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HEARING ON PENDING HEALTH-RELATED LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

APRIL 22, 2009

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HEARING ON PENDING HEALTH-RELATED LEGISLATION

WEDNESDAY, APRIL 22, 2009

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

The Committee met, pursuant to notice, at 2:30 p.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Begich, Burris, Sanders, Burr, and Johanns.

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

Chairman AKAKA. Thank you very much for being so patient. We had a vote call and decided to answer the call before we convened, so this is why we are starting late at this time.

Aloha, good afternoon, and welcome to today's hearing. I call the Committee on Veterans' Affairs of the U.S. Senate to order.

We have a lengthy agenda that reflects the work of many members on both sides of the aisle. The health care bills before us today address crucial issues and seek to improve services to veterans. I anticipate that today's hearing will allow us to develop another strong package of veterans health legislation. I will briefly highlight a few of the bills on our agenda.

Severely injured servicemembers and their families face many challenges as they return home. The bipartisan caregivers' bill, S. 801, will give family members the support they need to care for the Nation's wounded warriors in the form of health care, counseling, respite, and financial support. It also will give them the training they need to provide the best care possible for their loved ones.

I am joined by Senator Baucus and Senator Begich in supporting a bill, S. 734, which would provide much needed services for veterans returning to rural areas. The wars in Iraq and Afghanistan have placed extraordinary demands on the country's National Guard and Reserve, with multiple deployments. When they return home, it is often to a small town, far from a military base. This bill will improve VA's ability to recruit and retain health care providers and encourage VA to use volunteer counselors and telehealth services to reach more veterans. It also expands VA's ability to pay for travel when the only practical way for a veteran to reach a health care facility is by air.

Many other bills on the agenda reflect the dedication and hard work of my colleagues in support of the Nation's veterans. There are bills that will eliminate certain copayments for the catastrophically disabled, authorize additional health care facilities, and ensure the availability of services for women veterans and homeless veterans.

Senator Rockefeller has introduced a bill that would remove a limitation on VA employees' collective bargaining rights when employment actions are related to quality-of-care concerns. Many are working on this issue, including Luanne Long, who is a nurse from Hawai'i and president of the Hawai'i Nurses Association of the United American Nurses. Although she is not testifying before the Committee today she has submitted a statement for the record; and I appreciate her work on behalf of VA employees.

I am confident that VA's new leadership will work with the Committee in our efforts to provide comprehensive health care to the country's wounded warriors. We recently held confirmation hearings for the Secretary, the Deputy Secretary, and the Assistant Secretary for Public Affairs, all of whom expressed their support for the VA health care system. We will be counting on their support as we address many of these issues.

Dr. Cross, I believe you have been advised, VA will not be permitted to testify today. Indeed, in light of the very late submission of the Department's testimony—it was not received until 8:48 p.m. last night—I was inclined to exclude VA entirely, since the members have not had the opportunity to review the testimony. While I will submit my questions in writing, I am providing the opportunity for other members to ask questions of you directly if they wish.

I do not suppose that you are directly responsible for the unacceptable lateness of the submission of the Department's statement, but as the designated witness, you have to be the one to hear the Committee's concerns and carry them back to the Secretary and his top managers. If the Department is to participate in the legislative process, there must be, at a minimum, timely submission of testimony on pending legislation.

I realize that there are a significant number of bills on today's agenda, but other witnesses were able to review and comment on the pending legislation in testimony that was submitted by the Committee's deadline. I will communicate directly with Secretary Shinseki, both to learn exactly what happened with respect to today's hearing and to identify ways to keep this problem from occurring again.

The record of today's hearing will remain 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 our markup, tentatively scheduled for late May.

I want to thank the witnesses for being here today.

I would like to now call on Senator Burr, our Ranking Member, for his opening statement. Senator Burr?

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

Senator BURR. Thank you. Aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Senator BURR. You have outdone yourself with the number of bills we are trying to cover in this hearing, but I will never complain to you about the volume of what we are trying to undertake in this Committee, I will assure you.

Let me start by thanking you, Mr. Chairman, for working with me on legislation to provide assistance to the family caregivers of seriously injured veterans. I want to single out two special North Carolinians, Sarah and Ted Wade. Unfortunately, they are not here today, but they have spent many hours reviewing drafts of the bill before it was introduced. Their unique perspective on the needs of both family caregivers and seriously injured veterans needing full-time care was absolutely essential in the crafting of this legislation.

I am also proud to join you, Mr. Chairman, on legislation that would create a process under which the VA could be provided with a medical care budget 1 year ahead of time. It is very important and possible that we will have two appropriations for VA enacted this year, the first for 2010, the second for 2011. It will be nice to get the VA budget completed well ahead of time for a change.

I am pleased to see that legislation I introduced to create a voluntary dental insurance benefit for all veterans and survivors of veterans enrolled for care at VA is on the agenda. The legislation is modeled after the popular TRICARE retiree dental program and simply gives veterans the option to pool together and get coverage that they might need.

One of the bills on the agenda that I feel passionately about is S. 669, the Veterans' 2nd Amendment Protection Act. Three other Members of the Committee have joined me as cosponsors of the bill, along with 12 of my Senate colleagues. The Committee voted to approve this bill last Congress and I hope to see it enacted this year. As many of you know, if a veteran comes to the VA for help and is later determined to need assistance managing benefit payments, their name is sent to the National Instant Criminal Background Check System, known as NICS, which is a government database that is used to deny individuals their Second Amendment rights. Over 117,000 names have been sent by the VA to this government database since 1998. In contrast, the Social Security Administration sends no names to this government database, despite having over five million beneficiaries who require assistance managing their finances.

I have three problems with this policy. First, I believe our veterans are being unfairly targeted. Second, I believe it is inappropriate for a government employee to be able to make these types of decisions. And third, the current process doesn't even assess whether these individuals pose a danger to themselves or to others.

S. 669 would prohibit VA from sending the names of veterans and others to the government database unless—and I stress "unless" so it is clear to everyone—an appropriate judicial authority makes the determination that an individual poses a danger to themselves or to others, which is the same standard applied to every other American. By simply asking for due process, this bill respects protection of constitutional rights. We must provide our veterans with the due process granted to every other citizen.

I wish I knew what the position of the Department of Justice was on this legislation, Mr. Chairman. You were nice enough to invite the Attorney General or his designee to come to testify, and as you can see, they are not here. I don't understand the reason for their absence here today. If the current practice is justified, then there should be no reluctance to have an administration official testify about this bill. In my view, this is the second time in less than 2 weeks the Administration has tacitly endorsed an effort to unfairly target veterans.

Just last week, the Department of Homeland Security released a report entitled "Right-Wing Extremism," which states that, and I quote, "Returning veterans possess combat skills and experience that are attractive to right-wing extremists." unquote, without any data to support such a vile claim against our Nation's veterans. The report suggests that those veterans who are, and I quote, ". . . disgruntled, disillusioned, or suffering from the psychological effects of war," unquote, are more likely to join these groups. Again, without any data to substantiate such a claim, a Federal Government agency paints our veterans as extremists. This assessment of our veterans is not only misguided, it is an absolute insult to every one of them.

In closing, I would like to submit testimony for the record sent to the Committee by Retired Coast Guard Lieutenant Jerri Geer. Lieutenant Geer came to VA for help in 2002 because she was having problems with her finances. Shortly thereafter, she received a letter telling her that she was placed on the government's criminal database used to prevent the purchase of firearms. What is ironic is that Lieutenant Geer doesn't even like guns. She was simply offended by the arbitrary manner in which her name was placed on a list with criminals and people who are threats to themselves and to others; and by how easily her rights as an American could be violated. I think all of us in this room would be offended if, in fact, we were placed on that list.

I ask my colleagues for their support on S. 669 so that we can right what I think is a tremendous wrong.

I thank the Chair.

[The testimony of Lieutenant Geer is included in the Appendix.]

Chairman AKAKA. Thank you very much, Senator Burr.

Let me call for your statements, Senator Brown, followed by Senator Johanns. Senator Brown?

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

Senator BROWN. Thank you, Mr. Chairman.

I would like to thank Deputy Under Secretary Cross for joining us today and being able to answer questions. I would like to thank Dr. Cross for his previous testimony at a field hearing in New Philadelphia, Ohio, 18 months or so ago about veterans in Appalachia which led to legislation that will particularly help rural hospitals and some of the issues we deal with.

I want to thank the VSOs that are here and the representative from AFGE for your assistance.

The legislation pending before the Committee, all of it is beneficial. In the interest of time, I will focus on two bills that are vi-

tally important to my State. In Ohio, there are over one million veterans. That number is growing rapidly, as it is elsewhere, as men and women return from their service overseas in Iraq, Afghanistan, and deployments all over the world. In the last couple of years, I have held some 140 roundtables, at least one in each of Ohio's 88 counties, and several of them have been directly talking to groups of 15 or 20 veterans and listening to their ideas and concerns.

Last year, Petty Officer Glenn Minney, USN (Ret.), an Iraq veteran from Chillicothe in South Central Ohio, shared his transition experience after surviving an IED blast. Glenn was treated for his headaches with ibuprofen, and for his eye discomfort he was given pink eye medication. It wasn't until nearly 8 months after he was injured that Glenn Minney was diagnosed with severe TBI. He advocated for increased attention to eye trauma in relation to TBI to prevent other veterans from suffering the months of uncertainty that he endured as his eyesight continued to deteriorate.

TBI and PTSD are intimately related to vision problems as well as cognitive issues, memory lapses, anger, frustration, and other mental health issues. Glenn Minney is unfortunately not alone, as we know. As a result of the wars in Iraq and Afghanistan, there is an increasing number of head trauma and Traumatic Brain Injuries. Over one thousand servicemembers have been hospitalized with ocular or eye injuries.

The VA has a critical shortfall in the number of blind rehabilitation outpatient specialists, with nearly one-third of those positions unfilled. As more servicemembers return from combat with eye injuries, we have a commitment to ensure they have access to rehab specialists.

To address the gap in access to vision specialists, I introduced the Vision Scholars Act of 2009, which we will discuss today. The bill would improve VA recruitment of blind instructors while giving our Nation's veterans the comprehensive care they deserve.

The second bill I would like to briefly discuss improves collective bargaining rights of VA employees. All VA employees have a proud tradition of faithful service, but they work side-by-side in the same facility for our veterans but have unequal rights. Collective bargaining provides vital workplace protection for employees, helping to ensure higher safety standards, fair wages, and pension security.

In 1991, Congress provided VA medical professionals with the same labor relations rights held by other Federal employees but carved out three exceptions that dealt with direct patient care. In the 1990s, labor and management entered into a partnership that set a process for resolving disputes, which worked well until the Bush administration abandoned the partnership. The narrow exceptions of the law now bar grievances over disputes that Congress never envisioned, such as scheduling and floating assignments for nurses. As a result, VA health care professionals are unable to negotiate for working conditions that are widely available to other clinicians at the VA and outside, too, for that matter.

These workplace practices negatively affect recruitment and retention and morale and, ultimately, patient care. The veterans in my State and across the rest of this great country deserve the best health care and the best health care providers. Many of these pro-

viders, as we know—and we urge this more and more in the VA—are veterans themselves. That is why I have cosponsored this legislation with Senator Mikulski and my colleagues on this Committee: Senator Rockefeller, Senator Webb and Senator Sanders.

So, I am looking forward to hearing testimony on these two bills and beyond. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Brown.

Senator Johanns?

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Mr. Chairman, thank you very much for the opportunity to say a few words.

Let me, if I might, start out and, just for the record, join in the comments made by Ranking Member Burr. I also thought it was just completely inexcusable that the head of a Federal Department would make such statements about veterans in claiming that they pose a risk to our society. We bring them to military service to protect us, and then as they leave military service, to tag them with that kind of label is just enormously unfair.

Let me talk about a recent experience that I had. I was back home in Nebraska for a recess and we had a veterans' roundtable where we brought veterans in and representatives of veterans organizations to really talk about whatever was on their mind. It wasn't very long before we turned to health care issues. One of the things about this roundtable is we had a spouse there whose husband was suffering from Post Traumatic Stress Disorder. We had a veteran there who was continuing to receive care through the system. So, we really got some great information. I got some great information as to some of the challenges that they are facing.

The first thing I would like to say on Post Traumatic Stress Disorder—and it is hard to explain unless you have heard a family member speak of this—is how devastating it is, not only to the veteran but to the family members—the challenge that the veteran and family members face in terms of getting cured. It is something that I find just completely unacceptable. Anything we can do in this area is going to be a big improvement.

I would offer this thought. When services are provided by the Veterans Administration, it appears to me that the services are good. The challenge is how to get those services and how to uncomplicate the process by which a veteran can access those services—a very, very important issue.

The second issue that I wanted to visit is one which is a challenge for many of us on this panel. I come from a State that is a combination of large metropolitan communities like Lincoln and Omaha, Kearney, Grand Island, and very rural, small communities where we really, really struggle to provide services. We are facing that problem with medical services and mental health services. It is nearly impossible to get the trained personnel into those areas.

So again, anything that we can do to help in these areas is going to find my support. These veterans want to return to where they came from, and sometimes that is ranching or farming or taking on the family business in a small community in Western Nebraska. We want to do everything we can to encourage that. That is very,

very important to States like Nebraska. But if they need mental health services or medical services, we need to figure out ways to provide that to them. So, I am very anxious to hear the testimony today and very anxious to work with you in solving these problems.

Mr. Chairman, I will wrap up just by saying, thank you for having this very important hearing. I hope to be a partner with you as we work on these issues. Thank you.

Chairman AKAKA. Thank you very much, Senator Johanns.

Senator Tester?

STATEMENT BY HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman, and I want to thank all the distinguished witnesses who are here today to discuss pending health-related legislation before this Committee.

