Certified Registered Nurse Anesthetists from limitation on authorized competitive pay. These nurse specialists are in short supply and competition is keen for their services. We believe this provision could improve recruitment and retention efforts. Likewise, PVA supports eligibility of part-time nurses for additional nurse pay and the increased limitation on special pay for nurse executives from $25,000 to $100,000.

PVA congratulates the Committee on its aggressive efforts to enhance VA's capacity to recruit and retain scarce health care professionals. We especially appreciate your consideration of providing specialty pay for VA registered nurses serving in VA SCI/D Centers and in other specialized care units.

S. 2984, THE "VETERANS' BENEFITS ENHANCEMENT ACT"

PVA has no particular position on most of the provisions of Title III of S. 2984, the "Veterans' Benefits Enhancement Act." We do have concerns however about Section 304 of the proposed legislation. As we understand the bill, this section would repeal two reports that are required of the VA. The first report is an annual nurse pay report that is meant to be submitted to the House and Senate Committees on Veterans' Affairs. According to Title 38, this report shall set forth, by health-care facility, the percentage of such [pay] increases [to nurses] and, in any case in which no increase was made, the basis for not providing an increase. We wonder what the motivation is for eliminating this reporting requirement. It seems that the information garnered from the Nurse Pay Report could be helpful in addressing hurdles that exist when hiring nurses.

We are equally concerned about the repeal of the requirement to submit a report to Congress outlined in Section 8107, Title 38 U.S.C. Current statute states: "In order to promote effective planning for the efficient provision of care to eligible veterans, the Secretary, based on the analysis and recommendations of the Under Secretary for Health, shall submit to each committee an annual report regarding long-range health planning of the Department." More importantly it states that the report should include: "A 5-year strategic plan for the provision of care under chapter 17 of this title to eligible veterans through coordinated networks of medical facilities operating within prescribed geographic service-delivery areas, such plan to include provision of services for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) through distinct programs or facilities of the Department dedicated to the specialized needs of those veterans."

By repealing this report, it seems that this would allow the VA to conduct its construction planning without any transparency for key stakeholders—specifically the House and Senate Committees on Veterans' Affairs. We hope that the Committee will investigate the intent behind the repeal of these two reports and consider eliminating these provisions from the proposed legislation.

PVA appreciates the efforts of this Committee to improve the health care services available to the men and women who have served and sacrificed so much for this country. We look forward to working with you to ensure that meaningful changes are made to best benefit veterans.

Thank you again for the opportunity to testify. I would be happy to answer any questions that you might have.

Chairman AKAKA. Thank you very much, Mr. Blake.

Mr. Wilson?

STATEMENT OF JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. WILSON. Chairman Akaka, thank you for this opportunity to present the American Legion's views on the several pieces of legislation being considered by you today. The American Legion commends the Committee for holding a hearing to discuss these very important and timely issues. Due to the time constraint, I will discuss 4 of the 17 pieces of legislation. They include S. 2383, S. 2797, S. 2573, and S. 2963.

S. 2383, this bill seeks to implement a pilot program on the mobile provision of care and services for veterans in rural areas by the Department of Veterans Affairs. As veterans of Operation Iraqi Freedom and Operation Enduring Freedom, or OIF and OEF, return from the perils of combat, they continue to be plagued physically and mentally by the effects of their previous environment, to include improvised explosive devices, or IEDs, with its major catalyst—automobiles—being a sign of impending danger to veterans. Returning to an environment where this sign of danger is in abundance, veterans are migrating to more rural areas to avoid residing in the vicinity of these populated areas that contain automobiles.

In Section 1(c)(1), the legislation suggests that the pilot program be carried out in no less than three Veterans Integrated Service Networks, or VISNs. In Section 1(c)(2), subtitled "Locations," it states that the pilot program shall be carried out in one or more rural areas in each VISN. The legislation also requests that the Secretary shall take into account the number of veterans residing in or near an area and the difficulty of access of such veterans to the nearest VA medical facility. The American Legion will also ask that all veterans and VISNs be kept in mind during the planning of the pilot program's locations to ensure success. The American Legion supports this piece of legislation.

S. 2573, this bill seeks to require a program of mental health care and rehabilitation for veterans for service-related Post Traumatic Stress Disorder (PTSD), depression, anxiety disorder, or related substance abuse disorder, and for other purposes. The American Legion is opposed to the provisions of this legislation that restrict a veteran's right to file disability claims for both service connection and increased ratings for PTSD, depression, anxiety disorder, or related substance abuse disorder in order to be eligible for participation in the treatment and rehabilitation program prescribed under this legislation.

Limiting or restricting a veteran's right to pursue disability benefits in order to be eligible for treatment, despite a monetary stipend available to those who agree to such conditions for treatment purposes, appears to be based on an assumption that pursuing a disability claim somehow hinders the treatment process. As there is no evidence, scientific or otherwise, to support such an assumption, the American Legion cannot support such provisions as set forth in

this legislation. Moreover, such a restriction would set an unacceptable precedent that could be applied to other conditions or disabilities and compensation claims.

S. 2797, this bill seeks to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 2009. The American Legion supports the continued push to uphold the 2004 Capital Asset Realignment for Enhanced Services, or CARES, decision and urges Congress to appropriate adequate funds to ensure these projects aren't ignored.

S. 2963, a bill to improve and enhance the mental health care benefits available to members of the Armed Forces and veterans and to enhance counseling and other benefits available to survivors of members of the Armed Forces and veterans. Section 2 discusses the eligibility of members of active duty Armed Forces who serve in OEF/OIF for counseling and services through Vet Centers. The mission of Vet Centers is to provide professional readjustment counseling to veterans and their families.

Section 3 discusses restoration of authority of Vet Centers to provide referral and other assistance upon request of former members of the Armed Forces not authorized counseling. Due to current repeated deployments to the combat zone in Iraq and Afghanistan, the American Legion believes it is essential for VA and the Department of Defense, or DOD, to continue to collaborate to improve the continuum of care for those on active duty who would eventually become veterans. Early intervention by Vet Centers may help to alleviate the more debilitating onset of mental health conditions, thereby further assisting in the transition process from active duty to veteran status, and, ultimately, reintegration into the community.

Again, thank you, Mr. Chairman, for allowing the American Legion this opportunity to present its views on the above-mentioned issues. We look forward to working with the Committee to help increase and improve access to quality care for our Nation's veterans.

[The prepared statement of Mr. Wilson follows:]

PREPARED STATEMENT OF JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

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

S. 2273, ENHANCED OPPORTUNITIES FOR FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING ACT OF 2007

This bill seeks to enhance the functioning and integration of formerly homeless veterans who reside in permanent housing by providing outreach to low income and elderly veterans and their families who reside in rural areas; establish new, or expand existing programs to furnish transportation, childcare, and clothing assistance to certain individuals with service-related disabilities who are entitled to a rehabilitation program.

While permanent housing provides a stable base for veterans and their families the need for resources to improve their way of life is just as important. The American Legion supports such pilot programs that provide much needed resources to public and private sector agencies and organizations to aid homeless veterans and their families. These funded pilot programs will extend more opportunities for formerly homeless veterans, which in turn allow them to achieve and maintain a quality existence, deserving of their service to our country. The American Legion sup-

ports the Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act of 2007.

S. 2377, VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT

This bill seeks to amend title 38, United States Code, by improving the quality of care provided to veterans in Department of Veterans Affairs (VA) medical facilities; and to encourage highly qualified doctors to serve in hard-to-fill positions in such medical facilities.

The American Legion believes medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology. When implementing this bill The American Legion encourages VA to continue to strengthen its affiliation with surrounding medical schools in order to recruit and retain highly qualified doctors who are already accustomed to the VA environment.

The American Legion also believes VA should be able to offer incentives to new hires and employees who maintain certifications or can document on-going training in these areas above and beyond hospital credentialing and privileging processes. The American Legion supports the Veterans Health Care Quality Improvement Act.

S. 2383, MOBILE SUPPORT FOR RURAL VETERANS PROGRAM

This bill seeks to implement a pilot program on the mobile provision of care and services for veterans in rural areas by the Department of Veterans Affairs. As veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) return from the perils of combat, they continue to be plagued physically and mentally by the effects of their previous environment, to include Improvised Explosive Devices (IED's); with its major catalysts, automobiles, being a sign of impending danger, the veteran, returning to an environment where this "sign" of danger is in abundance, veterans are migrating to more rural areas to avoid residing in the vicinity of these populated areas that contain automobiles.

In section 1(c)1 the legislation suggests that the pilot program be carried out in no less than three Veterans Integrated Service Networks (VISN). In section 1(c)2, subtitled, "Locations," it states the pilot program shall be carried out in one or more rural areas in each VISN. The legislation also requests that the Secretary shall take into account the number of veterans residing in or near an area; and the difficulty of access of such veterans to the nearest VA medical facility.

The American Legion would also ask that all veterans and VISNs be kept in mind during the planning of the pilot program's locations to ensure success. The American Legion supports this piece of legislation.

S. 2573, VETERANS MENTAL HEALTH TREATMENT FIRST ACT

This bill seeks to require a program of mental health care and rehabilitation for veterans for service-related Post Traumatic Stress Disorder (PTSD), depression, anxiety disorder, or a related substance use disorder, and for other purposes.

The American Legion is opposed to the provisions of this legislation that restrict the veteran's right to file disability claims for both service connection and increased ratings for PTSD, depression, anxiety disorder, or a related substance abuse disorder, in order to be eligible for participation in the treatment and rehabilitation program prescribed under this legislation.

Limiting or restricting a veteran's right to pursue disability benefits in order to be eligible for treatment, despite a monetary stipend available to those who agree to such conditions for treatment purposes, appears to be based on an assumption that pursuing a disability claim somehow hinders the treatment process. As there is no evidence, scientific or otherwise, to support such an assumption, The American Legion cannot support such provisions as set forth in this legislation. Moreover, such a restriction would set an unacceptable precedent that could be applied to other conditions/disabilities and compensation claims.

S. 2639, ASSURED FUNDING FOR VETERANS HEALTH CARE

This bill seeks to provide an adequate level of assured funding for veterans health care. The American Legion supports this bill.

S. 2796, COMMUNITY-BASED ORGANIZATION PILOT PROGRAMS

This bill seeks to create a pilot program to evaluate the use of community-based organizations to provide veterans the care and benefits they have earned. The American Legion affirms its support for the continued development of community

based programs that meet established criteria as a means of improving veterans' access to high quality health care services in the most appropriate setting.

S. 2797, BILL TO AUTHORIZE MAJOR MEDICAL FACILITY PROJECTS AND MAJOR FACILITY LEASES

This bill seeks to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 2009. The American Legion supports the continued push to uphold the 2004 Capital Asset Realignment for Enhanced Services (CARES) decision and urges Congress to appropriate adequate funds to ensure these projects aren't ignored.

S. 2799, WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2008

This bill seeks to expand and improve health care services available to women veterans from VA, to include those serving in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). Women veterans have unique needs to include gender-specific physical care and mental health treatment for Military Sexual Trauma (MST).

S. 2799 will also provide extensive outreach to those unaware of the various programs available to assist women veterans with a proper transition back into their respective communities. The American Legion fully supports this piece of legislation.

S. 2824, A BILL TO AMEND TITLE 38, U.S.C. BY IMPROVING THE COLLECTIVE BARGAINING RIGHTS AND PROCEDURES FOR REVIEW OF ADVERSE ACTIONS OF CERTAIN EMPLOYEES OF VA

The American Legion has no position on this bill.

S. 2889, VETERANS HEALTH CARE ACT OF 2008

The American Legion supports the provisions of this bill which seeks to improve veterans' health care benefits.

Sec. 2 discusses community treatment plans for veterans who suffer from a Traumatic Brain Injury, has an accumulation of deficits in activities of daily living and instrumental activities of daily living, and who, because of these deficits, would otherwise require admission to a nursing home even though such care would generally exceed the veteran's nursing needs. It allows the Secretary of VA to contract with the appropriate entities to provide specialized residential care and rehabilitation services to accommodate veterans of OEF/OIF who are experiencing the aforementioned.

The American Legion believes this is an extremely vital factor in the continuum of care process because it would provide veterans an appropriate form of care that would be most attentive to their needs. It would also be the most conducive for reintegration back into the community. We concur with such proposals that seek to provide convenient access, as well as quality specialized residential care and rehabilitation services to our Nation's veterans.

Sec. 4 discusses copayment exemption for hospice care following nursing home care and medical services.

Sec. 8 discusses an increase in rates of disability compensation and dependency and indemnity compensation. The American Legion supports this adjustment in compensation benefits, to include dependency and indemnity compensation (DIC) recipients. It is extremely essential that Congress annually considers the economic needs of disabled veterans and their survivors and provides an appropriate cost-of-living adjustment to their benefits.

S. 2899, VETERANS SUICIDE STUDY ACT

This bill seeks to direct the Secretary of Veterans Affairs to conduct a study on suicide among veterans. VA reported that approximately 18 suicides among the veteran population of 25 million occur daily. In light of the increasing number of veterans taking their own lives, the demand for outreach is paramount. Outreach to family members is also important, since family and friends are usually the first to notice changes in the veteran's mental state.

The American Legion continues to urge Congress to increase outreach efforts by assigning suicide prevention counselors to all VA medical facilities.

S. 2921, CARING FOR WOUNDED WARRIORS ACT OF 2008

This bill seeks to implement pilot programs on training and certification for family caregiver personal care attendants for veterans and members of the Armed

Forces with Traumatic Brain Injury, and to require a pilot program on provision of respite care to such veteran and members.

The American Legion believes the proposals of this bill are necessary due to the gradual increase of severely injured veterans of OEF/OIF. Any opportunity to assist family caregivers to provide qualified personal care for their injured family member must be considered. Family caregivers are thrust into their new role as personal care attendants at an extremely stressful time. Providing training and certification to family caregivers will not only improve the abilities of the caregiver, but will benefit the rehabilitation of the injured servicemember. The American Legion fully supports this piece of legislation.

S. 2926, VETERANS NONPROFIT RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT OF 2008

This bill seeks to amend title 38, U.S.C., to modify and update provisions of law relating to nonprofit research and education corporations, and for other purposes.

The American Legion has no position on this bill.

S. 2937, BILL TO PROVIDE PERMANENT TREATMENT AUTHORITY FOR PARTICIPANTS IN DEPARTMENT OF DEFENSE CHEMICAL AND BIOLOGICAL TESTING CONDUCTED BY DESERET TEST CENTER AND AN EXPANDED STUDY OF THE HEALTH IMPACT OF PROJECT SHIPBOARD HAZARD AND DEFENSE (SHAD)

The American Legion supports this piece of legislation. In conducting this study we hereby recommend that all participants in this study consider all new information that surfaces and disclose any new developments related to SHAD in a timely manner. We also urge all involved to ensure that all of the 5,842 participants involved in the tests receive prompt notification of their entitlement to benefits and health care for any ailment that may have resulted from their exposures.

S. 2963, BILL TO IMPROVE AND ENHANCE THE MENTAL HEALTH CARE BENEFITS AVAILABLE TO MEMBERS OF THE ARMED FORCES AND VETERANS, AND TO ENHANCE COUNSELING AND OTHER BENEFITS AVAILABLE TO SURVIVORS OF MEMBERS OF THE ARMED FORCES AND VETERANS

Sec. 2 discusses the eligibility of members of active duty Armed Forces who serve in OEF/OIF for counseling and services through Vet Centers. The mission of Vet Centers is to provide professional readjustment counseling to veterans and their families.

Sec. 3 discusses restoration of authority of Vet Centers to provide referral and other assistance upon request to former members of the Armed Forces not authorized counseling.

Due to current repeated deployments to the combat zone in Iraq and Afghanistan, The American Legion believes it is essential for VA and the Department of Defense (DOD) to continue to collaborate to improve the continuum of care for those on active duty who will eventually become veterans. Early intervention by Vet Centers may help to alleviate the more debilitating onset of mental health conditions, thereby further assisting in the transition process from active duty to veteran status and ultimately reintegration into the community.

S. 2969, VETERANS' MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT OF 2008

This bill seeks to amend title 38, U.S.C., to enhance the capacity of the Department of Veterans Affairs to recruit and retain nurses and other critical health-care professionals, and for other purposes.

The American Legion supports the improvement of VA education-assistance programs for Advanced Practical Nurses (APNs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nursing Assistants by providing incentives such as equitable and competitive wages.

S. 2984, VETERANS' BENEFITS ENHANCEMENT ACT OF 2008, TITLE III

To ensure an accurate response from consensus of The American Legion is presented, we would prefer to respond at a later date.

Again, thank you Mr. Chairman for allowing The American Legion this opportunity to present its views on the aforementioned issues. We look forward to working with the Committee to help increase and improve access to quality care for our Nation's veterans.

Chairman AKAKA. Thank you very much, Mr. Wilson.

Ms. Ilem?

STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. ILEM. Mr. Chairman and Members of the Committee, thank you for the opportunity to present the views of the Disabled American Veterans on health care measures before the Committee today which cover a range of issues important to DAV veterans and their families.

Of the measures being considered, you requested that we direct our oral statement to only three or four bills for which we feel most strongly. The first bill we would like to discuss is S. 2639, the Assured Funding for Veterans Health Care Act. As you are aware, funding reform is a critical issue for DAV and the other VSOs making up the Partnership for Veterans Health Care Budget Reform. Mr. Chairman, DAV supports S. 2639 as a reasonable and responsible means to solve the funding problems experienced by VA.

However, we recognize there is strong opposition by some to mandatory funding. Therefore, we have been developing an alternative approach to achieve the goals of this bill, notably sufficient, timely, and predictable funding while addressing the concerns over pay-go, Congressional oversight, and fiscal responsibility. Our new proposal would shift VA medical care appropriations to a 1-year advanced appropriation and require that VA's health expenditure forecasting model be audited and reported to Congress by GAO.

VA's internal methodology for estimating the cost of providing care to enrolled veterans has become increasingly accurate over the past several years. Historically, VA's budget problems did not occur because of a flawed model, but rather from a flawed budget process. From the time estimates of need are developed to the time the administration's budget is submitted, there are a number of factors that cause changes to the estimate, usually resulting in a less than sufficient budget request sent to Congress.

This new alternative proposal would make VA's data-driven actuarial model and its estimates transparent while allowing Congress and the administration to retain all their discretionary powers and rights. It would shift the focus to the best estimate of what VA needs to care for veterans. Finally, since the advance appropriation would be discretionary, not mandatory, there would be no pay-go implications. Mr. Chairman, we urge the Committee to move forward this year with either S. 2639 or the alternative advanced funding proposal.

We also express our strong support for S. 2799, the Women Veterans Health Care Improvement Act, a comprehensive measure aimed at evaluating the unique needs of women veterans, including those who served in Operations Iraqi and Enduring Freedom, and improving VA's health care and mental health services for all women veterans.

The current number of women serving in active military service and its Guard and Reserve components has never been larger and this has resulted in proportionately increasing rates of enrollment into the VA mental health system. This legislation is consistent with recommendations from research experts in women's health, the VA Women's Advisory Committee, and the VA fiscal year 2009 *Independent Budget*. Therefore, we fully support this measure.

S. 2921, the Caring for Wounded Warriors Act of 2008, would authorize new pilot programs for respite care as well as training, certifying, and compensating family caregivers of severely wounded veterans and servicemembers. We believe this proposal, if implemented carefully, would provide new approaches to the care of severely-injured veterans as well as welcome relief to their family caregivers. Likewise, these proposals are consistent with recommendations made in the fiscal year 2009 Independent Budget. Thus, DAV fully supports this bill and urges the Committee to work toward its enactment.

Finally, we would like to briefly mention S. 2573, the Veterans Mental Health Treatment First Act. In summary, this measure would provide a new program approach to mental health care and rehabilitation for veterans with certain post-deployment mental health conditions. DAV strongly supports the provisions of the bill that promote early intervention in mental health treatment, prevention of chronic disability, and promotion of recovery.

However, DAV strongly opposes the provision that links wellness stipend payments to a veteran's commitment to postpone filing a disability claim. While science has enhanced our ability to recognize and treat mental health consequences of service in combat, the treatments are not universally effective. Therefore, we see no justification for the view that participation in evidence-based therapy will eradicate the illness or significantly reduce the rating evaluation in the majority of patients. We suggest that the health care provisions and wellness stipend be decoupled from the proposal to deny veterans the ability to apply for disability compensation during the treatment phase.

Mr. Chairman, that concludes my statement and I am happy to answer any questions you may have. Thank you.

[The prepared statement of Ms. Ilem follows:]

PREPARED STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman, Ranking Member Burr and other Members of the Committee: Thank you for inviting the Disabled American Veterans (DAV) to testify at this important legislative hearing of the Committee on Veterans' Affairs. DAV is an organization of 1.3 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

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

S. 2273—ENHANCED OPPORTUNITIES FOR FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING ACT OF 2007

This bill would authorize the Secretary of Veterans Affairs to conduct pilot programs to provide grants to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing. It would authorize VA to outreach to inform low-income rural elderly veterans and their spouses of benefits for which they may be eligible. The bill also would establish new or expanded VA programs or activities to furnish transportation, child care and clothing assistance to certain veterans with service-related disabilities who are eligible for a VA rehabilitation program.

The Independent Budget for Fiscal Year 2009 includes a series of recommendations that are consistent with this bill. Therefore, the DAV supports its purposes and urges its enactment.

S. 2377—VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT

This bill would direct the Secretary of Veterans Affairs to prescribe standards for appointment and practice as a physician within the VHA of the VA. The bill would require appointees to VA physician positions, and physicians already employed by VA at the time of enactment, to disclose certain private information, including each lawsuit, civil action, or other claim against the individual for medical malpractice or negligence, and their results. Each appointee would be required to disclose any judgments that had been made for medical malpractice or negligence and any payments made. The bill would require all new physician appointments to be approved by the responsible director of the Veterans Integrated Services Network (VISN) in which the individual would be assigned to serve and require all VA specialty physicians to be board certified in the specialties in which the individuals would practice. Also the bill would require State licensure by VA physicians in the State of practice.

The measure would establish new requirements and accountabilities in quality assurance at the local, VISN and VA Central Office levels, and directs the Secretary to review VA policies for maintaining health care quality and patient safety at VA medical facilities. The bill also would establish loan repayment programs for physicians in scarce specialties, a tuition reimbursement for physicians and medical students in exchange for commitments to serve in VA, and enrollment of part-time VA physicians in the Federal Employees Health Benefits Program. The bill would admonish the Secretary to undertake additional incentives to encourage individuals to serve as VA physicians.

DAV has no adopted resolution from our membership on these specific issues. Under current policy, VA is required to investigate the background of all appointees, including verifying citizenship or immigration status, licensure status, and any significant blemishes in appointees' backgrounds, including criminality or other malfeasance. The facility in question that likely stimulated the sponsor to introduce this legislation was not in compliance with those existing requirements, thus raising questions about VA's ability to oversee its facilities in the area of physician employment. Corrective action was taken by the VA Central Office when some unfortunate incidents related to these lapses came to light at that particular facility, and VA has advised that it has strengthened its internal policies.

We appreciate and strongly support the intent of the bill to stimulate recruitment and to promote VA physician careers with various new incentives, and, while it seems clear that additional oversight is necessary, we trust that the new reporting, State licensure and certification requirements in the bill would not serve as obstacles to physicians in considering VA careers in the future.

S. 2383—A BILL TO REQUIRE VA TO ESTABLISH A PILOT PROGRAM ON THE MOBILE PROVISION OF CARE AND SERVICE FOR VETERANS IN RURAL AREAS

If enacted, this bill would direct the Secretary of Veterans Affairs to carry out a pilot program to assess the feasibility and advisability of providing care and a variety of services (including counseling) to veterans residing in rural areas through a mobile system that transports VA medical and benefits personnel, as well as equipment and other materials, to the areas designated for the program. It would require a mobile system to visit each designated area at least once each 45 days and remain present during each visit for at least 48 hours.

The bill sets forth coordination requirements concerning identification of veterans who are not enrolled in, or otherwise being cared for by, the VA health care system, county and local veterans' service offices, and use of community-based VA outpatient clinics.

Resolution 188, adopted at the 2007 DAV national convention, calls for additional efforts by the Department to improve and increase access to VA health care services in rural, remote and frontier areas. Also, in the fiscal year 2009 *Independent Budget*, we recommended a number of actions coordinated through the VA's Office of Rural Health to increase availability of health care services in rural areas, and specifically including the deployment of innovative means to reach rural veterans with effective VA health care services. The aims of this bill are generally consistent with our views in both DAV Resolution 188 and the *Independent Budget*; therefore, we support the enactment of this bill.

S. 2573—VETERANS MENTAL HEALTH TREATMENT FIRST ACT

This bill would establish a new approach to dealing with veterans who are diagnosed with Post Traumatic Stress Disorder (PTSD), depression, anxiety disorder or co-morbid substance abuse disorder that, in the judgment of a VA physician, is related to military service. Financial support, known as a "wellness stipend," would

be provided to veterans who were willing to commit to a VA treatment plan with substantial adherence to that plan for a specified period of care. In order to be eligible for the wellness stipend, the veteran would be required to agree not to file a VA disability compensation claim for the covered conditions for 1 year or the duration of the treatment program, whichever time period would be shorter. Duration of treatment would be individualized and determined by the attending VA clinician. Under the program, there would be two proposed levels of wellness stipends. Receipt of the full wellness stipend would depend on the veteran having no service-related rating for PTSD, depression, anxiety disorder, or related substance abuse, and having no claim pending for one of the conditions mentioned.

Veterans with no service-connected rating or claim pending for the conditions mentioned who agreed not to file a new or an increased disability claim for one of the conditions and in addition agreed to "substantial compliance" with a prescribed treatment plan for those conditions for the duration of the prescribed program (or 12 months, whichever is sooner), would receive $2,000 immediately payable upon diagnosis; $1,500 payable every 90 days into treatment upon clinician certification of substantial compliance with the treatment regiment; and $3,000 payable at the conclusion of the time-limited treatment program. Under this proposal, the gross stipend for these veterans would be $11,000. This bill also would propose that any veteran, with a new or increased disability claim pending for PTSD, depression, anxiety disorder or related substance abuse, would receive only a partial wellness payment at identical intervals but totaling only up to 33 percent of the rates discussed above. Any participating veteran who failed to comply with the conditions of the program would be removed from the program, resulting in cessation of the stipends. The program would limit a veteran's participation to a single enrollment unless VA determined that extended participation would provide the veteran additional assistance in recovery.

Mr. Chairman, DAV has a growing concern about the effects of wartime exposures especially those being identified in the newest generation of disabled veterans of the wars in Iraq and Afghanistan. Military deployments in Iraq and Afghanistan are among the most demanding since the War in Vietnam nearly four decades ago. In addition to causing the heavy physical injuries and casualties, the rates of "invisible" wounds of war (primarily PTSD, depression, substance abuse, suicidal ideation, and family distress) for those who have served in Operations Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) are dramatically high and still rising. All too often these conditions go unreported and even unrecognized. There are several reasons for the emergence of PTSD in these veterans of Iraq and Afghanistan. Many studies have shown that more frequent and more intense involvement in combat operations increases the risk of developing associated mental health conditions. Military commanders report that the combat environment in Iraq is intense and constantly dangerous, and some serving members are being returned for second, third or even fourth deployments. Furthermore, our military is fighting an insurgency absent clearly identifiable fronts or marked enemy soldiers; these conditions demand vigilance because there are no safe military occupational specialties or safe harbors. For an increasing number of veterans of these types of conflicts, these stressors result in devastating mental health consequences and historically high rates of PTSD, and other post-deployment mental health issues.

Since the beginning of the Global War on Terrorism, more than 1.64 million American military servicemembers have served in OIF/OEF. Of those who have been discharged from active duty, approximately 38 percent have used VA health care services, and one-in-four have filed disability compensation claims. Overall, mental health conditions are one of the most common categories of conditions for which veterans apply for disability compensation. The most common among those for which veterans receive disability benefits is PTSD. Between fiscal year 1999–2004, PTSD compensation payments increased by 150 percent. This significant increase sparked debate and a number of studies were undertaken to further explore the issue. In the VA Office of Inspector General (OIG) report on a convenience sample of 92 PTSD disability claims, 39 percent of veterans reduced their use of mental health treatment after receiving a 100 percent service-connected disability rating. This report surfaced concerns that receiving disability compensation may provide an incentive for veterans to over-report symptoms and, worse yet, to remain ill.

A recent review of the scientific literature addressing this issue dispels this erroneous belief and demonstrates that there is no conclusive evidence of differences in health care utilization among compensation seeking and non-compensation seeking veterans with PTSD, nor is there evidence that compensation seeking veterans demonstrate less symptom improvement after PTSD treatment than veterans who are

not seeking compensation.[1] These careful, peer-reviewed scientific studies contradict the OIG findings. While it is possible that a small fraction of veterans exaggerate symptoms or fail to participate in treatment in order to receive more disability compensation, the evidence does not support this behavior as a major factor hindering treatment or recovery from PTSD.

DAV applauds the bill's focus on early intervention for PTSD and other service-related mental health problems, its emphasis on recovery, and making available financial support so that veterans gain the resources to fully engage in the hard work required for effective treatment and obtain a better quality-of-life. Three recent Federal commission reports and two independent studies have emphasized the need for new and improved approaches to compensation and treatment of veterans with service-related mental health disabilities. First, between 2005 and 2007, the Veterans' Disability Benefits Commission (VDBC) studied the benefits and service programs available to veterans, servicemembers and family members. The VDBC concluded that "PTSD is treatable, that it frequently recurs and remits, and that veterans with PTSD would be better served by a new approach to their care.

After benefits and care coordination problems were identified at Walter Reed Army Medical Center in 2007, the President's Commission on Care for America's Returning Wounded Warriors (also commonly known as the Dole-Shalala Commission) was appointed and published its report. The commission called for major change in the coordination of care and benefits for severely wounded service personnel and veterans. In addition, Dole-Shalala identified the need for better support of seriously injured veterans during their rehabilitation and recovery and called for study of long-term transition payments.[2]

The third commission of relevance to today's testimony is the President's New Freedom Commission on Mental Health. In 2003, the commission published its report. The commission made recommendations to transform mental health care in the United States and "* * * envisioned a future when everyone with a mental illness will recover, a future when mental illnesses are detected early, and a future when everyone with mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning and participating fully in the community." The commission indicated that this transformation rests on two principles:

- Services and treatments must be consumer and family centered.
- Care must be focused on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and building resilience—not just on managing symptoms.

By recovery, the commission meant a process that focuses on return of function and quality-of-life for those who suffer from mental health problems—in which people are able to fully engage life and live, work, learn and recreate in their communities. Recovery focuses on restoration of *ability* and is a fundamental departure from traditional models that focus primarily on reduction of symptoms. The mental health recovery model incorporates the best that medical science has to offer but enhances it by promoting a person-centered, team-based model of care that brings a full range of health and human services to bear to accomplish the maximal psychosocial-spiritual rehabilitation possible. The recovery model is a significant paradigm shift that should be fully embraced by VHA's mental health system. The commission also found that effective treatments were currently available for treatment of mental illness and recommended that efforts be stepped up to ensure that all providers are given tools and training to consistently deliver evidence-based treatments.

Over the years, science has broadened our knowledge about mental health and illnesses including the effects of combat stress and trauma. These studies have shown us new paths to effective treatment and recovery for military servicemembers and combat veterans. The Institute of Medicine (IOM) recently compiled and analyzed all of the research on the evidence for treatments proven effective for PTSD.[3] The IOM reported there is sufficient evidence to conclude that prolonged exposure and cognitive behavior therapies are effective in treatment of PTSD. While many military servicemembers and veterans have access to these treatments, gaps still re-

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[1] Laffaye C, Rosen C, Schnurr PP, Friedman MJ: Does Compensation Status Influence Treatment Participation and Course of Recovery from Post-Traumatic Stress Disorder? Military Medicine 2007; 172(10):1039–1045.

[2] President's Commission on Care for America's Returning Wounded Warriors: Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors. Washington DC, July 2007.

[3] Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence, The National Academy Press, Washington DC, 2007.

main in system-wide availability, not only in both VA and the Department of Defense (DOD), but also in the private mental health sector.

There is an overwhelming body of knowledge that documents the growing needs of OIF/OEF veterans for effective mental health services. In April 2008, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* was published by RAND. In addition to a comprehensive literature review, this study undertook a population-based telephone survey of 1,965 servicemembers and veterans who had deployed to Iraq or Afghanistan. This survey found substantial rates of mental health problems in the 30 days before the interviews, with 14 percent screening positive for PTSD, 14 percent for major depression and 19 percent for reporting a probable Traumatic Brain Injury (TBI) during deployment. Assuming that the prevalence of these conditions is representative, this study suggests that approximately 300,000 individuals who served in OIF/OEF suffer from PTSD or major depression, and 320,000 individuals may be at risk for TBI. RAND concluded at least one third of all OIF/OEF veterans have one of these conditions and 5 percent report symptoms of all three. RAND also found that OIF/OEF veterans seek treatment for PTSD and major depression at about the same rate as the general civilian population, and like the civilian population, many are not receiving any mental health care. Over the past year, only 53 percent of those who met criteria for current PTSD or major depression had sought health care from a physician or behavioral health provider.[4]

Recent data also suggest that the problems grow rather than diminish in the months after servicemembers return home. The alarming figures on marital and family stress, mental health challenges and substance abuse concerns were further amplified in a longitudinal assessment of mental health problems of 88,235 U.S. Army personnel who had served in Iraq. In this published study, soldiers reported a fourfold increase in interpersonal conflict on the delayed Post Deployment Health Re-Assessment (PDHRA) questionnaire, compared to their earlier Post-Deployment Health Assessment (PDHA) screenings. In addition, this study showed a large and growing burden of mental health and substance abuse concerns. Soldiers reported more mental health problems and were referred at higher rates for mental health care on the PDHRA when they were screened approximately 6 months after deploying home, than they had previously reported when completing questionnaires immediately after returning from Iraq. Clinicians who screened these soldiers determined that 20 percent of active duty and 42 percent of Army reservists required mental health care. Of great concern are the high rates of alcohol use reported by soldiers but the virtual absence of referral to treatment programs as a result of these screening programs.[5] These data have yet to reflect the full impact of extended 15-month deployments, the third, fourth or even fifth deployments for some individuals, or the impact of redeployed servicemembers who may already actively suffer from untreated PTSD or "mild" TBI. Likewise in a prospective military cohort study on the health outcomes of over 50,000 individuals who deployed to Iraq or Afghanistan, data indicated a threefold increase in new onset of self-reported PTSD symptoms among deployed members who reported combat exposures.[6]

All of these commissions, independent reports, and scientific studies provide ample evidence for pursuing early intervention for PTSD and other service-related mental health problems, for promoting recovery, and for providing adequate financial support so that veterans have the resources to engage fully in treatment and return to a better life after serving. Participation in treatment and counseling is often an intensive and time consuming process. Financial stipends such as those proposed by this bill would assure that veterans have at least a modicum of support to concentrate on participating as full partners in their therapy.

However, DAV strongly opposes any provision that attempts to link wellness stipend payments to a veteran's commitment not to file a disability claim. While science has enhanced our ability to recognize and treat the mental health consequences of service in combat including PTSD, the treatments are not universally effective. Using the best research and evidence-based treatment, complete remission can be achieved in 30–50 percent of cases of PTSD and partial improvement can

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[4] Tanielian T, Jaycox LH: Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, RAND Corporation, April 2008, Washington DC.

[5] Miliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among Active and Reserve Component soldiers returning from the Iraq War. JAMA, 2008; Vol. 298(18):2141–2148.

[6] Smith TC, Ryan MA, Wingard DL, Slymen DJ. Sallis JF, Kritz-Silverstein D, for the Millennium Cohort Study Team. New onset and persistent symptoms of Post Traumatic Stress Disorder self reported after deployment and combat exposures: prospective population based US military cohort study. BMJ 2008; 336;366–371.

be expected in most patients.[7] PTSD and major depression tend to remit and recur. There is no justification for the view that participation in evidence-based therapy will eradicate the illness or eliminate the need for a subsequent claim for disability.

In addition to the above concerns, we recognize the challenges that VA would have in establishing the administrative systems and management of this new program. In order to ensure the success of these efforts, DAV recommends that VA incorporate the following components into their program design:

- The VHA's capacity to provide access to mental health services has improved; however, gaps still exist. In order to provide high quality, timely mental health care, VA will need to recruit and retain additional highly skilled, dedicated mental health providers.
- Every veteran enrolled in the program should be assigned to a care manager to coordinate care and jointly track personal treatment and recovery plans.
- VA mental health providers should receive ongoing continuing medical education, intensive training and clinical supervision to ensure that they have the skills and capability to deliver the latest evidence-based treatments.
- VA should offer certifications to professionals for PTSD treatment, competency in veterans' occupational health, and cultural competency in veterans and military life.

Most of the military members who serve in combat will return home without injuries and readjust in a manner that promotes good health. However, it is the responsibility of our Nation to treat veterans who return with war wounds, both visible and invisible, and to fully support their mental health recoveries. Moreover, we believe that while transition payments will facilitate their recovery, they are not an adequate or acceptable substitute for fair and equitable disability compensation for service-related conditions.

In summary, S. 2573 would require a program of mental health care and rehabilitation for veterans for service-related Post Traumatic Stress Disorder or other stated post-deployment health conditions. DAV strongly supports the provisions of this bill that promote early intervention in mental health treatment, prevention of chronic disability, and promotion of recovery. However, we cannot support the bill in its current form because it restricts the rights of disabled veterans to apply for service-connected disability compensation for those disabilities under VA care. We suggest that the health care provisions and transition payments be decoupled from the proposal to deny veterans the ability to apply for disability compensation during the treatment phase.

S. 2639—ASSURED FUNDING FOR VETERANS HEALTH CARE ACT

Mr. Chairman, as you well know, this bill would reform VA health care funding by moving it from its current status as a discretionary appropriation to that of mandatory status. The formula proposed by this bill is well recognized and has been pending before Congress for the past 5 years. As we testified before your Committee on July 25, 2007, VA has been unable to manage or plan the delivery of care as effectively as it could have, as a result of perennially inadequate budget submissions from Presidents of both political parties; annual Continuing Resolutions in lieu of approved appropriations; late arriving final appropriations; offsets and across-the-board reductions; plus the injection of supplemental and even "emergency supplemental" appropriations to fill gaps. In 13 of the past 14 years, VA has begun its year with Continuing Resolutions, creating a number of challenging conditions that are preventable and avoidable with basic reforms in funding for VA health care.

DAV is especially concerned about maintaining a stable and viable health care system to meet the unique medical needs of our Nation's veterans now and in the future. The wars in Iraq and Afghanistan are producing a new generation of wounded, sick and disabled veterans, and some severe types at a poly-trauma level never seen before. A young veteran wounded in Iraq or Afghanistan today with brain injury, limb loss, spinal cord injury, burns or blindness will need the VA health care system for the remainder of their lives.

The goal of DAV and other members of the Partnership for VA Health Care Budget Reform (Partnership) is to see a long-term solution for funding VA health care to guarantee these veterans will have a dependable system for the future, not simply next year. Reformation of the funding system is essential so Federal funds can be secured on a timely basis, allowing VA to manage the delivery of care and to plan effectively to meet known and predictable needs. In our judgment a change is warranted and long overdue. To establish a stable and viable health care system,

[7] Friedman MJ: Posttraumatic Stress Disorder Among Military Returnees from Afghanistan and Iraq. American Journal of Psychiatry, April 2006; 163:4, 586–593.

any reform must include *sufficiency, timeliness, and predictability* of VA health care funding.

We ask the Committee to consider all the actions Congress has had to take over only the past 3 years to find and appropriate "extra" funding to fill gaps left from the normal appropriations system. Please also consider the Administration's efforts to explain to Congress why VA experienced a shortfall of billions of dollars each year—admissions that were often very reluctantly made. In one case, the President was reduced to formally requesting two VA health care budget amendments from Congress within only a few days of each other.

In past Congresses we have worked with both Veterans' Affairs Committees to craft legislation that we believe would solve this problem if enacted. The current version of that bill is S. 2639, the Assured Funding for Veterans Health Care Act, introduced by Senator Tim Johnson. A number of objections have been made related to this bill and its predecessors: primarily that it would cost too much, that VA would have no incentive to be fiscally responsible and that Congress would lose its oversight authority. We have previously provided commentary that rejects all these criticisms.

The recent Congressional Research Service report to Congress detailing the running expenditures for the Global War on Terror since September 11, 2001, revealed that veterans affairs-related spending constitutes only *1 percent* of the government's total expenditure. Without question, there is a high cost for war, but we strongly believe that caring for our Nation's sick and disabled veterans is part of that continued cost.

Mr. Chairman, DAV will continue to support S. 2639 as a reasonable and responsible means to solve funding problems experienced by VA. However, we and the other members of the Partnership understand there is strong opposition by some to mandatory funding and so we have been developing an alternative approach to achieve the goals of mandatory funding—sufficient, timely and predictable funding—while addressing the concerns over PAYGO, Congressional oversight, and fiscal responsibility. Over the last several weeks, we have briefed both majority and minority staffs of this and other relevant Congressional committees and Leadership on our alternative proposal. Essentially, this new proposal would shift VA medical care appropriations to a 1-year advance appropriation, and require that VA's health expenditure forecasting model be audited and reported to Congress by the Government Accountability Office (GAO) on an annual basis.

Mr. Chairman, VA's internal methodology for estimating the cost of providing health care to enrolled veterans has actually become increasingly accurate due to the implementation of a new actuarially based model developed and refined in the past several years. Historically, VA's budget problems have not arisen due to a flawed model; but rather from a flawed budget process. From the time such estimates of need are developed, to the time when the Administration's budget is submitted, there are political and other non-cost factors that result in changes to the estimate, usually resulting in a less than sufficient budget request sent to Congress. Former Secretary Principi admitted as much during his budget testimony in 2004; and in 2005, then-Secretary Nicholson contradicted his own budget testimony within weeks of its delivery by making not one, but two supplemental requests for additional health care funding totaling $1.2 billion. The reality is that no matter how accurately VA's internal model forecasts future costs, that estimate must run a political gauntlet through VA, the Office of Management and Budget (OMB), the White House, authorizing, budget and appropriations committees, both chambers of Congress and both political parties, before it can be approved.

That is why we propose the GAO audit and report to Congress on an annual basis about the accuracy and integrity of VA's health care cost forecasting model, as well as the data and assumptions upon which it is built. GAO's report would essentially report the most accurate estimate of providing currently-authorized health care services to next year's anticipated veteran enrollment, adjusted for next year's higher (or lower) cost of providing such medical services. By adding this transparency to the budget formulation process, Congress and the Administration are much more likely to arrive at a final budget that is sufficient to meet the anticipated health care needs of all enrolled veterans.

Having addressed sufficiency, we next propose that VA's medical care funding be done through a 1-year advance appropriation to ensure that it arrives on time in a manner that is easily predictable from year to year. Congress can and has provided advance appropriations for a number of important programs for both financial and political reasons. In some cases, such as in the Department of Housing and Urban Development (HUD) Section 8 housing vouchers, and in Head Start, the advance appropriation is a partial-year advance. In other cases, such as LIHEAP, the Low Income Home Energy Assistance Program, the appropriation is done a year in

advance to assure that this assistance can be delivered before the onset of winter and to allow for the purchase of heating oil during the best market conditions of the year prior. Other advance appropriations, such as for the Corporation for Public Broadcasting, were authorized to allow the program to plan and operate without needing to worry that partisan, political debates might negatively impact the program at the last moment. Advance appropriations are different from biennial budgets: advance appropriations pass a 1-year budget one or more years in advance, whereas a biennial budget approves a 2-year budget each 2 years.

In the case of veterans' health care funding, a 1-year advance appropriation would greatly enhance the programs by removing both financial and political impediments to providing quality medical care to veterans. A 1-year advance appropriation would allow Congress to approve funding for veterans medical care without VA having to compete against other programs. Additionally, since the advance appropriation would be discretionary, not mandatory, there would be no PAYGO implications. The only difference is that the appropriations act that allows funds to flow to VA would have been enacted the year beforehand, thus allowing VA to use those funds in an efficient manner.

Mr. Chairman, if we currently had an advance appropriations process for veterans medical care, VA would not have to worry about a budget showdown later this fall, or negative consequences of what appears to be an almost-certain Continuing Resolution again this year. Instead, the fiscal year 2009 appropriation for VA medical care would already have been in place and VA could right now be planning where and how to expand services in the most efficient and cost-effective manner to meet the needs of thousands of returning Iraq and Afghanistan veterans expected to come to VA this fall. Some have argued that this approach would put veterans' health care ahead of other Federal discretionary spending programs. This is true—and we believe there is just cause for doing so. When our Nation fights wars, there is no hesitation by Congress or the Administration to provide all the funding necessary, including emergency supplemental and "off-budget" funding. Health care for those injured in these wars is one additional cost that deserves the highest priority.

This new alternative proposal would make VA's data-driven, actuarial model and its estimates transparent to Congress, while allowing Congress and the Administration to retain all their discretionary powers and rights. It would shift the terms of the debate from political to financial, focusing on the best estimate of the cost to care for veterans. By completing the appropriation a year in advance, Congress can help assure that veterans health care funding is sufficient and finalized ahead of time and in a predictable manner from year to year.

Mr. Chairman, we urge this Committee to provide serious consideration to this new alternative VA health care funding proposal, and urge you to move forward this year with either our new proposal, or with Senator Johnson's mandatory funding bill.

S. 2796—TO REQUIRE A PILOT PROGRAM ON THE USE OF COMMUNITY-BASED ORGANIZATIONS TO ENSURE THAT VETERANS RECEIVE THE CARE AND BENEFITS THEY NEED, AND FOR OTHER PURPOSES.

This bill would establish a pilot program to facilitate veterans' use of community-based organizations to ensure certain veterans receive the care and benefits they deserve in transitioning from military to civilian life. The program would be carried out in five selected rural locations, and in areas with a high proportion of minority groups and individuals who have experienced significant disparities in their receipt of health care. The program would be conducted through VA grants to community-based organizations with the goal of providing information, outreach, mental health counseling, benefits and transition assistance and other relevant services in rural areas and in areas with a high proportion of minority veterans.

While we have no adopted resolution from our membership supporting this precise concept, DAV believes this is a well-intentioned proposal. We have some concern about VA as a granting agency for such broad purposes, but we believe if it is targeted and carefully managed by VA, this function could be an important and creative new tool in rural and remote areas where establishing a direct VA service presence would be impractical. If the bill is enacted, we also recommend VA carefully craft the services expected from a grantee in the area of aiding these veterans with their VA disability benefits claims. These are highly technical matters and require the assistance of expert service officers from the States, the veterans service organization (VSO) community and the Veterans Benefits Administration through its veterans benefits counselor function. Finally, for any health care involvement associated with these grants, we urge VA to coordinate this new grant program

through its Office of Rural Health. With these caveats, DAV supports the enactment of this bill.

S. 2797—TO AUTHORIZE MAJOR MEDICAL FACILITY PROJECTS AND MAJOR MEDICAL FACILITY LEASES FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2009, AND FOR OTHER PURPOSES.

This bill would authorize four major construction projects at the Palo Alto, San Juan and Tampa medical centers, and a new outpatient facility in Lee County, Florida. Also, the bill would extend expiring authorities for major projects in Denver and New Orleans. Twelve capital leases would be authorized as well, along with authorization of appropriations of nearly $2 billion to carry out both the major construction projects and leases.

DAV supports this bill and urges its enactment.

S. 2799—WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2008

Title I, sections 101–103 of the bill would authorize and mandate longitudinal studies by VA in coordination with the Department of Defense (DOD) to evaluate the needs of women who are currently serving, and women veterans who have completed service, in OIF/OEF. Also, VA would be required to study and report existing barriers that impede or prevent women from accessing health care and other services from VA. Third, this title would require VA to make an assessment of its existing health care programs for women veterans and report those findings to Congress. Section 104 of the bill would authorize IOM to study and report on the health consequences of women serving in OIF/OEF.

Title II, section 201 would amend title 38, United States Code, to authorize a period of 30 days of VA-provided or authorized contract care for the newborn infant child of a woman veteran. Section 202 would make improvements in VA's ability to assess and treat women veterans who have experienced military sexual trauma (MST) by requiring a new training and certification program to ensure VA health care providers develop competencies in caring for these conditions consequent to MST. Section 202 would also require the VA to establish staffing standards to ensure adequacy of supply of trained and certified providers to effectively meet VA's demands for care of MST. Section 203 would require a similar training and certification program for VA personnel caring for women veterans with PTSD and would mandate the use of evidence-based treatment practices and methods in caring for women veterans who suffer from PTSD that may be related to MST and/or combat exposure. The Secretary would be required to ensure appropriate training of primary care providers in screening and recognizing symptoms of sexual trauma and procedures for prompt referral and would require qualified MST therapists for counseling. Under this authority the Secretary would also be required to provide Congress an annual report on the number of primary care and mental health professionals who received the required training, the number of full-time employees providing treatment for MST and PTSD in each VA facility, and the number of women veterans who had received counseling, care and services associated with MST and PTSD.

Section 204 would authorize a 2-year pilot program in at least three VISNs of reimbursement for child care services expenses for qualified veterans receiving mental health, intensive mental health or other intensive health care services, whose absence of child care might prevent veterans from obtaining these services. "Qualified veteran" would be defined as a veteran with the primary caretaker responsibility of a child or children. The authority would be limited to reimbursement of expenses.

Section 205 would establish a non-medical model pilot program of counseling in retreat settings for recently discharged women veterans who could benefit from VA establishing offsite counseling to aid them in their repatriation with family and community after serving in war zones and other hazardous military duty deployments. Section 206 would require the VA to establish full-time women veterans program managers at VA medical centers. Section 207 would require recently separated women veterans to be appointed to certain VA advisory committees.

Mr. Chairman, women veterans are a dramatically growing segment of the veteran population. The current number of women serving in active military service and its Guard and Reserve components has never been larger and this phenomenon predicts that the percentage of future women veterans who will enroll in VA health care and use other VA benefits will continue to grow proportionately. Also, women are serving today in military occupational specialties that take them into combat theaters and expose them to some of the harshest environments imaginable, including service in the military police, medic and corpsman, truck driver, fixed and rotary wing aircraft pilots and crew, and other hazardous duty assignments. VA must pre-

pare to receive a significant new population of women veterans in future years, who will present needs that VA has likely not seen before in this population.

This comprehensive legislative proposal is fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women's health, VA's Advisory Committee on Women Veterans, the *Independent Budget*, and DAV. DAV was proud to work with Senator Murray and the original cosponsors of the bill in crafting this proposal. A similar bill was introduced in the House (H.R. 4107) on a bipartisan basis by Representatives Herseth Sandlin and Brown-Waite. DAV strongly supports this measure and urges the Committee to approve it and move it toward enactment.

S. 2824—TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE COLLECTIVE BARGAINING RIGHTS AND PROCEDURES FOR REVIEW OF ADVERSE ACTIONS OF CERTAIN EMPLOYEES OF THE DEPARTMENT OF VETERANS AFFAIRS

We do not have an approved resolution from our membership on this specific labor-management issue, but we do have concerns about the reported deteriorated state of labor relations in the VA. DAV typically concentrates on matters dealing with quality, access, and convenience of VA health care and other services and benefits for veterans, and relies on VA to manage its system properly to meet those ends. However, we believe labor organizations that represent employees in recognized bargaining units within the VA health care and benefits system have an innate right to information and participation that results in making VA a workplace of choice, and particularly to fully represent VA employees on issues impacting working conditions and ultimately patient care.

Congress passed section 7422 of title 38, United States Code, in 1991, in order to grant specific bargaining rights to labor in VA professional units, and to promote effective interactions and negotiation between VA management and its labor force representatives concerned about the status and working conditions of VA physicians, nurses and other direct caregivers appointed under title 38, United States Code. In providing this authority Congress granted to VA employees and their recognized representatives a right that already existed for all other Federal employees appointed under title 5, United States Code. Nevertheless, Federal labor organizations have reported that VA has severely restricted the recognized Federal bargaining unit representatives from participating in, or even being informed about, human resources decisions and policies that directly impact conditions of employment of the VA professional staff within these bargaining units. We are advised by labor organizations that when management actions are challenged VA has used subsections (b), (c) and (d) of section 7422 as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA's management decisions, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for nurses, physician market pay compensation panels, etc.).

Facing VA's refusal to bargain, the only recourse available to labor organizations is to seek redress in the Federal court system. However, recent case law has severely weakened the rights of title 38 appointees to obtain judicial review of arbitration decisions. Title 38 employees also have fewer due process rights than their Title 5 counterparts in administrative appeals hearings.

It appears that the often hostile environment consequent to these disagreements diminishes VA as a preferred workplace for many of its health care professionals. Likewise, veterans who depend on VA and care from physicians, nurses and others who provide direct professional medical care can be negatively affected by that environment.

We believe this bill, which would rescind VA's ability to refuse to bargain on matters within the purview of section 7422 by striking subsections (b), (c) and (d) and that would clarify other critical appeal rights of title 38 appointees, is an appropriate remedy and would return VA and labor to a more balanced bargaining relationship in issues of importance to VA's professional workforce. Therefore, DAV commends the sponsors for introducing this bill, and the Committee for considering it, and we would have no objection to its enactment.

S. 2889—THE VETERANS HEALTH CARE ACT OF 2008

Mr. Chairman, you requested DAV's views only on sections 2 through 6 of this bill. Section 2 would provide VA specific contracting authority to obtain specialized residential care and rehabilitation services for OIF/OEF veterans who are suffering from TBI, and who are exhibiting such cognitive deficits that they would otherwise require admission to nursing home facilities. Section 3 would provide full-time VA board-certified physicians and dentists the opportunity for continuing medical edu-

cation, with VA reimbursement of expenses up to $1,000 per year for such continuing education. Section 4 would exempt veterans in VA hospice care from the requirement of making copayments to VA for those services. Section 5 rescinds consent procedures related to VA tests for human immunodeficiency virus. Section 6 would authorize VA to disclose the name and address of a member of the armed services or of a veteran to a third party insurer in order to bill for collections of reasonable charges for care or services provided for an individual's nonservice-connected condition(s).

Except for the proposal in section 2, DAV has no resolutions from our members on any of the matters contained in this bill, but we see no reason to object to their passage. We do note, in section 2, that its language would limit eligibility for specialized residential rehabilitation contract care to one subset of veterans with residuals of TBI—those who served in OIF/OEF. Other veterans, of past and future conflicts, with TBI might also benefit from these services. Resolutions 079 and 175, adopted at DAV's 2007 National Convention, call for strengthening and enhancing VA long-term care programs for service-disabled veterans, and for addressing comprehensively the needs of disabled veterans of all wars who suffered TBI. We ask the Committee to consider broadening the eligibility for this new contract residential rehabilitation care option in section 2 of the bill to any veteran with a service-incurred TBI.

S. 2899—THE VETERANS SUICIDE STUDY ACT

This bill would require the Secretary, in conjunction with the Department of Defense, the Centers for Disease Control and Prevention, and all State public health and veterans affairs agencies and equivalent offices, to conduct a study to determine the number of veterans who have died by suicide between January 1, 1997, and the date of the enactment of this bill.

DAV has no adopted resolution from our membership dealing specifically with suicides in the veteran population. However, we agree with the Chairman that full and accurate data on the issue is crucial to VA's ability to reduce veterans' suicides. We note that the Committee has formally requested data from VA, including:

- The number of veterans who committed suicide or attempted to commit suicide;
- The number of veterans who have committed suicide or attempted to commit suicide while receiving care from VA;
- Information on VA's efforts to improve outreach and assistance for veterans between the ages of 30 and 64 years of age; and,
- All of VA's health care quality assurance reviews related to suicides and suicide attempts over the past 3 years.

While as a general observation we would have no objection to a bill requiring a study on suicide, we believe the study envisioned in this bill would be highly challenging to carry out, and might not satisfy Congress with dependable, accurate results. Therefore, we would appreciate reviewing VA's available data on suicides and attempted suicides, and we encourage continued oversight by the Committee of VA's efforts to reduce suicide in the veteran population.

S. 2921—THE CARING FOR WOUNDED WARRIORS ACT OF 2008

This bill would authorize new pilot programs for training, certifying and compensating family caregivers of severely wounded veterans and servicemembers, and would establish a second program to deploy graduate students in the health sciences as providers of respite care for severely disabled veterans and servicemembers in exchange for course credit.

Section 2 of the bill would establish up to three VA pilot programs for assessing the feasibility of providing training and certification for, and subsequent compensation to, family caregivers of severely disabled veterans and severely injured servicemembers who remain on active duty status but are presumably under VA care. In developing the pilot programs the VA Secretary would be required to do so in conjunction with the Secretary of Defense. In selecting the locations of the pilot programs, the Secretary would be required to give special emphasis to the VA's polytrauma center locations. The bill would require curricula to be developed to incorporate applicable standards, protocols and best practices to govern this pilot program. Under the terms of the bill, the Secretary would determine the eligibility of a family member for participation, and the type of care a family member would provide would be based on the needs of the veteran as determined by the veteran's attending physician. The bill would authorize compensation to be paid to a family caregiver for care and services rendered to the veteran or servicemember (in the case of a severely disabled servicemember, the bill would require reimbursement to VA by TRICARE for benefits provided under this authority). The bill would author-

ize VA to provide certain supportive services to a family caregiver, including an assessment of needs and referral to services that can assist them in continuing in that crucial role. This bill would not preclude VA reimbursement for health care services provided by a non-family member, nor would it bar access to other services and benefits otherwise available to disabled veterans with brain injury.

Section 3 of the bill would authorize a VA pilot program to assess the feasibility of providing respite care to severely disabled veterans and severely injured servicemembers remaining on active duty (who are under VA care), with a special emphasis on Traumatic Brain Injury, through students enrolled in graduate programs of education in certain health sciences. These students, in social work, psychology, physical therapy and similar fields, would be recruited by VA to provide relief to family caregivers, and would furnish socialization and cognitive skills development care to both family members and their patients in respite. The bill would require this pilot program to be carried out at no more than 10 locations, near VA facilities with relationships, academic affiliations, or established partnerships with institutions of higher education with graduate programs in appropriate mental health, rehabilitation or related fields. This section would require recruiting, providing specified training in applicable standards, protocols and best practices, and matching of interested students with disabled veterans and servicemember families. Participating students would submit required reports to a VA attending physician, meet other VA requirements as specified by the Secretary, and would receive coursework credit for such duties as determined by the Secretary in coordination with a participating or affiliated school.

These two ideas are worthy and if implemented carefully, could provide major new approaches to the care of severely injured veterans, and provide welcome relief to their family caregivers. DAV was pleased that Senator Clinton's staff consulted with DAV in developing this proposal to aid caregiver families. Also, these proposals are fully consistent with recommendations of the fiscal year 2009 *Independent Budget*. Thus, DAV strongly supports this bill and urges the Committee to work toward its enactment.

S. 2926—THE VETERANS NONPROFIT RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT OF 2008

This bill would modernize and enhance oversight and reporting requirements of nonprofit research and education corporations that support VA biomedical research by managing extramural grant funds made available to VA principal investigators. It would also provide new guidance and policy requirements for the operation of these corporations within the VA research program, and would be responsive to recent recommendations for improved accountability within some of these corporations made by the VA Inspector General.

The basic statutory authority for these corporations was enacted in 1988, so this bill would be the first significant amendment to that statute. If enacted this bill would authorize the corporations to fulfill their full potential in supporting VA biomedical research and education, the results of which would improve treatments and promote high quality care for veterans, while underwriting VA and Congressional confidence in these corporations' management of public and private funds.

While DAV has no adopted resolution on this particular matter, DAV is a strong supporter of a robust VA biomedical research and development program, and we believe enactment of this bill would be in that program's best interest. Therefore, DAV would have no objection to enactment of this bill.

S. 2937—TO PROVIDE PERMANENT TREATMENT AUTHORITY FOR PARTICIPANTS IN DEPARTMENT OF DEFENSE CHEMICAL AND BIOLOGICAL TESTING CONDUCTED BY DESERET TEST CENTER AND AN EXPANDED STUDY OF THE HEALTH IMPACT OF PROJECT SHIPBOARD HAZARD AND DEFENSE, AND FOR OTHER PURPOSES.

This bill would authorize permanent health care eligibility for veterans who were exposed to potentially toxic substances during their military service, as participants in "Project SHAD," a chemical warfare military testing exercise. The bill would also require the VA Secretary to contract with IOM to conduct an expanded study of the health impact of veterans' participation in these exercises. The bill would permit the IOM to take into account the results of its previously authorized study on Project SHAD.

DAV has no objection to the enactment of this bill.

S. 2963—TO IMPROVE AND ENHANCE THE MENTAL HEALTH CARE BENEFITS AVAILABLE TO MEMBERS OF THE ARMED FORCES AND VETERANS, TO ENHANCE COUNSELING AND OTHER BENEFITS AVAILABLE TO SURVIVORS OF MEMBERS

Section 1 of the bill would authorize a new scholarship program for education and training of behavioral health care specialists for Vet Centers of VA's Readjustment Counseling Service. The bill would specify the terms of eligibility for candidates for scholarships under this authority, and would authorize the Secretary to determine scholarship amounts. Recipients of such scholarships would be required as a condition of participation to serve as behavioral health care specialists in VA's Vet Center program. The bill specifies conditions warranting repayment in cases in which recipients fail to fulfill their obligated service, with specific terms of repayment to be determined by the Secretary. The bill would authorize $2 million annually to carry out its purposes.

Section 2 of the bill would authorize eligibility for OIF/OEF veterans, including serving members of the National Guard or Reserve, regardless of their duty status, to receive counseling and services through VA's Vet Centers. The bill would require the Secretaries of Veterans Affairs and Defense to promulgate regulations to carry out the purposes of this section.

Section 3 would provide VA's Vet Centers authority to refer for non-VA mental health care and counseling services any individual whose military discharge serves as a bar for the individual to receive VA benefits. The section would also admonish the Secretary, if pertinent, to advise such ineligible individuals of the individual's right to apply for governmental review of the character of that individual's military discharge.

Section 4 of the bill would statutorily reclassify suicides of certain veterans (cases of occurrence of suicide within 2 years of discharge or release from active duty) as deaths in the line of duty for purposes of eligibility of survivors for benefits associated with burial and other benefits under title 38, United States Code; the Survivor Benefit Plan under title 10, United States Code; and for death and other benefits under the Social Security Act. If enacted this section would require refunds of reductions in retired pay made in case of suicide under the Survivor Benefit Plan to surviving spouses and children of military-retired veterans who commit suicide within the specifications of the section. The section would limit applicability of these benefits to veterans and military retirees with medical histories of combat-related mental health conditions, PTSD, and TBI while serving.

Section 5 would authorize the Secretary of Defense to provide grants to non-profit organizations to provide peer emotional support services to survivors of members of the Armed Forces and veterans. Rules for eligibility, application, amounts, and duration of the grant program would be determined by the Secretary of Defense.

While DAV has no resolutions from our membership supporting the specific matters entertained by this bill, we believe each of these proposals would be helpful to survivors of military servicemembers and veterans whose lives are lost to suicide. Therefore, DAV supports the purposes of this bill and would have no objection to its enactment.

S. 2969—THE VETERANS' MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT OF 2008

Section 2 of the bill would provide authority to the Secretary of Veterans Affairs to establish additional "hybrid Title 38-Title 5" occupations (32 such occupations have been established by previous acts of Congress in section 7401, title 38, United States Code, including psychologist, physician assistant, licensed vocational or practical nurse, social worker, and numerous technical health fields). Under this section the Secretary would be required to report any such reclassification of VA occupations to the OMB, to your Committee and its House counterpart. This section would also add "nurse assistant" as a specific new occupational class in this hybrid category. Section 2 would clarify probationary periods and appointment policies for full-time and part-time registered nurses. The section also would authorize VA on a case-by-case basis to reemploy Federal annuitants with temporary appointments in selective health care positions under sections 7401 and 7403, title 38, United States Code, without offsetting their retirement annuities paid to them under title 5, United States Code. This section would provide VA additional authority to raise compensation of personnel employed in the immediate Office of the Under Secretary for Health; provide VA pharmacist executives eligibility for special incentive pay; and provide clarification on compensation policy for VA physicians, including cost of living adjustments and market pay provisions in chapter 74, title 38, United States Code. Finally, it would provide additional policy on nurse pay caps, special pay for nurse executives; locality pay systems for VA nurses; part-time nurse pay

rules; weekend pay rules, as well as clarified direction on the use and disclosures on wage surveys in nurse locality pay determinations.

Section 3 of the bill would add a new section 7459, title 38, United States Code, to specify VA policy on VA's use of overtime by VA nurses, in effect outlawing VA's practice of requiring "mandatory overtime," and extending specific protections to VA registered nurses, licensed practical or vocational nurses, nursing assistants (and other nursing positions designated by the Secretary for purposes of these protections), under the Civil Rights Act of 1964, from discrimination or any adverse action based on their refusal to work required overtime. Under the section the VA Secretary would be provided an emergency exigency power in certain circumstances to require a nurse to work overtime, but the section defines the term "emergency" within narrow grounds. Section 3 also clarifies language on weekend duty and other alternative work schedules for VA nurses, and would provide a number of associated technical and conforming amendments.