Just last month, after hearing from and working with a lot of veterans in Montana, I introduced the Rural Veterans Health Care Improvement Act. This legislation would expand health care for thousands of Montanans and millions of other veterans who live in rural and frontier areas of this country. I want to thank Senator Thune and Senator Begich for their work on this legislation and I appreciate their interest in this issue.

The obstacles faced by veterans and providers in rural areas are vastly different than those in urban areas. Rural veterans face a new combination of factors that create disparities in health care not found in larger cities and municipalities. Access, economic factors, cultural and social differences, educational shortcomings, a lack of provider and health care services, and the sheer isolation of living in remote rural areas all conspire to impede rural veterans in their struggle to obtain care and lead a normal, healthy life. Without question, our veterans have greater transportation difficulties reaching health care providers. They often travel great distances to reach a doctor or hospital. Sometimes, they just don't go at all.

I want to share a few statistics from the National Rural Health Association to underscore this issue. Ten percent of physicians practice in rural America, despite the fact that one-fourth of the population lives in these areas. It puts us at a big disadvantage. It means it is harder to find a rural veteran a doctor, period.

Twenty percent of the rural counties lack mental health services versus 5 percent of metropolitan counties. This means that our rural veterans are less likely to see or have access to mental health providers that can diagnose and treat things like PTSD and other combat-related mental conditions.

The suicide rate among rural men is significantly higher than in urban areas, particularly among adult male veterans. Who is there to intervene, and do we transport them in cop cars for hours to get them to mental treatment facilities or a critical care bed?

And finally, death and serious injury accidents account for 60 percent of total rural accidents, compared to some 48 percent in urban areas. One reason for this increased rate of morbidity and mortality is that in rural States, prolonged delays occur between the crash, the call for the EMT, and the EMT arriving. This means

that veterans driving long distances to obtain care are more likely to die if involved in a serious motor vehicle accident.

The statistics are sobering and highlight why we must improve health care for veterans who reside in rural areas. The Rural Veterans Health Care Improvement Act of 2009 does several things that will help. First, it locks in the current travel reimbursement for disabled veterans who travel for health care at 41.5 cents a mile. It authorizes the VA to award grants to Disabled American Veterans to transport veterans to their medical appointments, and it directs the VA to establish an Indian Health Coordinator in areas with high Native American veteran populations to improve the care given to Native veterans. It authorizes the VA to work with community health care centers and provide mental health services to Iraq and Afghan veterans in areas where the VA is unable to provide mental health care.

It is just a start and we have a lot more to do, and I certainly appreciate the VSOs for bringing the issue forward and remaining focused on our rural veterans. I want to personally thank Chairman Akaka for introducing additional legislation that will complement this bill by improving the VA's hiring and employee compensation practices.

With that, I conclude my remarks and I want to thank the panel members once again, the Committee, and Chairman Akaka.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Burris?

STATEMENT OF HON. ROLAND W. BURRIS, U.S. SENATOR FROM ILLINOIS

Senator BURRIS. Thank you, Mr. Chairman.

Members of the Committee, I hope I am around to get some answers to the questions, because during the recess I visited the Marion VA Hospital down in southern Illinois. My staff, Mr. Chairman, had a very difficult time with staff at the VA wanting to know why I was coming to Marion. Because Marion has had a few problems, they brought staff in from other locations. They brought staff in from Washington and they even brought the General Counsel in to be at the briefing that I was getting for visiting Marion Hospital, I assume because there have been problems there.

My staff advised me that the staff at the VA were telling them that we didn't give them enough time, that we should have given them more time to prepare, and I found that very disconcerting—for a Senator to try to visit a veterans hospital just to get educated and get a fact-finding tour—that the VA was very defensive in that regard. But come to find out they were very accommodating and it turned out to be a decent meeting. But I just would like for someone to give me an explanation on why that type of treatment—as a Senator, I went to a North Chicago hospital and there was no problem. I visited Jesse Brown Hospital and there was no problem. But I wanted to go to Marion and they sent in people from Washington and brought in the General Counsel.

Yes, there have been several veterans who died there as a result of incompetent medical care. So I just want to be on the record as having expressed my concern about that situation as I compliment what we are doing for our veterans.

And second, this health care issue is very important. Just this Saturday, I had over 250 veterans at a town hall meeting I attended. It is called the Coalition of Veterans Organizations, and these individuals expressed their main concern is health care—health care for women veterans. Women are not the same as male veterans. There is special care that women need, and so we must be sensitive to those situations. Also, on the dental care issue, we must make sure that we move in that direction; and I hope that we will hear some testimony in that regard. Mr. Chairman, if I am not around because I have got two or three other stops to make on other committees, I would hope to be able to bring some questions in reference to some issues that I have.

But I want to go on the record in terms of my commitment to those individuals—and this is my favorite expression, Mr. Chairman—that allow us to do what we do because they did what they did in protecting this country and fighting for us. And they are entitled to whatever we can give them as taxpayers for their commitment to allow us to be a free country. We cannot forget those individuals who put their lives on the line for us. I will reserve the rest of my time, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burris.

Senator Begich?

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much, Mr. Chairman. Thank you for holding this hearing to provide an opportunity to hear responses to the legislation sponsored by several of us here including, obviously, the Chairman, who has spearheaded many of these pieces of legislation. I am a cosponsor on six of these pieces and a lot of it for me is to hone in on the obvious health care, and also rural health care.

In Alaska, I think in the last Commerce Committee meeting, I coined the phrase "extreme rural," which is what Alaska is. And so, we have very unique situations that I think are also an opportunity for some prototype and some experimentation—some new ways to deliver health care that could be a model for other States around the country, especially those that have kind of mixed urban and rural geography—Montana, Nebraska, and others. So, I am going to be interested in your responses, especially on rural health care.

On another issue, reimbursement, not only vehicle miles and plane tickets for individuals, but one more step. We have a very unique program in Alaska, and during the questions I will ask a few more details about your thoughts on it. We have one program that actually has three or four, if I am not mistaken, maybe as many as five pilots that actually fly out on their own dime with their own plane to go help veterans out in rural communities which the VA will never get to; no commercial airline will ever get to. And so, the reimbursement for them is zero.

An idea I want to float to see how you would respond is one of the issues they asked for—not that they are asking for reimbursement of their time or their effort or their plane—but just some of the fuel costs as they reach rural areas, because if the VA had to fly these individuals out or pay for that, it would be very, very ex-

pensive. Uniquely so, there is a twist on it, because in Alaska we have the highest per capita amount of small planes per person in the country. We are in a very unique situation. The plane and bush pilot, is the cab driver, and so I want to explore that with you.

Another issue in Alaska is that we have about 600 homeless veterans. I know in a bigger sense, that may be small compared to other communities, but we have very unique climate conditions that homeless veterans live in. So, I would be curious—in your expansion, in your opportunities—of what you see down the road in regards to homeless veterans. I believe that number is going to grow because one of the common denominators among the homeless population is mental illness or issues with mental health. We are going to see, I think, a growing percentage and number.

And then the last question is, what efforts will you make in regards to new technologies? Telemedicine is a powerful technology in Alaska. I know the VA is experimenting with that and utilizing it. I think Alaska, again, is a great test ground for that and I would be interested in your commentary on that.

But again, Mr. Chairman, thank you for hosting this hearing. I am looking forward to the panel's comments in regards to the legislation. I do believe, based on all the legislation that is in front of us, there are opportunities to—I don't know what the process is. I am new to the Senate, but it seems like we could meld some of these pieces of legislation into one to really focus in and hone in on delivering additional and more supportive rural health care to our veterans. And the larger percentage of veterans—from some of the data that I have seen in Alaska, at least, and it may be occurring around the country—more and more veterans are living in rural areas than urban areas. They are growing to that, not necessarily raw numbers, but in percentage growth. So, again, I think rural health care and rural delivery of health care is going to be a huge piece of the equation.

I will end there and say thank you very much, Mr. Chairman, for this opportunity.

Chairman AKAKA. Thank you very much, Senator Begich.

Let me call on Senator Sanders.

STATEMENT OF HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you, Mr. Chairman.

Before I comment on the legislation before us, let me say a word about this so-called political controversy regarding the Secretary of Homeland Security. Of course, the Secretary of Homeland Security did not say anything disparaging about veterans. This is just politics that are the same old, same old. What she was reporting is that there has been a significant rise in right-wing extremism in this country, including some groups who advocate violence, and that they are targeting veterans as well as other groups. That is what she said, and I think she is right. We have to be concerned about that.

But Mr. Chairman, in terms of what we are talking about today, let me thank you for holding this important hearing. I am also delighted to have the witnesses with us today from the VA and other organizations.

I also want to congratulate the Chairman for his advanced appropriations legislation and to announce what everybody knows, is that we finally have a President of the United States who is in support of advanced appropriations. This is a big deal and I think is going to make the appropriations process for our veterans a lot more secure, a lot more predictable, and it is a huge step forward. I congratulate you, Mr. Chairman, and President Obama for taking that step.

In addition, I want to thank Chairman Akaka for including a version of Senator Feingold's and my legislation, S. 315, the Veterans Outreach Improvement Act of 2009, in his omnibus health care bill, S. 252, that is on the agenda today. This provision would create a VA pilot grant program funded by the Department of Veterans Affairs to give resources to eligible community-based organizations and local and State entities, including Veterans Service Organizations, to conduct outreach programs to inform veterans and their families about VA benefits.

The bottom line is, we could have the best programs in the world for our veterans, but if they don't know about them, it is not going to do anybody any good. In Vermont, we have developed an outreach program which is working. I think this concept will help. We want veterans to know what they are entitled to. If they want to take advantage of it, fine. If not, fine, but they should know about it.

Mr. Chairman, one of the bills included on today's agenda is another piece of legislation I have introduced, S. 821, a bill to prohibit the VA from collecting certain copayments from veterans who are catastrophically disabled. This Committee approved a version of this legislation last year and it also was passed in the House by the very close vote of 421 to nothing. Unfortunately, it was not signed into law and I hope we have better luck this year. I want to thank the Paralyzed Veterans of America, the Blinded Veterans Association, the DAV, and the American Federation of Government Employees, who all support this legislation.

In short, this legislation would eliminate copayments paid by catastrophically disabled veterans who are currently considered Priority Group 4 veterans, yet are charged fees and copayments as if they were in Priority Group 7 or 8. As the Paralyzed Veterans of America note in their prepared testimony, "In 1985, Congress passed legislation opening the VA health system to all veterans. In 1996, Congress revised the law and created a set of rankings or priority groups. When this was done, PVA worked to ensure that those veterans with catastrophic disabilities would be placed in a higher enrollment category known as Priority Group 4. However, unlike other Category 4 veterans, if they would otherwise have been in Category 7 or 8 due to their incomes, they are required to pay all fees and copayments . . ." I think clearly that is a miscarriage—a disservice to those veterans who are suffering from major physical problems.

So, Mr. Chairman, I hope very much that we can pass those pieces of legislation as well as the others that are before us today and I thank you very much.

Chairman AKAKA. Thank you very much, Senator Sanders.

Senator Murray?

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

Senator MURRAY. Thank you very much, Mr. Chairman. I thank you and Senator Burr for holding this hearing and thank you to all the witnesses who are before us today.

I think everyone on this Committee knows that the health care needs of our American veterans are shifting and diversifying and health care technologies and techniques are changing, too. So when it comes to providing care for our veterans, this really is a time of challenge and opportunities. And, of course, with our troops now fighting in Iraq and Afghanistan, it is very important that Congress use its legislative powers to make sure that the VA is prepared to meet the health care needs of our veterans tomorrow as well as today.

One of the best ways that I believe we can address the needs on the horizon is to pass the Women Veterans Health Care Improvement Act of 2009, which expands and improves health care services for our women veterans in the VA system. Women have always played a very important role in our military, going back to the founding of our country. However, as we all know, in today's conflicts, women are playing a far different and a far greater role. Women now make up about 15 percent of current active duty, Guard, and Reserve forces, and because today's conflicts don't have the clear front lines of past wars, women, like all of our servicemembers today, are on the front lines—riding on dangerous routes, guarding key checkpoints, and seeing the horrors of war firsthand.

Women have historically remained a very small portion of veterans and a small minority at the VA. That is changing. According to the VA, there are now 1.8 million women veterans who make up more than 7 percent of the total veteran population in the United States. And the number of women veterans who are enrolled in the VA system is expected to double in the next 5 years. That makes female veterans one of the fastest-growing demographics of veterans today.

So, we cannot overlook the growing number of women veterans or their unique needs any longer. We have to make sure that the VA is prepared to take care of the needs of these honorable veterans, and that is why Senator Hutchison and I have introduced the Women Veterans Health Care Improvement Act of 2009. This is legislation that will encourage female veterans to access care at the VA by increasing the VA's understanding of the needs of women veterans and the practices that will help them best.

I know that the VA recognizes they need to improve services for our women veterans, and the Department has taken some steps to do that. All VA medical centers are now supposed to have full-time women veterans program managers to make sure that women veterans' needs are taken care of. But a lot more needs to be done if we are going to ensure that women are able to access care at the VA and get the services they need, and that these services are tailored to women's needs.

So I believe that planning for the new wave of women veterans is going to be difficult and complex, but it is a task that needs to be addressed and I hope that this Committee can pass this legislation this year and move it to the President's desk.

I also want to mention another bill on the docket today that authorizes the construction of an outpatient clinic at the VA medical center in Walla Walla in the southeast corner of my home State. Not long ago, the VA came before us and recommended shutting down that facility. And I have been very proud to fight alongside the veterans in the three-State region served by the Walla Walla VA, to save Walla Walla VA and ensure that it has a future. This has been a battle very close to my heart—I know the VA knows that—because it is critical to 70,000 veterans who are served by that facility.

Since 2003, when this issue first arose, I have used every tool at my disposal to make sure that Walla Walla veterans are taken care of. I sent letters to the VA Secretary. I contacted President Bush. This Committee held a hearing out in Walla Walla to solicit the thoughts and concerns of local veterans. And I think all of our veterans in that area sent a loud, clear message that was heard, that southeastern Washington needs the existing VA facilities and it deserves a new, modern VA facility, as well.

So back in November, the VA announced that the Walla Walla VA is going to get more than $71 million for the design and construction of a new outpatient clinic to serve those local veterans; and I truly want to thank the VA for all of their work on this. I was thrilled by that development and it is a major victory for our veterans.

Now, since that money has already been approved, this legislation that is before us today simply authorizes the construction of a new multiple-specialty outpatient facility at the Walla Walla VA. So after 5 years of uncertainty and a whole lot of veterans speaking out, we are almost there. This legislation is key and I really thank the Committee for considering it today. I hope we can approve it soon and move it forward.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Murray.

Now let me introduce the first panel. Dr. Gerald Cross, Principal Deputy Under Secretary for Health, will be answering questions. He is accompanied by Walter Hall, Assistant General Counsel, and by Joleen Clark, Chief Officer for Workforce Management and Consulting at VHA.

I thank all of you for being here today. VA's full testimony will appear in the record.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JOLEEN CLARK, CHIEF OFFICER FOR WORKFORCE MANAGEMENT AND CONSULTING, U.S. DEPARTMENT OF VETERANS AFFAIRS

[The prepared statement of Dr. Cross follows:]

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

Good Afternoon 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 Joleen Clark, Chief Workforce Management and Consulting Officer for VHA. Unfortunately, we do not yet have views and estimates on several bills including S. 239, S. 498, S. 699, S. 772, S. 793, subsection (f) of S. 252 and S. 821. We will forward those as soon as they are available. Our support for the bill provisions discussed below is contingent upon VA's ability to fund such activities within the President's 2010 budget.

S. 226 "RENAMING OF THE HAVRE, MONTANA OUTPATIENT CLINIC"

Mr. Chairman, the first bill on the agenda is S. 226, a bill to rename the Havre, Montana VA Outpatient Clinic the Merril Lundman Department of Veterans Affairs Outpatient Clinic. VA defers to Congress concerning this matter.

S. 246 "VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT"

S. 246 is intended to encourage highly qualified doctors to serve in hard-to-fill positions. Section 2(a) would establish additional standards for appointment and practice as a VA physician. We note that S. 252, Section 104, has substantially similar provisions. Section 2(a) would require physicians, both before and following appointment, to disclose lawsuits, civil actions, other claims (whether open or closed) that result in payment and settlement payments and judgments that are based on the physician's medical malpractice or negligence, each investigation or disciplinary action taken relating to the individual's performance as a physician, and written notification from a State of a potential termination of license for cause or otherwise. It also would require a physician before appointment and at the time of biennial review of performance to authorize the State licensing board in each State in which the physician holds or has held a license to disclose anything in State records concerning such matters. Other provisions of this section would mandate enrollment of any privileged physician in the National Practitioners Data Bank (NPDB) Proactive Disclosure Service and encourage the hiring of board-certified physicians. VA has no objection to these requirements. However, legislation is unnecessary. VA already requires physicians to disclose anything that would adversely affect or otherwise limit their appointment and/or clinical privileges. Following appointment and at the biennial review of performance, VA also requires physicians to authorize the relevant State licensing boards to disclose information. Failure to disclose or provide authorization may be grounds for denial of appointment or termination from employment. Mandatory enrollment of VA physicians in the NPDB Proactive Disclosure Service has been required since November 2008. VA has long recognized board certification as important evidence of professional attainment and has given it significant consideration in recruiting and hiring physicians.

VA has no objection to the majority of the provisions in Section 2 relating to standards for appointment and practice of physicians in VA medical facilities and has already implemented most in agency policy. However, VA strongly opposes the requirement in Section 2 for Network Directors to approve physician appointments. This will introduce unacceptable and unnecessary delays into the process for appointing physicians. It is unnecessary since significant safeguards have been implemented to strengthen the process of medical staff appointments. Also it is important to recognize that granting clinical privileges requires local knowledge, including clinical performance and peer-review information, which is not readily accessed at the VISN level.

Section 3 would require the appointment of board-certified physicians as Quality Assurance Officers (QAO) at the national, VISN, and facility level. It would also mandate a comprehensive review of all quality and safety programs and policies, including a detailed review of the National Surgical Quality Improvement Program (NSQIP). A report to Congress of the results of this review would be due within 60 days of enactment. VA does not oppose Section 3, and has already taken steps to increase the involvement of qualified physicians in quality leadership throughout the health care system. We note that the needs of smaller facilities can often be met by a part-time QAO, who may also have other clinical or administrative duties.

Under Section 4(a), VA would provide certain incentives, including student loan repayment, to physicians for service in hard-to-fill positions. Since we do not believe another loan repayment program is necessary, VA does not support this provision. VA can currently authorize educational loan repayment incentives to physicians in hard-to-fill positions through the Education Debt Reduction Program (EDRP). The provisions of S. 246 would establish a second debt repayment program operating under separate legal authority and regulatory guidelines, increasing complexity and potential confusion. In addition, the legislation creates a loan repayment program only for physicians and excludes all other occupations, regardless of the hiring needs and priorities of the Department. Current law provides comprehensive incentives

available to more than 32 health care professional occupations. We estimate that the cost of the loan repayment incentive program described in Section 4(a) would be $4.6 million in the first year, $54.9 million over five years, and approximately $186.5 million over ten years.

We are opposed to another incentive program in Section 4(a) that would require VA to institute a program of tuition reimbursement for a course of education leading to board certification for physicians who agree to serve as physicians in VA. We cannot support this provision for several reasons. The time between the granting of tuition reimbursement and when the physician would become board certified is too long. Medical school and internship together can take seven years or longer to complete, depending on the specialty. Hard-to-fill specialties would likely have longer education requirements. During that time, VA's priorities and hard-to-fill positions can change significantly. Signing a contract today for services and obligations that will not begin for several years is subject to many risk factors that cannot be foreseen. Undoubtedly the personal circumstances and career objectives of many physicians would change, administering the contracts and monitoring the program would be complex, and the opportunities and occasions for civil court actions could also require substantial resources. Further, many students may fulfill their contract obligations but for one reason or another may not be an appropriate hire for VA at the time they are eligible. For example, certification may be beyond the capabilities of the graduating students in the tuition reimbursement program. There could be many circumstances under which VA's investment would not pay off but there would be insufficient grounds for seeking repayment. Assuming a student would receive the full reimbursement each year, as well as the annual stipend, over an eight-year period taxpayers will have invested $280,000 in the student before he or she begins working for VA. If upon graduation the doctor does not or cannot fulfill his or her employment obligation to VA, such a sizable investment would be very difficult to recoup. Considering the amount of the reimbursement and stipend per student and the cost of administration, we estimate that the program cost to be $283,000 in the startup year, $51.7 million over five years, and $174.7 million over ten years.

Section 4(b) would require VA medical facilities to seek to establish an affiliation with a medical school within reasonable proximity of such facility. Mr. Chairman, VA strongly supports the concept of affiliations and we are actively engaged in their expansion. In 2008, more than 100,000 medical and associated health students, residents, and fellows received some or all of their clinical training in VA facilities through affiliations with more than 1,200 educational institutions, including 107 medical schools. Many of these trainees have their health profession degrees and contribute substantially to VA's ability to deliver cost-effective and high-quality patient care during their advanced VA clinical training. As the Nation's health care system evolves, VA continues to be on the leading edge with innovative education and training programs. Therefore, we believe that the statutory requirement to pursue affiliations is unnecessary.

S. 252 "VETERANS HEALTH CARE AUTHORIZATION ACT OF 2009"

S. 252 contains seven separate titles addressing a wide range of issues including personnel matters, homeless veterans, nonprofit research and education corporations and many health care matters including provisions specific to mental health and women veterans health care. Title I contains several provisions intended to enhance VA's ability to recruit and retain nurses and other health-care professionals and set certain standards for appointment and practice of physicians. These provisions are virtually identical to those reported in S. 2969 from the 110th Congress. We appreciated the opportunity to work with Committee staff on the prior bill and to provide technical comments and operational observations. We note that the reported bill and now Title I of S. 252 address many of our concerns and comments. However, there are several provisions we cannot support.

Section 101 contains provisions for the enhancement of authorities for retention of medical professionals.

Secretarial Authority to Extend Hybrid Status to Additional Occupations

Subsection (a) would provide the Secretary authority to extend hybrid status to additional occupations. It would 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 Vet-

erans' 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, 11.1 percent for 2007 and 10.96 percent for 2008, 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 to help recruit and retain 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 hybrids, 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) Notwithstanding chapter 71 of title 5, United States Code, 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 Personnel Management, and the Office of Management and Budget 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 a maximum of its equivalency in hours, 4180. It also provides that a PT appointee 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 as these positions are temporary.

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

Subsection (c) would add a new section 7405(g) that would provide that part-time appointments of RNs are no longer temporary after no more than 4180 hours. After completion of the 4180 hours, the RN in essence would be converted to a permanent employee under section 7403(a) who has completed the probationary period. VA opposes this provision because it would impair our ability to adapt to changing demands in patient need and resource allocations. VA currently has the authority to create temporary appointments for up to three years. If this proposal is enacted, VA would lose this valuable flexibility. VA uses this flexibility to manage positions dur-

ing periods of changing patient care needs and budgets. Without this current flexibility, VA's ability to make adjustments in the size of our temporary workforce would be limited. VA and its employees would be put into an untenable dilemma of either preemptively dismissing employees just prior to the expiration of the their probationary periods when patient demand justifies their continued employment or allowing a nurse to convert and retain employment, even if patient demand no longer justifies that position. In either scenario, patient care would be placed in competition with organizational flexibility, while the current system allows VA to achieve and maintain both.

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 opposes this provision as 5 U.S.C. 8344 and 8468 provide the agency access to retired title 38 health care providers.

Rate of Basic Pay for Section 7306 Appointees Set to 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 in accordance with the 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. 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 $143,500). Locality pay is paid up to the rate for Level III (currently $162,900).

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 $177,200) pending OPM certification that the agency meets all regulatory criteria for certified performance appraisal systems, including that the employing agency makes meaningful distinctions based on performance. We estimate the costs of this provision to be $343,917 in FY 2010 and $3,765,786 over a 10-year period.

As noted, the SES pay system conditions pay up to EX Level 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 just last year recertified VA through July 2010. For consistency, we 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 101(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 and SES Appointees

Subsection (f) would amend section 7410 to add a new subsection to establish "comparability pay" for VHA non-physician/dentist section 7306 employees and SES 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, we recommend that the new administration be given an opportunity to review this matter. Public sector executive pay is dramatically below the private sector for comparable positions, particularly in the health care sector. This proposal would allow VA executives to receive salaries far exceeding executives in other agencies which also must compete with the private sector. It would be a potentially precedent-setting departure from the unitary approach to governmentwide SES pay.

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 proposed by subsection (f), this subsection 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). VA supports this provision. Long-standing, severe and worsening pay compression exists within the ranks of senior pharmacy program managers in VHA. A national survey performed yearly by the American Society of Health System Pharmacists provides evidence that a similar trend exists in the private sector. Currently VHA has had extreme difficulty in recruiting pharmacists for leadership positions. Some examples include: the VA Medical Center in Bay Pines has not had a permanent Pharmacy Manager for two years; the VA Medical Center, Portland, OR, position has been vacant for one year; the VA Medical Center, Asheville, NC, has been vacant over one year; and numerous other facilities are experiencing the same recruiting difficulties. Several other facilities with extended vacancies that were recently filled include: the VA Medical Center, Omaha, NE, for two years; VA Medical Center Dayton, OH, for two years; and VA Medical Center, Las Vegas, NV, vacant for one year. The current pay rate that we are able to pay executives varies minimally from staff pharmacist positions and therefore is not an incentive to recruit pharmacy executive/those in leadership roles to VA. This provision will provide a mechanism to alleviate this compression. VA is still developing costs for this proposal and will submit them for the record when they are available.

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, Guam, 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 administrative or executive leadership provisions from the panel process in determining the amount of market pay and pay tiers for such physicians and dentists. In situations where physicians or dentists occupy these leadership positions 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 these 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 administrative or executive physician/dentist positions that may be excluded from the 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 current cap for registered nurse from EL V to EL IV. VA supports this provision. 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 note that subsection (i) would obviate the need for subsection (j) as the two pay scales affected are already tied to each other. We

estimate the cost of this provision to be $6.16 million for FY 2010 and $72.31 million over a 10-year period.

Subsection (k) would make amendments to the RN locality pay system (LPS). These provisions are not helpful and are 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, including third party 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 proposed in section 2(f) of this bill. However, special pay of this amount would allow VA nurse executives to receive salaries far exceeding executives in other agencies that also must compete with the private section and there is no evidence that such levels of pay are necessary. Thus, VA opposes this provision.

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 it has serious technical flaws, is unnecessary, and is 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" requirement in the current law is intended to ensure 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 weekend 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 weekend pay under section 7453. The expansion of weekend pay proposed in this subparagraph 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 also would 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. It is not clear what positions "nursing positions otherwise covered by title 5" would include. RNs are appointed under title 38, LPNs/LVNs are hybrids, and section 101(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. We also note that adopting the title 5 fixed-percentage formula would render unnecessary the section 7455(c)(2) report for exceeding 94 percent of the grade maximum and, so, 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.

VA's concerns that pay setting authorized by this provision may be subject to collective bargaining are discussed in conjunction with S. 362.

Section 102(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 non-recurring 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 102(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. It would delete current 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. Currently, VA has only one employee working on the Baylor Plan. VA opposes this provision as providing an unwarranted windfall.

Section 102(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. The problem stems from the 36/40 language requiring three 12-hour tours in a work week and because VA defines "work week" as Sunday to Saturday. The problem occurs because the work week requirement prevents scheduling one of the 12-hour tours over two different weeks, e.g., 6PM Saturday to 6AM Sunday. 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. We would be glad to provide appropriate bill language.