Section 4 of the bill would reinstate the former Health Professionals Educational Assistance Scholarship Program, an authority that expired in 1998, and would extend its coverage to employees appointed under paragraphs (1) and (3) of section 7401, title 38, United States Code. It would add "retention" as an additional purpose of VA's Education Debt Reduction Program, and would increase the amounts of assistance to eligible VA employees. The section would establish a loan repayment program targeted to VA clinical research personnel who come from disadvantaged backgrounds.

Mr. Chairman, DAV has no resolution adopted by our membership addressing these matters, but we are strong supporters of VA as a preferred employer. We see the provisions in this measure as supportive of that goal and therefore would not object to their enactment. Nevertheless, we note that our colleagues in the VA labor community are concerned about ceding additional authority to the Secretary to expand the "hybrid" appointment authority without further intervention from Congress, and we believe these unions may have a valid basis for those concerns, based on VA's apparent struggle to establish qualification and classification standards for some of the occupational classes already included in that hybrid authority. Therefore, we defer to their expertise in this case and ask the Committee's further consideration of those matters in Section 2 of the bill.

S. 2984—THE VETERANS BENEFITS ENHANCEMENT ACT OF 2008

Mr. Chairman, you have requested our views only on Title III of this bill.

Section 301 would make permanent VA's existing authority to provide "non-institutional extended care services," a health care service originally authorized in Public Law 106–117, the 1999 Veterans Millennium Health Care and Benefits Act.

Section 302 would extend for 5 years, until 2013, VA's existing authority to provide nursing home care to veterans rated 70 percent or more service-connected disabled, and to veterans in need of nursing home care for service-connected conditions. This section would extend through 2013 VA's authority to establish nonprofit research and education corporations and VA's existing contractual recovery audit programs for its fee-basis, contract hospitalization and other contract medical services activities.

Section 303 of the Title III would provide the Secretary permanent authority to provide health care to veterans possibly exposed to chemical and biological warfare agents conducted by the Deseret Test Center. Similar language is included in S. 2937, also before the Committee today.

Section 304 of the bill would repeal an existing annual report to Congress on pay adjustments made to the basic pay of VA nurses and certain other health care personnel appointed under section 7401, title 38, United States Code. The section would also repeal VA's existing annual report on long-range planning, including operational and construction plans for VA health care facilities.

Section 305 of Title III would change the reporting date of an annual executive branch report to the Committees on Veterans' Affairs of the Senate and House detailing research undertaken by any agency of government dealing with Persian Gulf War illnesses. The section would also specify a termination of such annual reports in 2013.

Section 306 of the bill would specify that VA payments under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) would constitute payments in full that extinguish any CHAMPVA beneficiary's financial liability to providers under that program.

Section 307 of the bill would provide that health care providers of care to children of Vietnam veterans with spina bifida participating in VA's health care program

would be authorized to bill liable third parties for excess costs not paid by VA for health care services to these eligible children.

Section 308 of this Title would authorize a VA practitioner to release certain medical information concerning a veteran's condition, to a veteran's surrogate when a veteran lacks decisionmaking capacity; when a veteran has not formally designated a representative nor authorized a release of such information; and, when the VA practitioner deems the conveyance of such information to be supportive of an informed decision the surrogate needs to make related directly to the care or condition of the veteran. This authority would apply only in cases involving substance-use disorder and addictions, infection with the human immunodeficiency virus, and in sickle cell anemia cases.

Section 309 of the bill would require that applicants for, and recipients of, VA health care furnish the Secretary the veteran's private health plan contract information (specifications dealing with coverage, the plan's identifying number and the group code, if applicable) as well as Social Security Number. Under the Section, this information would become a condition of eligibility for VA health care, and a veteran's declination to provide such information would be grounds for determination of ineligibility for VA health care.

Although DAV has no resolutions specific to the matters entertained in S. 2984, we are generally supportive of the provisions in this bill with exception of those matters in Section 304. We believe, both in instances of its knowledge of, and oversight in, VA practices with regard to paying nursing personnel and in conducting its strategic planning, that these reporting requirements should be retained in the law. We are particularly concerned at VA's proposal to discontinue its construction-related reporting while asking the Committee to rely primarily on VA's budget proposal as a source for relevant information on construction planning. The current reporting requirement in Section 8107 of title 38, United States Code, covers extensively more than simply the requested facility construction and leasing authorizations retained in the annual budget for a given year. We believe both Congress and the community of veterans service organizations, in properly representing veterans' interests, need to continue receiving these comprehensive reports on VA's strategic plans, including its construction planning.

Mr. Chairman, this concludes my testimony and I will be pleased to consider any questions by you or other Members of the Committee.

Chairman AKAKA. Thank you very much, Ms. Ilem.

Mr. Needham?

STATEMENT OF CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. NEEDHAM. Mr. Chairman and Members of the Committee, on behalf of the 2.3 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I would like to thank you for the opportunity to present our views at today's important legislative hearing.

There is a wide range of health care bills before us, so I will limit my remarks to a few of them. Our full comments on all may be found in our written statement.

First is S. 2799. We are pleased to support the Women Veterans Health Care Act. This bill would expand upon and improve the health care services provided to women veterans. Female veterans in OEF/OIF are experiencing types of conflicts that previous generations did not. They are involved in a conflict with no true front line and in a high-stress situation with almost no relent. The difficulties they face are a challenge for VA, which still is adapting to how it treats women veterans as it is a system that is predominately used to caring for male veterans. It is essential that VA's strategies for dealing with OEF/OIF issues are not one-size-fits-all. VA has made great strides, but the Department can certainly do more.

To that end, there are a few sections of the bill that I would like to highlight. Section 101 would create a long-term study of the health of female OEF/OIF veterans, which can only help to better serve their needs in the future.

Section 102 would study potential barriers to care, which would allow VA to develop strategies to expand access.

Section 203 would create training programs on how to deal with women veterans suffering from PTSD. It is likely that today's conflicts have different impacts upon men and women, and a mental health strategy that adapts to the needs of female veterans will likely see more success.

We have had a longstanding resolution in support of Section 206, which would mandate full-time Women's Program Managers at VA medical centers. We have found that many of these program managers are assigned on a part-time basis, doing that job in addition to their regular duties. With the growth in the number of female veterans, full-time employees would better be able to help the facility fulfill its duty to female veterans. We urge the Committee to pass this important bill.

The second bill today is S. 2921, the Caring for Wounded Warriors Act. This bill would create pilot programs to help family caregivers. The first program would let VA develop training and certification programs so that family caregivers can be compensated as personal care attendants. We strongly support this provision. For veterans suffering from the effects of severe Traumatic Brain Injuries, intensive care is critical. We have seen over the last few years that many families put their lives on hold at great financial penalty to care for their wounded heroes. This compassionate bill would allow these family members to be compensated for their time and effort in caring for those grievously wounded men and women.

The second program aims to expand respite care services to give these family caregivers a well-deserved break when they need it with proper oversight and management. We strongly support this, as well.

The third bill I will speak to is S. 2963. This comprehensive bill would make many improvements to the mental health care provided to veterans in the Armed Forces. We ask the Committee to approve this legislation, too.

Section 2 of this bill would allow active duty members to seek counseling service through Vet Centers. This is a terrific idea that could do a lot to break down one of the largest barriers of care—the stigma associated with seeking help. Giving these men and women a care option outside of regular DOD channels would allow them to seek care when they need it with no fear of reprisal. They would be free to do what is right for themselves, not what they believe they need to do to further their career or to avoid a negative impression from others.

Our only concern with this, though, is that Vet Centers are becoming victims of their own success. Increasing numbers of veterans have flocked to them, pushing their workload closer to the breaking point. If we are going to expand their services, we simply must have an expansion of staffing. To that end, Section 1 of the bill, which would create scholarship and incentive programs to recruit and train new staff, is a good step.

Before I conclude, just a quick note on S. 2639. The VFW continues to support this bill as it would lead to our ultimate goal of an adequate and on-time budget. But we understand the reticence of many to support a mandatory funding stream. With the Partnership for Veterans Health Care Budget Reform, we continue to look for new solutions that will achieve the same goal—a health care budget that is sufficient, timely, and predictable.

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

[The prepared statement of Mr. Needham follows:]

PREPARED STATEMENT OF CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee: On behalf of the 2.3 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I thank you for the opportunity to present our views at today's important legislative hearing. There is a broad range of health care legislation before us, ranging from funding the system to expanding care and services to our newest veterans. Our members appreciate the role you allow us to play in their consideration.

S. 2273

The VFW supports the "Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act."

This legislation would authorize the VA secretary to create a pilot program to provide grants to a number of entities providing housing for homeless veterans. Included in it would be grants for support services to low-income formerly homeless veterans residing in permanent housing, and grants for programs that assist veterans with transportation and child-care issues when working with VA's vocational rehabilitation programs. Both are worthy goals that could positively help these veterans get back on their feet.

We also strongly support section four of the bill, which would award grants for programs to conduct outreach to elderly and rural veterans and their spouses with respect to VA's pension programs. There certainly must be a great number of men and women who are not aware of their entitlement to this helpful benefit. Getting them access to the benefits they deserve and providing full outreach to them is clearly the right thing to do.

S. 2377, THE VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT

The VFW offers our support to this important bill, which aims to improve the quality of health care practitioners within VA.

It would tighten hiring practices for VA physicians by requiring them to disclose previous malpractice judgments, disciplinary actions and ongoing investigations. The importance of this issue came to light with the unfortunate incidents at the Marion VA facility. A doctor practiced medicine there despite agreeing to stop practicing in a different State and having two malpractice settlements and a disciplinary action elsewhere. If the doctor had had to disclose those facts, VA likely would not have hired him.

The bill would also create a quality assurance officer to oversee a health care quality assurance program. The program is designed to be an independent reporting system with multiple layers to ensure that any concerns about the quality of care are addressed and vetted independently.

A third part of the bill would create several new programs to help encourage high-quality doctors to work for VA. It would create loan repayment programs, tuition reimbursement for physician students, and allow part-time physicians to enroll in the Federal employee health benefits plan. These incentives would help VA hire experienced doctors as well as recruit and retain younger physicians.

If approved, this bill would likely mean higher quality physicians in VA, and for that reason, we urge its passage.

S. 2383

The VFW is happy to back this bill, which would create a pilot program to provide mobile health care services to veterans in rural areas. It would bring VA health care

providers and caseworkers directly to veterans in locations where access to a clinic or an office is highly limited. The mobile services would provide basic health treatments, provide prescriptions, screen for mental health issues as well as providing support and information with respect to the compensation system and other veterans benefits.

The number 1 issue brought up by rural veterans is the difficulty they have in accessing care. This is an innovative attempt to find a solution to some of the problems faced by veterans, by bringing them to VA instead of forcing them to travel many hours for even basic health care. This bill is a good step in addressing some of those problems, and we hope that if passed, the results from the pilot program would allow for the expansion of this program throughout the country.

S. 2573

While we appreciate the effort of the bill to try a new approach at tackling these difficult issues, the VFW does not support the "Veterans Mental Health Treatment First Act."

The aim of the bill is to incentivize treatment for veterans suffering from PTSD and other mental health issues. While that on its face is a good thing, much of the rationale behind it, we believe, is wrong. There are two main premises lurking behind the bill: (1) Veterans exaggerate their mental health problems to game the system and get higher levels of compensation; (2) Veterans discontinue their treatment because there is a financial disincentive to not get better, or to even get worse. Both are wrong.

On the first, we continue to believe that veterans do not exaggerate their symptoms. While it's true that the number of mental health diagnoses have increased dramatically over the last decade, that is not evidence in and of itself of fraud, nor is it an indication that something is wrong with the system. To us, it's a sign that veterans are becoming more aware of the terrific range of services and benefits VA provides them, and that these men and women are finally able to come forward with what must certainly be a difficult decision. Seeking help is not easy, and for many years, we have seen a negative stigma associated with mental health issues—look no further than the stereotypical image of the wacko Vietnam veteran. Coming forward to seek help is not easy, and rather than looking askance at those who do, we should trust that they are doing what they need to do to become healthy and whole.

The Institute of Medicine's 2007 study, "PTSD Compensation and Military Service" bears this out further. In the section discussing the trends in PTSD compensation, the study notes several reasons for the increase. While noting that PTSD diagnoses have gone up while anxiety disorders have decreased, they observe that it is possible that "some of the growth in PTSD was actually a change in diagnostic labeling with, for example, fewer veterans being classified with other anxiety disorders than in the past because these veterans were now being diagnosed with PTSD." If true, then the problem—if there is truly a problem—lays not with the veteran as this bill assumes, but with VA's ability to diagnose mental health disorders.

In the same section, the study notes some other reasons for the increase. The information they found "is consistent with the suggestion that the growth in PTSD awards is due to a greater willingness on the part of veterans to apply for PTSD compensation. It may also, though, reflect in part an increasing tendency for VA to recognize a diagnosis of PTSD and, more generally, to recognize disability resulting from any mental disorder." Again, the problem—if you can call veterans seeking out the treatment they need a problem—is with VA's diagnosis, not with veterans looking for treatment options.

On the second premise of the bill, the IOM's study found that this is a mistaken belief as well. In the chapter on "Other PTSD Compensation Issues," they note that most other scientific evidence does not support the 2005 VAOIG report, which claimed to have found evidence that veterans receiving compensation received less mental health treatment. "Longitudinal studies suggest that disability claim approval results in increased use of mental-health services. Cross-sectional research shows that veterans with service-connected disability for PTSD do not differ from non-service-connected veterans in their levels of participation in treatment, and there is some evidence that service-connected veterans are more likely to participate in treatment."

Overall, with the bill, we have serious problems with asking veterans to forgo their disability compensation. Even with the payments for treatment that this bill would provide, we cannot support legislation that will require a veteran to give up—even temporarily—one of their entitlements. This is especially true in the case of a veteran who would ultimately be diagnosed with a high level of PTSD or mental

health issue, even after treatment. The wellness stipend would not come close to that level of compensation, financially harming the veteran. And since there is no way for a veteran to know what his or her disability rating is ultimately going to be, a number of veterans and their families could be financially harmed by the choice to participate in the program. The choice is free for them to make, but veterans lack enough information prior to making it to determine whether it is a good decision or not.

Also, because the evidence indicates that the vast majority of veterans are already seeking care, are we sure that this would be the proper incentive to get new patients into treatment? If most already are seeking some sort of health care treatment through VA, it stands to reason that a number of those incentive payments would be provided to people already in the system, wasting money that could otherwise be used to bolster VA's mental-health programs.

We certainly support expanding access to health care options for veterans with mental health problems, and we would certainly like to see all veterans using the terrific resources of the VA health care system, but as the bill is written, the VFW cannot support it.

S. 2639

The VFW has had a long-standing resolution in support of amending the current discretionary funding process. We support the "Assured Funding for Veterans Health Care Act" as it would meet our goal of having a funding mechanism to provide VA with a sufficient, timely and predictable budget.

While great strides have been made in the yearly increases provided to VA, we are concerned that that same political will may not be there in the future once the Nation's attention shifts from the overseas conflicts. Further, we are disappointed with the timeliness of the health care budget. For 13 of the last 14 years, VA has not had its health care budget when the fiscal year began, forcing VA to make do with insufficient funding under continuing resolutions. We have also seen in previous years the need to go back to the drawing board halfway through the fiscal year to provide more money for VA through an emergency supplemental appropriation because insufficient money was provided the first time.

Taken together, these all point to a system that is broken and a system badly in need of reform.

VA's hospital managers cannot be expected to efficiently manage and plan for the health care needs of this Nation's veterans when they are unsure of their funding level from year to year and when the budget they do receive is months late. This yearly uncertainty impairs VA's ability to recruit and retain staff—a significant challenge recently with specialty care providers—contract for services and perform proper planning and other administrative functions.

We need an assured funding mechanism that provides VA with a sufficient, predictable and timely funding stream so that VA can efficiently and effectively provide first-rate health care to this Nation's veterans.

S. 2796

The VFW supports this legislation, which would create pilot programs for community-based organizations to help veterans better understand the benefits and services available to them. The grants provided under this program would allow organizations to set up telephone hotlines, assist veterans in applying for benefits, help families adjust to deal with the transition, provide outreach information on benefits and to help coordinate health care and benefits services to veterans.

While VA and the military services have done a better job about informing veterans—especially separating servicemembers—about their benefits and entitlements, we still can do a better job. As this bill acknowledges, there are gaps in awareness that should be filled so that all veterans equally have access to the full range of benefits. By working with community-based groups, the bill could better coordinate those groups underserved by VA and who may be less aware of their veterans benefits, and we strongly urge its passage.

S. 2797

The VFW supports this bill, which would authorize the construction and leasing of a number of major medical facilities throughout the country. Included in the list of projects are the top construction priorities as determined by VA's capital asset prioritization process. It also extends and increases the authorization for several projects previously authorized but that have not yet been completed.

The VFW hopes that Congress will fully fund VA construction so that we can move beyond the CARES process and address the growing backlog of construction needs throughout the country.

S. 2799

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

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

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

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

Section 102 would require VA to study any potential barriers to care faced by women veterans to determine any improvements that VA must make so that women veterans can access the care to which they are entitled. This is especially true of those women veterans who choose not to use VA care. Is it because of a stigma associated with VA, a previous bad experience or other reasons? To better prepare for the future, VA must know the answers to these questions and we strongly support this study. Along those same lines, section 103 would require VA to develop an internal assessment of the services it provides to women veterans, as well as plans to improve where it finds gaps. We, too, welcome this assessment. Section 104 would study the health consequences of military service among female OEF/OIF veterans.

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

The VFW supports section 204, which would create a pilot program to provide child care for veterans receiving health care through VA. This is a terrific idea, which has the potential to eliminate a barrier for care, especially for single parents.

We also strongly support section 206, which requires VA to have a full-time women veterans program manager at each medical center. We have had a longstanding resolution in support of this issue as a number of current program managers are assigned as part-time employees, or given the task in addition to their other duties. This severely limits their effectiveness and their ability to help the medical facility fulfill its duty to women veterans.

S. 2824

The VFW takes no position on this legislation.

S. 2889, SECTIONS 2–6

The VFW approves of the changes in sections two through six of this bill, which was introduced by request of VA.

Section 2 would allow VA to contract for specialized residential and rehabilitation care for certain OEF/OIF veterans. We have supported contracting for care in specialized circumstances where VA is otherwise unable to adequately provide care. Ideally, we would like VA to gain the in-house expertise to handle these issues, especially since a number of these veterans are likely to be accessing VA for their health care for many years, but contracting for care is valuable in the short-term.

Ultimately, though, we need VA to have the care of these brave men and women in mind over the long term.

Section 3 would reimburse certain physicians and dentists for their continuing education expenses, which can only help to serve as a recruitment benefit for those seeking to practice at VA.

Section 4 would prevent veterans receiving hospice care from having to pay copayments. This is a humane thing to do when a veteran is nearing the end of his or her life, and it shows compassion to their families at a most difficult time.

Section 5 would repeal section 124 of Pub. L. 100–322, which set out the specific circumstances and requirements under which VA could conduct testing for HIV. If repealing this section will result in VA being able to provide testing to more at-risk veterans with less inconvenience, then we support it.

We do not oppose Section 6, which would allow VA to permanently use information from the IRS and Social Security Administration for income-verification purposes.

S. 2899

The VFW certainly supports the idea of the "Veterans Suicide Act." This bill would require VA to study the number of suicides among veterans using information from the Department of Defense, veterans organizations, the Centers for Disease Control and Prevention, and various State offices.

The risk and problems of suicide among service men and women have come to the forefront over the last few months, especially with the increased attention paid to the various mental health issues many OEF/OIF veterans face. These reports have painted a confusing picture with uncertainty over the quality and accuracy of data, but the bottom line is that even one suicide is one too many.

Understanding the rate, the number of attempts and various other figures is essential for VA to properly implement a successful strategy of suicide prevention. VA certainly has improved their efforts and treatment is readily available for those who seek it, but more can certainly be done, and fully understanding the size and scope of the problem is one step toward a solution.

We would note that VA recently testified before the House Veterans' Affairs Committee on their efforts at data collection, which primarily relies on matching names and information it has with the efforts of the Center for Disease Control's National Death Index. We believe that they are on the right track with collecting the bulk of this information, but we would urge you to continue oversight to ensure that they remain on the right track and that they yield meaningful results.

To that end, we applaud the recent efforts of Chairman Akaka in requesting more information about suicides from VA, and we hope that this action will help us get closer to the truth.

S. 2921

The VFW urges passage of the "Caring for Wounded Warriors Act." This legislation would create two pilot programs to improve care for veterans suffering from Traumatic Brain Injuries. Both pilot programs would provide support for family caregivers, who are increasingly taking on a pivotal role in the health care and day-to-day life of those veterans affected by these disabilities.

The first program would require VA to develop a training and certification program for family caregivers to serve as personal care attendants. This would qualify them to receive compensation from VA for the services they are rendering to their loved ones. This compassionate program would absolutely make a positive difference in the lives of those affected. It would allow more family members to play an active role, ensuring that the veteran receives excellent care from someone who truly cares about their condition.

The second program would test the feasibility of using properly trained graduate students to provide respite care for families serving as caregivers. This is an innovative approach at managing a difficult problem, and with proper oversight of this program, we would support it.

We think the provisions of this bill would be of real benefit to those veterans suffering from the effects of TBI. We strongly support its passage, and would hope that the pilot program would yield results that would merit it being expanded nationwide where appropriate.

S. 2926

The VFW endorses the "Veterans Nonprofit Research and Education Corporations Enhancement Act." This legislation would make several changes, which would strengthen and improve the nonprofit research corporations affiliated with VA.

These NPCs help VA to conduct research and education and assist in the raising of funds for VA's essential projects from sources VA otherwise might not have access to, including private and public funding sources.

Included in the legislation is a section that would reaffirm that these NPCs are 501(c)(3) organizations that are not owned or controlled by the Federal Government. This is important to ensure that they are able to receive funding from all intended sources and to clarify their purpose in accordance with various State laws or private foundation regulations.

It would also allow for the creation of multi-medical center NPCs to streamline and make the administration of these important organizations more efficient. Ultimately, this should make more funds available for critical research purposes. Additionally, it would improve the accountability and oversight of these corporations, requiring more information in their annual reports and periodic audits of their activities. As these corporations continue to expand, we urge continued oversight of their actions to ensure that they continue to serve the best interest of America's veterans.

The legislation would address some of the concerns laid out in the recent VAOIG report, "Audit of Veterans Health Administration's Oversight Nonprofit Research and Education Corporations."

S. 2937

The VFW supports this legislation, which would permanently extend treatment for veterans who participated in chemical and biological tests conducted by the Department of Defense through the Deseret Test Center.

Project 112/Project SHAD were programs started in 1962 to test the capability of protecting and defending potential chemical and biological warfare threats. The tests, conducted through the Deseret Test Center in Utah, involved nearly 6,000 servicemembers as part of 134 planned tests. These tests sometimes used highly toxic agents, such as sarin and VX, as well as infectious bacteria.

With the uncertainty of their medical conditions as well as the DOD's delays in declassifying essential information, VA has provided cost-free health care to these veterans for conditions that may be related to their exposure. This has clearly been the right thing to do. This bill would give these veterans permanent access to health care for the treatment of any potentially related conditions.

Although a May 2007 Institute of Medicine study found no clear evidence of specific long-term health effects related to the participation of these tests, the authors also made it clear that "their findings should not be misconstrued as clear evidence that there are no possible long-term health effects." With this in mind, giving these servicemembers the benefit of the doubt is sound policy.

S. 2963

This comprehensive legislation would make many needed improvements to the mental health care services provided to veterans, but also to members of the Armed Forces and survivors. This bill recognizes that many of today's war wounds are invisible wounds—wounds that often take months to appear—making the transition our service men and women face all the more difficult. The looming crisis necessitates action, and this bill is a strong first step in that direction.

Sections 1 through 3 of the bill concern Vet Centers. The VFW is a strong supporter of Vet Centers and their approach to providing care—especially mental health care—to veterans. VA has done a pretty good job expanding their reach, but they are victims of their own success. We are starting to see Vet Centers struggle with difficult workloads as increasing numbers of veterans turning to them for the essential services they provide. A report done by the staff of the House Veterans Affairs Subcommittee on Health showed that these centers are nearing a breaking point. They need more staff to manage the workload. Section 1 would help this in that it provides a scholarship program for individuals seeking education and training in health care specialties needed by the Vet Centers. Finding qualified mental health professionals is a challenge for VA, and the more incentive they can provide potential employees, the more likely that these men and women will turn to VA as their employer of choice.

Section 2 would allow OEF/OIF veterans to receive counseling services through Vet Centers, even before they separate. With the number of these brave men and women diagnosed or likely to be diagnosed with a mental health condition, expanding access to health care services for them is the right thing to do. This change is important for two reasons. First, military mental health services come with a stigma. That stigma has been shown repeatedly to be the biggest impediment to these men and women getting care when they need it. Allowing them to seek care outside regular military channels can only serve as an incentive for them to get care early,

when it is often found to be most effective. With no fear of reprisal or reporting, they are free to do what they need for themselves, instead of having to worry about their careers or the impressions of others. The second reason is that the military does not have a sufficient number of mental health care providers. While this legislation does not absolve the military of their need to properly care for these men and women while in service, it helps fill in the gaps in care that too often swallow up those in need.

We do have some slight concerns about this provision in combination with the issue of the current demand for services, though. With the anticipated expansion in workload this change would make, we would like to see more resources dedicated to staffing Vet Centers to ensure that those currently utilizing them are not delayed or denied care.

Section 3 would require VA to help seek outside counseling services for veterans who are otherwise not authorized to receive care through VA. This is clearly the right thing to do.

Section 4 would treat suicides of veterans who have a combat-related mental health issue, PTSD or TBI on their record as being in the line of duty if it occurred within 2 years of their separation. This would entitle their family members and beneficiaries to the range of benefits this Nation provides to help them deal with the tragedy. It acknowledges that these invisible wounds of war are often as traumatic and life altering as the physical wounds, even if their impact can occur years after the veteran faces the last shot.

Section 5 would allow DOD to provide grants to non-profit organizations that provide support for survivors of deceased members of the Armed Forces and veterans. These services would expand and go beyond the limited services provided by the military's casualty assistance officers and can only help ease the burden on these families at a most difficult time in their lives.

S. 2969

The VFW asks the Committee to approve the "Veterans Medical Personnel Recruitment and Retention Act." We believe that this legislation would dramatically improve VA's ability to recruit and retain high-quality medical professionals and that this would increase the quality of care provided to this Nation's veterans.

VA has had difficulty attracting and retaining medical professionals. Many facilities are understaffed, which is in essence a rationing of health care. The April 2008 hearing this Committee held on these issues showed a broad range of reasons for why VA has difficulties recruiting and retaining health care employees, and we believe that this legislation addresses the largest of those concerns.

It would increase pay for critical jobs, bringing them in line with what the private sector can pay. It would create special incentive pays for certain specialties and hard-to-fill positions. It would create market pay and provide adjustments for localities to bring salaries in line with what local markets bear for similar employees elsewhere.

Beyond compensation, it would make nursing more attractive, by limiting mandatory overtime and providing for flexible work schedules, which are highly attractive to potential recruits in a highly competitive labor market.

It would also improve educational assistance programs, loan repayments and provide education debt reduction for certain employees.

Taken together, these meaningful changes would likely improve VA's ability to recruit and retain employees, making VA the employee of choice for greater numbers of health care professionals. We strongly support these provisions, and we would urge its swift passage.

S. 2984, TITLE III

Title III of this legislation, which was introduced at VA's request, deals with various health care matters.

Section 301 adds non-institutional extended care services to the list of medical services VA provides. Section 302 extends various authorities, including nursing home care through 2013 and research corporations through 2013. Section 303 gives permanent authority for medical care services to veterans who participated in certain chemical and biological testing. We strongly support this section. Section 304 would amend annual reporting requirements and section 305 would change reporting requirements for the annual Gulf War research report; we do not object to either.

Section 306 would consider would determine that payment by the Secretary for care provided under CHAMPVA would be considered payment in full, eliminating any liability for the beneficiary to pay. We support this. Section 307 would allow

health care providers who give services to children of Vietnam veterans born with Spina Bifida to seek the full costs of care from third parties. In that this would likely mean more care providers would provide the often intensive care these children need, we would be inclined to endorse it.

Section 308 would allow VA to share records of patients who lack decisionmaking capacities with their representatives. Section 309 would require a veteran to provide third-party insurance information and their social security number for verification purposes when receiving VA health care. We are not opposed to this, and proper and full collections from third parties can only help free up health care resources that could be better spent elsewhere in the system.

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

Chairman AKAKA. Thank you very much, Mr. Needham.

Now I will call first on Senator Murray for her questions.

Senator MURRAY. Thank you, Mr. Chairman, and thank you all for your testimony and long-time service for veterans.

Ms. Ilem, let me start with you. The VA, you just heard them express strong opposition to the staffing standards for MST care in the women veterans health bill before. I just wanted to ask you, as a woman veteran yourself, you have undoubtedly heard from female veterans who have received treatment for MST at VA facilities. Have the women that you have talked to or heard from that have been treated for MST been satisfied with their current treatment or care? Do they feel they have been rushed? What has been their experience?

Ms. ILEM. I haven't heard negative things from women veterans themselves regarding it. They usually have very high praise for the counselors, their mental health providers for MST. What we have heard, though, is on the side of the providers. These are often very complex cases, very time consuming cases, and there is a high burn-out rate among providers who provide this very unique type of care. And so, our concern is to make sure, number 1, that we do have providers that are adequately trained; have expertise in military sexual trauma, since it is unique; and have a good cultural understanding/background of military service and that component of women within the military service.

So, we think it would be important to definitely have qualified providers and to make sure that they don't have burn-out rates. It is very interesting to see VA's numbers in terms of how many people they really have—if not certified, but officially—that claim expertise in these areas, because that would be, to us, very critical for those patients.

Senator MURRAY. Do you think there is care across the country that is the same, or do you see different things in different places?

Ms. ILEM. I think that the care can vary from facility to facility, and I guess the biggest thing that we often hear is that a provider leaves that has expertise, whether it is in their medical health or mental health for women veterans, but when they leave, it is a very big gap, and they often have a hard time recruiting for those positions or maintaining those positions, but it is usually a big hole, obviously, when they leave, and so I think that is a key issue.

Senator MURRAY. So, I assume you support the staffing standards that we have put in the bill?

Ms. ILEM. Yes.

Senator MURRAY. One of the other things that we discussed quickly with the VA was the issue of barriers for women accessing

VA facilities, child care in particular, and I often find there is a lack of understanding from some people why child care is a barrier to women getting care, especially mental health care. Ms. Ilem, do you have any views on that?

Ms. ILEM. I think that the studies that have been done—and we have been hearing this for years now—about a barrier to care that often women are the primary caretaker of children, not always, but predominately; and oftentimes if they have intensive mental health treatment or intensive medical appointments to attend to, it is difficult for them to secure child care in those cases. And I think VA—in looking over VA's statement just briefly, it does give concern as you mentioned—that they admit that this is known to be a barrier to care for women veterans oftentimes and, therefore, if we are really trying to do outreach for women and look at those barriers, what is the point if we are not going to do something about it? I can appreciate that they are saying it is going to come out of their medical care budget. However, this is an access to medical care issue, we believe.

Senator MURRAY. I agree. Any other comments from any of you on this? Mr. Wilson?

Mr. WILSON. Yes, Senator Murray. I have visited the State of Washington—Walla Walla, Spokane VA Medical Center, as well as Puget Sound—and something unique and particular that I noticed that wasn't consistent across the board was a private entrance for those suffering from—or seeking help for—MST. I think I visited in 2006 and returned in 2007. In 2006, there was no private entrance, and that was in Puget Sound, and we returned in 2007 and there was a private entrance.

The difference in those two visits were basically comments by women. They were pretty apprehensive about visiting there. So, any issue that arises, including child care, that stigma was in their minds. So, any little issue would turn them away. While we couldn't tell how many were there, or we couldn't assess how many were there, there were women who were exiting from the building and we interviewed them regarding how they felt about that and we got a positive response, and that is as opposed to other VA medical centers they visited where they did not have a private entrance.