Section 103 would make amendments to VA's Education Assistance Programs. VA supports these proposals. Section 103(a) would amend section 7618 to reinstate the Health Professionals Educational Assistance Scholarship Program through the end

of 2014. 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 are still determining costs for this provision and will forward them to the Committee as soon as they are available.

Section 103(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 six months. VA's experience has been that this is not a sufficient period. In several instances, employees applying just missed the six-month deadline. In many cases it takes more than six months for employees to become aware of this very helpful recruitment and retention program. This proposal offers greater flexibility to VA in applying the program. VA also supports the increased amounts in light of increased education costs since the program was enacted. We note this program can be implemented in a cost-neutral fashion.

Section 103(c) would authorize VA researchers from "disadvantaged backgrounds" to participate in a loan repayment program that the VA may establish using the Public Health Service Act authorities for the NIH Loan Repayment Program. We agree that loan repayment incentives would be helpful to clinicians with medical specialization and research interests who might consider career clinical care or clinical research opportunities relating to the work of VHA.

Section 104 is nearly identical to S. 246, Section 2(a), which I have previously discussed.

Section 201 would eliminate two reporting requirements: the Nurse Pay Report and the Long-Term Planning Report. VA supports this provision. There would be no discernible cost savings associated with this provision. Similarly, VA supports Section 202 to amend the Persian Gulf War Veterans' Health Status Act to change the due date of the annual report to Congress from March 1 to July 1. This change would have no impact on cost.

VA also supports Section 203. Section 203 will provide clarification of the legal authority beyond the existing regulations that will prevent providers from collecting from the beneficiary any amounts in excess of the CHAMPVA determined allowable amount. VA favors this provision. There would be no significant cost to VA.

Section 204, relating to payer provisions for care furnished to certain children of Vietnam Veterans, has been made moot by the passage of Pub. L. 110–387, Section 408, "Spina Bifida Comprehensive Health Care."

VA strongly supports Section 205 of S. 252, which 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. This provision would only permit such a disclosure when the practitioner deems the 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.

Section 206 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 authorizes 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.

Given the significant privacy concerns related to this provision, we defer views until further analysis can be made and the new administration is given an opportunity to review this matter.

Section 207 addresses quality management in VA facilities and establishes quality management officer positions at the national, VISN and facility level. Section 207 is similar to S. 246, Section 3, although the position established is termed "Quality Management Officer" (QMO), and there is no stipulation that the position be filled by a board-certified physician. Section 207 would require the QMO to be responsible for and undertake specific actions to carry out VHA's quality management program. Section 207 additionally would require the National QMO to assess quality of care by developing an aggregate quality metric from existing data sources, monitoring and analyzing existing measures of quality, and encouraging research and development in the area of quality metrics. Section 207 would authorize appropriations necessary to carry out the quality management program, including $25,000,000 for the quality metric provisions during the 2 fiscal year period following enactment. Mr. Chairman, we support the intent of these provisions, that is enhancing VA's quality management programs, and have already undertaken 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.

Section 208 requires submission of an annual report to Congress describing progress toward implementing provisions of Sections 104 and 207. VA has no objection to this requirement and, in fact, supports the concept of transparency in health care. We note that a comprehensive Hospital Quality Report was prepared by the Department in 2008 and is updated annually.

We estimate that the requirement that the VISN Director review all information needed for physician appointment would require an additional FTEE (GS 14) at the VISN level. We also estimate that the appointment of a board-certified physician to serve as QAO at the facility and network levels would require 162 physicians for 141 medical staffs and 21 networks. We estimate salary and benefits costs for each QAO to be approximately $200,000 (actual will vary according to specialty, time commitment, and local market factors). We estimate total costs for a FTE MD QAO and FTE VISN coordinator to be $35.10 million in the first year, $188.05 million over five years, and approximately $413.22 million over ten years. We estimate that salaries plus benefits for the new positions will include a 4% increase in costs for each subsequent year.

Section 209 would require the Secretary to conduct a pilot program, 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. The pilot program would be conducted at three VA medical centers and, if determined appropriate, at one DOD medical center. 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 for the costs of training family members of servicemembers. Family caregivers certified under this program would 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 209. 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. Moreover, it does not put VA in the position of having to tell family members how, at the risk of losing their caregiver compensation, they have to care for their loved ones. If enacted, we estimate the cost of the three-year pilot to be $178.4 million.

Section 210 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 provide respite relief to the servicemember's or veteran's family caregiver, while also providing socialization and cog-

nitive 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.

VA does not support section 210. Individuals providing respite care do not require advanced degrees, only appropriate training. Respite care does not require specialized skills, and its functions are not applicable to curricula objectives in the graduate degree programs related to mental health or rehabilitation that we are aware of. Further, section 210 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. We also 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 conducting the pilot program to be $3.5 million in the first year and approximately $11.4 million over five years.

Section 211 would require the Secretary to carry out a two-year pilot grant program (at five locations selected by the Secretary) to assess the feasibility of using community-based organizations and local and State government entities 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. Grantees could use grant funds for purposes prescribed by the Secretary.

VA opposes section 211 because it is duplicative of the Department's on-going efforts. Vet Centers are already providing many of the services contemplated by this provision. 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. The duplicated efforts required by the bill would likely create significant confusion for the beneficiary.

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 and assure the quality of services provided. That approach also gives us an accurate way to project the cost of the services. This provision, 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.

Although the proposed pilot project is limited to five locations, the bill does not specify the number and amount of the grants to be awarded. We are unable to estimate the cost of this provision due to the lack of specificity.

Section 212 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 represents an extremely small subset of the OEF/OIF population. In fact, for FY 2010, VA estimates only 10 veterans would qualify and participate in this program. Age appropriate day health and other community programs, VA's home based primary care, and medical foster homes will be expanded to provide these Veterans with long-term specialized rehabilitation services. VA supports this legislation as it would enable us to provide these veterans 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 212 to be $923,000 for the first year, $12.2 million over five years, and $76.8 over ten years.

Section 213 would amend sections 5701 and 7332 of title 38, United States Code. The amendments would 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 infor-

mation 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.

Given the significant privacy concerns related to this provision, we defer views on this section until further analysis can be made and the new administration is given an opportunity to review this matter.

Section 214 would require VA to enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD). VA opposes this proposal. The 2007 four-year, $3.8 million, VA-sponsored study by the National Academies of Sciences (NAS) "Long-Term Health Effects of Participation in Project SHAD" represented an exhaustive effort to locate and evaluate the health of every living or deceased SHAD veteran. That study found little or no long-term health effects linked to SHAD participation, and spending additional resources with the hope that possibly tracking down a small number of additional SHAD veterans might significantly change those results is unrealistic. We have been assured by the NAS group who conducted the original study that they have spared no effort in tracking down every SHAD participant as part of their study. We estimate that such a study would cost $2.5 million.

When VA is providing inpatient or outpatient care for a patient with Traumatic Brain Injury, VA is required to develop an individual plan for the veteran or servicemember. In implementing such plans, 38 U.S.C. § 1710E authorizes the Secretary to provide hospital care and medical services through cooperative agreements with appropriate public or private entities that have established long-term neurobehavioral rehabilitation and recovery programs. Section 215 would amend this authority by defining covered individuals as servicemembers or veterans receiving inpatient or outpatient rehabilitative hospital care or medical services for Traumatic Brain Injury to whom the Secretary is unable to provide treatment or services at the frequency or for the duration described in the plan, or for whom the Secretary determines such care is optimal. This provision would also require that facilities participating in such cooperative agreements maintain standards for the provision of treatment or services that have been established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with Traumatic Brain Injury.

VA supports this provision but recommends that the plan referenced in this provision be described as the VA Individualized Rehabilitation and Reintegration Plan developed in accordance with section 1710C. Further, the bill as currently drafted states that the Secretary may not provide treatment or services at the non-VA facility unless the facility "maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with Traumatic Brain Injury."

Section 216 would include federally recognized tribal organizations in certain State home programs. Specifically, section 216(a) would authorize VA to treat a health facility or certain beds in a health facility of a tribal organization as a State nursing home for veterans. This would allow VA to pay per diem to the organization for the nursing home care of veterans in the home. The home would be required to meet the existing standards for State homes and such other standards as VA requires. In addition, the organization would have to demonstrate that, but for treatment in the home, a substantial number of veterans residing in the area would not have access to nursing home care, and the Secretary would have to determine that treatment of the facility or beds as a State home would best meet the needs of veterans for nursing home care in the area. Finally, tribal organizations would be subject to limitations on the number of beds that could receive per diem under this provision.

VA opposes Section 216(a). It would be very difficult to maintain a critical mass of staff with expertise in the care of frail, elderly patients in such a setting. Moreover, this would duplicate the function of the existing Community Nursing Home Program under which VA can pay for the care of Veterans placed in nursing homes in the private sector. VA contracts with more than 4,500 community nursing homes nationally and can add more as needed to assure Veterans' access to care.

Section 216(b) would authorize VA to award grants to tribal organizations for the construction or acquisition of state homes in the same manner and under the same conditions as grants awarded to States subject to exceptions prescribed by VA to take into account the unique circumstances of tribal organizations. This provision would require VA to give priority to grant applications from tribal organizations that had not previously applied for a grant even if the State in which the tribal organization was located had previously applied for (or received) a grant.

VA also opposes Section 216(b). The proposal would disenfranchise the states for which the construction grant program was expressly established since priority for awarding of grants is prescribed in statute and regulation. The first priority is for renovations necessary to protect the lives and safety of Veterans residing in the home. The second priority is for grants to states, or under this provision, tribal entities, that have never previously received a grant from this program. Since every state has received a grant and no tribal entity ever has, all construction and renovation applications from tribes would take precedence over all applications from states, except for life safety grants, until all tribal entities that wished to submit applications had done so. Since there are more 500 recognized tribal entities, it could be years before states are again able to receive grants other than life safety grants, and even then they would have to compete with more than 500 eligible applicants instead of the 50 states and a few territories now eligible for the grants. The radical change being proposed would be detrimental to the states for which this program was specifically established.

VA estimates the cost of Section 216 to be $2.6 million for the first year, $14.2 million over five years, and $31.5 million over ten years.

Section 217 would require the Secretary to carry out a pilot program to assess the feasibility and advisability of providing a dental insurance plan to veterans enrolled for VA health care pursuant to section 1705 of title 38 and survivors or dependants enrolled for care under section 1781 of title 38 (CHAMPVA). Under this plan, VA would manage and administer a group dental plan. VA opposes section 217 as this provision would establish an entirely new and dramatically different role for VA.

Section 301 of this bill corresponds to section 101 of S. 597, another bill on today's agenda. This section would require VA to contract with a qualified independent entity or organization to carry out a comprehensive assessment of the barriers encountered by women veterans seeking comprehensive health care from VA, building on the VA's own "National Survey of Women Veterans in Fiscal Year 2007–2008" (National Survey). Many requirements related to sample size and the scope of the survey would apply to the conduct of the assessment. Section 301 would also require the contractor-entity to conduct research on the effects of the following concerns on the study participants:

- The perceived stigma associated with seeking mental health care services.
- The effect of driving distance or availability of other forms of transportation to the nearest appropriate VA facility on access to care.
- The availability of child care.
- The acceptability of integrated primary care, or with women's health clinics, or both.
- The comprehension of eligibility requirements for, and the scope of services available under, such health care.
- The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.
- The gender sensitivity of health care providers and staff to issues that particularly affect women.
- The effectiveness of outreach for health care services available to women veterans.
- The location and operating hours of health care facilities that provide services to women veterans.
- Such other significant barriers identified by the Secretary.

Additionally, section 301 would require the Secretary to ensure that the heads of the Center for Women Veterans and the Advisory Committee on Women Veterans review the results of the comprehensive assessment and submit their own findings with respect to it to the Under Secretary for Health and other VA offices that administer health care benefits to women veterans.

The results of our National Survey will not be available until later in the fiscal year. Consequently, we do not think it feasible to enter into a contract for the mandated assessment and research until we have first had a chance to complete and fully analyze the results of the National Survey. Only in this way can the assessment and research adequately build on the National Survey and reliably augment, rather than duplicate, VA's efforts in this area. We estimate the cost of section 101 to be $3.5 million.

The next section, section 302, corresponds to section 201 of S. 597 and requires VA to develop a plan to improve the provision of health care services to women veterans. VA fully supports the evaluation and enhancement of care to women veterans and initiated a planning and implementation program in September 2008. Consequently, this provision is unnecessary as the initiative is already underway.

Section 303 of S. 252 corresponds to section 102 of S. 597. This section would require VA to enter into a contract with an entity or organization to conduct a very detailed and comprehensive assessment of all VA health care services and programs provided to women veterans at each VA facility. The assessment would have to include VA's specialized programs for women with PTSD, homeless women, women requiring care for substance abuse or mental illnesses, and those requiring obstetric and gynecologic care. It would also need to address whether effective health care programs (including health promotion and disease prevention programs) are readily available to, and easily accessed by, women veterans based on a number of specified factors.

After the assessment is performed, the bill would require VA to develop an extremely detailed plan to improve the provision of health care services to women veterans, taking into account, among other things, projected health care needs of women veterans in the future and the types of services available for women veterans at each VA medical center. VA would then be required to report to Congress on the assessment and plan, including any administrative or legislative recommendations VA deems appropriate. What is unclear in the bill is whether the contractor-entity conducting the assessment would also be required to develop the follow-up "plan," as the terms of section 303 refer to the contractor's conduct of "studies and research" required by that section. VA supports section 303 only if the development of the mandated plan would be conducted by a contractor-entity. We estimate the total costs of this section to be $4,354,000 during the period of Fiscal Year 2010 through Fiscal Year 2012.

Section 304 corresponds to section 202 of S. 597. This provision 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 304 because they are duplicative of existing programs. In FY 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related training and education opportunities nationwide. VA also hosts an annual four-day long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. 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 section 304's 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 inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 305 would require VA, not later than six 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.

We are unclear as to the purpose of and need for this provision. The term "group retreat setting" is not defined, but we assume it could not include VA medical facilities or Vet Centers, as we could not limit Vet Center access to any one group of veterans. Moreover, it is important to note that many Vet Centers are already well

designed to meet the individual and group needs of women veterans. We estimate that the cost of the pilot would be around $300,000.

Section 306 mandates a report to Congress to ensure that health care needs of women are met and to assess whether there is at least one full-time Women Veterans Program Manager employed at each VAMC. This section is substantially similar to section 103 of S. 597. The report shall include an assessment of whether there is at least one full-time employee at each VA medical center who is a full-time women veterans program manager. VA does not oppose this provision but we believe it is unnecessary. VA is already reporting regularly on the employment of Women Veteran Program Managers. To date, 137 of the 144 positions have been filled as full-time employees. No additional funds would be required to submit this report.

Next, section 307 (and the corresponding provision in S. 597, section 204) 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 fully support section 307. These amendments would help both Committees to better identify and address the needs of their respective veteran-populations.

Section 308 would require the Secretary, commencing not later than six months after the date of enactment, to carry out a two-year pilot program, at no fewer than three VISN sites, to pay veterans the costs of childcare 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. The corresponding provision is in section 205 of S. 597.

VA is very cognizant of the veterans' needs for convenient access to health care; however, we oppose section 308 as this expansion would divert resources from direct medical care.

We support section 309, which would authorize VA to furnish health care services up to seven days after birth to a newborn child of a female veteran who is receiving maternity care furnished by VA if the veteran delivered the child in a VA facility or in another facility pursuant to contract for service related to such delivery. This provision corresponds to section 206 of S. 597. We estimate that the cost would be $55.3 million the first year, $293.6 million over five years, and approximately $589.4 over ten years.

VA supports Section 401, which would make members of the Armed Forces who serve in Operation Enduring Freedom or Operation Iraqi Freedom eligible for counseling and services through Readjustment Counseling Service, but we are concerned with the precedent that would be established by providing disparate eligibility to veterans of different conflicts. Under this provision active duty combat veterans of OEF/OIF would have access to Vet Centers for counseling and related mental health services and behavioral health services, including substance abuse assessment, counseling, and referral. Active duty veterans of the Persian Gulf War or other prior or subsequent combat would not have access to those services. Providing these services to active duty OEF/OIF personnel would cost approximately $3.7 million in the first year, $19.8 over five years, and $44.1 million over ten years. DOD has reimbursed VA for services provided to active duty members; however, we have not yet discussed the funding of this provision or possible reimbursement rates with DOD for readjustment counseling services.

Until 1996, VA had specific statutory authority to refer ineligible veterans to non-VA resources and to advise such individuals of the right to apply for review of the individual's discharge or release. VA supports Section 402, which would reinstate these provisions. Reinstatement of these provisions would give the Vet Centers the latitude to help Veterans with problematic discharges with problems deemed by Vet Center staff to be related to war trauma, through referral to services outside the VA and/or referral for assistance with discharge upgrades when appropriate. The total number of Veterans this provision would affect is assumed to be small so the costs of this provision would be negligible.

VA opposes Section 403, requiring VA 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. VA opposes conducting the study because other information, more valuable in guiding VA's strategy for suicide prevention, is already available and is continually being refined through other research and data collection efforts. Moreover, we do not believe that the new requirement would yield any additional information of significant value.

Rates and counts of deaths from suicide are available from 2000 onward for Veterans who utilized the VHA Health Care System. In addition, they are available on specific cohorts of Veterans including those who served in OEF/OIF and in the first Persian Gulf War, whether or not they utilize VHA health care services. Finally, they are available on all individuals identified at the times of their deaths as Veterans by their families in the sixteen states that participate in the Centers for Disease Control and Prevention's National Violent Death Reporting System. VA estimates that the overall cost for conducting such a study would be $2,356,000 in FY 2010 and $7,224,000 over five years.

VA is opposed to Section 404, which would transfer $5 million from VA to the Department of Health and Human Services (HHS) by the end of FY 2010 for a graduate psychology education (GPE) program. This transfer of funds to the GPE Program would reduce funding available for VA programs or services without any clear benefit to VA in exchange for those services. VA much prefers to target these funds to increasing internship and post-doctoral training positions within VA facilities. VA already supports 435 Psychology internship positions in 90 different programs and 200 postdoctoral fellowship programs in 54 programs. Thus we already provide the "training of psychologists in the treatment of Veterans with Post Traumatic Stress Disorder, Traumatic Brain Injury, and other combat-related disorders" that this legislation aims to achieve. Assuming that this $5 million would become a recurring transfer of funds, the estimate over ten years is $50 million.

Sections 501 and 502 of S. 252 would authorize VA to conduct two five-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 pilot programs would require the Secretary to promulgate regulations establishing criteria for receiving grants and the scope of supportive services covered by the grant program.

The 2005 Base Realignment and Closure process has been completed and local plans have already been developed. Therefore the new authority as proposed in section 501 would be ineffective. Further, the Veterans Mental Health and Other Care Improvement Act of 2008, Public Law 110–387, Title VI, Section 604 provided authorization for VA to facilitate the provision of supportive services for very low income veterans for veteran families in permanent housing. VA is in the process of writing regulations and hopes to offer funding later this year. Section 604 allows VA to effectively aid veterans better than either of the two pilots. We respectfully suggest that the two pilots are no longer needed and believe that the supportive services grants under Pub. L. 110–387 which this Committee approved last year to be a more effective way to assist veterans.

Section 503 of S. 252 would require that VA establish a pilot program for financial support of entities that provide outreach to inform certain veterans about pension benefits. To this end, the bill would provide VA with additional authority to make grants to public and non-profit organizations (including faith-based and community organizations) for purposes of providing outreach to inform low-income and elderly veterans and their spouses residing in rural areas about potential eligibility for VA pension. The bill authorized the expenditure of $1,275,000 from General Operating Expenses (GOE) in each of fiscal years 2010 through 2014. Although VA supports the intent of Section 503 of S. 252, we oppose the bill because it duplicates ongoing outreach efforts by VBA to conduct outreach to low income and elderly veterans and their spouses and dependents. If this legislation is enacted, VA would need additional GOE to administer the pilot program and to train the public and non-profit organizations to accurately discuss VA benefit programs.

VA's outreach efforts to elderly veterans and their survivors include several approaches. We have provided the Social Security Administration with our pamphlet "Federal Benefits for Veterans and Dependents." Additionally, we have participated and will continue to participate in the annual conference of the American Association of Retired Persons (AARP). This year VA will participate in the National Convention of the Association of Directors of Assisted Living Facilities. From January 2008 to January 2009 the number of veterans receiving disability pension declined about two percent or less than 7,000 veterans. That decline can be almost entirely accounted for by the decline in the number of World War II veterans receiving pension. The decline in this population accounted for 85 percent of the decline. The

Vietnam Era veteran population is only now reaching age 65 where entitlement exists based on age. We expect their participation in the pension program to rise. With respect to survivor pension, the number of widow(ers) on the rules has increased 5,924 or 7.2 percent over the same January to January period. In light of the significantly lower allowable income limits for survivors, this rise is primarily attributable to entitlement being established as a result of high medical expenses. The rise is reflective of our work with social security and AARP and soon with the assisted living organizations.

Section 504 of the bill would authorize a 3-year pilot program to assess the feasibility of providing grants to public or nonprofit organizations as a means of providing expanded services to veterans participating in vocational rehabilitation programs under chapter 31 of title 38, United States Code. Under this program, VA would provide financial assistance through grants to public or nonprofit organizations that would then establish new programs or activities, or expand or modify existing programs or activities, to provide assistance to veterans participating in vocational rehabilitation programs under chapter 31. The type of assistance to be provided includes transportation, childcare, and clothing to facilitate participation in a vocational rehabilitation program or related activity. The pilot program would be used to assess the feasibility of providing such expanded services to veterans through these types of grants.

VA supports efforts to facilitate successful completion of vocational rehabilitation programs under chapter 31. However, VA does not support the use of grant programs to achieve this objective. The administrative burden associated with creating and administering such a grant program would be prohibitive, particularly since VA must continue to monitor grantee's activities to ensure alignment with VA program objectives and each program participant's individual rehabilitation plan. VA personnel already use existing systems to process direct reimbursements to veterans for authorized, necessary costs associated with participation in their specific vocational rehabilitation programs. VA believes that, subject to the availability of funding for the purpose, any incentive programs to facilitate completion of vocational rehabilitation programs should be built onto existing VA reimbursement authorities.

The Department would be authorized $5 million from the amounts available in VA's GOE account in each of fiscal years 2010 through 2012 to carry out section 504 of this bill.

Section 505 would require that not less than one year before the expiration of the authority to carry out the pilot programs established under section 501 through 504, VA would submit a report to Congress including the following: lessons learned, recommendations on whether to continue such pilot program, the number of veterans and dependents served by such pilot program, an assessment of the quality of service provided to veterans and dependents, the amount of funds provided to grant recipients, and the names of organizations that have received grants.

VA supports sections 601 to section 606 of Title VI, which would update and clarify provisions of Public Law 100–322 authorizing VA-affiliated Nonprofit Research Corporations (NPCs). Title VI promulgates revisions that will allow the NPCs to better serve VA research and education programs while maintaining the high degree of oversight applied to these nonprofits. There are no added costs associated with Title VI. VA supports Title VI.

Subsection (a)(1) of section 701 of the bill would amend section 902(a) of title 38, U.S.C., so as to permit VA police officers to: (1) carry VA-issued weapons, including firearms, while off VA property in an official capacity or while in official travel status; (2) conduct investigations, on and off VA property, of offenses that may have been committed on VA property, consistent with agreements with affected local, state, or Federal law enforcement agencies; (3) carry out, as needed and appropriate, any of the duties described in section 902(a)(1), as revised, when engaged in such duties pursuant to other Federal statutes; and (4) execute any arrest warrant issued by a competent judicial authority. Subsection (a)(2) of section 701 would further amend section 902 of title 38 to specify that the powers granted to VA police officers be exercised in accordance with guidelines approved by the Secretary and the Attorney General of the United States. VA will work with the Department Justice to formulate our views on this proposed legislation. We will submit our views at a later date.

Section 702 of the Committee bill would amend section 903(b) of title 38, U.S.C., which governs the uniform allowance for VA police officers, to limit the allowable amount to the lesser of: (1) the amount prescribed by the OPM; or (2) the estimated or actual costs as determined by periodic surveys conducted by VA. The provision would also amend section 903(c) of title 38 to provide that the allowance established under subsection (b) of section 902 of title 38, as modified by the Committee bill, shall be paid at the beginning of an officer's appointment for those appointed on or

after October 1, 2008, and for other officers at the request of the officer, subject to the fiscal year limitations established in subsection (b), as modified by the Committee bill.

VA supports these provisions. Under current section 903, uniformed Department of Veteran Affairs Police are paid $400 for an initial uniform allowance, and then $200 annually throughout their careers. This is a marginal amount and does not cover the actual costs of uniforms and equipment required by the Department for our officers. VA Police officer uniforms are required by the Department and purchased by the officers using the statutorily authorized allowance. These amounts were last updated in 1991. Our Police Officers generally have to reach into their own pockets to supplement both the initial purchases and annual upkeep.

The Office of Personnel Management (OPM) published new regulations in the Federal Register that increase the authorized uniform allowance amount up to $800 initially and $800 annually. Section 702 would allow the Department to occasionally review and increase initial allowances up to the OPM-authorized maximum, if that is necessary.

The Department requires that all VA police officers present an image of professionalism and authority. Authorizing an updated uniform allowance will help to achieve that. We also note that uniform allowances are a recruiting tool. We estimate costs at $1.58 million for one year, $6.5 million for five years, and $16.82 million for ten years.

S. 362 "REPEAL OF EXCEPTIONS TO RIGHTS OF CERTAIN DEPARTMENT OF VETERANS AFFAIRS EMPLOYEES TO ENGAGE IN COLLECTIVE BARGAINING"

S. 362 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. More specifically, 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. Last, the bill imposes an unrealistic and unworkable time limit on certain grievance appeals. VA strongly opposes this provision.

Our concern with this bill is its potential to adversely impact VA's ability to deliver quality patient care. While we appreciate the many positive contributions collective bargaining and labor-management partnership make to VA's mission, VA strongly opposes S. 362, which, if enacted, would imperil VA's ability to furnish timely and quality care for veterans. S. 362 would 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 the clinical training and health care management expertise to make such determinations. While S. 362 would result in a host of untenable situations, we limit our comments here to the most significant problems raised by the legislation.

First, the rules for collective bargaining often lead to protracted negotiations and third-party proceedings. On average, it takes 60 days to negotiate national MOUs with AFGE, which does not include local-level bargaining which can take as long as 30 to 60 days. While this is acceptable for most workplace matters, it is not when it comes to providing quality patient care. If this bill were enacted, critical changes in patient care (e.g. new, mandated training on care of Traumatic Brain Injury or extended hours for mental health facilities) could not be implemented until after national and local bargaining had been completed. This would very likely result in veterans' experiencing delays or gaps in their receipt of needed clinical care or services. Indeed, we foresee the situation where a VA facility is not able to change the standards requiring 24-hour assessments of patients without first engaging in collective bargaining, even though immediate patient care concerns are the cause for the change. Such delays and the very practice of negotiating clinical matters would be an anathema to patient-centered medicine.

Second, S. 362 would allow Title 38 professionals to grieve matters or file Unfair Labor Practice grievances on clinical matters currently exempted from collective bargaining. If a grievance were not resolved at the informal stage, it would go to a third-party arbitrator for decision. 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. VA would be bound by that third-party's decision. As a provider, this is wholly unacceptable. VA clinicians need to make the clinical decisions involving their patients

to ensure care is furnished in compliance with VA and prevailing medical practice standards.