Senator MURRAY. I thank you for pointing that out. We worked very closely with our VA facilities in the State of Washington to provide that separate entrance, because particularly for women suffering from mental health, or MST in particular, it is very challenging to walk into a waiting room with all men, and that has eased their access tremendously. We have gotten great positive feedback from that, because the last thing we want, Mr. Chairman, is for these women with MST, with PTSD, with other mental health issues, to choose not to get care, and that is why this bill is so important. Everything within it is to make sure those women get the care they need.

So, I really appreciate, Mr. Chairman, your having the hearing on this. I know you have scheduled a markup for later, and I look forward to working with you to get it passed. So, thank you to all of our witnesses today.

Chairman AKAKA. Thank you. Thank you very much, Senator Murray.

This question is to all of our witnesses. In your testimony, you all expressed your support for allowing active duty servicemembers to access Vet Centers for readjustment counseling. However, only one of you addressed the issue of the impact that allowing an entire new population into the Vet Center system may have on its resources. Do you believe that sufficient capacity currently exists within the veterans system to allow all active duty servicemembers through its doors? Mr. Blake?

Mr. BLAKE. Well, Mr. Chairman, I would say that as it is currently constructive, that it probably doesn't have sufficient capacity, but I think that this is a leap worth taking and if it means improving the capacity of the Vet Centers, then it should be done. I think given some of the discussion about the stigma relating to mental health and seeking treatment, it is certainly something that has come out for active duty soldiers. I know there have been a number of things announced by DOD in recent weeks regarding trying to destigmatize seeking mental health treatment, but the fact is that stigma still exists; and if opening the Vet Centers to these individuals opens another door for them to seek that treatment, then we need to take whatever steps are necessary.

Chairman AKAKA. Thank you. Mr. Wilson?

Mr. WILSON. I think we could mirror the concept of Vet Centers, as Mr. Blake stated, regarding the stigma at the VA medical facility; and it may not be there, but the thought is Vet Centers provide a very comfortable atmosphere. We visited well over 50 last year and they are consistent across the board. They have been around since 1979. Something seems to be working, and I have heard VA medical center employees outside of the Vet Center. I think they are a little envious and want to work closely with Vet Centers—well, they actually are working closely with Vet Centers. So, I think that is—and that is good.

In answer to your question, I think that we should allow our Armed Forces members to access Vet Centers. They have proven effective in the past and are currently effective.

Chairman AKAKA. Ms. Ilem?

Ms. ILEM. Just briefly, I would concur with my colleagues' statements regarding this issue. I think that they would have to address the capacity issue of the centers—that it is extremely important, given especially our Guard and Reserves, as they go into veteran status, back on active duty, and repeated deployments; and that the OEF/OIF veteran population has repeatedly indicated that they have concerns about going within the military structure due to the impact on their career or stigma within. So, if it offers an opportunity to get early treatment for some of these conditions and delay or prevent long-term problems, we think it would be in their best interest.

Chairman AKAKA. Thank you. Mr. Needham?

Mr. NEEDHAM. As we said in our testimony, we have slight concerns about the future. It is our understanding that Vet Centers are basically managing right now. The concern is with the added burden of them as well as the returning servicemembers in the future, but we brought that up not as our objection to the bill. Like

the other organizations have said, we strongly support this provision. It is something that we think would have a tremendous impact on the quality-of-life of active duty as well as when they separate and could lead to perhaps fewer diagnoses of PTSD or other mental health illnesses in the future, or at least the illnesses being less severe.

The key thing is, like we said, we just need to devote more resources to staffing for Vet Centers. We strongly support passage of that provision, but like we said, we just need more staff.

Chairman AKAKA. Thank you. Mr. Blake, you discussed PVA's support of S. 2921, Senator Clinton's bill to support family caregivers. It is also my understanding that this program is based upon a similar program in San Diego for spinal cord injury patients. Can you tell us more about the San Diego program and how it has helped SCI patients and their caregivers?

Mr. BLAKE. I would say first, Senator, that I am not the subject matter expert and I can probably pull together more information to submit to you. But, as I understand what the program does, it is not unlike what the legislation proposes here on a broader scale. The San Diego VA undertook an initiative along with the spinal cord injury center (that is co-located there) to provide a training program that would result in certification for personal care attendants for veterans who have experienced spinal cord injury, who are among the most severely disabled, obviously, veteran population.

What this does is it provides family members who often are the personal care attendants or caregivers of these individuals the professional training and the certification they need, and the skills and abilities to kind of become an extension of the specialized treatment of these veterans outside of the VA medical center itself. It also opens up some financial assistance to these caregivers as a result of the certification they receive from the VA.

We have advocated for expanding this program in the past. We are certainly glad to see that Senator Clinton's legislation would undertake that proposal.

Chairman AKAKA. Thank you. This question is to all of you. Please share with us what your members and your staff in the field relay to you about the impact that delayed funding has had on patient care and facilities across the VA system. Mr. Wilson?

Mr. WILSON. Delayed construction and space——

Chairman AKAKA. Yes, and facilities and patient care—delayed funding for them.

Mr. WILSON. Yes. The commonality from my guys who actually travel throughout VA medical centers, as far as delayed funding, to ensure that I represent the full consensus of the American Legion, I would like to reserve my response to a later date.

Chairman AKAKA. The question was, what impact does that——

Mr. WILSON. Yes. I would like to reserve the response for a later date, just to ensure that I represent the full consensus of the American Legion.

Chairman AKAKA. Thank you. Anyone else?

Ms. ILEM. I am happy to take a stab at it.

Chairman AKAKA. Ms. Ilem?

Ms. ILEM. I think not only from our membership, but thinking back to the testimony actually before this Committee in July 2007

regarding funding reform or funding issues, were the comments made for the record or in written statements from the former Directors of the VA about what the impact really was on patient care. And the one thing that I remember is that they all had in common that health care for veterans was their absolute highest priority within trying to deal with the budget that they had. But, those impacted on a series of things including: maintenance, delay in maintenance issues, capital asset issues, being able to hire staff, and a variety of other issues, which then, in turn, to us equates to there can definitely be an impact on health care of veterans related to those things that we have seen over the years. So, I think those issues are important to remember as an impact of the delayed funding that occurs.

Chairman AKAKA. Mr. Needham?

Mr. NEEDHAM. I think one of the challenges, as Joy just said, is certainly the recruitment and retention of staff—that if there is year-to-year uncertainty about what the final budget number is, it makes hiring and retaining effective staff difficult. I mean, we have certainly seen in the last few years VA having problems with secondary care, particularly with mental health counselors, as they are trying to increase the number there; and certainly an on-time budget affiliated with that would allow VA to better plan and process, to know what the ultimate number of employees they are going to need, and to recruit and attract those employees ahead of time.

Chairman AKAKA. Thank you. Thank you for that.

Let me ask Senator Murray, do you have any further questions?

Senator MURRAY. I don't have any additional questions at this time.

Chairman AKAKA. Well, let me ask a final question to this panel. In your testimony, all of you expressed your support of my personnel bill and I thank you for that. I would like to ask, however, what your thoughts are on VA's assertion that the provision in S. 2377—requiring that VA doctors be licensed in the State that they are practicing in—could be detrimental to the recruitment of VA physicians. VA's concerns stem largely from the fact that because VA is a nationwide system, many physicians often cross State lines to practice medicine within the system. Do you have a comment on this?

Mr. BLAKE. Senator, I would say it is certainly a valid concern. Maybe I am a little unclear as to what the legislation calls for. Maybe I don't understand. If a doctor is licensed in another State but not in this particular State, can they still practice, or must they then get licensed in the particular State? I think we have to be careful that it doesn't limit the VA's ability to hire individuals who would otherwise be needed professional staff. So, I think it is a valid concern and I can understand at the same time, in light of the discussion about Marion, Illinois, where this becomes a concern, as well. But, I think some more thought needs to be put into this and a little bit—dig in a little deeper to see what the real impact could be of this particular provision.

Chairman AKAKA. Thank you. Any other comments? Mr. Wilson?

Mr. WILSON. Yes, Senator. In light of what occurred in Marion—and it seemed to have begun in Massachusetts, but it ended in Massachusetts and—it was, I will say, negotiated and manipulated

over to Marion and there was no effective communication. Tragedies took place. I think that is a loophole that should be closed and we are not so sure that that loophole is closed. We are not sure if it is occurring elsewhere. Because you have one piece of legislation in one State and another in another as far as requirements, there is going to be a gap or loophole unless we get to communicating. And the one who suffers, or the ones who suffer, will be the veterans.

Chairman AKAKA. Thank you. Any other comment? Ms. Ilem?

Ms. ILEM. I would just briefly indicate I think the VA did raise some valid concerns today and I know they mentioned in their statement that no other Federal agency, I believe, had those requirements and it could impede them in terms of their flexibility and the VISN layout where they cross State lines and things like that. So, certainly we are hoping that the Committee will take an additional look at that and consider it based on VA's expertise.

Chairman AKAKA. Thank you. Mr. Needham?

Mr. NEEDHAM. Yes. If the reason for imposing the requirement is for a proper vetting procedure, then perhaps, as is being suggested, there are other ways to go about vetting to determine that a doctor is qualified in a particular State without necessarily having a license in that State.

Chairman AKAKA. Well——

Mr. BLAKE. Senator, could I add one thing?

Chairman AKAKA. Yes, Mr. Blake?

Mr. BLAKE. I think the Marion situation points out a problem with communication across the VA system and not necessarily a breakdown of the licensing or certification of the doctors themselves. A concern we would have would be for specialized care doctors, like those who provide care for spinal cord injured veterans. It is a very limited pool of professionals out there that can provide this type of care and it is a very competitive market. So, if a doctor is prevented from being hired simply because they are not at this time licensed in a particular area and yet they have well-established credentials and have otherwise demonstrated the ability, we would have some concerns with not hiring an individual, particularly in a specialized care field where they might be needed.

Chairman AKAKA. I thank this panel very much for your testimonies and this will be helpful to us. Thank you very much.

I would like to welcome the third panel. First, I welcome Dr. Stan Luke, Vice President for Programs of Helping Hands in Hawaii. I welcome J. David Cox, a Registered Nurse and the National Secretary-Treasurer of the American Federation of Government Employees. Next, I welcome Cecilia McVey, a Registered Nurse and former President of the Nurses Organization of Veterans Affairs. I also welcome Donna Lee McCartney, Chair of the National Association of Veterans Research and Education Foundations. I welcome our fifth witness, Dr. Sally Satel, Resident Scholar at the American Enterprise Institute. And finally, I welcome Dr. Thomas Berger, Chair of the National PTSD and Substance Abuse Committee for Vietnam Veterans of America.

I thank all of you for being here today. Please know that your full testimony will appear in the record of the Committee.

I would like to call on Dr. Luke to please begin your testimony, and thank you very much for coming from Hawaii to testify. Thank you.

STATEMENT OF STAN LUKE, Ph.D., VICE PRESIDENT FOR PROGRAMS, HELPING HANDS HAWAII

Mr. LUKE. Chair Akaka, Senator Murray, distinguished Members of the Committee, thank you for the opportunity to offer testimony on this critical matter. I am Dr. Stanley Luke, a clinical psychologist and the Vice President of Programs for Helping Hands Hawaii, a provider of mental health services for Hawaii adults.

Since the start of the Iraq War, we have seen an increase in demand for treatment of PTSD and Traumatic Brain Injury. There are two major problems that we have identified. First, barriers to treatment. The volume of eligible veterans has increased so much that the system is unable to accommodate the demand. The consequence on a clinical level is that those with PTSD and Traumatic Brain Injury are left untreated and their illnesses and injuries get worse, resulting in increased family conflict, financial burdens, and many veterans dropping out of necessary treatment out of frustration.

Second, delays and hurdles in disability applications. Many veterans experience financial hardship because their applications are delayed in a system that is overwhelmed. For many disabled veterans, this confluence of financial pressure, frustration with the system, and their attendant disability results in bad outcomes.

Consider the following hypothetical case, which is typical. Sergeant John Doe comes home from a tour of duty in Iraq and Afghanistan. He was wounded and removed from his unit, stayed in a military hospital in Germany, and returns to his hometown. Upon return, he is having nightmares, irritable mood, family conflicts, hypervigilance, and a startle response—classic Post Traumatic Stress Disorder. Anything, a pile of trash on the side of the road, an abandoned car, can trigger a memory of an IED or another upsetting occurrence. This is the kind of psychiatric disorder that requires immediate attention after separation from the military. The current delays exacerbate the condition and may result in violent behaviors.

From a Hawaii perspective, the lack of a stand-alone veterans hospital means that active duty military and the veterans are treated at the same facility. This makes it nearly impossible for Tripler Hospital and the VA clinic to handle both groups effectively and efficiently. There is literally not enough room.

From a Native Hawaiian perspective, it would be unusual and uncharacteristic for a soldier to assert that he or she is experiencing mental health problems and needs help. The cultural disconnect between the skilled VA staff and the so-called, quote, "local" people decreases the likelihood that Hawaii's veterans will willingly seek the services that they need.

Our Hawaii-based efforts have focused on bridging the divide and utilizing our cultural competency to assist veterans in accessing the care they deserve. The proposal for a pilot program to assess the feasibility and the advisability of using community-based organiza-

tions to ensure that veterans receive the care and benefits that they need is a wise beginning.

Helping Hands Hawaii has endeavored to start this process with the establishment of a small office dedicated to identifying eligible veterans and assisting them with navigating the complexities of the VA system, as well as providing group therapy and other necessary case management services. A staff psychologist and a case manager have been visiting National Guard units both before and after deployment to educate soldiers about their treatment options and rights. In addition, we have been collaborating with Native Hawaiian health centers and a health-related organization called Papa Ola Lokahi to reach out to eligible veterans.

As someone with a specialization in treating PTSD, I want to personally thank the Members of this Committee for their vigilance and their commitment to providing the care that our returning soldiers need. With pilot projects such as this, combined with your oversight and sufficient funding, we will honor our veterans, improving their quality-of-life and perhaps even saving lives.

Thank you for the opportunity to provide testimony.

[The prepared statement of Mr. Luke follows:]

PREPARED STATEMENT OF DR. STANLEY LUKE, VICE PRESIDENT OF PROGRAMS, HELPING HANDS HAWAII

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Since the start of the Iraq War, we've seen an increase in demand for treatment of PTSD, and Traumatic Brain Injury. There are two major problems that we've identified:

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The volume of eligible veterans has increased so much that the system is unable to accommodate the demand. The consequence on a clinical level is that those with PTSD and Traumatic Brain Injury are left untreated, and their illnesses and injuries get worse, resulting in increased family conflict, financial burdens, and many veterans dropping out of necessary treatment out of frustration.

SECOND, DELAYS AND HURDLES IN DISABILITY APPLICATIONS

Many veterans experience financial hardship because their applications are delayed in a system that is overwhelmed. For many disabled veterans, this confluence of financial pressure, frustration with the system and their attendant disability results in bad outcomes.

CONSIDER THE FOLLOWING HYPOTHETICAL CASE, WHICH IS TYPICAL:

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ple decreases the likelihood that Hawaii's veterans will willingly seek the services that they need. Our Hawaii-based efforts have focused on bridging the divide and utilizing our cultural competency to assist veterans in accessing the care they deserve.

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Helping Hands Hawaii has endeavored to start this process, with the establishment of a small office dedicated to identifying eligible veterans and assisting them with navigating the complexities of the VA system, as well as providing group therapy and other necessary case management services. A staff psychologist and a case manager have been visiting National Guard Units, both before and after deployment to educate soldiers about their treatment options and rights. In addition, we've been collaborating with native Hawaiian health centers and a health related organization called Papa Ola Lokahi to reach out to eligible veterans.

As someone with a specialization in treating PTSD, I want to personally thank the Members of this Committee for their vigilance and their commitment to providing the care that our returning soldiers need. With pilot projects such as this, combined with your oversight, and sufficient funding, we will honor our veterans, improve their quality of life, and perhaps even save lives.

Thanks for the opportunity to provide testimony.

Chairman AKAKA. Thank you very much, Dr. Luke.

Mr. Cox?

STATEMENT OF J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Mr. COX. Chairman Akaka, Ranking Member Burr, and distinguished Members of the Committee, thank you for the opportunity to testify today on behalf of the American Federation of Government Employees and the nearly 160,000 VA employees we represent. My oral statement focuses on pending health care personnel legislation.

Chairman Akaka, we greatly appreciate your introduction of S. 2969. It offers a comprehensive solution for VA nurse recruitment and retention problems. Your bill recognizes the importance of VA's part-time nurses and provides them with the right to become permanent employees. Last year, the VA rejected AFGE's grievance on mandatory nurse overtime. This bill will ensure that the VA has a sound and safe policy to protect nurses and patients from prolonged, unnecessary overtime consistent with overtime limits already in place in 15 States.

Provisions to increase management training on the nurse locality pay process will address chronic implementation problems. Increased employee access to pay survey data will make facility directors more accountable for their locality pay policies. For this reason, AFGE strongly opposes the proposal in Section 304 of S. 2984 that eliminates the current reporting requirements on nurse pay adjustments.

AFGE strongly objects to Section 2(a) of S. 2969, expanding the Secretary's Title 38 authority and converting thousands of nursing assistants to a hybrid Title 38 process that is plagued by severe backlogs, as simply bad policy. Delayed appointments of psychologists and social workers are impeding the VA's ability to meet the unprecedented demand of OEF/OIF veterans for mental health treatment. Employees placed in hybrid Title 38 positions also lose their veterans' preference protections. AFGE urges this Committee to reject this proposal to expand Title 38 authority and rather con-

duct a pilot project using a streamlined Title 5 hiring process to compare the two systems.

AFGE also thanks Senator Murray for introducing S. 2799, to ensure the VA meets the unique health care needs of women veterans.

Turning to S. 2824, that restores Title 38 collective bargaining rights, we are very grateful to Senator Rockefeller for responding to the VHA personnel crisis by introducing this bill, and cosponsors Webb and Brown. S. 2824 is an essential enforcement tool for past and future recruitment and retention legislation aimed at front-line nurses, physicians, and other Title 38 providers.

In 1991, Congress enacted Section 7422 of Title 38 to provide these providers with the rights to challenge improper personnel policies through grievances, arbitrations, and the courts. Providers lost these rights because the VA began using an arbitrary interpretation of the three exceptions in Section 7422 of Title 38, professional conduct and competency, peer review, and compensation. Management's 7422 policy directly contradicts Congressional intent, as is evident in the plain language of the law and legislative history. Management's 7422 policy is inconsistent with its own position in a 1996 labor-management agreement to allow grievances over working conditions that affect patient care indirectly, such as scheduling matters and access to pay survey data.

The Under Secretary for Health's published decisions reveal a direct assault on the rights established through legislation on nurse locality pay in 2000, physician pay in 2004, and limits on nurse overtime the same year. The VA testified that S. 2824 will allow labor to disrupt patient care, but management's rights to determine the agency's mission under Title 5 already protect against that. The VA cannot point to a single case where a grievance involved a challenge to medical procedures. VHA employees who have full grievance rights, such as LPNs, psychologists, social workers, and pharmacists, never use these rights to disrupt patient care.

The VA testified that employees already have a fair process through the Under Secretary for Health review, but fair to whom? One hundred percent of these decisions have been in favor of management for the past 3 years. Shouldn't VA health care dollars be spent on caring for veterans, not looking for ways to block legitimate concerns of hard-working, dedicated nurses and physicians?

Thank you, Mr. Chairman. I will be glad to take any questions.

[The prepared statement of Mr. Cox follows:]

PREPARED STATEMENT OF J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

The American Federation of Government Employees, AFL-CIO (AFGE) thanks you for the opportunity to testify today on behalf of the nearly 160,000 AFGE members working at the Department of Veterans Affairs (VA), more than two-thirds of whom are on the front lines caring for veterans at VA hospitals, clinics and long-term care facilities. AFGE's testimony will focus primarily on pending personnel legislation.

In my nearly 25 years as a registered nurse and union official at the Salisbury, North Carolina VA Medical Center, I have seen the impact of many Veterans Health Administration (VHA) personnel policies on provider recruitment and retention providers. In the 1980's, I saw firsthand how good labor-management relations helped transform the VA into a world-class health care system, enabling the VA to become a model in patient safety, health care information technology, and best practices due to regular collaboration between front line providers and management.

Sadly, what I have seen over the past 7 years is a sea change in VA's personnel practices that now hurt, rather than help recruitment and retention, and exclude front line providers from medical affairs. We are extremely grateful to Chairman Akaka and other Members of the Committee for their efforts to make VHA's personnel practices more competitive, transparent and equitable.

S. 2969. VETERANS' MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT OF 2008

We greatly appreciate Chairman Akaka's comprehensive effort to address VA nurse recruitment and retention in this legislation. AFGE supports S. 2969 except for the provision in Section 2(a) to expand the Secretary's Title 38 authority.

Section 2(b) provides a long overdue adjustment to the rules that apply to part-time registered nurses (RN), allowing them to earn the rights of permanent employment and to retain permanent status if previously full-time. The flexibility of a part-time schedule is a valuable recruitment and retention tool in today's nursing shortage.

Section (3):

Mandatory Overtime: Fifteen States already limit the amount of overtime that a nurse can be forced to work. State legislatures enacted these protections because of a growing body of research finding that prolonged overtime puts both the nurse and patient at risk. It is time for the VA to implement its own evidence-based overtime policy using a common definition of emergency to mandate longer hours. Section 3 will establish a sensible and safe overtime policy that ensures that all nursing positions are equally protected:

Pay:

Section 3 will ensure that VA pay policies are more consistent and competitive. Lifting the current pay caps for Certified Registered Nurse Anesthetists and Licensed Practical Nurses will enable facilities to offer these employees needed pay incentives. Clearer rules on premium and overtime pay for all nursing positions will increase the uniformity of VA pay policies and decrease nurse frustration.

Management training on the nurse locality pay process will increase compliance with the 2000 nurse locality pay law that Congress enacted to address recruitment and retention; greater employee access to pay survey data will add accountability to the locality pay process to ensure that surveys are done timely and properly and that needed pay adjustments are made. AFGE is strongly opposed to any proposal that lessens accountability for nurse pay policies, including the proposal in Section 304 of S. 2984 to eliminate current reporting requirements, as will be discussed.

An effective nurse locality pay process also serves the interests of veterans who cannot get hospital beds due to staffing shortages, and the interests of taxpayers footing large bills for agency nurses and diversion of patients to non-VA hospitals.

Section 4 provides a much needed boost to the Educational Debt Reduction Program (EDRP). This program has a long and impressive track record in attracting new nurses to the VA and supporting current employees who want to pursue RN careers in the VA.

Section 2(a):

AFGE strongly objects to Section 2(a). Conversion of nursing assistants to hybrid Title 38 and expanded Secretary discretion to convert other positions will devastate a severely backlogged hybrid appointment process. Employees already face extreme delays in appointment and promotion. Ironically, we hear reports that on average, it is quicker to hire or promote under Title 5, even though Congress' top objective in establishing hybrid positions was to provide a faster alternative to Title 5.

Delays in hybrid appointments have already hurt the VA's ability to expand its mental health capacity to treat OEF/OIF veterans. For example, all new hybrid employees were supposed to be boarded by September 30, 2006 but many VA psychologists are still waiting to be boarded; AFGE waited over 4 years for social worker qualification standards.

Hybrid Title 38 employees are not covered by the same veterans' preference rules as their Title 5 counterparts. Therefore, expanded hybrid authority will adversely impact veterans' employment opportunities at the VA—the Federal agency that should be a model employer for others.

In the alternative, AFGE recommends that the VA suspend future hybrid appointments pending the completion of a pilot project using a streamlined Title 5 hiring process and comparative study of the two systems. AFGE would like to work with the Committee to develop this pilot project. It can also provide valuable lessons for other Federal agencies.

S. 2824. TITLE 38 COLLECTIVE BARGAINING RIGHTS AND PROCEDURES FOR REVIEW OF ADVERSE ACTIONS

AFGE supports S. 2824. We greatly appreciate the leadership of Senator Rockefeller in introducing this urgently needed legislative remedy to the current personnel crisis at VHA. We also extend our gratitude to original cosponsors, Committee members Webb and Brown, and Senator Mikulski, for cosponsoring S. 2824.

S. 2824 is an *essential* companion to any past or future legislation that addresses VHA recruitment and retention of the following providers ("provider"): RNs, physicians, physician assistants, chiropractors, podiatrists, optometrists, dentists and expanded-duty dental auxiliaries (also known as "pure Title 38" or "non-hybrid Title 38" employees.)

S. 2824 will reverse the damaging and unintended consequences of the 1991 law that added Section 7422 ("7422") to Title 38. Section 7422 widely impacts employee rights in grievances, arbitrations, labor-management negotiations, unfair labor practices (ULP) and litigation before the Federal Labor Relations Authority (FLRA) and courts.

S. 2824 will curb the VA's widespread noncompliance with Federal laws that make the VA a desirable place to work such as physician and RN pay laws, limits on nurse overtime, rights to information and equal employment laws. Current 7422 policy has undermined nearly every recent Congressional attempt to address VHA recruitment and retention, leaving providers with "rights without remedies" which, according to the old adage "are no rights at all."

How can one section of the law cause so much harm to these valuable members of VA's health care workforce? That harms result from management's arbitrary interpretation of three narrow exceptions in the law to block provider rights: professional conduct and competence (defined as direct patient care or clinical competence); peer review; and compensation.

Management's 7422 policy is arbitrary because it directly contradicts Congressional intent as to the scope of these three exceptions. Specifically:

- Congress viewed Title 38 and Title 5 employees as having the same collective bargaining rights when it enacted the Civil Service Reform Act (CSRA) in 1978.
- Congress enacted Section 7422 in direct response to a 1988 Federal appeals court decision involving annual nurse "comparability pay" increases. The Court held that the VA could not be compelled by the CSRA to engage in collective bargaining over conditions of employment for Title 38 providers. *Colorado Nurses Ass'n* v. *FLRA*, 851 F.2d 1486 (D.C. Cir. 1988).
- The plain language of the 1991 law narrows the scope of the exceptions by specifying that the matter must relate to "*direct* patient care" or "*clinical* competence."
- The 1990 House committee report on the underlying bill defined the "direct patient care" exception as "medical procedures physicians follow in treating patients." This report also cited guidelines for RNs wishing to trade vacation days as falling *outside* the exception. (H. Rep. No. 101–466 on H.R. 4557, 101st Cong., 2d Sess., 29 (1990)).

Management's 7422 policy is also arbitrary because it contradicts its own 1996 agreement with labor to clarify the scope of the law and resolve remaining disputes in a less adversarial manner. Sadly, the VA unilaterally abandoned this useful, inclusive agreement in 2003. More specifically, in that agreement:

- The VA committed to a new process for resolving 7422 disputes that departed from the "adversarial, litigious, dilatory * * * nature of past labor-management relations."
- The VA acknowledged that providers provide valuable input into medical affairs: "We recognize that the employees have a deep stake in the quality and efficiency of the work performed by the agency."; "The purpose of labor-management partnership is to get the front line employees directly involved in identifying problems and crafting solutions to better serve the agency's customers and mission."
- The VA recognized the narrow scope of the direct patient care exception, i.e. it does not extend to "many matters affecting the working conditions of Title 38 employees [that] affect patient care only *indirectly*" (emphasis provided).
- The VA agreed that scheduling matters may be grievable: "For example, scheduling shifts substantially in advance so that employees can plan family and civic activities may make it more expensive to meet patient care standards under certain circumstances. That does not relieve management of either the responsibility to assure proper patient care or to bargain over employee working conditions."
- The VA agreed that pay matters other than setting pay scales are grievable: "Under Title 38, pay scales are set by the agency, outside of collective bargaining

and arbitration. Left within the scope of bargaining and arbitrations are such matters as: procedures for collecting and analyzing data used in determining scales, alleged failures to pay in accordance with the applicable scale, rules for earning overtime and for earning and using compensatory time, and alternative work schedules."

The 7422 appeals process: Section 7422 gives the Undersecretary of Health (USH) the sole authority to determine what matters are grievable. USH decisions are posted on the VA website. AFGE is not informed about unpublished decisions or pending cases.

A review of posted decisions and member reports received by AFGE reveals how VA's 7422 policies directly undermine recruitment and retention legislation passed over the past decade and deprive providers of a fair appeals process. For example:

• *No right to grieve over denial of request to review nurse locality pay survey data*
– Background: Congress enacted legislation in 2000 to authorize directors to conduct third party surveys to set competitive nurse pay (P.L. 106–419)
– USH Ruling: "Compensation" exception blocks employees' access to third party survey data. (Decision dated 1/06/05)

• *No right to grieve over VA nurse mandatory overtime policy*
– Background: Congress enacted legislation in 2004 requiring facilities to establish policies limiting mandatory overtime except in cases of "emergency" (P.L. 108–445)
– USH Ruling: National grievance over definition of "emergency" for requiring overtime is barred by the "professional conduct or competence" exception. (Decision dated 10/22/07)

• *No right to grieve over composition of panels setting physician pay*
– Background: Congress enacted legislation in 2004 to use local panels of physicians to set market pay that would be competitive with local markets (P.L. 108–445). AFGE contended that management unfairly excluded practicing clinicians and employee representatives from the panels.
– USH Ruling: Grievance barred by "compensation" exception. (Decision dated 3/2/07)

• *Other grievances blocked by VA's 7422 policy* (based on member reports of pending disputes or unpublished USH decisions)
– No right to challenge Intimidation of arbitration witnesses: After two VA nurses testified for the union at arbitration, management sent them letters questioning their conduct and suggesting that they could be subject to discipline. The union filed an unfair labor practice with the FLRA which initiated steps to file charges against management. Management invoked the "professional conduct or competence" exception to suspend FLRA action pending an USH ruling.
– No right to challenge performance rating based on use of approved leave: Management invoked 7422 when a nurse tried to grieve the lowering of her performance rating that was based on her authorized absences using earned sick leave and annual leave, and carried out without any written justification.
– No right to challenge error in pay computation: Management invoked 7422 when a nurse was incorrectly denied a within-grade pay increase because of lost time arising out of a work-related injury covered by workers compensation.
– No right to challenge low reimbursement for costs of required training: Management invoked 7422 when a nurse tried to grieve the amount of reimbursement she received for attending required training to maintain her Advanced Practice RN certification.
– Exclusion from hospital affairs: Management invoked 7422 to block a local union's efforts to have input into the drafting of medical staff bylaws that impact personnel policies.
– No right to challenge unfair bonus policies: VA physicians are unable to challenge policies that are not in compliance with the 2004 physician pay law because managers set arbitrarily low bonuses and impose unfair performance measures based on factors beyond the physician's control.

Recent court decisions upholding the VA's 7422 policy highlight the need for Congressional action to enforce critical workplace rights and recruitment and retention legislation:

• In *AFGE Local 446* v. *Nicholson*, 475 F.3d 341 (D.C. Cir. 2007). The Federal court held that the VA operating room nurses could not file a grievance over denial of premium pay weekend and evening shifts.

• In *AFGE Local 2152* v. *Principi*, 464 F.3d 1049 (9th Cir. 2006), a VA physician was removed from his surgical duties at age 76 and his specialty pay was discontinued. The court held that the physician's grievance alleging unlawful age and gender discrimination was barred by the "professional conduct or competence" exception

in 7422. The court rejected the union's contention that management's 7422 assertion was a mere pretext for unlawful discrimination. (Similarly, in a posted USH decision dated 6/1/07, a nurse alleging that management's denial of specialized skills pay was racially motivated was not allowed to pursue a grievance.)

Amending 7422 will not hurt patient care. Opponents to S. 2824 are likely to suggest that labor will try to disrupt patient care if 7422 is amended. In fact, Title 5 makes the three exceptions in 7422 redundant and unnecessary. Federal sector unions are only authorized to negotiate on "conditions of employment" as that term is defined in 5 USC 7103(a)(14). In contrast, 5 USC 7106(a)(1) makes it a management right (i.e., not to be modified at the bargaining table) for an agency to determine its "mission."

Furthermore, a review of published cases that have come before the USH did not reveal even one attempt to interfere with medical procedures or other direct patient care matters.

Finally, if grievance rights can interfere with VHA operations, then why do hybrid Title 38 providers hired under Title 5 and working side by side with "pure" Title 38 providers have rights to grieve over these prohibited matters? For example, psychologists have full grievance rights while psychiatrists do not; licensed practical nurses have full grievance rights while RNs do not.

The current dispute resolution process for 7422 is broken and biased against employees. Opponents of S. 2824 are also likely to argue that employees already have a fair process though the USH for resolving 7422 disputes. Numbers tell a very different story: Of the 25 published USH decisions over the past 3 years, the USH ruled in favor of management *one hundred percent* of the time. Opponents are unlikely to mention that many, many more cases never get to the USH even though the law clearly states that he has sole authority to make these rulings. Across the country, human resource departments with no authority regularly make 7422 determinations and refuse to go through the proper USH channels.