Moreover, these decisions should not be made by a non-clinical third party who is not accountable for ensuring the health and safety of the veterans receiving their care through the Department. If the Secretary and the Under Secretary for Health are going to be held responsible and accountable for the quality of care provided to veterans, it is they who must be able to determine which matters affect that care. They must be able to establish standards of professional conduct for, and competency of, our clinical providers based on what is best for Veterans from a medical perspective rather than what is the best that can be negotiated through collective bargaining or based on what a non-clinical arbitrator or FLRA judge decides is appropriate. At the least, because the third party's final decision on a clinical matter would be imposed on VA, the relevant union should be held accountable and liable, along with the Department, for any adverse patient outcomes resulting from the decision.

Additionally, S. 362 would adversely affect patient care and safety by permitting Title 38 providers to file grievances based on changes made in their shifts (e.g., whether or not to utilize compressed work schedules) that are needed to maximize providers' skills and best meet patient care needs. VA needs the ability to quickly change shift assignments to meet patient needs that cannot be anticipated. Shift changes may also be necessitated by a medical emergency. However, S. 362 would permit the union to submit a proposal to define what constitutes emergency situations, limiting situations when VHA could schedule staff, such as RNs, to work longer than 12-hour shifts. In such a case, the impact on patient care would be fourfold:

- By imposing a collectively bargained-for definition of "emergency," the proposal would open to grievance and arbitration any management determination that a nurse should work beyond 12 hours to meet emergent patient care needs;
- It would effectively prohibit management from determining that an emergency exists when the specific limitations of the bargained-for definition are not met;
- It could delay adequate nurse staffing for the affected unit, leave the unit under-staffed for the entire tour, or force VA into procuring expensive contract care that may not equal that of VA employees; and,
- It would place limitations on management's ability to mandate a particular nurse, with personal professional qualifications that render him/her the preferable or necessary patient care provider under the circumstances, to work in an emergency, directly impacting patient care.

It is even foreseeable that the union could submit a proposal empowering RNs to be able to refuse mandatory overtime in excess of 12 hours, even if based on critical patient needs. This would effectively prohibit VA from taking any disciplinary action against an RN who refused to work more than 12 consecutive hours. If no RN agreed to work longer than 12 hours on a particular unit, then the unit would be left short-staffed, or VA would need to procure expensive contract care that may not equal that of VA employees, either of which would adversely impact patient care. This is not to say, however, that any changes in shift assignments at the facility level are invariably clinical care matters excepted from collective bargaining. We are committed to ensuring that changes in staffing are not the result of any facility's failure to make adequate staffing plans to meet their foreseeable, projected, and routine patient workloads.

We cannot underscore enough that veterans would find little solace in learning that their care was delayed or denied because of our statutory obligation to first participate in collective bargaining with the unions on a clinical matter related to their care (including staffing), particularly if their medical situation leads to grave consequences. Nor could our veteran-patients be expected to understand why their VA providers—a coterie of highly qualified, trained, and trusted professionals—have no option but to follow the decisions of third-parties with whom they disagree. This would be particularly hard for them to accept when the final arbiter is a stranger to patient and provider alike and otherwise completely uninvolved in the patient's care.

S. 362 would also thwart VA's ability to immediately re-assign staff from direct patient care duties to administrative duties based on an allegation that the staff committed patient abuse or posed some other danger to patient safety. Until such serious allegations can be properly investigated, the only reasonable action VA can take to protect patients is to immediately remove that staff member from direct patient care duties. Under the bill, however, such staff reassignments would be subject to negotiations, as staff would be able to grieve them. Such decisions should not be

left to arbitrators, who lack any clinical training and who have no responsibility for providing health care.

Another example of the problems raised by this legislation concerns VA's Peer Review process, which VA uses to assess the clinical skills of our Title 38 professionals and also to assess whether our patients received the high-standard of care they deserve. The Peer Review program is now expressly exempted from collective bargaining under section 7422. S. 362 would change that, permitting non-VA, non-clinical third-parties to assess the clinical skills of our Title 38 professionals and determine whether they are clinically competent in their area of practice. This would be an absurdity were it not such a serious threat to our patients' welfare.

In addition to clinical-care issues, S. 362 would also result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under Title 5, including the determination of the amount of an employee's compensation. Permitting Title 38 staff to negotiate the discretionary aspects of their compensation would simply be at odds with how other Federal employees are treated. Such inequitable treatment among Federal employees cannot be justified.

By significantly changing VA's collective bargaining obligations, S. 362 would also adversely impact VA's budget and management rights. It would also skew toward a slippery slope the current balance maintained between providing beneficial working conditions for Title 38 professionals and providing quality patient care services that are timely and that meet, if not exceed, the diverse, and often complex, medical needs of our veterans.

Congress purposefully left it to the Secretary's discretion to decide which matters would be excluded from collective bargaining. In so doing, Congress implicitly acknowledged that our large, dynamic health care system should not permit real-time clinical decisions and clinical management decisions to be decided through the collective bargaining process. The Under Secretary for Health has been delegated the authority to make these discretionary determinations. Since 1992, there have been no more than 17 decisions issued by the Under Secretary in a one-year period. This means that very few section 7422 grievances have been filed and pursued by employees up to the Under Secretary level. This is particularly striking given the number of VA health care facilities and bargaining unit employees at those facilities.

In fact, our data reflect that, on the whole, our efforts to recruit and retain health care professionals (particularly nurses) have been widely successful notwithstanding the exceptions from collective bargaining now provided for by section 7422. We are glad to share our data with the Committee and brief the members on our continuing efforts in this area.

In view of the foregoing, we strongly oppose this legislation. Although we appreciate the valuable role the unions can play on behalf of their members, this bill would give them bargaining rights on clinical care matters that would clearly and foreseeably endanger the well-being of our veteran-patients.

In addition, section 2 of the bill, a proposed new section 7463(f)(1), would impose a requirement for VA to decide grievance appeals no later than 60 days after the grievance is filed. In many cases however, the grievance examiner's review could take most or all of those 60 days, leaving no time for a review of, and decision on, the examiner's findings and recommendations called for in section 7463(d)(3). If the Committee does not forebear in its consideration of S. 362, we suggest that provision of the bill be modified to (1) amend section 7463(d)(2) to impose a 120-day time limit for the examiner's review and recommendations, and (2) to amend 7463(d)(3) to impose a 60-day time limit for that section's review and decision on the examiner's findings and recommendations.

Finally, section 3 of the bill would amend the Disciplinary Appeals Board statute to require the provision of a transcript to the employee three weeks before the submission of post-hearing briefs. We think this unnecessarily constrains the time for DABs to consider their decisions, which must be rendered within 45 days of the DAB hearing and no later than 120 days after commencement of the appeal. In fact, there may be instances where it will be impossible to provide the three weeks and meet the 120-day time limit.

In sum, VA's ability to manage its health care facilities and to monitor the professional conduct and competence of its employees are management actions that must be reserved for the VA professionals responsible for delivering quality patient care.

S. 404 "VETERANS' EMERGENCY CARE FAIRNESS ACT OF 2009"

VA supports S. 404, the "Veterans' Emergency Care Fairness Act." This bill would expand Veteran eligibility for reimbursement by VA for emergency treatment furnished in a non-VA facility. Under current law, VA is a payer of last resort. Con-

sequently, a Veteran who would otherwise be eligible for reimbursement or payment of private emergency medical expenses is ineligible for the benefit because a third party makes partial payment toward the Veteran's emergency treatment expenses pursuant to other contractual or legal recourse available to the Veteran. In these cases, Veterans are often left with sizable medical debts for which they are personally liable. VA payment as secondary payer would fully extinguish the Veteran's liability to the private provider who furnished the emergency treatment.

It is difficult to cost this proposal without extensive data on Veterans' personal liability for non-VA emergency care expenses. We have estimated the cost based on the average payment made by VA for unauthorized non-VA emergency treatment of Veterans' non-service-connected disabilities. We estimate the cost of implementing this draft bill to be $500,000 for FY 2010, $3 million over a 5-year period, and $7.8 million over a 10-year period.

S. 423 "VETERANS HEALTH CARE BUDGET REFORM ACT"

S. 423 would authorize advance appropriations for certain medical accounts of the Department by providing two-fiscal year budget authority. Mr. Chairman, we know that Congress and the Administration share the same objective—to ensure VA delivers timely, accessible, and high-quality care that Veterans expect and deserve. On April 9, 2009, the President emphasized that care for Veterans should never be hindered by budget delays and expressed support for advanced funding for Veterans' medical care. We believe that advanced funding will ensure that sufficient resources are available from the first day of the fiscal year so that the health care needs of Veterans can be provided on a timely basis. We look forward to working with Congress to make advanced funding for VA health care a reality.

S. 509 "AUTHORIZE A MAJOR MEDICAL FACILITY PROJECT AT THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, WALLA WALLA, WASHINGTON."

S. 509 would authorize a major medical facility project at the VA Medical Center in Walla Walla, Washington, in an amount not to exceed $71,400,000. The project includes construction of a new multi-specialty outpatient clinic, campus renovations and upgrades, as well as additional parking. Mr. Chairman, funds for this project were appropriated last year in Pub. L. 110–329. We support this bill.

S. 543 "VETERAN AND SERVICE-MEMBER CAREGIVER SUPPORT ACT OF 2009"

Mr. Chairman, S. 543 describes a pilot program to train, certify and pay family caregivers for care provided to an eligible veteran or servicemember. There are similarities between this provision and the previously described section 209 of S. 252, which would also establish a pilot program for family caregivers, but there are also some significant differences. While S. 252 pertains specifically to veterans or servicemembers with Traumatic Brain Injury, the eligibility criteria set forth in S. 543 would authorize a much larger and less well-defined population. In addition, S. 543 differs in the duration and location of the pilot programs and also authorizes the inclusion of private facilities in the pilot. S. 543 provides more specificity concerning eligibility of family members, veterans and servicemembers, and is more proscriptive in describing the development of the curriculum. It also sets forth a detailed mechanism for determining amounts paid to family caregivers. Another provision in the bill directs the Secretary to review VA respite care programs, identify options for enhancing respite care and enhance the availability of such care. The bill also directs the Secretary to collaborate with the Secretary of Defense to develop a pilot program to make certain counseling and social services available to each eligible family caregiver participating in the pilot program.

The concerns we identified with section 209 of S. 252 also apply to this pilot program. VA currently contracts for caregiver services with home health and similar public and private agencies. The contractor trains and pays the family member, affords them liability protection, and oversees the quality of their care. As previously noted, this arrangement is preferable because it does not divert VA from its primary mission of treating veterans and training clinicians.

VA does not oppose the intent of the subsection of this bill addressing respite care but believes that it is unnecessary. VA already has a comprehensive respite care program that provides Veterans with short-term services to give the caregiver a period of relief from the demands of daily care for the chronically ill or disabled Veteran or active duty servicemember. Respite care services are planned in advance for the benefit of the caregiver in conjunction with the necessary medical care of the patient. As noted earlier with regard to section 210 of S. 252, Veterans are entitled to 30 days of respite care a year in inpatient, community, or other settings.

VA has two pilot programs underway to expand respite services. VA Voluntary Services (VAVS) is establishing and operating a community-based volunteer home respite program to benefit Veterans and their primary caregivers. Respite services provided through VAVS are in addition to the 30 days of respite care per year. This program is underway at ten VA medical centers. A caregiver assistance pilot program is also underway to provide 24-hour in-home respite care at two VA medical centers. Additionally, every Veteran and caregiver has access to a VA social worker who provides an assessment of individualized needs of the family caregiver with respect to the family member's role as a caregiver, assistance with the development of a plan for long-term care of the Veteran, and implementation of a treatment plan.

S. 597 "WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT"

S. 597, is nearly identical to sections 301 through 309 of S. 252. The views expressed regarding those sections are also applicable to the provisions in S. 597.

S. 658 "RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009"

S. 658 contains several sections. I will address each section separately.

Section 2 would establish the beneficiary travel allowance for mileage at a rate of 41.5 cents per mile. It would also require the Secretary amend the VHA Handbook to clarify that the allowance for mileage may exceed the cost of public transportation. VA does not oppose this provision but believes that it is unnecessary. VA currently reimburses beneficiary travel mileage at 41.5 cents per mile. Public Law 110–387 gave the VA Secretary authority, based on availability of funds, to prescribe a rate higher than the Federal employee rate and, using this authority, the Secretary raised the mileage reimbursement rate to 41.5 cents per mile effective November 17, 2008. S. 658 would also remove the Secretary's authority to adjust the mileage reimbursement rate when it is determined that such change is appropriate.

Section 3 directs VA to establish at least one and no more than five, geographically dispersed centers of excellence for rural health research, education, and clinical activities. VA opposes this legislation because proposed centers of excellence are duplicative of the Veterans Rural Health Resource Centers (VRHRCs) that were established to improve care and services for veterans residing in geographically isolated areas. Provisions within this section are also duplicative of efforts of VA's Veterans Rural Health Advisory Committee which was established to examine ways to enhance VA health care services for Veterans in rural areas by evaluating current programs and identifying barriers to health care. We estimate the cost of Section 3 to be $2 million in the first year, $10.8 over five years, and $23.8 million over ten years.

Section 4 would require the Secretary to establish a grant program for State veterans' service agencies and Veterans Service Organizations to provide innovative transportation options to veterans in rural areas. VA supports this provision. Section 4 authorizes appropriations of $3,000,000 annually for fiscal years 2009–2013.