The current 7422 process wastes taxpayer dollars. Finally, the VA's 7422 policies result in a great waste of taxpayer dollars that would be much better spent on patient care. The Asheville case previously discussed was pending for 7 years. HR departments in facilities around the country regularly block or delay the Section 7422 review process, draining resources and staff time away from the VA's mission of caring for veterans.

S. 2639. ASSURED FUNDING FOR VETERANS HEALTH CARE ACT

AFGE supports S. 2639 to fund VA health care through mandatory, rather than discretionary appropriations. The current lack of predictability and adequacy in the VA health care funding process causes havoc every year in the budget process nationally, and in the ability of facility directors to plan for staffing, equipment and other operational expenses. VA health care is hurting from year after year of continuing resolutions, budget shortfalls and supplemental funding arriving long after the start of each new fiscal year. AFGE urges the Committee to support reform of the funding system so that VA health care dollars are available on a timely and predictable basis, based on a funding formula that reflects current demand and cost of providing medical care to our veterans.

AFGE also supports alternative approaches, such as those being developed by the Partnership for VA Health Care Budget Reform (Partnership) that would utilize 1-year advance appropriations, an approach that has a strong track record for other Federal agencies. AFGE also supports annual Congressional oversight of the VA's health care forecasting model. Politics has already exacted a huge toll on the functioning of VA's world class health care system. Again, we urge this Committee to move forward with S. 2639 or the Partnership's alternative funding proposal.

S. 2799. WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2008

AFGE supports this important legislation to address the needs of the unprecedented number of female veterans entering the VA health care system. These veterans have unique medical and mental health needs that should be the focus of more research, best practices and health care innovations. S. 2799 will ensure that women veterans receive care through specialized programs and that more female providers are available to care for them. Currently, many women veterans must receive at least a portion of their health care outside the VA system. Women veterans deserve equal access to VA's exemplary in-house care, and S. 2799 will make it possible for VA to build the capacity to achieve that goal.

S. 2889. VETERANS HEALTH CARE ACT OF 200

AFGE objects to Section 3 of this bill. AFGE has no position on other sections of this bill. At a time when the VA is facing widespread difficulties recruiting and retaining physicians and relies increasingly on costly fee basis care, this proposal to weaken the already modest professional education benefit in 38 USC Section 7411 is a step in the wrong direction. Physicians already face a growing number of challenges to receiving reimbursement for continue medical education (CME). The $1000 maximum annual payment has not been increased since 1991, and today, the typical CME program costs three times that amount or higher.

VA's in-house CME courses are helpful but not sufficient to meet the increasingly high credit requirements set by medical boards. In addition, boards are setting more stringent standards for qualifying courses. We hear from many members that management is often reluctant to provide physicians with the time to attend grand rounds and other in-house courses.

In addition, VA physicians want and deserve exposure to a wide breadth of medical knowledge through courses offered by their colleagues in their practice areas outside the VA. The proposal in S. 2889 to give directors greater discretion to deny reimbursement for outside courses ("may reimburse" would replace "shall reimburse") is certain to result in more frustration by VA physicians already facing so many obstacles to receiving this modest annual reimbursement. The problem is already so widespread that AFGE filed a national grievance and settlement discussions with the VA are currently in progress.

Therefore, AFGE urges this Committee to defer any revisions to Section 7411 pending settlement of the national grievance, and further study of current State medical board requirements and costs of outside courses.

S. 2984. VETERANS' BENEFITS ENHANCEMENT ACT OF 2008

We oppose Section 304. At a time when the VA is facing a critical nursing shortage and Congress is scrutinizing nurse pay policies to increase their effectiveness in recruitment and retention, it would be very unwise to eliminate the once-a-year reporting requirement in 38 USC 7451(f). VA's locality pay process needs greater, not less, accountability. As already discussed, management is unwilling to share survey pay data with employees at the local level. Congress must have this data at the national level to determine whether locality pay adjustments (or lack of adjustments) are justified, and whether additional funding or training needed to carry out this important nurse pay process effectively. This bill runs directly counter to the goals of Section 3 of S. 2969. We urge the Committee to reject Section 304 of S. 2984 and instead, expand the transparency and accuracy of the locality process as proposed by S. 2969.

Thank you.

Chairman AKAKA. Thank you very much, Mr. Cox.

Ms. McVey?

STATEMENT OF CECILIA McVEY, MHA, R.N., FORMER PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS

Ms. MCVEY. Mr. Chairman and members of the Senate Veterans' Affairs Committee, the Nurses Organization of Veterans Affairs, NOVA, would like to thank you for inviting us to present testimony on the Veterans Medical Personnel Recruitment and Retention Act of 2008. I am Cecilia McVey, Associate Director for Patient Care Nursing at the VA Boston Health Care System and I am here today as the Immediate Past President of NOVA. NOVA is a professional organization for registered nurses employed by the Department of Veterans Affairs.

NOVA respects and appreciates what our labor organizations, such as AFGE and NAGE, do for VA nurses. NOVA clearly deals with the VA on R.N. professional matters, not working conditions, for which VHA R.N.s have their union representatives. Because this Committee has invited NOVA to share its views on this bill, however, I am here to offer the following observations.

NOVA has identified retention and recruitment of health care staff members as a critically important issue in providing high quality health care to America's heroes. NOVA supports the Veterans Medical Personnel Recruitment and Retention Act of 2008 based on the following rationale. Waiver of offset from pay for certain reemployed annuitants will allow VA to bring back a corporate and clinical knowledge housed in these individuals and allows VA to utilize some of its most precious resources. There aren't comparable restrictions on nurses who retire from the military.

Senior Executive Schedule position in VHA is critical to ameliorate the pay inequities which have grown with each subsequent year. Nurse executives and medical center directors, for example, do not receive pay comparable with their peers in the private sector. This underscores the need for VA to move quickly to remedy a problem that is already manifesting itself in turnover and in recruitment problems at key upper-level positions in VA.

The mean salary for a nurse executive, for example, is $129,000. Many nurse executives did not receive additional pay in the form of a bonus because a bonus was not mandatory.

There is a need to increase the pay limitation for VA nurses from Level 5, currently $136,200, to Level 4, currently $145,400, of the Executive Schedule to address the pay disparity between the Nurse 5 maximum rate and the GS–15 rate in some geographic areas. A change to 38 U.S.C. 7451 is needed to increase the pay cap under the nurse locality pay system.

This change would also favorably affect the same issue which pertains to our Certified Registered Nurse Anesthetists. A search of a commercial website that lists job openings for CRNAs revealed that in 66.8 percent of the listings, the potential pay rates exceeded the VA cap.

Information and training on locality pay surveys would also assist in applying a law which is not flawed but merely needs the appropriate application in order to be successful.

Reestablishment of the VA Health Professionals Scholarship Program for non-VA employees needs to be reinstituted to compete for recruitment of students who are currently not VA employees. NOVA's recommendation would be to include the addition of the following Section 4, improvements to certain educational assistance programs, and reinstate the scholarship program as described in U.S.C 7611–7618, which expired in 1988, with the following additional provisions: Qualifying education or training leading to employment in Title 38 or hybrid Title 38 occupation; provision of funding at $25 million per annum.

Inclusion of the revised definition of nurses who wish to work the 36/40 work week as utilized in the community will address this misinterpretation of the statement in the current VHA handbook and should read, "The Secretary may provide, in the case of nurses employed at such facility, that such nurse who works six regularly scheduled 12-hour periods of service within a pay period shall be considered for all purposes to have worked a full 80-hour pay period." Current use of this retention tool has been rendered ineffective and not applicable because of this interpretation.

NOVA also requests your support to eliminate the 19th step restriction under the special rate authorization for LPN/LVN, as has

been done previously for Physical Therapists and Pharmacists based on a highly competitive market for this occupation. This has been a longstanding issue and we look forward to its resolution for this critical and worthy group of caregivers that we are consistently having challenges to hire due to current regulations.

NOVA appreciates the Committee on Veterans Affairs' attention to these timely actions to further enhance the VA workforce. Thank you.

[The prepared statement of Ms. McVey follows:]

PREPARED STATEMENT OF CECILIA MCVEY, IMMEDIATE PAST PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS

VETERANS' MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT OF 2008

Mr. Chairman and Members of the Senate Veterans' Affairs Committee, the Nurses Organization of Veterans Affairs (NOVA) would like to thank you for inviting us to present testimony on the Veterans' Medical Personnel Recruitment and Retention Act of 2008.

I am Cecilia McVey, BSN, MHA, RN, Associate Director for Patient Care/Nursing at the VA Boston Health care System and am here today as the Immediate Past President of NOVA. NOVA is the professional organization for registered nurses employed by the Department of Veterans Affairs.

NOVA respects and appreciates what our labor organizations such as AFGE and NAGE do for VA nurses. NOVA clearly deals with VA on RN professional matters, not working conditions for which VHA RNs have their union representatives. Because this Committee has invited NOVA to share its views on this bill, however, I am here to offer the following observations.

NOVA has identified retention and recruitment of health care staff members as a critically important issue in providing high quality health care to America's heroes. As Veterans Health Administration (VHA) executives face growing vacancies, elevated turnover due to retirements and increasingly complex care delivery, the demands on the workforce today are greater than ever.

NOVA supports the Veterans' Medical Personnel Recruitment and Retention Act of 2008 based on the following rationale.

- Waiver of offset from pay for certain reemployed annuitants will allow VA to bring back a corporate and clinical knowledge housed in these individuals and allows VA to utilize some of its most precious resources. During this time of a critical nursing shortage, it is more important than ever to keep these valuable resources to provide the best care to veterans. There aren't comparable restrictions on nurses who retire from the military.
- Senior Executive Schedule Position in VHA is critical to ameliorate the pay inequities which have grown with each subsequent year. Nurse Executives and Medical Center Directors, for example, do not receive pay comparable with their peers in the private sector. This underscores the need for VA to move quickly to remedy a problem that is already manifesting itself in turnover and in recruitment problems for key upper level positions in the VA. The mean salary, for example, for a Nurse Executive is $129,000. Many Nurse Executives did not receive additional pay in the form of a bonus that is included in retirement computation under Public Law 108–445, because the bonus was not mandatory.
- There is a need to increase the pay limitation contained in 38 USC 7451(c)(2) for VA nurses from level five (currently $136,200) to level four (currently $145,400) of the Executive Schedule to address the pay disparity between the nurse five maximum rate and the GS–15 maximum rate in some geographic areas.
- A change to 38 USC 7451 is needed to increase the pay cap under the nurse locality pay system. With an increase to EL–4, each nurse pay schedule, which is currently limited by the EL–5 cap, would be recalculated based upon the existing beginning rate for the grade. This change would also favorably affect the same issue which pertains to the Certified Registered Nurse Anesthetists (CRNA). Presently, the pay of 286 of the 531 CRNA's (54 percent) in VA is frozen at the Executive Schedule, Level V ($139,600). A search of a commercial website that lists job openings for CRNA's revealed that in 66.8 percent of the listings, the potential pay rates exceeded the VA cap.
- Information and training on Locality Pay Surveys would also assist in applying a law which is not flawed but merely needs the appropriate application in order to be successful. VA nurses are concerned they do not receive appropriate pay raises

due to this inappropriate application of the law which impacts both recruitment and retention during this critical nursing shortage. We support any and all activities that lead to increased education and enhancement as well as knowledge of application of Locality Pay Law.

• Reestablishment of the Health Professionals Scholarship Program (for non-VA employees) needs to be reinstituted to compete for recruitment of students, who are not currently VA employees.

NOVA's recommendation would be to include the addition of the following to Section 4—Improvements to Certain Educational Assistance Programs and reinstate the scholarship program, as described in USC 7611–7618 (expired 1988) with the following additional provisions.

• Qualifying education or training leading to employment in Title 38 or Hybrid Title 38 Occupation. Priority for funding of the occupation education to be determined by the Department of Veterans Affairs based on recruitment needs.

• Provision of funding at 25 million dollars per annum. These additional monies would allow funding of other high need occupations such as pharmacists, since the law that expired did not include all Title 38.

• Inclusion of the revised definition of nurses who wish to work the 36/40 work week as utilized in the community will address this misinterpretation of the statement in the current VHA handbook and should read, "The Secretary may provide, in the case of nurses employed at such facility that such nurse who works six regularly scheduled 12 hour periods of service within a pay period shall be considered for all purposes to have worked a full 80 hour pay period." Currently use of this retention tool has been rendered ineffective and not applicable because of the interpretation.

• NOVA also requests your support to eliminate the 19th step restriction under the special rate authorization for LPN/LVN as had been done previously for Physical Therapists and Pharmacists based on the highly competitive market for this occupation. This has been a longstanding issue and we look forward to its resolution of this critical and worthy group of caregivers that we are consistently unable to hire due to current regulations.

NOVA appreciates the Senate Committee on Veterans' Affairs' attention to these timely actions to further enhance the VA workforce.

Chairman AKAKA. Thank you very much, Ms. McVey. I am also aware that your son and his girlfriend are here today at this hearing and I just want to add a welcome to them.

Ms. MCVEY. Thank you.

Chairman AKAKA. Thanks. Ms. McCartney?

STATEMENT OF DONNA McCARTNEY, CHAIR, NATIONAL ASSOCIATION OF VETERANS RESEARCH AND EDUCATION FOUNDATIONS, AND EXECUTIVE DIRECTOR, PALO ALTO INSTITUTE FOR RESEARCH AND EDUCATION

Ms. MCCARTNEY. Chairman Akaka and Members of the Committee, thank you for the opportunity to testify with regard to S. 2926, the Veterans Nonprofit Research and Education Corporations Enhancement Act of 2008.

I worked for VA for over 28 years in various administrative capacities and it is my privilege to continue my service to veterans in my current position as the Executive Director of the Palo Alto Institute for Research and Education at the VA Palo Alto. I mention this because the fundamental purpose of the nonprofits that are the subject of S. 2926 is to serve veterans by supporting VA research and education to improve the quality of care that veterans receive.

At this time, 84 affiliated nonprofits provide VA medical centers with this highly valued flexible funding mechanism for administering $230 million in non-VA Federal research awards and private sector funds in support of VA-approved research and education activities. These nonprofits provide a full range of onsite

support services to VA researchers, thus enabling investigators to focus on their research and care of veteran patients.

For example, a seed grant to my institution provided several years ago from our funds to a gastroenterology clinician investigator resulted in his finding that an easily overlooked type of abnormality in the colon is the most likely type to turn cancerous and is more common in this country than previously thought. This finding will change colonoscopy practices and may well lead to widespread earlier detection of a cancer that is preventable or curable through surgery.

Chairman Akaka, we are so pleased that you introduced this bill. There is a rapidly growing nonprofit affiliated with the Honolulu VA that just accepted a $3.3 million Department of Defense award to conduct research on veterans with Post Traumatic Stress Disorder. That nonprofit and all the other VA nonprofits, and, ultimately, veterans will benefit from S. 2926.

It is noteworthy that the bill's objectives are consistent with the findings in the recently released VA Office of Inspector General review of five nonprofits and VHA's oversight of these nonprofits. Two major provisions in S. 2926 directly address the OIG findings. First, Section 2 allows formation of multi-medical center research corporations. This will allow interested VA facilities with small research programs to affiliate with larger ones to ensure an appropriate level of internal controls, including segregation of financial duties. Second, the last item in Section 5(a) broadens VA's ability to guide nonprofit expenditures.

S. 2926 provides a number of other welcome enhancements to the nonprofit authorizing statute. Section 4(b)(2) of the bill allows the boards of directors to acquire members with the legal and financial expertise needed to ensure sound governance and financial management. Section 5(a) permits efficient administration of funds generated by educational activities. Additionally, Section 5(a) of the bill permits VA to continue to benefit from the more than 500 nonprofit employees on Intergovernmental Personnel Act assignments to VA from the nonprofits.

S. 2926 also contains a number of useful clarifications of these organizations' status and purposes. For example, Section 2(c) codifies—without changing—their legal status as State chartered independent nonprofits subject to VA oversight and regulation.

Thus far, my testimony has focused on the substantive changes that S. 2926 will implement. Before I conclude, I want to emphasize that this statute makes no changes in VA's power to regulate and oversee the nonprofits. Further, their records remain fully available to the Secretary and his designees, to the Inspector General, and to the Government Accountability Office.

In conclusion, I urge the Committee to report S. 2926 to the Senate for enactment at the earliest possible opportunity. We believe enactment will allow these nonprofits to maximize their support for VA research and education while ensuring both VA and Congressional confidence in their management.

Chairman Akaka, thank you again for introducing this legislation and for the opportunity to testify today. I would be pleased to answer any questions you may have.

[The prepared statement of Ms. McCartney follows:]

PREPARED STATEMENT OF DONNA MCCARTNEY, CHAIR, NATIONAL ASSOCIATION OF VETERANS' RESEARCH AND EDUCATION FOUNDATIONS, AND EXECUTIVE DIRECTOR OF THE PALO ALTO INSTITUTE FOR RESEARCH AND EDUCATION

S. 2926 THE "VETERANS NONPROFIT RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT OF 2008"

Chairman Akaka and Members of the Committee, Thank you for the opportunity to testify on behalf of the National Association of Veterans' Research and Education Foundations (NAVREF) in regard to S. 2926, the "Veterans Nonprofit Research and Education Corporations Enhancement Act of 2008."

NAVREF is the membership organization of the 85 VA-affiliated nonprofit research and education corporations (NPCs) originally authorized by Congress under Public Law 100–322, and currently codified at sections 7361 through 7368 of the United States Code. NAVREF's mission is to promote high quality management of the NPCs and to pursue issues at the Federal level that are of interest to its members. NAVREF accomplishes this mission through educational activities for its members and interactions and advocacy with agency and congressional officials. Additional information about NAVREF is available on its web site at *www.navref.org*.

I am Donna McCartney, the chair of the NAVREF Board of Directors and the executive director of the Palo Alto Institute for Research and Education (PAIRE). I worked for VA for over 28 years in various administrative capacities, and it is my privilege to continue my service to veterans in my current position. I mention this because the fundamental purpose of the nonprofits that are the subject of S. 2926 is to serve veterans by supporting VA research and education to improve the quality of care that veterans receive.

BACKGROUND ABOUT THE NPCS

In 1988, Congress allowed the secretary of the Department of Veterans Affairs to authorize "the establishment at any Department medical center of a nonprofit corporation to provide a flexible funding mechanism for the conduct of approved research and education at the medical center." [38 U.S.C. § 7361(a)] At this time, 85 NPCs provide their affiliated VA Health Care Systems and medical centers with a highly valued means of administering non-VA Federal research grants and private sector funds in support of VA research and education.

Last year, the NPCs collectively administered $230 million with expenditures that supported nearly 5,000 VA-approved research and education programs. These nonprofits are dedicated solely to supporting VA and veterans. This includes providing VA with the services of nearly 2,500 without compensation (WOC) research employees who work side-by-side with VA-salaried employees, all in conformance with the VA background, security and training requirements such appointments entail.

For example, at the Palo Alto NPC, the nonprofit for which I am the executive director, we have 130 research employees and support 170 projects. Of these, approximately one-third are Federal awards. During fiscal year 2007 we expended $10.4 million in support of VA research and education activities and expect our fiscal year 2008 expenditures to approach $16 million. We provide a full range of on-site support services to VA researchers, including assistance preparing and submitting their research proposals; publishing the results; hiring lab technicians, study coordinators and other dedicated staff to work on the projects; procuring supplies, services and equipment; monitoring the required VA approvals; facilitating travel to scientific conferences, and providing a host of other services that enable investigators to focus on their research and veteran patients.

Beyond administering research projects and education activities these nonprofits support a variety of VA research infrastructure and administrative expenses. They have provided seed and bridge funding for investigators; staffed animal care facilities; funded recruitment of clinician researchers; paid for research administrative and compliance personnel; supported staff and training for institutional review boards (IRBs); and much more.

At my own institution, a seed grant PAIRE provided several years ago to a gastroenterology clinician-investigator resulted in his finding that an easily overlooked type of abnormality in the colon is the most likely type to turn cancerous, and is more common in this country than previously thought. This finding, reported on the front page of the March 5, 2008, New York Times and in the Journal of the American Medical Association, will change colonoscopy practices and may well lead to widespread earlier detection of a cancer that is preventable or curable through surgery. This year alone we have been able to make nine similar awards to VA Palo Alto investigators, in the hope of equally significant research success down the road.

S. 2926 ENHANCES AND CLARIFIES NPC AUTHORITIES

Chairman Akaka, I am so pleased that you introduced this bill. There is a rapidly growing NPC affiliated with the Honolulu VA that just accepted a $3.353 million Department of Defense (DOD) award to conduct research on telemental health and cognitive processing therapy for rural combat veterans with Post Traumatic Stress Disorder (PTSD). That nonprofit and all the other NPCs—and ultimately veterans—will benefit from S. 2926.

The bill heading correctly states that the purpose is to "modify and update" the 1988 statute, but we also view this as an opportunity to modernize and clarify the statute after nearly 20 years of experience under its current terms. The NPCs have already proven themselves to be valued and effective "flexible funding mechanisms for the conduct of approved research," and this bill will further enhance their value to VA.

The objectives of S. 2926 are consistent with the findings in the recently released VA Office of Inspector General (OIG) review of five NPCs and VHA's oversight of them. I know that VHA is working hard to address the shortcomings in oversight that the OIG identified. And we on the nonprofit side are working equally hard to ensure that we have appropriate controls over funds and equipment (including supporting documentation for all transactions), and that all NPC officers, directors and employees are certifying their awareness of the applicable Federal conflict of interest regulations. While we firmly believe that NPC boards and administrative employees strive to be conscientious stewards of NPC funds, we thank the OIG for its thorough review of those five NPCs and for bringing to light these areas in need of improvement.

It is noteworthy for the Committee that the OIG report cited no actual misuse of funds or instances of conflicts of interest, dual compensation of Federal employees or fraud. However, we take very seriously the OIG finding that these NPCs nonetheless did not have adequate controls over some of the funds they manage. We believe that two major provisions in S. 2926 directly address this finding.

First, section 2 of S. 2926 allows formation of "multi-medical center research corporations" (MMCRCs). That is, two or more VA medical centers may share one NPC, subject to board and VA approval, while preserving their fundamental nature as medical center-based organizations. This will allow interested VA facilities with small research programs to join with larger ones. Or several smaller facilities may pool their resources to support management of one NPC with funds and staffing adequate to ensure an appropriate level of internal controls, including segregation of financial duties.

Second, the last item in section 5(a) of S. 2926 addresses the OIG criticism by broadening VA's ability to guide NPC expenditures. The only constraint on VA is that such guidance must be consistent with other Federal and State requirements as specified in laws, regulations, executive orders, circulars and directives—of which there are many—applicable to other 501(c)(3) organizations. The purpose of this limitation is to avoid the possibility of imposing on NPCs conflicting requirements and reducing their ability to remain "flexible funding mechanisms."

S. 2926 provides a number of other welcome enhancements to the NPC authorizing statute.

- Section 4(b)(2) of the bill broadens the qualifications for the two mandatory non-VA board members beyond familiarity with medical research and education. This will allow NPCs to use these board positions to acquire the legal and financial expertise needed to ensure sound governance and financial management.
- Section 4(c) of the bill also deletes the overly broad stipulation in the current statute that these non-VA board members may not have "any financial relationship" with any for-profit entity that is a source of funding for VA research or education. This absolute prohibition conflicts with regulations applicable to Federal employees with respect to conflicts of interest, which are invoked for all NPC directors and employees in section 7366(c)(1) of title 38, United States Code. Unlike the deleted provision, Federal conflict of interest regulations provide means of recusal as well as *de minimus* exceptions. Additionally, the prohibition has been interpreted to apply to any individual who has ever accepted compensation or reimbursement from a for-profit sponsor of VA research for purposes unrelated to VA research, thereby eliminating many otherwise desirable and qualified individuals from serving on NPC boards.
- Section 5(a) of the bill provides NPCs with authority to reimburse the Office of General Counsel (OGC) for legal services related to review and approval of Cooperative Research and Development Agreements (CRADAs), the form of agreement used to establish terms and conditions for industry-funded studies performed at VA medical centers and administered by NPCs. The funds generated under this provi-

sion will help OGC to staff Regional Counsel offices to accommodate the workload these agreements entail and to provide training in CRADA requirements and related VA policies.

• Section 5(a) also increases the efficiency of NPC administration of funds generated by educational activities. This clause allows NPCs to charge registration fees for the education and training programs they administer, and to retain such funds to offset program expenses or for future educational purposes. However, it also explicitly sustains the existing prohibition against NPCs accepting fees derived from VA appropriations.

• Additionally, section 5(a) of the bill includes authority for VA to reimburse NPCs for the salary and benefits of NPC employees loaned to VA under Intergovernmental Personnel Act (IPA) assignments conducted in accordance with section 3371 of title 5, United States Code. This provision responds to recent OIG questions asking whether such reimbursements are allowable and permits VA to continue to benefit from this efficient and cost-effective mechanism to acquire the temporary services of skilled research personnel.

S. 2926 also contains a number of useful clarifications of NPC status and purposes.

• Section 2(c) codifies—without changing—the legal status of the NPCs as state-chartered, independent organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Service (IRS) code and subject to VA oversight and regulation. This clause of the bill codifies the congressional intent, previously expressed in the House report that accompanied the original NPC authorizing statute (H. Rept. 100–373), that nonprofits established under this authority would not be corporations controlled or owned by the government. As a result, S. 2926 resolves longstanding differences of opinion among stakeholders, overseers and funding sources about the legal status of NPCs.

• Section 3(a)(1) of the bill establishes that in addition to administering research projects and education activities, NPCs may support "functions related to the conduct of research and education." This resolves differences of opinion about the allowability of NPC expenditures that support VA research and education generally, such as purchase of core research equipment used by many researchers for many projects, and enhances the value of NPCs to VA facilities.

• Section 5(a) ascertains that all NPC-administered research projects must undergo "scientific" rather than "peer" review. This change recognizes that peer review is not necessary or appropriate for all research projects administered by NPCs. However, the bill leaves in place the overarching requirement for VA approval and the medical center's Research and Development Committee remains in a position to determine on a case-by-case basis whether a project also requires peer review as a condition of approval for NPC administration.

In addition to these enhancements and clarifications, S. 2926 reorganizes the NPC authorizing statute to put all provisions regarding their establishment and status in one section; describes their purposes in another; and gathers in one section the clauses enumerating their powers. Many other revisions are largely technical and conforming amendments.

S. 2926 PRESERVES MEASURES PROVIDING OVERSIGHT OF NPCS

Thus far my testimony has focused on the substantive changes that S. 2926 will implement. Before I conclude, I want to emphasize that this statute makes no changes in VA's power to regulate and oversee the NPCs. Further, NPC records remain fully available to the Secretary and his designees; to the Inspector General; and to the Government Accountability Office (GAO). Likewise, NPCs are still required to undergo an annual audit by an independent auditor in accordance with the sources—Federal or private—and amount of its prior year revenues, and they must submit to VA the resulting audit report along with detailed financial information and descriptions of accomplishments.

In the wake of the Sarbanes-Oxley Act and new Federal Accounting Standards Board (FASB) requirements and auditing standards, even the most basic form of nonprofit audit has become an effective means for assessing an organization's financial controls. Additionally, as more NPCs assume responsibility for Federal grants, a higher percentage of NPC funds are subject to Generally Accepted Government Accounting Standards (GALAS) and OMB Circular A–133, the most rigorous and comprehensive level of auditing standards. Before the last independent financial audit of the Palo Alto nonprofit, my accounting staff had to respond to 40 pages of questions about our controls over funds and program compliance, and the auditors were on-site examining and testing our records for several weeks. I can assure you from personal experience that these audits are comprehensive and provide a sound

framework for examining an organization's controls over funds as well as compliance with program requirements.

CONCLUSION

In conclusion, on behalf of NAVREF and the NPCs, I urge the Committee to report S. 2926 to the Senate for enactment at the earliest possible opportunity. The NPCs are already a highly efficient means to maximize the benefits to VA of externally-funded research conducted in VA facilities, ably serving to facilitate research and education that benefit veterans. Additionally, they foster vibrant research environments at VA medical centers, enhancing VA's ability to recruit and retain clinician-investigators and other talented staff who in turn apply their knowledge to state-of-the-art care for veterans.

Twenty years after the VA-NPC public-private partnership was first authorized by Congress, and co-incident with expiration of authority to establish new NPCs, this is a timely opportunity to update and clarify the NPCs' enabling legislation. This bill will accomplish those objectives. Experience working within the statute has brought to light its many strengths, but also areas that will benefit from modification, enhancement and updating, particularly in light of the increasing complexity of both research and nonprofit compliance. We believe enactment of S. 2926 will allow NPCs to better achieve their potential to support VA research and education while ensuring VA and congressional confidence in their management.

Chairman Akaka, thank you again for introducing this legislation and for the opportunity to testify on behalf of NAVREF during this hearing. We look forward to working with you, the Members of the Committee and your House counterparts toward enactment of S. 2926. I would be pleased to answer any questions you may have.

Chairman AKAKA. Thank you very much, Ms. McCartney.

Now we will hear from Dr. Thomas Berger.

STATEMENT OF THOMAS J. BERGER, Ph.D., CHAIR, NATIONAL PTSD AND SUBSTANCE ABUSE COMMITTEE, ON BEHALF OF VIETNAM VETERANS OF AMERICA

Mr. BERGER. Good morning, Mr. Chairman, other distinguished Senators who are here, and guests. On behalf of VVA National President John Rowan and all of our officers and members, I thank you for the opportunity to share our views on pending health care legislation for our Nation's veterans and for your leadership in holding this hearing today.

My name is Tom Berger. I am Chair of the National PTSD and Substance Abuse Committee for Vietnam Veterans of America. I am a Vietnam combat veteran, having served as a Fleet Marine Force Navy corpsman, the 3rd Marine Division, 1966 to 1968, in I Corps, Vietnam. Obviously, there is a range of issues to be considered here today, but VVA will focus on the proposed legislation, S. 2573, the Veterans Mental Health Treatment First Act that is, to some degree, derived from the Dole-Shalala Commission's recommendations.

Although the bill focuses on service-connected disability compensation and does not directly address evidence-based mental health diagnoses, treatment modalities, or recovery programs, the potential impact of this bill, if enacted, on veterans suffering from PTSD, TBI, and related mental health disorders cannot be overstated. This practice has the potential to change virtually everything, but not in a positive direction.

While we are appreciative of Senator Burr's sincere motivation to do what is best for all concerned, including potentially affected veterans, VVA does not believe that the program outlined in the legislation initiative is either the best way to address this problem nor

is it a productive or prudent course in regard to assisting veterans to continue to serve our Nation in civilian life as they did in the military.

VVA remains opposed to S. 2573 principally because it would create a two-tiered disability benefit system that would treat veterans differently based on their periods of service—that is, a system that gives different disability rating awards to classes of veterans from different combat eras under the guise of saving the VA money. VVA is especially concerned with the impact of the so-called "buy-out" program of this bill, not only on those veterans currently suffering from mental health disorders, but also on those who will encounter mental health problems later in life as a result of their military service.

As you know, one of the well-known characteristics of PTSD is that the onset of symptoms is often delayed, sometimes for decades, despite unfounded assertions to the contrary. This is especially applicable to our Nation's largest living veterans cohort, Vietnam veterans, who are now aging, retiring, and suffering the aftermath of physical and emotional injuries incurred as a result of their military service 40 years ago.

The legitimacy of veterans' claims that they suffer from PTSD is apparently again under the gun by a small number of media-savvy professional skeptics who have waged a campaign to discredit PTSD as a valid diagnosis and whose views, I might add, are not generally shared by the mainline PTSD experts, nor by the vast majority of mental health professionals, or even by the Institute of Medicine of the National Academies. Without a shred of evidence, veterans who suffer PTSD are portrayed by these skeptics as looking for easy disability payments that provide an incentive for staying sick rather than getting well, with the implication that sick veterans are welfare cheats. In addition to claims of veteran fraud, the skeptics also claim the delayed onset of PTSD is rare to nonexistent and that PTSD is an acute, not chronic, disease and only rarely should there be a need to give long-term disability.

In fact, there is no data to support these opinions. Studies done at the National Center for PTSD confirm the delayed onset of PTSD as well as the fact that mental health utilization is actually higher for veterans granted disability claims than for those who apply and are turned down. VVA would also argue that the use of the standardized and validated PTSD diagnostic assessment tools in the VA's own best practices manual for PTSD would pick up any factious PTSD claims and provide for better guidance in developing individualized treatment plans.

Thank you, Senator. I appreciate the opportunity to address this issue and I will be glad to answer any questions.

[The prepared statement of Mr. Berger follows:]

PREPARED STATEMENT OF VIETNAM VETERANS OF AMERICA, PRESENTED BY THOMAS J. BERGER, PH.D., CHAIR, NATIONAL PTSD AND SUBSTANCE ABUSE COMMITTEE; WITH RICK WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS

Good morning, Mr. Chairman, Ranking Member Burr, other distinguished Senators of this Committee, and guests. On behalf of VVA National President John Rowan and all of our officers and members, I thank you for the opportunity to share our views on pending health care legislation for our Nation's veterans and for your leadership in holding this hearing today.

My name is Tom Berger, Chair of the National PTSD & Substance Abuse Committee for Vietnam Veterans of America (VVA). I am a Vietnam combat veteran, having served as a Fleet Marine Force Navy corpsman with the 3rd Marine Division, 1966–68, in I Corps, Vietnam.

S. 2573—THE "VETERANS MENTAL HEALTH TREATMENT FIRST" ACT

Obviously there is a range of issues to be considered here today, but VVA wishes to start by focusing on the proposed legislation S. 2573, the "Veterans Mental Health Treatment First" bill that is to some degree, derived from the Dole-Shalala Commission's recommendations. Although this bill focuses on service-connected disability compensation and does not directly address evidence-based mental health diagnoses, treatment modalities, or recovery programs, the potential impact of this bill if enacted on veterans suffering from PTSD, TBI and related mental health disorders cannot be overstated. This in practice has the potential to change virtually everything—but not in a positive direction.

I am certain that we're all aware of the independent Rand Corporation study released last month showing that 18.5 percent of returning OEF/OIF troops meet the criteria for either PTSD or depression (i.e., 14 percent for PTSD and 14 percent for depression) some 19.5 percent have experienced a probable TBI. Even more distressing is the testimony by Colonel Charles Hoge, M.D., before the House Veterans' Affairs Health Subcommittee last month in which he indicated a 20 percent PTSD rate for troops serving two combat tours and a 29.9 percent PTSD rate for those serving three tours—a number that is very close to that obtained for Vietnam veterans in the original National Vietnam Veterans Readjustment Study conducted in the 1980's, some years after the end of the war that put PTSD on the reality map. Our troops now are seeing both more and longer deployments, with at least four Army Brigade Combat Teams (CBCTs) now in their fourth deployment cycle. What is beyond argument is that the more combat exposure a soldier sees, the greater the odds that soldiers will suffer mental and emotional stress that can become debilitating. And in wars without fronts, "combat support troops" are just as likely to be affected by the same traumas as infantry personnel.

While we are appreciative of Senator Burr's sincere motivation to do what is best for all concerned, including potentially affected veterans, VVA does not believe that the program outlined in this legislative initiative is either the best way to address this problem nor is it a prudent course in regard to assisting veterans to continue to serve our Nation in civilian life as they did in the military.

In truth, with no end to the Iraq and Afghanistan wars in sight, the true incidence of PTSD among active duty troops may still be underreported because of stigma and discrimination. Without proper diagnosis and treatment, the psychological stresses of war never really end, increasing the odds that our soldiers will suffer mental and emotional stress that can become debilitating if left untreated. This places them at higher risk for self-medication and abuse with alcohol and drugs, domestic violence, unemployment & underemployment, homelessness, incarceration, medical co-morbidities such as cardiovascular diseases, and suicide.

VVA remains opposed to S. 2573 principally because it would create a two-tiered disability benefits system that would treat veterans differently based on their periods of service—that is, a system that gives different disability rating awards to classes of veterans from different combat eras under the guise of saving the VA money. VVA is especially concerned with the impact of the so-called "buy out" program of this bill, not only on those veterans currently suffering from mental health disorders, but also on those who will encounter mental health problems later in life as a result of their military service. As you know one of the well-known characteristics of PTSD is that the onset of symptoms is often delayed, sometimes for decades, despite unfunded assertions to the contrary.

We are not disputing the fact that claims for mental health service-connected disability compensation are rising and the accompanying costs for such are growing as well. But under S. 2573, this problem cannot be resolved unless fewer vets are rated disabled and/or fewer disabilities are rated, and/or smaller amounts of compensation are awarded. The responsibility of providing service-connected disability compensation for a veteran's mental health injuries must not be trivialized by providing a one-time payment for wounds that may take years to heal, if ever.

This is especially applicable to our Nation's largest living veteran cohort, Vietnam veterans, who are now aging, retiring, and suffering the aftermath of physical and emotional injuries incurred as a result of their military service 40 years ago.

The legitimacy of veterans' claims that they suffer from PTSD is apparently again under the gun by a small number of media savvy professional skeptics (some would call them "hired guns"), who have waged a campaign to discredit PTSD as a valid

diagnosis, and whose views, I might add, are not generally shared by mainline PTSD experts nor by the vast majority of mental health professionals nor by the Institute of Medicine of the National Academies of Science. (The IOM convened several panels at the request of the Department of Veterans Affairs relating to this issue of whether PTSD was a legitimate medical condition, whether PTSD could be accurately diagnosed, and whether PTSD could be effectively treated. (All three of these reports, released on June 16, 2006, May 8, 2007, and October 17, 2007, respectively, are available at *www.iom.edu* in the Military & Veterans section.)

Without a shred of evidence veterans who suffer from PTSD are portrayed by these skeptics as looking for easy disability payments that provide an incentive for staying sick rather than getting well, with the implication that sick veterans are welfare cheats. In addition to claims of veteran fraud, these skeptics also claim that cases of delayed onset of PTSD "are rare to non-existent," and that "PTSD is an acute, not chronic, disease and only rarely should there be a need to give long-term disability." In fact, there are no data to support these opinions. Studies done at the National Center for PTSD confirm the delayed onset of PTSD, as well as the fact that mental health utilization is actually higher for veterans granted disability claims than for those who apply and are turned down. VVA would also argue that use of the standardized and validated PTSD diagnostic assessment tools in the "Best Practices Manual for PTSD" would pick up any factitious PTSD disability claims, and provide for better guidance in developing individualized treatment plans.

VVA's concern is also focused on those veterans suffering from TBI, the so-called "signature wound" of the war in Iraq, because it presents a most puzzling challenge, especially in mild to moderate cases. Symptoms can be hidden or delayed, diagnosis is difficult, and evidence-based treatments are as of yet largely undetermined. And if left untreated over time, even mild TBI can cause epilepsy/seizure disorder. Very few medical facilities in the U.S. are capable of providing even the most minimal level of specialized care for brain-injured patients, forcing most survivors to find treatment hundreds of miles from home, if they can find it at all—and more than 40 percent of our military deployed in Afghanistan and Iraq come from rural America.

In addition, the most commonly utilized current treatment modality for epilepsy/seizure disorder is medication. However, we must remember that epilepsy/seizure disorder caused by either a concussive or contusive brain injury, is never just an isolated incident. Over time without proper treatment and care, TBI can affect nearly everything associated with the survivor, including one's cognitive, motor, auditory, olfactory, and visual skills, perhaps resulting in behavioral modifications, not mental illness. Epilepsy/seizure disorder treatment, recovery services and programs can also collapse a family and its finances. Of all the medically challenging injuries, brain injuries require the most involvement and cost over time.

And so the question then becomes: How can we really expect a veteran currently suffering from chronic PTSD or TBI—perhaps even on medication for such wounds—to be able to make an informed decision now about his/her future mental health care needs and service-connected disabilities?

Last, VVA acknowledges that the culture of the VA mental health system itself may play a yet undefined role in this current debate over PTSD and VA compensation. For example, the studies of Sayer and Thuras (1), as well as Kimbrell and Freeman (2) suggest that VA clinicians had a more negative view of the treatment engagement of veterans who were seeking compensation and of clinical work with these patients in comparison with those veterans not seeking compensation and those certified as permanently disabled and thus not needing to reapply for benefits. The longer VA clinicians had been working with veterans who had PTSD, the more extreme were these negative perceptions.

What is clear to us is that these so-called clinical "researchers" are not even aware that their patients seek service connection so that they will not have to pay for medical treatment for a condition that they believe resulted from their military service. This, and the sense of validation of the reality of the suffering they endure is in fact a result of neuro-psychiatric wounds suffered in service are often more important to the individual veteran that any compensation payment he or she may derive (and deserve!) as a result of this psychiatric wound(s) that are every bit as real as a gunshot wound, if properly diagnosed according to the VA's own "Best Practices Manual."

VVA would point out that the VA refuses to issue these manuals to relevant staff in the Veterans Benefits Administration and in the Veterans Health Administration because "it takes too much time" and to follow the best practices is "too expensive." VVA's rejoinder is that if you do not have the time and resources to do it right the first time, when are you going to have the time and money to do it over, and then

do it over yet again? Our veterans deserve better than slapdash, simplistic "fixes" that in fact do not address their legitimate needs, and would actually serve to exacerbate their very real wounds incurred in military service.

S. 2273—THE ENHANCED OPPORTUNITIES FOR FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING ACT OF 2007

VVA strongly supports this legislation. The crux of the problem with transitional housing for homeless veterans (aside from the fact that there is not enough of it) is that often there is no available permanent housing to which a transition can take place. In other words, persons make it off the street into a transitional housing unit, but then have no permanent affordable housing to go to when their time in the transitional supportive housing is done. What is needed are both affordable permanent housing, and supportive services that are available and focused on the needs of these persons to help them maintain a stable life situation. It is very important that the VA provide grants to fund such services, as HUD is increasingly cutting back on program dollars and focusing on "bricks and mortar." (Whether that is a smart public policy move on the part of HUD is certainly debatable, but the fact remains that this is the direction in which they seem to be heading.)

The pilot program as outlined in this proposal is solid, but we would suggest that you consider both enlarging the size of the pilot, provide for regular reporting to Congress at regular intervals (at least once per year), and after evaluation of the experience of what works and what does not work, provide for moving beyond the pilot in short order should the model(s) prove to be as successful as we think they will be if the VA implements them correctly. VVA has no doubt that Pete Dougherty (who coordinates homeless programs at VA nationally) will do a sterling job of the implementation and running this additional needed aspect of the VA homeless program(s), if he is given the resources and the backing.

S. 2377—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE QUALITY OF CARE PROVIDED TO VETERANS IN DEPARTMENT OF VETERANS AFFAIRS' MEDICAL FACILITIES, TO ENCOURAGE HIGHLY QUALIFIED DOCTORS TO SERVE IN HARD-TO-FILL POSITIONS IN SUCH MEDICAL FACILITIES, AND FOR OTHER PURPOSES.

VVA endorses passage of this bill. We do, however, have some suggestions that we hope you will consider. First, the Chief of Staff and the top medical officer of each VA Medical Center need s to be written into the chain of reporting in this bill. Similarly, so does the clinical director of each Veterans Integrated Services Network (VISN and the Under Secretary for Health of the Department of Veterans Affairs. While the principal ones to carry out the activities mandated by this bill may in fact be as described, it is the chief medical officer at each level who does have, and should have, ultimate responsibility for the overall quality of medical care delivered to veterans by that unit. While the mechanism prescribed in this legislation will be another tool toward that end, it is only part of the puzzle of how to maintain the highest quality of care for our Nation's veterans.

VVA also strongly favors additional financial and other incentives to attract and keep high-quality physicians and other vitally needed clinicians and medical specialists in the VA.

Last, although it is not at the high professional credential level of the mechanism described in this legislative proposal, the fact is that many veterans cannot properly communicate with their clinician, nor is their clinician able to effectively communicate with them and others in the VA. Language barriers have become an impediment to quality care in too many instances. The lack of full command of the English language by clinicians and others at the VA is probably the most common complaint we hear from our members, their families, and other veterans.

This is a complaint that is founded on frustration voiced by many veterans that they cannot understand what their physician is trying to say to them, and their physician simply does not understand or misunderstands what they are trying to communicate. This can result in erroneous medical notes in the veterans' record, or even misdiagnoses. In more than a few cases, it would appear that these communication barriers impede the delivery of quality medical care. At minimum, it detracts from it.

The reality is that the VA will likely need to continue to hire foreign born physicians. So the question is: what can be done to help those physicians to be more effective in communicating with their patients, and therefore more effective clinically? VVA urges that Congress consider mandating the VA to regularly offer basic communication skills courses to clinicians and others within the VA, and to make it a requirement for a physician or other clinician (no matter where they were born or what their native tongue) to pass both an oral and written test in English before

being made permanent in their employment. (The same would hold true for Spanish at the Puerto Rico VAMC.)

S. 2383—A BILL TO REQUIRE A PILOT PROGRAM ON THE MOBILE PROVISION OF CARE AND SERVICES FOR VETERANS IN RURAL AREAS BY THE DEPARTMENT OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES.

VVA endorses this proposal.

As VVA noted in our last appearance before this distinguished Committee, the current paradigm for delivery of health care is predicated on placing resources where there is a large concentration of veterans eligible for service. In other words, the mechanism for service delivery of veterans' health care is in or near urban centers. However, those fighting our current wars in Iraq and Afghanistan (and elsewhere) comprise the most rural army we have fielded since before World War I.

The Department of Defense reports that about 40 percent of the current military force comes from towns of 25,000 or less. What this means is that we collectively must re-think the paradigm of how we deliver medical services to veterans in need.

The pilot program outlined in this bill is a good start toward testing what is going to work in regard to delivering quality health care to veterans (including demobilized National Guard and Reserves) who live in less populous areas of our country, and deserves to be immediately enacted, and implemented as quickly as possible.

S. 2639—THE ASSURED FUNDING FOR VETERANS HEALTH CARE ACT

Americans have long held that health care for veterans is a national obligation, part of the covenant between the American people, through our democratically elected representatives and agencies of government, and the men and women who have pledged to defend the Constitution and the cherished principles of our Nation. Because those who render military service pledge not only their loyalty but their life, knowing that they may be called to combat, understanding that they may give up their life, this covenant is more profound than a legal contract. Now, at a time when a new generation of our sons and daughters is on the front lines defending America's interests, it is our obligation as citizens of a generous and compassionate society to ensure that the funding to care for the injuries, illnesses, and disabilities they may suffer is assured and not relegated to a "discretionary" appropriation of inadequate proportions.

Those who serve during times of war or conflict, particularly those who are deployed to a war zone, return home changed. Many are seared psychologically. Some are wounded or maimed by the weapons of modern warfare. Yet just as they have fulfilled their obligation to their country—to all of us—it is our collective obligation to do all that we can, through the appropriate agencies of government, to restore as much as possible to each veteran who has been lessened physically, psychologically, or economically; and all that we can individually and through our communal and religious institutions to heal each veteran who has been lessened spiritually.

All Americans committed to justice for veterans understand that the annual budget battles in Congress do little to inspire confidence that we will do right by our veterans. Budgets and appropriations are, of course, a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does "discretionary" funding for the care of men and women who defend our country say about America? What does the "temporary" triage of veterans classified as "Priority 8" say about our government's priority for veterans who want to use the VA health-care system?

In the last five sessions of Congress, legislation has been introduced in both the House and Senate that would drastically re-engineer the process by which the Administration and Congress fund veterans' health care.

The highest legislative priority of Vietnam Veterans of America is the institution of assured funding for veterans' health care, or another mechanism that will enable predictable schedules of appropriations increases that account for medical inflation and is calculated on a truthful per capita basis of projected use of VHA services. The Disabled American Veterans have been working on such a model that while still not what VVA's ultimate goal is—assured funding—is still better that the mess we have now.

Of all such mechanisms, however, VVA is still committed ultimately to the assured funding mechanism as described in Senator Johnson's bill.

VVA also strongly supports immediate reinstatement of eligibility for enrollment for Priority 8 veterans. VVA asks that this Committee take the first steps toward directing that the VA use numbers for its future planning and projection purposes that include provision of services for Priority 8 veterans who are not currently en-

rolled. A funding mechanism that annually makes allowances for the growth in the beneficiary population and inflation would ensure adequate additional funding as needed. Many of these plans offer similar funding mechanisms that already exist for the TRICARE for Life program serving the Nation's military retirees and their dependents that are also eligible for Medicare. The funding mechanism created for this program requires annual increments based on health care inflation and growth in the number of beneficiaries. Rather than allowing politics to affect funding decisions, the Government Accountability Office (GAO) considers whether the annual increment determined will be adequate to meet costs. This methodology brought stability and predictability to a program that, in its infancy, suffered significant problems attributable to funding.

Unfortunately, despite a recommendation from its own Task Force to Improve Health Care for Our Nation's Veterans (Final Report, 2003) to consider mandatory funding for VA health care, the Administration has rejected any meaningful consideration of funding reform. Bills have been introduced in both the House and Senate to no avail.

VVA is grateful to and salutes Senator Tim Johnson of South Dakota for his fortitude in not only overcoming his own health crisis, but for his extraordinary efforts in continuing to push for real reform in the way in which our Nation funds health care for our Nation's veterans.

Unfortunately the debates regarding funding of veterans' health care continue to focus on the year-to-year "band-aids" and quick fixes needed to keep the health care system afloat. Last year, $3.7 billion had to be appropriated as emergency supplemental funding in order to make progress on restoring both the infrastructure and the organizational capacity of the VHA to deal with the needs America's veterans.

It is time to act to ensure a consistent, predictable, and responsible level of funding that will give more than lip service to the mandates for health care set forth in law, and by the will of the American people, for those who have borne the battle in the fertile fields of Europe, the islands of the South Pacific, the rice paddies and jungles of Southeast Asia, the sands of Kuwait and Afghanistan and Iraq, and the peacetime confrontations of the cold war.

Establishing a method that will ensure the fair, adequate and predictable funding of the VA health care system which would better ensure timely access to quality care remains the highest legislative priority of Vietnam Veterans of America.

In the 5 years that have followed publication of our original White Paper asserting the need for assured funding, the Administration and Congress have continued to provide compelling demonstrations of the weaknesses of the current funding method.

VVA is grateful to you, Senator Akaka, and to all Senators on both sides of the aisle who have accorded the veterans health care system with more increase in the past eighteen months than they have ever had, and to your counterparts on the other side of the Hill for all of their hard work as well to achieve these record increases.

However, despite these efforts and progress, the appropriations for the VA health care system continue to be inadequate to the degree that the VA is still barring eligibility to health care for many working-class veterans without compensable service-connected disabilities, limiting long-term care options, and compromising access to quality health care.

The uncertainty of when and how much funding it will receive wreaks havoc upon the VA's ability to make effective planning, policy and purchasing decisions. While that has appeared to improve, it will take increases of the magnitude of the last calendar year for another several years to restore what was lost from the funding base, and the overall organizational capacity of the VHA during the "flat line" years of 1996 to 1999, and several years thereafter when the increase in funding did not keep pace with either the increase in veterans entering the system, nor rapidly rising costs of medical care, many of which are not controllable.

Recent budget cycles call into question the VA's ability to produce a budget that credibly funds its health care system. Even after compensating for the savings and foregone revenues that have proven to be distasteful to Congress (new enrollment fees and dismantlement of the State home program, for example), the VA had to admit it would be $1 billion deficient in funding for fiscal year 2005 and also would require almost $2 billion more than originally projected for fiscal year 2006.

Critics of the VA continue to call for it to live within its budgets by increasing efficiency. While VVA supports much greater accountability for VA officials, VA has proven its efficiency by actually reducing per user costs in a time of double-digit health care inflation. VA users' per capita costs actually decreased by about 6 percent (without including the eroding effects of inflation), while Medicare per capita costs and those of the average American consumer will have almost doubled.

Other federally funded health programs do not annually suffer through the funding cycle as the VA does. The Nation's largest health care system that serves some of our most deserving citizens—veterans—should be accorded the same funding assurances as Medicare and TRICARE for Life.

Accordingly, VVA has joined every other major veterans' service organization as part of the Partnership for Veterans Health Care Budget Reform in calling for assured funding that is indexed for medical inflation and accounts for a credible expectation of utilization of health care services of all eligible veterans who desire enrollment. Without fundamental changes in the VA's budget process, veterans who rely upon the VA's health care services will continue to have a system plagued by deficiency and unpredictability.

For the coming fiscal year (FY 2009), VVA testified earlier this year that we believe the VA medical care business line will require at least $5.24 billion over fiscal year 2008 VHA appropriations. Some contend that even adding that amount will not allow VHA the latitude to restore access to all veterans.

As we all are aware, on January 17, 2003, then-Secretary Anthony J. Principi decided to "temporarily" suspend enrollment to Priority 8 veterans. While this decision may be reconsidered on an annual basis, every budget proposal sent to the Congress by the Administration since continues to omit funding for this group, and attempts to discourage use and enrollment of "higher income" groups—that is, all Priority 7 and Priority 8 veterans who had enrolled prior to the suspension. The Administration has proposed new enrollment fees for these groups in addition to imposing higher co-payments for the pharmaceutical drugs that are largely responsible for bringing many into the system. These proposals are designed to do two things—eliminate services provided to higher income veterans and generate additional revenues to partially cover the cost of their care.

Priority 8 veterans—mostly working-class Americans without compensable disabilities incurred during their military service—are known as "higher-income" veterans. "Higher income" is a misleading label considering the growing rates of uninsured Americans directly subjected to spiraling health care costs and the relatively low-asset levels of those affected (currently, as low as about $27,000 for a veteran with no dependents). Far from redressing what veterans' advocates were given to believe was a "short-term" panacea, budgets for the 5 years since suspension of enrollment have omitted funding to restore access to these veterans and have espoused policies—such as new enrollment fees and higher co-payments—that are specifically designed to discourage these veterans' use of their health care system.

In last year's proposal, the VA estimated that more than one million "higher-income" veterans who have not been suspended from enrollment would be discouraged from using their health care system under their plan. Additionally it has been reported that more than a half a million veterans have been excluded from vitally needed services of the VHA system since that time. VVA has reason to believe that this is too conservative a figure, and the number of those excluded is higher still.

In an era in which health care inflation has regularly outstripped increases in wages, it is not surprising that veterans remain attracted to the re-engineered VA system. The proliferation of new outpatient clinics in addition to the benefits provided to all enrollees, including some that are not typically covered by private-sector health plans, such as prescription drugs, eyeglasses, and hearing aids, continue to encourage veterans' use of VA health care services. Even more veterans who are not considered regular users will be enrolled. VVA estimates 8.4 to 9 million would enroll if Priority 8 veterans were reinstated for enrollment without an enrollment fee).[1] Enrollment is a prerequisite for eligibility for health care services for all but the most highly rated service-connected disabled veterans.

Recent budgets sent to Congress have also attempted to ration services for veterans—particularly long-term care. In recent years, State homes have overtaken the VA in the long-term care workload they provide veterans and these homes are the only VA-sponsored settings that continue to support custodial care for veterans whom VA is not mandated to treat. Yet in VA's fiscal year 2006 budget request, a policy shift was proposed that would have effectively shuttered as many as 80 percent of the State veterans homes (as estimated by the National Association of State Veterans Homes) with whom the Federal Government has been working for more than 100 years. The VA is currently planning a study of the law that requires providing nursing home care for veterans with a high-level of disability because of military service that may result in requests for further curtailments in their authority. Over the last decade VA has attempted to shift care as quickly as possible from its

[1] VVA estimated this number by applying the growth in numbers of enrollees from 2002–2003 to estimates of enrollees (without the proposed enrollment fee) in the Administration's budget submission for 2006. VVA estimated 70 percent of these enrollees would use VA services.

own settings to the community where veterans can be made eligible for the similarly fiscally challenged Medicaid program. The folks at OMB just want to shift the cost away from the Federal budget, whether the States have the resources to help here or not. Frankly, it is easy to get the impression OMB does not care whether these veterans get the services they need or not as long as the Federal Government does not have to pay.

The uncertainty of when and how much funding it will receive wreaks havoc upon VA's ability to make effective policy (including enrollment), personnel, contracting and other purchasing decisions. The VA often misses critical windows to hire new physicians and nurses because officials do not know when new funding will become available. Health care workers are not willing to put off employment indefinitely when other—and often more lucrative—opportunities are readily available in their communities. In years of relative scarcity, most of the VHA 21 regional Veterans Integrated Service Networks (VISNs) routinely delay badly needed equipment purchases and repairs to meet their operating expenses.

Since fiscal year 2002, management "efficiencies" have accumulated, creating a $1.8 billion hole in the VA's medical services funds by fiscal year 2006 (or about 8 percent the medical services budget). In a February 1, 2006 report to Senator Daniel Akaka, Ranking Member of the Senate Veterans' Affairs Committee and Congressman Lane Evans, Ranking Member of the House Veterans' Affairs Committee, the Government Accountability Office found that VA lacked a methodology for producing the management efficiencies projected in budget submissions for fiscal year 2003 and fiscal year 2004 and that:

> the management efficiency savings assumed in these requests were savings goals used to reduce requests for a higher level of annual appropriations in order to fill the gap between the cost associated with VA's projected demand for health care services and the amount the President was willing to request.

From fiscal year 1996 through fiscal year 2006, however, it is clear that the VA has had to do "more with less." Although the Administration continues to tout increases in the funding for the veterans health care system, the VA's resources per veteran user have dropped precipitously, particularly in comparison to the per capita costs based on national health care expenditures and the costs per Medicare enrollee. VA users' per capita costs actually decreased by about 6 percent (without including the eroding effects of inflation), while Medicare per capita costs will have almost doubled.

VA's per capita costs for users, once higher than national per capita costs and costs per Medicare enrollee, have actually dropped below both of these groups and this was not included third party collections While national health care expenditures and Medicare enrollees' costs have almost doubled over the period of time studied, VA's per capita costs have actually decreased. Fiscal year 2006 dollars were adjusted for health care inflation they would not have nearly as much buying power as the 1996 dollar. The average annual medical care inflation for 2001–2004 has been double the growth for the Consumer Price Index for all other items (2.2 percent versus 4.4 percent). A comparison of per capita costs is particularly compelling since national health care expenditures include the costs of all Americans—many of whom are young and healthy and may not be expected to require the same level services as the mostly older and disabled populations Medicare and VA serve.

Without considering the effects of medical care inflation, in sharp contrast to the average American's health care expenditures or the average Medicare enrollee's costs (both of which almost doubled), VA's per capita costs actually drop slightly from 1996 to 2006. This is because VA health-care funding is not linked to growth in the beneficiary population or medical inflation.

What led to this drop in funding per VA user during a time when other health care consumers' costs doubled? Simply put, the growth in the number of veterans who now use their health system has outpaced the growth in financial resources the Federal Government has invested in it (or, at least the growth has outpaced to willingness of the OMB to recommend increases that are needed just to maintain stasis.)

Still, the effects of deficient budgeting are still being felt in many areas, despite the tremendous strides made in the past 2 years. The VA estimates that almost half of its obligations for medical services in 2006 would be spent on personal services and benefits for its 130,000 employees. Decreases in the VA's per user costs have clearly translated to fewer doctors and nurses per patient. The most likely outcomes of understaffing are adverse effects on the timeliness and quality of care. At this time there are still many thousands of veterans projected to wait longer than 6 months for an appointment with a clinician, even though the "official" estimates are

much smaller than VVA would estimate. The Inspector General report that was released research points out that VHA is still often not telling the truth about waiting times, and so many clinics are "gaming" the system that it is hard to figure out what the actual figures might be. In many areas of the country, such as Florida, VA has experienced severe problems placing even service-connected veterans on waiting lists.

With funding uncertainties removed, the VA leadership could focus on implementing measures to create a true veterans health-care system—a system in which every veteran that enrolls would be given a full physical examination, including a comprehensive military health and medical history and a psychosocial evaluation. This history would provide an epidemiological baseline to help measure future health conditions not only for a particular veteran but potentially for others with whom (s)he served. When an extensive epidemiological database is finally compiled, it can serve as an invaluable tool for physicians. With more information about a patient's military background, a doctor would know to test for particular conditions, parasites, and toxic exposures that may already be adversely affecting the health of that veteran. Such a database could reveal whether others who served in the same unit reported similar health effects. It could also serve as a tool to identify common exposures that may be related to the incidence of conditions that have long latency periods.

Such findings, combined with better sharing of military records, including the location of troops, deployment health, and pre- and post-deployment health information, could serve as the basis for research into the health effects of a particular exposure, occupation or even combat or theater experience.

VVA has long stressed the importance of collecting such information, and the results are taking root in the Veterans Health Initiative (VHI). This VA endeavor educates providers about certain exposures and health effects that are prevalent among veterans or for which veterans have been shown to be at unique risk The VA has made these training modules available to its providers and should take further steps to educate the general medical community from whom most veterans seek care.

VVA still maintains that managerial accountability goes hand-in-hand with assured or "mandatory" funding. To its great credit, the VA has implemented a clinical information system which allows it to evaluate its success in meeting a variety of clinical and administrative goals. However, some managers who have had problems overseeing high-investment projects or publicized breaches in government protocols, spotty records of adherence to departmental directives and law, and cited problems in Government Accountability Office and Inspector General reports on their area in negative ways continue to be rewarded. Rewards cannot solely be based on achievement of certain goals, if there are well documented (and often highly publicized) problems that are not rectified. The deposition of the Associate Deputy Under Secretary for Health for a recent civil action in Federal Court demonstrated (in his own words) that in regard to quality assurance for delivery of PTSD and other neuro-psychiatric are that "we do not have metrics in place to measure that."

When clearly understood performance standards have been met and there are not clear violations in protocol, rewards should be made from the top-down. Just as rewards must be provided, the system must also sanction those whose performance is inadequate.

While there is a legitimate need to make significant adjustments in the compensation for critical health care workers, the current use of "merit bonuses" has been corrupted. Merit bonuses must be just that: bonuses for merit and achievement above and beyond that which is required. The current mode does a disservice to the many fine VA physicians and administrators who deserve more competitive pay and bonuses for truly outstanding performance. The system of rewards and punishment must be adjusted to sanction those who do a poor job or are not fully open and honest with appointed or elected officials.

To ensure accountability, the VA must develop adequate training and testing tools for personnel at all levels of the organization. Neither managers nor their employees can be held responsible for violating protocols of which they are not aware. In a constantly evolving health care environment governed by a complex array of law, regulations, internal guidance and voluntarily imposed guidelines from accreditation agencies, compliance is difficult. Without ensuring that management and employees receive updates and appropriate training it is impossible.

We as a nation can and must do better for our veterans. Funding for veterans' health care has been woefully inadequate for years. As Dr. Linda Spoonster Schwartz, currently Commissioner of Veterans Affairs for the State of Connecticut and Chair of the Health Care Committee of the National Association of State Directors of Veterans Affairs put it: "The lack of a consistent, reliable budget has, in essence, obstructed VA's capacity to respond to the changing needs of the health-care

system, to efficiently grow, to acquire competent personnel and maintain a viable service infrastructure." And as the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans concluded:

> Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner * * *. Full funding should occur through modification to the current budget and appropriation process by using a mandatory funding mechanism, or by some other change in the process that achieves the desired goal.

It is imperative to enact legislation that would assure funding for veterans' health care. An assured, predictable and reliable funding stream would enable the VA to concentrate on achieving accountability for performance from senior managers and building a system that is not only cost-effective and efficient, but contributes to the mission of restoring veterans who have been lessened physically through injury or illness or the psychic wounds of war, or economically by virtue of military service.

VVA and other VSOs believe it is ultimately disingenuous for our government to promise health care to veterans and then fail to provide adequate funding. Rationed health care must only be a temporary expedient as Congress moves toward an assured funding model. We endorse the proposition that "by including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our Nation's sick and disabled veterans."

A WORD ON THE OFFICE OF MANAGEMENT AND BUDGET (OMB)

It should be clear to all that the current method of funding health care services to veterans has not been working very well for some years now, despite some nigh on to heroic efforts by the Congress. Some of this is due to the funding for this vital function being classified as "discretionary" funding. But it needs to be publicly noted that much of the difficulty in this being "discretionary" spending is the difficulty of overcoming the churlish attitude toward veterans of the OMB and their willful ignorance of the reality of veterans' needs or even of what actually happens in VA facilities.

The current Deputy Director of OMB and her staff have never visited a VA medical center, not even once. The previous permanent ranking civil servant permanent employee the veterans unit at OMB had held her job for about two decades and never once even entered a VA medical facility. We would also point out that the last time we checked, OMB less than 10 veterans employed out of more than 970 employees, and 0 disabled veterans. And yet OMB is theoretically subject to the same Veterans' Preference laws as the rest of the government.

The only way this could happen is in a corps. Just by accident they should have had more than 10 veterans and at least SOME disabled veterans in their orate culture that condones the conscious and deliberate patterns and practices of overt discrimination against persons who served our Nation in military service, and particularly prejudice against employing disabled veterans.