Section 5 would require the Secretary to create demonstration projects through partnerships with the Department of Health and Human Services and the Indian Health Service to examine the feasibility and advisability of alternatives for expanding care for Veterans in rural areas. VA does not support this provision as it is duplicative of pilot programs that are required under Section 107 and Section 403 of Public Law 110–387. Section 107 of that law requires VA to establish pilot programs in rural areas to use contracted community health centers, the Indian Health Service, or other appropriate entities to provide peer outreach, peer-to-peer counseling, readjustment counseling, and other mental health services to Operation Enduring Freedom and Operation Iraqi Freedom Veterans. The enactment of section 403 requires VA to establish a pilot program under which VA provides health services to highly rural Veterans through qualifying non-VA health care providers. Overall, we estimate that the demonstration projects outlined in Section 5 would cost $4.4 billion over three years.

Section 6 directs the Secretary to establish a program to provide peer outreach services, peer support services, readjustment counseling services, and mental health services to Veterans of Operation Enduring Freedom and Operation Iraqi Freedom, particularly those who served while in the National Guard and Reserves. This section would also provide the Secretary the authority to contract with community mental health centers and other entities to provide services in areas not adequately served by Department facilities. VA opposes this section as it would blur the fundamental distinction between the readjustment counseling services and mental health services currently provided by the Department. These services are authorized by separate authorities and employ different eligibility criteria. Moreover, they should

not be combined as they are conceptually and operationally very distinct areas of treatment.

Readjustment counseling is a special community-based counseling service that goes beyond medical care to provide combat veterans services needed to facilitate a successful readjustment to civilian life. VA's authority to furnish readjustment counseling services already includes the authority to furnish limited mental health services necessary for effective treatment of the veteran's readjustment issues. Vet Centers, for example, provide professional treatment for combat-related PTSD, depression, and substance abuse and, if necessary, refer the veteran to VA facilities for treatment of additional or more complex mental health needs. In contrast, comprehensive mental health services are furnished as medically needed to all enrolled Veterans, regardless of combat status, as part of VA's standard medical benefits package.

VA currently contracts for readjustment counseling and related readjustment services with private sector community mental health agencies and other professional entities. Most of these contract providers are located in rural areas. Similarly, VA has authority to contract for mental health services for enrolled Veterans if VA cannot provide needed services in a timely manner. In this regard, section 6 is duplicative of existing contract authorities and ongoing activities.

Vet Centers also provide veteran-peer outreach and counseling. In 2004, VA began an aggressive outreach effort, which included hiring theater of combat OEF/OIF Veterans to provide outreach services and peer counseling to their fellow veterans. To date, the Vet Center program has hired 100 OEF/OIF outreach workers. In addition, the program has seen a significant expansion of its resources. Starting from a total of 206 Vet Centers in fiscal year (FY) 2006, there are now 232 Vet Centers, and another 39 planned to be operational by the end of FY 2009. Funding to support all of the Vet Center program initiatives is included in the program's annual operating budget.

Section 7 would establish an "Indian Veterans Health Care Coordinator" at the 10 medical centers which serve the greatest number of Indian veterans to improve outreach to tribal communities, coordinate medical needs with the Indian Health Service, expand access and participation in the Veterans Affairs Tribal Veterans Representative program, and advocate on behalf of Indian veterans. This section would also require the integration of electronic health records between VA and the Indian Health Service and would permit the Secretary to transfer medical and IT equipment to the Indian Health Service.

VA does not support Section 7 because the agency is already providing support to American Indian Veterans, primarily through our rural health initiatives. VA encourages cooperation and resource sharing between the Indian Health Service and VHA to deliver quality health care services and enhance the health status of American Indian and Alaska Native (AI/AN) veterans. VA also maintains the VISN Tribal Veterans Representative (TVR) Program, which provides outreach and open communication to veterans in extremely rural and underserved areas, especially the AI/AN and Hawaiian Native (HN) populations. The VISN TVR program trains individuals on outreach techniques to assist, facilitate and encourage veterans to access their full range of earned VA benefits. Multiple agencies use VA's VISN TVR outreach services including the Indian Health Service, Tribal Health Services, Community Health Centers and veterans' service organizations. VA estimates the cost of the provisions in Section 7 at $985,000 in the first year, $5.3 million over five years, and $11.6 million over ten years.

Section 8 would require the Secretary to provide an annual report to Congress on matters related to care for Veterans who live in rural areas. VA is not opposed to this reporting but we believe it is unnecessary. VA already provides a number of periodic reports to Congress on the status of rural and highly rural Veterans. For example, Public Law 110–329 requires that the Secretary of the Department of Veterans Affairs report quarterly to the Congress on new rural health initiatives implemented through appropriations funding. The Office of Rural Health also provides regularly recurring reports to the SVAC and HVAC.

S. 669 "VETERANS 2ND AMENDMENT PROTECTION ACT"

S. 669 would clarify the conditions under which certain persons may be treated as adjudicated mentally incompetent for certain purposes. Pursuant to section 103(e)(1) of the Brady Handgun Violence Prevention Act (Pub. L. 103–159), VA is required to provide the Department of Justice (DOJ) with information concerning individuals who, due to a determination by VA, are prohibited from purchasing or possessing firearms under the standards imposed by 18 U.S.C. § 922(d)(4) and (g)(4), which prohibits the purchase or possession of firearms by any person "adjudicated

as a mental defective." Under existing DOJ regulations, the phrase "adjudicated as a mental defective" includes persons found to be a danger to themselves or others and persons found to lack the mental capacity to manage their own affairs. Pursuant to those requirements, VA's Veterans Benefits Administration (VBA) currently provides DOJ with information on persons adjudicated by VA under 38 CFR § 3.353, as lacking the mental capacity to contract or manage their own affairs. This information is then included in databases managed by DOJ's Federal Bureau of Investigation and Bureau of Alcohol Tobacco and Firearms, and serves to prevent, through the National Instant Criminal Background Check System, prohibited individuals from purchasing firearms.

S. 669 would provide that a person VA finds to be mentally incapacitated, mentally incompetent, or experiencing an extended loss of consciousness "shall not be considered adjudicated as a mental defective" for purposes of 18 U.S.C. § 922(d)(4) and (g)(4), unless a "judge, magistrate, or other judicial authority of competent jurisdiction" concludes that "the individual is a danger to himself or herself or to others." This amendment would revise the reporting requirements contained in title 18 of the United States Code, by adding additional prerequisites to the reporting by VA to DOJ, of information pertaining to persons VA adjudicates as incompetent. VA takes no position on this bill at this point as the Administration is still working with the Department of Justice to formulate views.

S. 734 "RURAL VETERANS' HEALTH CARE ACCESS AND QUALITY ACT OF 2009"

I will address individually the several sections of S. 734.

VA opposes Section 2, which would remove the current cap for the Education Debt Reduction Program (EDRP) and would cover the full cost of the principal and interest owed by participants. This section could result in significantly higher awards, but would mean significantly fewer people could participate. Moreover, EDRP is a reimbursement program, meaning that VA provides awards to employees at the end of the year covering their out-of-pocket payments on their loans. In many situations, employees would be unable to bear the cost of higher per year awards. For example, an individual with a $150,000 loan would have to pay $30,000 on their own before VA could reimburse them at the end of the year. We also note by removing the cap on loan repayment awards, VA's programs would be inconsistent with other student loan repayment or reimbursement programs in the Federal Government. Moreover, this bill does not eliminate the six-month eligibility requirement and thus does not improve the retention value of EDRP. VA estimates Section 2 would cost $9.7 million in FY 2010, with a five-year total of $145.9 million and a ten-year total of $389.2 million.

Section 3 proposes to transfer $20 million to the Department of Health and Human Services to include VA among the list of facilities eligible for assignment of participants in the National Health Service Corps Scholarship Program. VA believes that participation in this program would help attract high caliber research-focused candidates to VA; however, we believe that VA funding would be better spent supporting our current recruitment and retention initiatives, such as the Employee Debt Reduction Program, the Employee Incentive Scholarship Program, or the Health Professionals Educational Assistance Scholarship Program, which would be resumed under section 103 of S. 252.

Section 4 of S. 734 would require the Director of the Office of Rural Health (ORH) to develop a five-year strategic plan. VA does not oppose this provision but believes it is unnecessary. The ORH is already developing a national strategic plan and has informed Congress of its planning process. The plan under development will exceed the requirements of the bill by enabling ORH to focus on six key areas: access, technology, quality, education and training, collaborations, and workforce recruitment and retention. Additionally, the national ORH strategic plan will meet ORH's mission requirements, which are to promulgate policies, best practices and innovations to improve health care services to Veterans who reside in rural and highly rural areas, while undertaking ongoing initiatives to find better health care solutions and improving overall access. This national strategic plan will include specific goals for timely and quality access and incremental milestones for measuring the achievement of these objectives. Telehealth and telemedicine are important elements of these objectives and ORH will work in close collaboration with VHA's Office of Care Coordination Services to appropriately include this method of health care delivery. VA estimates there would be no significant costs associated with Section 4.

Section 5 of S. 734 would permit VA to use paraprofessional volunteers and eligible volunteer counselors to support the mission of Vet Centers and outreach efforts. VA does not oppose section but believes it is unnecessary as VA already has the

authority under 38 U.S.C. 513, 38 U.S.C. 7405, and VHA Directive 1620 (September 28, 2005) to use volunteers for these services to supplement, rather than replace, VA compensated staff. Additionally, these authorities permit volunteer assistance by physicians, dentists, nurses and other professionally licensed persons to assume full responsibility for professional services in their respective fields with the approval of the facility Chief of Staff, provided the volunteer is properly privileged and credentialed to perform such service and that any activities in which they engage are under the supervision of VA-compensated clinical staff. VA estimates there would be no significant costs associated with Section 5.

Because they are either unnecessary or redundant of current activities, VA does not support a number of the provisions in Section 6. This section would require VA to: (1) carry out a program of teleconsultation for the provision of remote mental health and Traumatic Brain Injury (TBI) assessments; (2) carry out a program of teleretinal imaging in each VISN, expanding the number of patients enrolled in such a program by five percent annually through FY 2015; (3) develop in cooperation with affiliated universities an elective rotation in telemedicine for medical residents; and (4) modify the Veterans Equitable Resource Allocation (VERA) system to provide incentives for utilizing telehealth and to incorporate such consultations in facility workload data.

Regarding the first provision, VA has already implemented a national program to provide teleconsultation for remote mental health assessments. VA is currently undertaking a pilot of the remote assessment of TBI via teleconsultation in Denver. There are also clinical, technological, and business processes that need to be formalized before national implementation. We are working within VA and with external partners to establish technical and clinical care standards. The costs that would result from this proposal are insignificant.

VA similarly does not support the second provision concerning teleretinal imaging. VA has already instituted teleretinal imaging programs in each of the 21 VISNs. While VA's teleretinal imaging program is currently growing by more than five percent each year, we do not want this requirement enacted into law because it is overly prescriptive. Advances in technology or clinical care within the next five years could produce a more effective approach to treatment, so a requirement to expand enrollment in one program that has been superseded by another would run contrary to the best interests of our Veterans. VA estimates this proposal would cost $455,000 in FY 2010 and would have a five-year cost of $2.5 million.

While VA supports the concept of expanding opportunities for medical residents to participate in telemedicine programs and to gain experience in these technologies, we oppose the provision in this bill that would require each facility involved in resident training to develop an elective rotation in telemedicine as it cannot be implemented. The curriculum in medical residency training programs is tightly regulated by the Accreditation Council for Graduate Medical Education, which does not approach specific delivery methods as separate from the scientific curriculum. However, VA does provide opportunities for many residents to participate in telemedicine health care delivery and will continue to do so. There are no significant costs associated with this provision.

VA supports subsection 6(c) concerning enhancements of VERA. In the absence of appropriate VERA incentives to encourage VISNs and facilities to adopt telehealth, the expansion of telehealth can be delayed and in some cases faces disincentives when compared with other means of care delivery. This proposal would expand access to care in areas where telehealth can address unmet patient needs while reducing costs through home telehealth and telemental health. VA estimates no costs associated with this provision.

Section 7 addresses oversight of contracts and fee basis care. From a legal perspective, the provision 7(a) raises issues with regard to prohibited 'bundling' of contracts. 'Bundling' is combining two or more requirements previously performed under separate contracts and thus making it unlikely to be suitable for award to small businesses. Many VA Community-Based Outpatient Clinic acquisitions are set aside for small business. Our interpretation of "consolidate such contracts" would be to make a single contract whenever multiple contracts awarded to the same provider. Upon re-competition, VA would then necessarily advertise that combined requirement and that may make the requirement too large for a small business set-aside. Federal Acquisition Regulation 7.107 includes specific determinations that have to be made, including anticipated cost savings, for bundling that must be made and approved prior to 'bundling' contracts. While this section includes a qualifier, that each VISN "to the maximum extent practicable" shall consolidate such CBOC contracts, if enacted, this section would create a conflict with the bundling rules. Further, we do not believe this provision would result in any significant administration or oversight savings or relief.

Subsections (c), (d), and (e) appear to treat peer review and accreditation as worthy of additional compensation. VA does not support these provisions as we believe our obligation is to ensure Veterans receive the highest possible standard of care, regardless of where that care is provided. Accreditation and participation in peer-review programs are "floor requirements" that every provider should already meet. Moreover, we interpret these provisions as providing the same level of compensation for participation in a peer review program as for obtaining accreditation. This would create a greater incentive to participate in peer review as there are additional costs for the medical practice associated with accreditation that are not present for peer review. VA estimates this section would cost $385,000 in FY 2010, with five-year costs of $2 million, and ten-year costs of $4.6 million.

Section 8 would authorize the use of air transportation when travel by air is the only practical way to reach a Department facility. We believe this criterion is vague and subject to broad interpretation. Even with carefully crafted regulatory implementing language, this criterion could result in substantial confusion for Veterans and VA staff and wide variations in actual benefit implementation and administration. Moreover, the benefit outlined in Section 8 would not be limited to veterans living in rural areas. The cost of implementing Section 8 is also very difficult to calculate since VA does not know how many Veterans, either currently eligible or eligible under the new legislation, might be considered to require air transport. We cannot precisely predict the distances that will be traveled, how often air travel will be required, and any special requirements such as oxygen, gurney, or other special needs that may be necessary during flights. Based on available data and assumptions of usage, we estimate the cost of this provision to be $400 million for the first year, approximately $2.3 billion over five years and approximately $5.4 billion over ten years.