If OMB had hired no women, or no African-Americans, or no of Hispanic decent, or no Asian Americans would anyone accept their contention that could find no qualified candidates from those groups to work there? VVA thinks not, and that similarly we should not accept this continued illegal pattern and practice by OMB that discriminates against veterans, particularly disabled veterans.

Given OMB's clear attitude toward employing veterans, it should come as no surprise to anyone that this lack of respect should be reflected in their work and budgets produced in regard to the VA and other programs vital to veterans. At least it is now more understandable that they always try to give too few resources to properly assist veterans, no matter how good the program. That does not make it proper or legitimate, but at least we know what we are dealing with.

S. 2796—COMMUNITY-BASED ORGANIZATION PILOT PROGRAMS

VVA strongly endorses this bill. The experience of Vietnam veterans in the 1970's showed that the most effective, and certainly the most efficient, mechanism for serving otherwise "under-served" veterans was by means of funding community based organizations (CBOs) for specific purposes on a pay for performance basis. The experience in the past decade has clearly shown that the most cost effective, cost efficient means of reaching and properly serving homeless veterans has been though funding community based organizations to do this.

For example, the Homeless Veterans Reintegration Project (HVRP) which helps place homeless and formerly homeless veterans in full time employment is far and away the most cost effective, cost efficient program administered though any branch of the U. S. Department of Labor. It is therefore a mystery to VVA as to why this program is not funded at the full $50 million that is authorized, as it works and works well to move veterans from the welfare dole to the tax rolls, and helps them restore their sense of dignity and self worth, in addition to helping them lift themselves off of the street and back into society, through supporting them in their effort to work their way back up.

A similar program funded by up to $50 million at VA to perform the duties as outlined in this proposed legislation would be similarly successful. We can cite at least two organizations that are CBOs that have been doing this multi-service center work successfully for three decades. One is Swords to Plowshares, in San Francisco, California, and the other is the Veterans Outreach Center in Rochester, New York. Both of these organizations have received funding from various sources over the years, some from private donations, some via grants from private donations, at times they have received State funding, and sometimes local government funding. From time to time their funding sources have changed, but their core commitment to serving the whole person, and assisting the veteran in all aspects of his or her life to re-construct a decent life and a way forward toward a more complete human existence has not changed or wavered. Furthermore, they do so and achieve a success rate of reaching and substantially assisting veterans to meet their recovery goals at a cost per participant that is far less than most programs delivered by large agencies. This model already demonstrably works.

Chairman Akaka is to be commended for introducing this legislation, but we suggest that you consider giving this pilot an authorized amount of funding for at least 3 years, and direct VA to work with already existing similar programs in developing the Request For Proposal, as well as consulting with the National Coalition for Homeless Veterans and the veterans' service organizations who may have knowledge of such programs. We also suggest that the VA be directed to report back to you within 180 days of enactment their plan for issuing a Request for Proposal, and that VA deliver a report and analysis of the pilot to VA on a yearly basis thereafter.

S. 2797—CONSTRUCTION AUTHORIZATION

VVA has no objection to most of these requests, as most of the items requested by the Administration are needed. VVA does believe, however that the pace of reconstructing and replacing of the physical infrastructure of the Veterans Health Administration needs to be quickened. For quite a number of years virtually no construction was funded until VA designed a plan that had some sense and rationale to it. Even though VVA still has significant reservations in regard to the CARES formula, at least there is a comprehensible model to formulate a plan for facilities for the future. Therefore, we should get on with it at a faster pace, before construction costs soar even higher.

However, in regard to the medical facility in San Juan, Puerto Rico VVA has serious reservations about VA's plan to try and jury rig and shore up an outdated and outmoded early 1960's style building that is in danger of collapsing in a hurricane currently, as opposed to designing and building a new, strong, and modern medical facility. If you fix up an outmoded structure that was poorly designed to begin with, then you have a poorly designed facility that still is inadequate to meet the needs of the future.

Frankly, one has to question whether some other factor was operating here that Denver gets a $2 billion state-of-the-art beautiful facility that will not even be fully owned by VA, but San Juan gets some leftovers and an as cheap as possible retrofit of an outmoded and energy inefficient structure that even when the projected work is finished will not even approach being the "best," nor will it be able to withstand a direct hit of the likely stronger storms that we will experience in the coming decades. VVA understands that if the money is authorized and appropriated to do this retro-fit in San Juan, then the possibilities of a proper new building will be slim to none.

Therefore, VVA strongly encourages the Committee to take a very strong look at Puerto Rico as to every aspect of services provided there, from medical services to claims adjudication to the State of the cemetery which will be full in a relatively short time. The construction plans for parking, the medical facility, and additional space for proper burial of veterans there all seem to be less than one would expect, or certainly less than accorded other areas in the United States. The veterans in Puerto Rico performed no less well, and fought no less valiantly, and in fact served in a higher than average percentage in the combat arms than those from elsewhere,

and so should not be relegated to cut rate facilities or service. The veterans of San Juan deserve no less consideration than the veterans of Denver.

S. 2799—WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2008

VVA salutes Senator Murray for introducing this much needed legislation, which should be enacted as soon as possible.

Women comprise the fastest growing segment of the Armed Forces, and therefore as they leave the military, the fastest growing sub-set of the veterans' population. Thousands have been deployed to Iraq and Afghanistan. This has particularly serious implications for the VA health care system because the VA itself projects that by 2010 more than 14 percent of all veterans utilizing its services will be women.

Women's health care is not evenly distributed or available throughout the VA system. Although women veterans are the fastest growing subset, there remains a need for increased focus on health care and its delivery to women, particularly the young women coming home today. What is needed are real women's medical clinics that are separate places within each hospital, and ensure that the women get the privacy and the "comfort level" needed for them to seek assistance for the full range of maladies from which they may suffer, including Military Sexual Trauma (MST).

Although women veterans are the fastest growing population within the VA, there remains a need for an increased focus on health care and its delivery for women, particularly the new women veterans of today. Although VA Central Office may interpret women's health services as preventive, primary, and gender-specific care, this comprehensive concept remains ambiguous and splintered in its delivery throughout all the VA medical centers. Many at the VHA appear (unfortunately and wrongly) to view women's health as only a GYN clinic. It certainly involves more than gynecological care. In reality, women's health is viewed as a specialty unto itself as demonstrated in every University Medical School in the country.

Furthermore, some women continue to report a less than "accepting," "friendly," or "knowledgeable" attitude or environment both within the VA and/or by third party vendors. This may be the result, at least in part, of a system that has evolved principally (or exclusively) to address the medical needs of male veterans. But reports also indicate that in mixed gender residential programs, women remain fearful and unsafe.

The nature of the combat in Iraq and Afghanistan is putting servicemembers at an increased risk for PTSD. In these wars without fronts, "combat support troops" are just as likely to be affected by the same traumas as infantry personnel. They are clearly in the midst of the "combat setting". No matter how you look at it, Iraq is a chaotic war in which an unprecedented number of women have been exposed to high levels of violence and stress as more than 160,000 female soldiers have been deployed to Iraq and Afghanistan * * *. This compared to the 7,500 who served in Vietnam and the 41,000 who were dispatched to the Gulf War in the early '90's. Today, nearly one of every 20 U.S. soldiers in Iraq/Afghanistan is female. The death and casualty rates reflect this increased exposure.

With 15–18 percent of America's active-duty military being female (20 percent of all new recruits) and nearly half of them have been deployed to Iraq and/or Afghanistan, there are particularly serious implications for the VA health care system because the VA itself projects that by 2010, more than 14 percent of all its veterans will be women, compared with just 2 percent in 1997. Although the VA has made vast improvements in treating women since 1992, returning female OIF and OEF veterans in particular face a variety of co-occurring ailments and traumas heretofore unseen by the VA health care system.

There have been few large-scale studies done on the particular psychiatric effects of combat on female soldiers in the United States, mostly because the sample size has heretofore been small. More than one-quarter of female veterans of Vietnam developed PTSD at some point in their lives, according to the National Vietnam Veterans Readjustment Survey conducted in the mid-'80's, which included 432 women, most of whom were nurses. (The PTSD rate for women was 4 percent below that of the men.) Two years after deployment to the Gulf War, where combat exposure was relatively low, Army data showed that 16 percent of a sample of female soldiers studied met diagnostic criteria for PTSD, as opposed to 8 percent of their male counterparts. The data reflect a larger finding, supported by other research that women are more likely to be given diagnoses of PTSD, in some cases at twice the rate of men. Matthew Friedman, Executive Director of the National Center for PTSD, a research-and-education program financed by the Department of Veterans Affairs, points out that some traumatic experiences have been shown to be more psychologically "toxic" than others. Rape, in particular, is thought to be the most likely

to lead to PTSD in women (and in men, where it occurs). Participation in combat, though, he says, is not far behind.

Much of what we know about trauma comes primarily from research on two distinct populations—civilian women who have been raped and male combat veterans. But taking into account the large number of women serving in dangerous conditions in Iraq and reports suggesting that women in the military bear a higher risk than civilian women of having been sexually assaulted either before or during their service, it's conceivable that this war may well generate an unfortunate new group to study—women who have experienced sexual assault and combat, many of them before they turn 25.

Returning female OIF and OEF troops also face other crises. For example, studies conducted at the Durham, North Carolina Comprehensive Women's Health Center by VA researchers have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD. And according to a Pentagon study released in March 2006, more female soldiers report mental health concerns than their male comrades: 24 percent compared to 19 percent.

VA data showed that 25,960 of the 69,861 women separated from the military during fiscal years 2002–06 sought VA services. Of this number, approximately 35.8 percent requested assistance for "mental disorders" (i.e., based on VA ICD–9 categories), of which 21 percent was for Post Traumatic Stress Disorder or PTSD, with older female vets showing higher PTSD rates. Also, as of early May 2007, 14.5 percent of female OEF/OIF veterans reported having endured military sexual trauma (MST). Although all VA medical centers are required to have MST clinicians, very few clinicians within the VA are prepared to treat co-occurring combat-induced PTSD and MST. These issues singly are ones that need address, but concomitantly create a unique set of circumstances that demonstrates another of the challenges facing the VA. The VA will need to directly identify its ability and capacity to address these issues along with providing oversight and accountability to the delivery of services in this regard. All of these issues, traumas, stress, and crises have a direct effect on the women veterans who find themselves homeless. Early enactment of Senator Murray's bill on women veterans currently pending in the Senate will do much to rectify this situation, and VVA commends her for her leadership in this and other matters of vital interest to veterans.

Although veterans make up about 11 percent of the adult population, they make up 26 percent of the homeless population. Of the 154,000 homeless veterans estimated by the VA, women make up 4 percent of that population. Striking, however, is the fact that the VA also reports that of the new homeless veterans more than 11 percent of these are women. It is believed that this dramatic increase is directly related to the increased number of women now in the military (15 percent–18 percent). About half of all homeless veterans have a mental illness and more than three out of four suffer from alcohol or other substance abuse problems. Nearly forty percent have both psychiatric and substance abuse disorders. Homeless veterans in some respects make use of the entire VA as do any other eligible group of veterans. Therefore all delivery systems and services offered by the VA have an impact on homeless veterans. Further, the failure of the Department of Labor system to provide needed employment assistance in a nationwide accountable manner to many veterans means they lose their slim purchase on the lower middle class, and therefore end up homeless. Once homeless, it becomes very difficult for these veterans to find employment for a multiplicity of reasons.

The VA must be prepared to provide services to these former servicemembers in appropriate settings.

VVA thanks Senator Patty Murray for her leadership on the issue of ensuring that women veterans get proper health care and services that is different but equal to me. This bill warrants speedy passage and prompt full implementation.

S. 2824—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE COLLECTIVE BARGAINING RIGHTS AND PROCEDURES FOR REVIEW OF ADVERSE ACTIONS OF CERTAIN EMPLOYEES OF THE DEPARTMENT OF VETERANS AFFAIRS.

VVA supports collective bargaining rights, and commends Senator Rockefeller for his leadership in introducing this bill.

S. 2889—VETERANS HEALTH CARE ACT OF 2008, SECTIONS 2, 3, 4, 5, AND 6 (AKAKA, BY REQUEST)

VVA generally supports Sections 3, 4, 5, and 6 of this proposed legislation. In regard to Section 2, VVA suggests you consider revising to say Global War on Terror, which is generic enough to cover anyone who experiences such deficits due to Traumatic Brain Injury wherever they might be serving in the world in the United

States Armed Services. Further, VVA suggests that a clause be added to the effect "and other such veterans who may be eligible for and in need of this type of care."

As you know, VVA's founding principle is "Never again shall one generation of veterans abandon another generation." VVA continues to try and live up to that principle in regard to both our fathers who served in World War II and toward the young people serving today and who have already come home, all too often wounded. However, the disturbing trend in much of what the Administration proposes would divide the generations. We suggest that by adding "and other such veterans as may be in need of this type of care" that this distinguished Committee can avoid the slippery slope of dividing the generations, no matter whether that is intended or not.

S. 2899—A BILL TO DIRECT THE SECRETARY OF VETERANS AFFAIRS TO CONDUCT A STUDY ON SUICIDES AMONG VETERANS

VVA generally favors anything that will produce reliable data regarding the thorny question of suicide among veterans of every generation. Any suicide is a terrible thing that leads almost all who know the person to question themselves: what could I have done better to have saved him or her? Good data on suicides is a very scarce commodity. Suicide has been a topic of much (often quite animated and passionate) debate and discussion about and among Vietnam veterans for 30 years, for instance.

However, since VA refuses to obey the law and complete the National Vietnam Veterans Readjustment Study replication, thus producing a longitudinal study of Vietnam veterans utilizing a statistically valid random sample, we do not have any idea of why Vietnam veterans and, we suspect young veterans are dying by their own hand in disproportionate numbers.

Given their poor track record in regard to telling the whole truth on this and other sensitive subjects (particularly regarding suicides), VVA does not feel that VA can be trusted to do such a study on its own, as most people would have doubts as to the credibility of almost any statistics on suicide they advance at this time.

Therefore we urge that this bill be modified so as to prescribe the protocol to be used and direct VA to contract it out to a nationally respected research institution after first consulting with the VSOs, entities such as the American Psychiatric Association, the American Psychological Association, and others as appropriate to produce a Request for Proposal (RFP) that is supplied to the Committees on Veterans Affairs for review prior to publishing said RFP.

S. 2921—CARING FOR WOUNDED WARRIORS ACT OF 2008

VVA generally favors this proposal. As VVA has pointed out in numerous forums, soldiers are surviving initial wounds that would have killed them in previous wars, and therefore are suffering really grievous wounds in larger percentages than previous conflicts. When we came home from Vietnam, when you were in the hospital, you were literally in the hospital for many months or even years while undergoing treatment. That is just not the case today, as the overwhelming majority of health care delivery is on an outpatient basis, even for those with really severe multiple wounds, or wounds that would preclude them being able to drive a car or function on public transport (where there is such public transportation).

The treatment model currently being used for these veterans with severe conditions is all predicated on having an intact nuclear family akin to Ozzie & Harriet, where a parent or the spouse can be full time chauffeur and caregiver for many months or even years. This has placed terrible strains on many young marriages that were already stressed by the absence of one member of the couple in a war zone, and then the swift change of reality for the soldier or marine (and by extension his or her family) in one terrible instant.

For starters, many spouses or other family members have to work to help provide additional income to keep the family together and the bills paid. This proposal would allow spouses, mothers, or other family members to receive remuneration and training to provide these essential services that are necessary for the best possible recovery and rehabilitation of these fine servicemembers. Further, this proposal would allow graduate students to be trained to provide respite care, which is necessary so that the primary care giver does not suffer from utter exhaustion and compassion fatigue. VVA suggest that you consider opening this up further to nursing students, students in other medical and helping professions (particularly veterans who are attending institutions of higher education after return from military service), and possibly undergraduates, if they are more than 21 years old and/or they are returning veterans themselves that have completed at least 1 year or more of study in their field.

This proposal is a practical one, and meets a real need.

S. 2926—VETERANS NONPROFIT RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT OF 2008

VVA does not have objection to this legislation. However, we do urge that there be much more disclosure of the activities of each of these corporations as may be established, both to the Secretary of Veterans Affairs and to the Congress. We also urge that public posting on the Internet of who are on the Boards of Directors of these corporations, what their profession and or business interests are, and regular summaries of any and all funds accepted and the source(s), all funds spent on research for each purpose, and other information regarding governance or what research is being funded by what source of funds, producing what results toward what end?

There is already a disturbing trend in the Veterans Health Administration toward excessive secrecy, e.g. conducting the Secretary of Veterans' Affairs Advisory Committee on PTSD in total secrecy, with not even a minimal publication of the work of this Committee. Similarly, the decision of the previous Undersecretary and which the current Undersecretary continues to intransigently insist on keeping the sunshine of daylight and public or consumer advocates off of much of the proceedings of the Advisory Committee on Serious Mental Illness.

It will certainly take action by the Congress and probably a new President who is committed to open and honest government of the people by the people to change this "We know best, and if you only knew what we know" current mentality of some in VHA that is unworthy of a constitutional democracy.

Until then, the attitude at VHA apparently will continue to be one of "SHHHhhhh!!!!"

This attitude does a great disservice to veterans who depend on this system for quality medical care, and a great disservice to the many thousands of fine clinicians across the country in VA who just want to do a good job of helping veterans heal, and who do in fact manage to do outstanding work, no matter how much some of them are punished for doing right by the veterans we all serve.

S. 2937—A BILL TO PROVIDE PERMANENT TREATMENT AUTHORITY FOR PARTICIPANTS IN DEPARTMENT OF DEFENSE CHEMICAL AND BIOLOGICAL TESTING CONDUCTED BY DESERET TEST CENTER AND AN EXPANDED STUDY OF THE HEALTH IMPACT OF PROJECT SHIPBOARD HAZARD AND DEFENSE, AND FOR OTHER PURPOSES.

VVA favors making permanent the right of all participants in chemical, biological, and pharmacological testing by the military services or any other Federal Government entity to be able to receive medical care without charge from the VA.

VVA is very supportive of the right that those who participated in the Shipboard Hazards and Decontamination (Project SHAD).

However, Project SHAD was just one part of Project 112, which includes many more individuals than served in Project SHAD tests, per se. VVA urges this Committee to broaden the group covered by this part of the bill.

VVA also urges the Committee to consider the proposed legislation being advanced in the House of Representatives by Congressman Mike Thompson of California, which would go further in that it would create a commission to study all of Project 112, and possibly other tests that took place of a chemical, biological, or pharmacological nature during that same time period of 1963 to 1973.

Last, there is a real need for further study of the adverse health effects due to exposure of servicemembers in Project SHAD that focuses on the crews of the light tugs, and others who were not properly covered by the previous IOM study. VVA will be pleased to work with Senator Tester and with staff to make the changes briefly outlined here to produce a bill that we can enthusiastically support.

S. 2963—A BILL TO IMPROVE AND ENHANCE THE MENTAL HEALTH CARE BENEFITS AVAILABLE TO MEMBERS OF THE ARMED FORCES AND VETERANS, TO ENHANCE COUNSELING AND OTHER BENEFITS AVAILABLE TO SURVIVORS OF MEMBERS OF THE ARMED FORCES AND VETERANS, AND FOR OTHER PURPOSES.

Vietnam Veterans of America is grateful to Senator Bond for his leadership on this and other issues of medical care and treatment of returning war fighters, both while they are still in the Armed Forces, and once they become veterans. The work and thinking that went into this proposal is both laudable and solid.

In regard to Section 1 of S. 2963, VVA has favored and advocated such scholarships for the education and training of behavioral health specialists for Vet Centers operated by the Readjustment Counseling Service of the VHA for 26 years, ever since VVA made the motion that led to the very first recommendation of the then

brand new Administrator's Advisory Committee on the Readjustment of Vietnam Veterans (now the Secretary's Advisory committee on the Readjustment of Combat Veterans) that called for such scholarships to be created. VVA does urge that preference be accorded to veterans for receipt of these scholarships, especially those who have served in a combat theater of operations.

In Section 2 of S. 2963, VVA recommends that the wording be changed to veterans of the Global War on Terror (GWOT) who have served in a theater of combat, or have experienced combat situations. Those who have and are serving in the southern Philippines or the horn of Africa, and elsewhere should be covered by this provision as well.

Further, VVA strongly believes that the Vet Centers are the ones who have the mind set, training, and the treatment models to best help the still on active duty troops and their families. However, the VA must be mandated to add to the credentialed professional counseling staff in significant numbers before we can fully support this title. The Congress gave VA an additional $20 million specifically to add at least another 250 counseling staff members to the Vet Centers as part of the Emergency Supplemental War Appropriation bill signed by the President on March 7, 2007. The VA did not release the money to the Readjustment Counseling Service until past the mid-August, which was far too late to spend any of these funds on personnel before the fiscal year ended. Therefore the VA bought much needed computers and computer software upgrades in addition to purchasing vehicles for outreach into rural and other hard to reach areas where veterans currently were not being served.

Since that time the RCS has only hired another 62 professional counselors in the pre-existing centers (to wit, separate and apart from the staff being hired to staff the more than two dozen new Vet Center sites that have already or will be opening by the end of this year.).

The problem is that the existing Vet Centers (or at least the majority of them) are virtually over-run with more veteran clients than they can effectively serve. The reason they have so many clients is that they are generally very good at what they do. So, what already is happening in regard to basically pushing aside earlier generations of veterans will be accelerated if the centers are opened to active duty personnel and their families.

The solution is to add the resources beginning immediately so that the Vet Centers are not forced into a situation of forced "Triage" that leaves some older veterans who depend on their local Vet Center to keep them alive, help them keep it together to successfully continue in their job, and veterans of previous conflicts who need the Vet Center to help them deal with relationship and family problems, to keep families together, are not pushed out into the cold (both figuratively and in some instances literally).

The simple solution is for them to start adding more staff immediately. For the VHA to say they do not have enough money to do so is simply disingenuous, as the Congress gave them more than $3 Billion for the current fiscal year more than they said they needed to provide all services to all legally entitled to service.

VVA very much wants to support this section, but the VA must be compelled to add another 250 to 350 staff members to serve the needs of those whom they are already seeing, as well as to be ready to effectively serve those active duty servicemembers who will seek their services once they know of the Vet Centers, and understand they can go there with no potentially bad effect on their military career. That way these fine young war fighters will be able to enhance their career as they learn to better cope with their symptoms, and overcome their neuro-psychiatric wounds.

In regard to Section 3 of S. 2963, VVA favors this provision, and recommends in addition that all former members of the Armed Services who were separated from the military for reason of "personality disorder" after having served in a combat theater of operations be accorded full rights under the law to utilize any and all services of the VA Vet Centers.

In regard to Section 4 of S. 2963, VVA strongly supports this provision.

Further VVA asks that the Committee considers adding the phrase "died by their own hand" so as to include those who take their lives via single car accidents and one person "hunting accidents" and the like to this category. Coroners are often loath to list these formally as suicides in many cases, even though we have good reason and experience to suspect that many of these so-called "accidents" within the first 2 years after return from a combat situation are really suicides.

In regard to Section 5 of S. 2963, VVA strongly favors utilizing the services of not for profit organizations to provide services to veterans in hard to reach communities and too hard to reach constituencies whether they are located in rural or in urban areas. As one example, perhaps the most effective way to reach veterans who live in the Bedford-Stuyvesant or Fort Green sections of Brooklyn is through contracting

with the "Black Veterans for Social Justice" organization that has been amassing credibility with veterans and their families, and delivering quality services to veterans in a way in which they will accept that help for thirty years.

S. 2969—VETERANS' MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT OF 2008

VVA has no objection to this proposed legislation.

We do have some concerns, however. In regard to "nursing assistants" VVA hopes that there will continue to be an emphasis on a career track for nursing assistants to acquire needed education to become vocational nurses or registered nurses if they so desire. VVA also urges the Committee to consider including a special scholarship program for returning Army medics and Navy Medical Corpsmen/women to become Physician Assistants, and to require VA to have a range of practice for PAs in the VA that is comparable to the range of practice for PAs in the military services.

VVA has long favored competitive salaries for top VA personnel and managers. Thus we support the proposed increases to enhance recruitment and retention of top professionals to run the VA health care system. However, with increased pay must come much greater accountability. For someone in the VA to make just a bit less than the Nation pays the Commander in Chief does seem to be pushing the limits. Therefore, VVA will ask on behalf of all veterans (and all other tax payers as well), what are the mechanisms/means in place for evaluation to ensure that we are getting our money's worth?

VVA suggests that the VA will pay attention to this crying need for holding these same highly paid employees more accountable for performance or non-performance by VA officials if the Congress takes steps to require them to pay attention to measuring and evaluating the value that the Nation gets for expenditures made.

S. 2984—"VETERANS BENEFITS ENHANCEMENT ACT OF 2008"

At first blush VVA has no objection to this bill, although we do recommend that Committee study the provisions pertaining to the elimination of certain reporting requirements very carefully to assess what if any impact this will have on the already most inadequate transparency of the workings of the VA.

This concludes our testimony. I shall be glad to answer any questions you might have. Again, all of us at VVA thank you for the opportunity to provide our thoughts and hopefully useful suggestions regarding these proposed legislative initiatives. VVA thanks you and your distinguished colleagues for your fine efforts on behalf of America's veterans.

References

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Chairman AKAKA. Thank you very much.

Dr. Satel?

STATEMENT OF SALLY SATEL, M.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE, AND LECTURER, YALE UNIVERSITY SCHOOL OF MEDICINE

Dr. SATEL. Thank you, Mr. Chairman. I am speaking as a psychiatrist and a former VA clinician. The purpose of my remarks today is to endorse the premise of the Veterans Mental Health Treatment First Act, that premise, of course, being that veterans with PTSD and other mental illnesses are best served when they first pursue treatment with the goal of recovery before assuming that they will be chronically incapacitated and thus candidates for full and total disability status.

I am thinking of a real case: a 22-year-old young man who was discharged from the military a few months ago. He is flooded with terrible memories, classic PTSD symptoms. He can't concentrate. He is agitated. He is depressed. He is certain he will never be able to work again, that he will never be able to develop intimate rela-

tionships or have a family or even fully function in society. So, he naturally thinks, why even bother with treatment? My situation is hopeless. So, he applies for permanent and total disability.

I understand this perfectly, but I also believe that permanent and total disability status is the last thing a 22-year-old needs. It confirms his worst fears—that, in fact, he will be a psychiatric invalid. In fact, what receipt of disability compensation would say to him is, yes, you are right, there is no hope of significant recovery. We wouldn't dream of doing this to someone with a spinal cord injury—that is, tell him forget it, you will never work again. First, obviously, he would have surgery. He would have intensive physical therapy. These kinds of things come first.

Let me say that there is much more at stake than granting disability to someone who actually has good prospects for recovery. The problem to me is that the very act of granting full disability can actually diminish those prospects of recovery. But let me say right here that I am not claiming compensation, per se, is harmful. In fact, it is a Godsend for people who need it. But what I am saying is that the timing of granting disability compensation is critical.

For one thing, granting full disability too quickly sends a powerful negative message of enduring disablement when what this young man or woman needs to hear about hope and recovery. This optimism I am talking about, it is not just a feel-good strategy, it is a well-established clinical truth: that a person's perceptions of his or her capabilities and expectations for the future is critical to improvement after trauma. These truths are data from the National Center for PTSD, in fact.

Also, giving full disability status first, before treatment, naturally leads a patient to assume he won't be able to work, and given that work is one of the best therapies we know, puts him at a real disadvantage. He loses the sense of purpose and confidence that one derives from work—even the daily structure it affords, the opportunity for socializing it creates. Being deprived of these virtues before—and I emphasize before—there is good reason to believe he is truly and permanently totally disabled is a very high price to pay.

In closing, a "treatment first" approach is by far the most clinically rational way to manage young veterans with war-related mental illnesses. This has nothing to do with curtailing access to disability compensation, but everything to do with making these young men and women healthy enough so that they won't need it in the first place.

Thank you very much.

[The prepared statement of Dr. Satel follows:]

PREPARED STATEMENT OF SALLY SATEL, M.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE, LECTURER, YALE UNIVERSITY SCHOOL OF MEDICINE

Mr. Chairman, thank you for the invitation to appear before the Committee. I am a psychiatrist who formerly worked with disabled Vietnam veterans at the West Haven VA Medical Center in Connecticut from 1988–1993. Currently, I am a resident scholar at the American Enterprise Institute (and work, part-time, at a local methadone clinic). I have been interested in applying the lessons we learned in treating Vietnam veterans to the new generation of service personnel returning from Iraq and Afghanistan.

The purpose of my remarks today is to endorse the concept behind S. 2573 Veterans' Mental Health Treatment First Act.

The animating idea behind the legislation is that young men and women who are suffering from military-related mental illness service will benefit most when they pursue treatment with the goal of recovery before labeling themselves beyond hope of improvement—and thus a candidate for total and permanent service-connected disability status.

As a clinician I agree wholeheartedly with the premise of the bill that the most appropriate sequence begins with treatment, moves to rehabilitation, and then—if necessary—goes on to assessment for disability status.

The following vignette underscores the intrinsic wisdom of the bill.

CLINICAL SCENARIO

Imagine a young soldier wounded in Iraq. His physical injuries heal but his mind remains tormented. He is flooded with memories of bloody firefights, he can't concentrate, and sudden noises make him jump out of his skin.

He is 22 years old and was discharged from the military a few months ago. He is certain he'll never again be able to hold a job, tolerate being around people, develop an intimate relationship, go on to have a family, and fully function in society. "Why even bother with treatment," he thinks, "The situation is hopeless." Convinced he is facing life as a psychiatric invalid and worried about financial security he applies for total and permanent disability from the Department of Veterans' Affairs.

Yet the last thing this 22-year-old man needs is confirmation of his fearful pessimism. Unfortunately, that will be precisely the message he gets if his claim is approved for full permanent and total disability: "You're right, there is no hope of significant recovery. You are irreparably damaged."

How can we make a responsible determination about an individual's life-long psychiatric incapacitation before he or she has even allowed himself to be helped?

Implications—Judging an individual doomed to a life of invalidism before he has even had a course of therapy and rehabilitation is drastically premature. This is particularly so when the young soldier is being evaluated for mental disability status *while still on active duty*.

Full disability status may actually undermine the possibility of recovery; its implicit message is that the beneficiary has a very small likelihood of improvement. As a result, the status itself can become a self-fulfilling prophecy for the patient.

Without question, some patients will remain severely and irretrievably impaired by their war experience. Treatment will help them, almost surely, but return to the workforce may not be possible. These men and women deserve generous disability compensation.

Yet, so many others do have the potential to resume work, greater family participation, and engagement in their community. The problem is that once a patient receives a monthly check because he is diagnosed with (a treatable) psychiatric illness, his motivation to hold a job can diminish. Full disability would naturally lead him assume—often incorrectly—that he is no longer able to work, and then, the longer he is unemployed, the more his confidence in his ability to work erodes and his skills atrophy.

At home on disability, he adopts a "sick role" that ends up depriving him of the estimable therapeutic value of work. Lost are the sense of purpose and competence work gives (or at least the distraction from depressive rumination it provides), the daily structure it affords, the occasion for socializing it creates, and the opportunity to reach for goals. That work serves as a prophylactic against psychological distress is especially evident among veteran retirees.

This is a good place to mention remission rates of PTSD. According to the National Vietnam Veterans' Readjustment Study (NVVRS, 1988) fifty percent of those who develop the diagnosis of PTSD will recover fully over time. A recent re-analysis of the NVVRS (*Science*, vol. 313 18 August 2006), found the lifetime rate of PTSD to be 18.7 percent vs. point prevalence (current) of 9.1 percent. Notably, those with a lifetime history of PTSD but not current PTSD exhibited virtually no lingering functional impairment at the time of assessment. Thus, to grant total disability compensation in light of a fifty percent chance of total remission (and a much higher chance of achieving partial or near-total remission) makes little sense.

IS DISABILITY COMPENSATION A BARRIER TO SEEKING TREATMENT?

In 2006 the Veterans' Disability Benefits Commission asked the Institute of Medicine (IOM) to evaluate the evidentiary basis for various influences of compensation

on treatment and recovery. The IOM panel concluded that "PTSD compensation does not, in general, serve as a disincentive to seeking treatment."

Healthy skepticism surrounding this conclusion is warranted, not least because there are so few studies on the subject. Moreover, the IOM conclusion is based on studies of Vietnam veterans. I will elaborate presently on why the IOM report does not justify dismissing the importance of a "treatment first" approach for young veterans from Iraq and Afghanistan.

First, let us briefly review the data they interpreted. The IOM committee reviewed six studies of veterans claiming combat-related PTSD.

Longitudinal studies—Three of the six examined data from the phases before and after disability status was granted.

The best known is a 2005 study conducted by the Inspector General of the DVA. Ninety-two cases were examined and revealed that most veterans' self-reported symptoms of PTSD become steadily worse over time until they reached the 100 percent disability level—at which point there is an 82 percent drop in use of VA mental health services (but no change in VA medical health service use).

These findings are contradicted by two studies from the Minnesota VAMC which found increased attendance at treatment after receipt of disability compensation. Samples sizes were 452 and 102, respectively. Authors reported an increase in the number of sessions attended and in the percentage of patients who used services. Patient drop out after receipt of disability compensation is not a problem, they concluded.

Comparison of compensation-seeking patients versus non-seeking regarding service use—A 2004 study from the Charleston VA reported the study of 68 veterans as having found that compensation-seeking veterans were more likely to use PTSD services compared to non-seekers. *Yet, notably, the actual paper itself denies any significant difference in PTSD service utilization between the two groups.*

Comparison of compensation-receiving patients and non-recipients regarding symptom reduction—This 2006 study found an equivalent degree of symptom reduction among 54 veterans at the Boston VAMC with chronic PTSD irrespective of their receiving disability compensation.

Comparison of compensation-seeking patients versus non-seeking regarding symptom reduction—Researchers at the West Haven VAMC published a 1998 study of 1,000 compensation-seeking veterans undergoing either outpatient or inpatient treatment. Symptom reduction was observed among the outpatient cohort but not among the inpatients. Notably, despite amelioration of symptoms, employment was low at 1 year following treatment initiation: outpatient subjects had worked, on average, almost 7 days per month (an increase of less than a full day compared to pre-treatment) and inpatient subjects worked just under 2 days per month (a decline from slightly over 2 days pre-treatment).

Limited relevance to today's situation—Many features of these studies limit their relevance to the subjects of today's hearing, namely young veterans returning from Iraq and Afghanistan who (1) suffer new-onset PTSD symptoms (2) seek or receive total and permanent disability status, and who (3) have not received sustained, quality treatment.

By contrast, the studies examined by the IOM examine involve almost exclusively Vietnam veterans with chronic PTSD who are already in treatment.

These are two very different populations. Most veterans of the Vietnam War who came to the attention of VA psychiatrists were neither diagnosed with PTSD, nor treated, until over a decade after experiencing combat trauma. Presenting for treatment so many years later typically means a diagnostic picture is very complex (e.g. overlaid with substance abuse problems, long-term employment difficulties, and diagnoses such as depression). At this advanced stage, responsiveness to treatment is usually compromised.

Consider, also, the age of most of the Vietnam veterans who were subjects of the studies. They were in their forties and fifties when seeking disability and had been ill for many years; for most, the struggles with long-standing psychiatric conditions were an acknowledged aspect of daily life and personal identity. By comparison, veterans from Iraq and Afghanistan have not been ill for such a long time. They are in a different, earlier phase of life, still configuring what their post-service lives will be. Within this vulnerable period their perceptions of their capabilities and futures are being formed; so are the meanings they give to their symptoms.

In short, this is a highly impressionable stage; a time to offer untreated veterans a message of promise and hope, not enduring disablement.

Finally, bear in mind that the studies reviewed by the IOM reveal very little about real-world functioning. In fact, the take-home lesson from the single study that measured change in occupational functioning (West Haven) was that symptom reduction is a poor proxy for overall improvement. Recall, the study found post-

treatment employment rates of only two to 7 days of work per month among disability-seekers. True, attendance at treatment sessions and measurable reductions in symptoms may be a sign of engagement with the VA, but this is only a part of the picture: the major goal of treatment is social reintegration and re-entry, especially into the workplace community.

Studies of treatment utilization among compensation seeking Vietnam veterans tell us little to nothing about the potential for functional improvement/recovery in young, never-treated veterans returning from Iraq.

Note, also, that the studies' observations are consistent with the well-established finding within civilian populations that individuals who receive disability compensation are less likely to work when compared to their counterparts who do not receive compensation but exhibit the same degree of mental illness severity (see p. 6–3, IOM).

Disability doesn't necessarily inhibit treatment seeking, but it inhibits recovery. Not only does full disability status signify dysfunction, it presents a basic disincentive to recovery.

MAKING TREATMENT WORK FIRST AND WORK WELL

We must think of PTSD and other war-related mental conditions as a treatable and time-limited affliction. We must treat it early when symptoms are most responsive to treatment.

There are excellent treatments for the component parts of PTSD (e.g., the phobias, anxiety, depression, existential dislocation). Treatments include desensitization protocols (such as Virtual Iraq), cognitive-behavioral therapy, psychotherapy, and medication. There is often a period in which treatment and rehabilitation overlap.

Rehabilitation is critical to psychiatric recovery and familial and community reintegration. And the most effective efforts capitalize on the well-established finding that patients' prognoses depend on what transpires in the "post-trauma" phase. One element of this is the patient's self-image. How does he view himself "post-event?" Is his expectation one of recovery? Does he view himself as in control? Is he hopeful?

In addition to the importance of a forward-looking stance is the extent to which problems of reintegration are managed. This is why quality rehabilitation addresses marital discord, readjustment to civilian life as well as to being a parent, vocational training, and financial concerns. Some veterans will need help with skills in relating to family, friends, neighbors, colleagues, and bosses.

When daily life can be made more manageable, the patient feels more in control. Not only can he tolerate some symptoms better (sleep problems, distressing memories), those symptoms will fade faster. He will be less likely to ascribe morbid interpretations to symptoms and to less apt to feel discouraged. Demoralization is not a formal diagnosis, but in my experience, it can be the difference between someone who throws in the towel and someone who prevails. The virtue of rehabilitation is that it can turn risk factors for a prolonged course of illness into protective factors.

CONCLUSION

Veterans who are afflicted with PTSD or other mental disorders in the wake of their military experience deserve the best treatment. But it is imperative that we pair concern over the quality of care with serious consideration of the philosophy guiding the timing of that care. Imagine giving young men and women permission to surrender to their psychological wounds without first urging them to pursue recovery. Imagine even trying to make an accurate determination of one's potential for recovery before he or she has even received therapy. For many young veterans, a "treatment first" approach could mean the difference between a rich civilian life and withdrawal into disability.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. RICHARD BURR TO DR. SALLY SATEL, M.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE, AND LECTURER, YALE UNIVERSITY SCHOOL OF MEDICINE

1. In a 2007 report the Institute of Medicine (IOM) examined available research on the link between veterans seeking, or in receipt of, disability compensation and their propensity to obtain mental health treatment. IOM made the final finding and conclusion: "Research reviewed by the committee indicates that PTSD compensation does not, in general, serve as a disincentive to seeking treatment."

Question. Please comment on the IOM finding. Should the IOM's conclusion preclude VA from adopting a treatment first focus? Why or why not?

Response. The IOM finding has very little relevance to the question of the VA's establishing treatment-first as a focus. To rely on the IOM as justification for the VA's rejection of the treatment first focus is a mistake as the report offers a flawed interpretation of the research.

First, the studies included in the IOM report concern Vietnam veterans who have experienced PTSD symptoms for years, if not decades, and who are already in treatment. This is not relevant to young veterans returning from Iraq and Afghanistan who: (1) suffer new-onset PTSD symptoms, (2) seek or receive total and permanent disability status, and (3) have not received sustained, quality treatment.

These are two very different populations. Most veterans of the Vietnam War who came to the attention of VA psychiatrists were neither diagnosed with PTSD, nor treated, until over a decade after experiencing combat trauma. Presenting for treatment so many years later typically means a diagnostic picture is very complex (e.g. overlaid with substance abuse problems, long-term employment difficulties, and diagnoses such as depression). At this advanced stage, responsiveness to treatment is usually compromised.

Also, keep in mind that the studies reviewed by the IOM reveal very little about real-world functioning. In fact, the take-home lesson from the single study that measured change in occupational functioning (West Haven) was that symptom reduction is a poor proxy for overall improvement. Recall, the study found post-treatment employment rates of only two to 7 days of work per month among disability-seekers. True, attendance at treatment sessions and measurable reductions in symptoms may be a sign of engagement with the VA, but this is only a part of the picture: the major goal of treatment is not simply attending sessions, it is making use of them to achieve greater levels of social reintegration and re-entry into the workplace community.

Thus, even if we can conclude that disability payments do not necessarily inhibit treatment seeking, they often inhibit recovery. And that is the key outcome.

A more detailed analysis can be found in my written statement for the May 21 hearing.

2. The 2005 VA Inspector General report found that most veterans' PTSD symptoms gradually worsened until 100 percent disability is achieved. You noted that the Vietnam veterans you worked with had incorporated their disorders as part of their identities.

Question. Do you believe an early, more holistic approach that emphasizes recovery before resignation to disability could reverse this trend? How can we change the mindset that results from the label of a disability rating?

Response. Most definitely, the emphasis must be on recovery. That is not falsely optimistic; it is simply a reflection of the natural course of PTSD. Yet, it will be hard to change the mindset because of the pattern established with the Vietnam generation wherein PTSD was believed to be a lifelong affliction.

Furthermore, all troubling symptoms and behaviors were attributed to PTSD, no matter how many years post-war they manifested. When patients, abetted by clinicians, understand themselves in that way, therapy suffers greatly as the search for the true basis of distress is abandoned and treatment is targeted at the wrong problem.

However, many mental health professionals at individual VAMC's realize that the most effective way to treat young veterans is to regard the condition as temporary and to reassure them that the chances are excellent that they will recover and resume full lives with their families and communities.

I believe that no veteran should be eligible for total and permanent disability until we (and they) have evidence that they are refractory to treatment. Perhaps disability status should not even be available to them for at least 2 years post separation.

However, the equivalent of treatment scholarships (similar to the Burr bill) should be available so that they have a safety net while pursuing intense treatment with an emphasis on vocational rehabilitation and family therapy.

The image of PTSD as a diagnosis must change from a chronic problem to a temporary one (based on the data we have amassed within the past decade and more). Psychiatrists and psychologists who work in VA environments are more attuned to this than they were years ago (though some of those in leadership positions at the National Center for PTSD seem too willing, in my view, to perpetuate the traditional model of PTSD as it emerged during the Vietnam era).

Perhaps the biggest obstacles to reform are some of the veterans groups—in particular the Vietnam Veterans of America. Unfortunately, these groups are so single-mindedly focused on preserving entitlements to veterans that they perceive any innovation, no matter how clinically beneficial it might be, as a grave threat. If reform

is to be made, in my opinion, there needs to be political will to resist the urgent lobbying efforts of some advocacy groups.

Question. Reflecting on the veterans you worked with, and based on your professional knowledge, do you believe early rehabilitative intervention would have helped in their readjustment to civilian life?

Response. I worked with the veterans who never received early intervention. These men described having difficulties readjusting when they returned from Vietnam. They did not receive formal assistance. Some went to Vet Centers which tended to entrench their bitterness about the political dimensions of the war. Many were suspicious about going to a VAMC, considering it an agent of the government that failed them as soldiers.

Keep in mind that the large majority of Vietnam veterans went on to lead full, productive lives (as the National Vietnam Veterans Readjustment Study shows). But the patients who came to us never regained their civilian footing: they did not work regularly or at jobs with advancement potential, they abused alcohol or other drugs, they had tumultuous marriages, and they often had run-ins with the law.

The longer they lived chaotic lives, the more entrenched they became in those habits, and the harder it was to change themselves or their circumstances. I believe that early intervention would have changed the trajectories of the lives of many of them.

Question. If so, should we therefore apply the treatment first concept to recently separated combat veterans as a first priority in order to avoid the mistakes we made with the Vietnam generation of veterans?

Response. Most assuredly. This is a new generation of young veterans. They have much promise and we must not repeat with them the clinical errors made during the Vietnam era. I must add, though, that the errors to which I refer (including lengthy, regressive inpatient stays, incessant rehashing of war stories at the expense of forward-looking rehabilitation, and an expectation of disability) were made in good faith. We now have sufficient data to guide us in a different direction. And we have effective exposure therapies and CBT.

One of the most important strategies is to "front load" help to the veterans so they can readjust to civilian life as quickly as possible. The other is to transform the image of PTSD so that it is understood as a time-limited condition. Also, the VA should have a high threshold for granting full and total disability status.

3. Recent studies suggest that full or partial remission of PTSD should be the norm and not the exception for the vast majority of PTSD cases.

Question. Please comment on the risks of labeling individuals as disabled (especially totally and permanently disabled) through the disability compensation process. In your view, does such labeling potentially hinder the recovery process for many?

Response. Full disability status and compensation—unless applied appropriately to the small minority of severely afflicted veterans—paradoxically suppresses recovery by (a) suggesting to the patient that his condition is hopeless, (b) depriving him of the world of work, (c) eroding his confidence in his ability to work, (d) creating a perverse incentive to remain ill because payments stop when he recovers. For someone who hasn't worked in years, the prospect of losing the safety net is understandably anxiety-provoking.

Chairman AKAKA. Thank you. I want to thank all of you for your testimonies.

Dr. Luke, in your statement, you mentioned that Helping Hands Hawaii seeks to identify eligible veterans and assist them with navigating the VA system. Can you please provide the Committee with some more specific examples of how an organization such as Helping Hands Hawaii reaches out to returning veterans, especially those in rural areas or minority populations, to let them know what services are available to them?

Mr. LUKE. As already mentioned in the previous panel, there is a stigma regarding mental health services and we have noticed also in the various ethnic groups in Hawaii, including the Native Hawaiians, the stigma is particularly strong. You see that in the normal and the general population, as well. So, when people do present for treatment, usually it is out of desperation, because nothing else has worked for them.

What we do is we use a very open and very engaging process to welcome people into our office, to engage with our case manager and also our psychologist—and both of them have previously worked for the VA, such as myself. And what we do is we try to encourage them not to drop out of treatment and not to drop out of the disability application process. Long lines, long wait time, the paperwork is so overwhelming for the veterans that they often give up and decide it is not worth the process. So, we try to encourage them not to disengage from the VA and the disability application process.

Chairman AKAKA. Thank you. This question is for Mr. Cox and Ms. McVey. You have both presented numerous suggestions that would strengthen hiring and retention of nurses in VA and I appreciate your support of S. 2969, the Veterans Medical Personnel Recruitment and Retention Act of 2008. In your view, what are the two most important steps VA can take to attract and retain a greater number of highly qualified nurses? Mr. Cox or Ms. McVey?

Mr. COX. Well, Senator, I believe probably the first thing that I would say today, to be able to recruit and retain the best qualified nurses in the world, is to give them full collective bargaining rights in the VA and to support the legislation that Senator Rockefeller has introduced. Because, you know, the Congress of the United States said the public's best interest is served through collective bargaining, and for those nurses to have a way to be treated properly in the worksite, to be able to deal with the workplace issues, you would recruit those nurses and retain those nurses.

And the other issue, I would say, you have got to pay them and pay them properly. The nurse pay is a very big issue in the VA. It is a very secretive issue in the VA. It needs to become transparent, an open book; and pay those nurses properly, treat them well, give them their collective bargaining rights.

Chairman AKAKA. Thank you, Mr. Cox. Ms. McVey?

Ms. MCVEY. I think, as I stated in the testimony, several of the provisions in the bill, if they were to be addressed, would go a long way to enhancing both recruitment and retention for VHA, such as education and implementation of what exists in locality pay law. That would be one way to do that. It would be an important thing.

And I think also in the pay issues that Mr. Cox testified on, as well, streamlining some of the human resource issues that exist still—outdated classification systems, hiring processes that are cumbersome—need to be addressed in order to facilitate. That is more actually on the recruitment end of it, but will go a long way also to facilitating the recruitment and then retention for VHA nurses.

Chairman AKAKA. Ms. McCartney, thank you for your testimony in support of S. 2926, the Veterans Nonprofit Research and Education Corporation Enhancement Act of 2008. As you discussed, the recent Inspector General report raises a number of concerns about NPCs. How will this legislation facilitate VA oversight of NPCs?

Ms. MCCARTNEY. VA has always had the power to oversee these nonprofit corporations, which are inextricably linked to VA, and that has not changed at all. One of the things that this bill does, and a very important component, is that it does provide the capacity for small corporations to merge with larger corporations. So, in

terms of oversight, that would lessen the number of institutions that VA would have to oversee and it would also strengthen the operation of these institutions by having, as Mr. Hall testified earlier, critical mass and enough resources for the local institutions to manage them.

The nonprofits welcome this oversight. We are happy to work closely with VA in developing any kind of standards; and would be very willing to work with them to make sure that the oversight is there, that the standards are clear, and that we are in full compliance with these standards.

Chairman AKAKA. Thank you, Ms. McCartney.

Dr. Berger, do you believe that veterans in receipt of compensation for mental health conditions are the targets of recurring scrutiny? Does such scrutiny exist for veterans with physical conditions?

Mr. BERGER. Sir, are you asking me about mental health conditions or physical conditions? Obviously——

Chairman AKAKA. This is mental health conditions.

Mr. BERGER. OK. Yes, that is true. There are people who undergo periodic review.

Chairman AKAKA. I see. And does such scrutiny exist for veterans with physical conditions, as well?

Mr. BERGER. I am not aware of any, although I could not answer across the board.

Chairman AKAKA. Dr. Berger and Dr. Satel, I share the concern noted by VA in testimony about the potential conflict that would arise for health care practitioners if S. 2573 were enacted as introduced. Do either of you see a problem with health care practitioners who are furnishing health care services being pressured by their patients to grant requests for extensions of treatment in order to maximize the amount of money patients would receive under the program?

Dr. SATEL. My understanding of the Treatment First Act is, first, that it is completely voluntary, and second, that the critical period ends either at a year or when treatment ends. Certainly in my experience, which I admit was a while ago, I always felt completely insulated from any kind of financial pressures. We did our clinical work and our focus was the well-being of the patient. I have no reason to think that this has changed.

Chairman AKAKA. Yes. I would like to thank all of you for your testimony. This will be helpful to us, and I want to thank all the witnesses who have appeared today. We appreciate your views on this legislation. Your input on these issues will be valuable to the Committee as it moves forward, and I thank you so much for your help to the Committee.

This hearing is adjourned. Thank you.

[Whereupon, at 12:01 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF DAVID A. BUTLER, PH.D. AND FREDERICK ERDTMANN, M.D., M.P.H., ON BEHALF OF THE INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, NATIONAL ACADEMY OF SCIENCES

S. 2573, "VETERANS MENTAL HEALTH TREATMENT FIRST ACT"

The National Academies were asked by Committee staff to provide testimony for the record on issues raised by the "Veterans Mental Health Treatment First Act" (S. 2573) that are addressed in the 2007 report *PTSD Compensation and Military Service* (hereafter referred to as *PTSD Compensation*). This report contains the results of a study conducted by the Members of the Committee on Veterans' Compensation for Post Traumatic Stress Disorder. The committee was convened under the auspices of the Institute of Medicine and National Research Council (IOM/NRC). These institutions are operating arms of the National Academy of Sciences, which was chartered by Congress in 1863 to advise the government on matters of science and technology.

The IOM/NRC committee was charged with evaluating how veterans with PTSD are compensated for their mental health condition and assess how that compensation might influence attitudes and behavior in ways that might serve as barriers to recovery. Their work was requested by the Department of Veterans Affairs, which provided funding for the effort. The report results were also presented to and used by the congressionally-constituted Veterans Disability Benefits Commission.

Our testimony is limited to this topic. The Committee—which is now disbanded—did not examine the "Veterans Mental Health Treatment First Act" and The National Academies have no opinion on the Act. Our role is to provide independent, non-partisan scientific advice to the government and we wish to make it clear that we are neither for nor against this legislation. Neither of us is an authority on mental health treatment and we are therefore not qualified to offer personal expert opinion on the proposals put forward in the Act.

The "Veterans Mental Health Treatment First Act" touches on two topics that are addressed in the *PTSD Compensation* report. The first of these is the imposition of a requirement to pursue treatment as a condition for receiving compensation. The report notes that, in civilian disability-compensation systems in the US, "[p]eople who qualify for compensation may be required to follow prescribed medical treatment and to participate in rehabilitation in order to continue receiving payment" (p. 53). It later observes that "[m]ost [workplace long-term disability] plans require that a person be receiving appropriate medical treatment for the disabling condition" (p. 61). However, the report also states—in a section entitled "Philosophy of U.S. Disability Systems"—that society does not apply civilian-program standards to veterans' benefits:

> VA disability benefits, including compensation, reflect a somewhat different set of principles of social justice. * * * One of the reasons that societies form is to provide safety and security for their members, so when individuals put themselves at risk to preserve a society's security, social justice implies that they should be compensated for losses resulting from taking that risk. (p. 52)

The second topic is the possible effects of compensation on treatment-seeking, which is dealt with in Chapter 6 of the Committee's report. The sections entitled "Disability Compensation and the Use of VA Mental-Health Care Services" and "Disability Compensation and Treatment Outcome" (pages 178–184) are particularly relevant.

PTSD Compensation cites a 2005 report from the VA's Office of the Inspector General that found that when VA PTSD disability ratings were increased to 100 percent, veterans sought less treatment for the conditions. Quoting the VA report:

> In a judgment sample of 92 PTSD cases, we found that 39 percent of the veterans had a 50 percent or greater decline in mental-health visits over the 2 years after the rating decision. The average decline was 82 percent, and some veterans received no mental-health treatment at all. While their mental-health visits declined, non-mental-health visits did not. (Department of Veterans Affair, 2005, p. 52)

The IOM/NRC report states that, although the OIG analysis has received some attention "it is clearly limited by the selective nature of the sample and the lack of supporting data" and that "[t]his is unfortunate because other scientific evidence does not support the OIG findings" (p. 179). The report's review of that evidence, detailed on pages 179–182, indicates that disability compensation does not in general serve as a disincentive to seeking treatment. While some beneficiaries will undoubtedly understate their improvement in the course of pursuing compensation, the scientific literature suggests that such patients are in the minority, and there is some evidence that disability payments may actually contribute to better treatment outcomes in some programs. The literature on recovery indicates that it is influenced by several factors, and the independent effect of compensation on recovery is difficult to disentangle from these.

The report concludes that "in spite of concerns that disability compensation for PTSD may create a context in which veterans are reluctant to acknowledge or otherwise manifest therapeutic gains because they have a financial incentive to stay sick, the preponderance of evidence does not support this possibility" (p. 184). It goes on to state that "[t]he committee's review of the literature on misreporting or exaggeration of symptoms by PTSD claimants yielded no justification for singling out PTSD disability for special action and thereby potentially stigmatizing veterans with the disability by implying that their condition requires extra scrutiny" (p. 187).

The report also offers a recommendation to address the concern that the current system creates an incentive to stay sick. It notes that PTSD—along with multiple sclerosis, lupus, and many mental disorders including depression—may exhibit a relapsing and remitting course (p. 141). The report recommends that VA "consider instituting a set, long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the [compensation and pension] examination" (p. 185). It states:

> Regulation already specifies an analogous approach for other disorders, including conditions whose symptoms may remit and relapse over time. Multiple sclerosis, for example, has a minimum rating of 30 percent without regard to whether the condition is disabling at the moment that the subject is evaluated. However, rather than being limited to a particular minimum rating, the committee suggests that the VA consider what minimum benefits level—where "benefits" comprise compensation and other forms of assistance, such as priority access to VA medical treatment—would be most likely to promote wellness. It is beyond the scope of the charge to the committee to specify the particular set of benefits that would be most appropriate or the level[s] of impairment that would trigger provision of these benefits. This would require a careful consideration of the needs of the population, of the new incentives that the policy change would create, of the possible effects on compensation outlays and demand for other VA resources, and of how to maintain fairness with respect to other conditions that have a remitting/relapsing nature.
>
> Providing a guaranteed minimum level of benefits would take explicit account of the nature of chronic PTSD by providing a safety net for those who might be asymptomatic for periods of time. A properly designed set of benefits could eliminate uncertainty over future timely access to treatment and financial support in times of need and would in part remove the incentive to "stay sick" that some suggest is a flaw of the current system. (p. 185–186)

The IOM/NRC committee also reached a series of other recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the body of its report. We previously provided a copy of this report to the

Committee and would be happy to submit additional copies upon request. The report is also freely accessible on-line at the URL listed in the references below.

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and

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Director, Board on Military and Veterans Health and Director, Medical Follow-up Agency, Institute of Medicine, National Academy of Sciences.

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STATEMENT OF THE BRAIN INJURY ASSOCIATION OF AMERICA

S. 2921—CARING FOR WOUNDED WARRIORS ACT OF 2008

The Brain Injury Association of America (BIAA) and its nationwide network of State affiliates representing survivors of Traumatic Brain Injury (TBI), their families, researchers, clinicians and other professionals, strongly endorses S. 2921, and urges the U.S. Senate Committee on Veterans' Affairs to approve this important legislation in a timely manner.

The Caring for Wounded Warriors Act of 2008 (S. 2921) would significantly improve support for family caregivers of returning servicemembers with Traumatic Brain Injury (TBI). This important bill proactively acknowledges the reality that a brain injury happens to an entire family, not just the individual survivor.

Importantly, this legislation acknowledges the critical role played by family caregivers in facilitating recovery from brain injury and addresses the pressing need to increase support for these caregivers through pilot programs providing access to training, certification and financial compensation.

The Brain Injury Association of America also applauds the bill's introduction of innovative pilot programs to leverage existing partnerships between Veterans Affairs facilities and the Nation's leading universities through the training of graduate students in related fields to provide respite care for wounded warriors with TBI.

Family care is the most important source of assistance for people with chronic or disabling conditions, including people with brain injury. Yet, research has found that all too often, the Traumatic Brain Injury of a spouse or close relative places extreme stress on family caregivers, frequently resulting in negative physical and emotional outcomes for the caregivers themselves. Unfortunately, despite these documented physical hardships and psychological stress, family caregivers receive little support.

Specifically, stress reaction is known to occur in situations where the demands of the environment exceed an individual's resources. One critical component which has been found to be related to caregiver burden is whether or not the caregiver perceives the effects of the injury to exceed the caregiver's resources to manage the situation. In other words, perceived stress ha s consistently predicted negative outcomes for the caregiver.[i] A lack of financial resources and social supports are some of the common perceived stresses impacting family caregivers of loved ones with TBI.

One longitudinal study found that 47 percent of family caregivers of individuals with TBI had altered or given up their jobs at 1 year postinjury, and 33 percent at 2 years postinjury, and decreases in both employment and financial status were reported over a 2-year time period postinjury. [ii] Particularly in light of the fact that caregivers often report severe financial strain and frequently must give up their jobs in order to take care of their loved one with TBI, increased financial support and access to respite care for family caregivers of returning servicemembers with TBI is vital and long overdue.

Again, the Brain Injury Association of America enthusiastically endorses the "Caring for Wounded Warriors Act of 2008," and strongly encourages the Committee to approve this legislation.

Sincerely,

SUSAN H. CONNORS,
President/CEO,
Brain Injury Association of America.

[i] Chwalisz, Kathleen. "Perceived Stress and Caregiver Burden after Brain Injury: A Theoretical Integration." [p1]Rehabilitation Psychology, Vol. 37, No. 3, 1992. pp 189–203.

[ii] Hall KM , Karzmark P, Stevens M, Englander J, O'Hare P, Wright J. Arch Phys Med Rehabil. 1994 Aug;75 (8): 876–84.

PREPARED STATEMENT OF THE NATIONAL COALITION FOR HOMELESS VETERANS

The National Coalition for Homeless Veterans (NCHV) appreciates the opportunity to submit written testimony to the Senate Veterans' Affairs Committee regarding S. 2273, the Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act of 2007, a bill that would authorize the Secretary of Veterans Affairs to conduct pilot programs of grants to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing.

The homeless veteran assistance movement NCHV represents began in earnest in 1990, but like a locomotive it took time to build the momentum that has turned the battle in our favor. In partnership with the Departments of Veterans Affairs (VA), Labor, and Housing and Urban Development (HUD)—supported by funding measures this committee has championed—our community veteran service providers have helped reduce the number of homeless veterans on any given night in America by 38 percent in the last 6 years.

This assessment is not based on the biases of advocates and service providers, but by the Federal agencies charged with identifying and addressing the needs of the Nation's most vulnerable citizens.

To its credit, the VA has presented to Congress an annual estimate of the number of homeless veterans every year since 1994. It is called the CHALENG project, which stands for Community Homelessness Assessment, and Local Education Networking Groups. In 2003 the VA CHALENG report estimate of the number of homeless veterans on any given day stood at more than 314,000; in 2006 that number had dropped to about 194,000. We have been advised the estimate in the soon-to-be published 2007 CHALENG Report shows a continued decline, to about 154,000.

Part of that reduction can be attributed to better data collection and efforts to avoid multiple counts of homeless clients who receive assistance from more than one service provider in a given service area. But in testimony before this committee in 2006, VA officials affirmed the number of homeless veterans was on the decline, and credited the agency's partnership with community-based and faith-based organizations for making that downturn possible.

ADDRESSING PREVENTION OF VETERAN HOMELESSNESS

The reduction in the number of homeless veterans on the streets of America each night proves the partnership of Federal agencies and community organizations—with the leadership and oversight of Congress—has succeeded in building an intervention network that is effective and efficient. That network must continue its work for the foreseeable future, but its impact is commendable and offers hope that we can, indeed, triumph in the campaign to end veteran homelessness.

However, the lessons we have learned and the knowledge we have gained during the last two decades must also guide our Nation's leaders and policymakers in their efforts to prevent future homelessness among veterans who are still at risk due to health and economic pressures, and the newest generation of combat veterans returning from Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF).

The lack of affordable permanent housing is cited as the No. 1 unmet need of America's veterans, according to the VA CHALENG report. Last year, Public Law 110–161 included $75 million in fiscal year 2008 for the joint HUD-VA Supported Housing Program (HUD-VASH), which allowed HUD and VA to make up to 10,000 HUD-VA supportive incremental housing vouchers available to veterans with chronic health and disability challenges. NCHV is pleased HUD has requested another increase in equal measure in fiscal year 2009 and hope this new funding will be approved by the Congress.

The affordable housing crisis, however, extends far beyond the realm of the VA system and its community partners. Once veterans successfully complete their Grant and Per Diem (GPD) programs, many formerly homeless veterans still cannot afford fair market rents, nor will most of them qualify for mortgages even with the VA home loan guarantee. They are, essentially, still at risk of homelessness. With another 1.5 million veteran families living below the Federal poverty level (2000 U.S. Census), this is an issue that requires immediate attention and proactive engagement.

Many homeless veterans receiving services today are aging and the percentage of women veterans seeking services is growing. Moreover, OIF and OEF combat veterans, both men and women, are returning home and suffering from war related conditions that may put them at risk for homelessness.

Veterans who graduate from 2-year GPD programs often need supportive services while they continue to build toward economic stability and social reintegration into mainstream society. Those who will need permanent supportive housing—the chronically mentally ill, those with functional disabilities, families impacted by poverty—may be served by the HUD-VASH program. But the majority of GPD graduates need access to affordable housing with some level of follow-up services for up to 2 to 3 years to ensure their success.

Many community-based organizations are already providing that kind of "bridge housing," but resources for this purpose are scarce. At present, the VA cannot meet the range of housing and resource needs of currently homeless and at-risk returning veterans. While the agency can provide homeless veterans with primary care and mental health services, along with transitional housing, it lacks the authority and funding to provide supportive services for the growing number of veterans who will need long-term affordable permanent housing.

To meet these current and future needs, NCHV urges this Committee to support S. 2273, a measure that would authorize the Secretary of Veterans Affairs to establish several pilot programs that would provide grants to public and non-profit (including faith-based and community organizations) to provide local supportive services to very low-income, formerly homeless veterans residing in long-term or permanent housing. The programs would be conducted at former military properties or installations in addition to properties where permanent housing is provided to formerly homeless veterans.

Homeless and at-risk veterans need a community-based, coordinated effort that provides secure housing and nutritional meals; essential physical health care, substance abuse aftercare and mental health counseling; and personal development and empowerment. Veterans also need job assessment, training and placement assistance. NCHV believes all programs to assist homeless and at risk veterans must focus on helping veterans reach the point where they can obtain and sustain employment and live independent lives in their community. Passage and implementation of S. 2273 would be a giant step toward helping these veterans have a higher chance of becoming productive citizens again.

IN SUMMATION

NCHV believes it is now time to take the next step in the campaign to end veteran homelessness. Developing solutions that address the health and economic challenges of veterans who served in Viet Nam and other conflicts as well as OEF/OIF veterans—before they are threatened with homelessness—and provide the necessary funding and resources should be a national priority. Never before in U.S. history has this Nation, during a time of war, concerned itself with preventing veteran homelessness. For all our collective accomplishments, this may yet be our finest moment.

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