Finally, VA opposes Section 9, which would create a three-year pilot program offering incentives for physicians who assume inpatient responsibilities at community hospitals in health professional shortage areas. VA has no statutory authority to bill third-party payers for services provided to non-Veterans in non-VA facilities. A more practical approach would be to develop agreements with the community hospital to reimburse VA for the care provided by VA physicians to non-Veterans. This would remove the logistical challenges of billing for care not provided in a VA facility, not documented in VA records, and for which no authority or rate exists. However, VA must strongly emphasize that assigning VA doctors to non-VA facilities to provide care to non-Veterans is outside of the scope of our mission to care for Veterans and other eligible beneficiaries. VA is unable to estimate the cost of this section because VA does not currently have authority to treat, bill or collect for care provided to non-Veterans.

S. 801 "FAMILY CAREGIVER PROGRAM ACT OF 2009"

S. 801 is divided into four separate sections. I will address each section separately; however, VA has not yet evaluated the costs of implementing the provisions of S. 801. We will provide an estimate to the Committee as soon as it is completed.

Section 2 would authorize VA to waive charges for humanitarian care provided to caregivers accompanying certain severely injured veterans as they receive medical care. VA does not object to the concept of providing humanitarian medical benefits to caregivers but we must oppose this section. As currently written, Section 2 identifies an extensive list of family members as potential caregivers and provides no criteria regarding the extent or duration of their service to the Veteran. Family caregivers could change frequently and we are concerned that the provision of humanitarian care could become a primary factor in designating a caregiver rather than that person's ability to assist the veteran. Further, language that has historically appeared in VA appropriation statutes (requiring reimbursement for hospital care and medical services provided to individuals who are not otherwise eligible for these benefits) may restrict VA's ability to waive charges as outlined in this provision of the bill. We are also considering the impact of Section 2 on the implementation of the family medical care provisions of the National Defense Authorization Act of 2008 (§ 1672(b) of Public Law 110–181).

Section 3 of S. 801 addresses family caregiver assistance. I have previously discussed the family caregiver provisions of S. 252 and S. 543, which would require the Secretary to conduct pilot programs to assess the feasibility of training family caregivers as personal care attendants. While the eligibility criteria for this section are very similar to those in S. 543, S. 801 differs dramatically from S. 252 and S. 543 because it would establish a program of instruction, preparation, training, certification and ongoing support for designated family caregivers across VA. The mechanics of the program under S. 801 are also different as eligible veterans and their family

member (or other designated individual) would make a joint application to VA which would then evaluate the veteran to identify the personal care services needed by that individual and determine if they could be provided by a family member. The applicant family member is also evaluated to determine the training they would need to provide those services. Unlike S. 252 and S. 253, S. 801 does not address the development of the training curriculum. However, it does distinguish between a family member who provides personal care services and a family member who is designated as the veteran's primary personal care attendant. The agency would be required to provide training, certification, technical support, and counseling to both; however, a primary personal care attendant would also be furnished mental health services, medical care under 38 U.S.C. 1781, respite care and a stipend.

VA strongly opposes Section 3. The same concerns identified in conjunction with caregiver provisions of S. 252 and S. 543 apply here as well. VA currently contracts for caregiver services with various providers and this arrangement is preferable because it does not divert VA from its primary mission of treating veterans and training clinicians. We also would like to reiterate that S. 801 would establish the caregiver program across the agency and we caution against implementing a program of this magnitude without first exploring its feasibility and effectiveness. Should the Committee decide to proceed with a caregiver assistance proposal, we urge you to opt for the program defined in section 209 of S. 252 which would allow VA to conduct a three-year pilot providing assistance to caregivers of TBI patients. Moreover, the concerns that I addressed in discussing Section 2 relative to the large cadre of eligible caregivers would make this proposal challenging to administer and monitor for quality and effectiveness. The administrative burden on VA to re-identify and track caregivers could be considerable.

Finally, S. 801 in general, and Section 3 in particular, would create preferential benefits for one generation of Veterans that are not available to others. VA believes that caregiver assistance would benefit veterans of all ages and periods of service and any initiative to support caregivers should not be limited to post-September 11 veterans.

Section 4 would amend VA's beneficiary travel statute (38 U.S.C. 111) to include lodging and subsistence as travel expenses for attendants of certain veterans receiving VA health care. This provision would also define the travel period to include travel to and from the facility and the duration of the treatment episode. We believe that the proposed amendments would apply to all attendants eligible for beneficiary travel under 38 U.S.C. 111, not just those attendants defined by S. 801. VA opposes Section 4 as this benefit expansion would divert resources from medical care. In addition, 38 U.S.C. 111 already provides travel benefit attendants for severely injured veterans.

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.

ADDITIONAL WRITTEN VIEWS SUBMITTED FOR THE RECORD

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, May 14, 2009.

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

DEAR MR. CHAIRMAN: This letter is in response to your invitation to submit for the record the Department's views on six bills, S. 239, S. 498, S. 699, S. 772, S. 793, and S. 821. As you know, we received some of these legislative items too late to address in testimony before the Committee on April 22, 2009. In addition, while our views remain the same, we are submitting additional information and costs on four bills that were addressed in the April 22 testimony, S. 252, S. 404, S. 423, and S. 801. Thank you for giving us this valuable opportunity to submit our views before the hearing record closes.

S. 239 "VETERANS HEALTH EQUITY ACT OF 2009"

Section 2 of the Veterans Health Equity Act of 2009 would amend 38 U.S.C. 1716 to require the Department to ensure Veterans in each of the 48 contiguous states have access to at least one full-service VA hospital or to comparable hospital care and medical services through contract with other providers in the State. It also requires VA submit a report to Congress describing the extent to which the Depart-

ment has complied with this provision and the effect this requirement has on improving the quality and standards of care provided to Veterans.

While VA supports the intent of S. 239, which we believe is to ensure Veterans access to medical treatment and hospital care in the State of New Hampshire, we are opposed to the bill as drafted because it is vague and confusing. Subsection (b), Rules of Construction, discusses "enhanced care" but does not define this term. Moreover, this provision indicates that subsection (a) should not be construed to prevent a Veteran from receiving care at a VA hospital in another State but subsection (a) addresses only access to care, not the provision of care. Further, subsection (b) is silent about providing out-of-state contract care. This is concerning as many Veterans now obtain nearby services from both VA hospitals and contract facilities across state lines, but would have to travel considerable distances to receive comparable services within their state of residence.

We understand that there is considerable interest in establishing a full-service VA hospital in Manchester, New Hampshire. VA engages in extensive analysis of factors in order to identify appropriate sites for VA health care facilities. These factors include, but are not limited to, projected total Veteran population, Veteran enrollee population, and utilization trends.

To address the needs and concerns of the New Hampshire constituency, VA is providing expanded acute care services to New Hampshire Veterans by means of a contract with a local acute-care facility. This model has been used for nine years to provide VA coordinated care in a safe and cost-effective manner. An expanded contract is now being negotiated that will service additional Veterans who are currently being transferred to other VA facilities.

In evaluating the impact and estimating the cost of S. 239, VA focused attention specifically on the State of New Hampshire. We have assumed that contractor services would be provided in-state. With these parameters in mind, we estimate that the proposal would cost $3.4 million in 2010, approximately $20 million over five years, and nearly $48 million over ten years.

S. 252 "VETERANS HEALTH CARE AUTHORIZATION ACT OF 2009"

VA provided testimony on many provisions of S. 252 for the April 22, 2009, hearing. Below are the views and costs on provisions of S. 252 that were not provided in that testimony.

Subsection 101(f) would amend 38 U.S.C. 7410 to add a new subsection to establish "comparability pay" for VHA non-physician/dentist section 7306 employees and SES employees of not more than $100,000 per employee in order to achieve annual pay levels comparable to the private sector. VA requests that the new administration be given an opportunity to review this matter. The estimated cost would be $10.35 million in the first year, approximately $54 million over five years and $113.3 million over ten years.

Section 101(g) would provide special incentive pay for Department Pharmacist Executives. We expressed support for this provision in VA's April 22 testimony; however, our support is contingent upon finding offsets within the 2010 funding level requested by the President. VA estimates the cost to be $1.44 million in 2010, $7.72 million over five years and $16.85 million over ten years.

Section 103(a) would reinstate the Health Professionals Educational Assistance Scholarship Program and extend it through 2014. VA supports the proposal, contingent upon finding offsets within the 2010 funding level requested by the President. We estimate the cost to be $725,000 in 2010 and $21,380,000 over the five year period.

Section 103(b) would make amendments to VA's Education Debt Reduction Program (EDRP). As the Committee had several questions related to VA's April 22 testimony on EDRP, we would like to elaborate on our assertion in that testimony that section 103(b) can be implemented in a cost-neutral fashion. Specifically, this provision would amend 38 U.S.C. 7683 to increase the authorized EDRP statutory amounts to $60,000 and $12,000, respectively. VA generally awards amounts below the statutory maximum to ensure a greater number of applicants will receive awards. If the award amounts are not limited, fewer applicants will receive them, thus limiting the recruitment benefits of the program. Though section 103(b) raises the maximum award payable under EDRP, VA would continue to implement the program within the existing budget allocation. Currently, $20 million annually is allocated for the program.

Section 206 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 applicant's 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's 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. Moreover, VA will assist veterans who are unable to provide a social security number due to homelessness, mental illness, or other infirmity to gain access to this information. 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 authorizes 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.

There is no permanent provision in title 38 to require the provision of information concerning health insurance coverage. This section would ensure that VA obtains the health-plan contract information.

This legislation would enable VHA to use social security numbers to accurately match an individual's information with both internal and external sources. Consistent with Executive Order 9397, collection of this information is necessary to meet the compelling business needs of the agency. Specifically, social security numbers for veterans, beneficiaries and dependents could be used to match veteran income data with the Internal Revenue Service and the Social Security Administration, allowing VA to carry out its income verification responsibility under 38 U.S.C. 5317 and 5317A. While VHA has obtained verified social security numbers from the vast majority of veterans and spouses through voluntary reporting, there were over 1 million beneficiaries' household incomes in 2008 that VHA was unable to match because the social security numbers had not been provided. Social security numbers are also necessary for data matching with the Department of Defense. Military service data is essential for VHA as medical care eligibility determinations may be based on such factors as qualifying military service and service-connected disabilities. In addition, VHA uses social security numbers to collect health care expenses from insurance companies as most insurance companies use social security numbers to ensure a match. VHA may also obtain or verify individual 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.

Be assured that VA would 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. Enactment of section 206 would require VA to issue an updated notice of privacy practice and review and update all associated information collection forms.

Section 213 would amend sections 5701 and 7332 of title 38, United States Code. The amendments would 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. Given the significant privacy concerns related to this provision, we defer views on this section until further analysis can be made. VA projects revenue from this proposal to be close to $10 million in the first year, $51.4 million over five years, and $113.3 million over ten years.

Section 217 would establish a pilot program on providing dental insurance plans to Veterans and survivors and dependents of Veterans. As indicated in our April 22 testimony, VA opposes this provision. The estimated cost of this pilot is $8 million over three years.

S. 404 "VETERANS EMERGENCY HEALTH CARE FAIRNESS ACT OF 2009"

This bill would expand Veteran eligibility for reimbursement by VA for emergency treatment furnished in a non-VA facility. As discussed in our April 22, 2009, testimony, VA supports this legislation as it would establish VA as a secondary payer thereby fully extinguishing a Veteran's liability to the private provider who fur-

nished the emergency treatment. However, we inadvertently overlooked the absence of a specific amendment to 38 U.S.C. 1725 necessary to fully achieve the purpose of this legislation. Specifically, S. 404 should further amend 38 U.S.C. 1725 by striking subsection (f)(2)(E).

Currently, section 1725 grants the authority to reimburse certain Veterans the reasonable value of emergency treatment furnished in a non-Department facility. To be eligible for reimbursement, among other requirements, a Veteran must be personally liable for the treatment. "A Veteran is personally liable * * * if the Veteran * * * has no entitlement to care or service under a health-plan contract." 38 U.S.C. 1725(b)(3)(B). A health-plan contract includes a State law "* * * that requires owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance." 38 U.S.C. 1729(a)(2)(B); 38 U.S.C. 1725(f)(2)(E). In other words, a Veteran who is emergently treated in a non-VA facility for injuries sustained in a motor vehicle accident is not, pursuant to 38 U.S.C. 1725, personally liable for the cost of his treatment if he is required by State law to maintain motor vehicle reparations insurance. Consequently, this Veteran would not be eligible for reimbursement from VA. To fully achieve the intent of S. 404, language should be added to strike subsection (f)(2)(E) from 38 U.S.C. 1725. This technical amendment would ensure that Veterans required by State law to maintain certain automobile insurance remain eligible for reimbursement for emergency treatment. We estimate the cost of implementing S. 404 to be $500,000 for FY 2010, $3 million over a 5-year period, and $7.8 million over a 10-year period. Note that our support for this provision is contingent upon finding offsets within the 2010 funding level requested by the President.

S. 423 "VETERANS HEALTH CARE BUDGET REFORM ACT "

S. 423 would authorize advance appropriations for three critical medical care accounts of the Veterans Health Administration: Medical Services, Medical Support and Compliance, and Medical Facilities. These are vital accounts that should never fall prey to interruptions of funding. VA shares the President's support for advance appropriations as a way to provide uninterrupted care to our Nation's Veterans.

Implementing an advance funding mechanism is not without challenges, and careful planning is needed to ensure timely funding without unintended consequences. Budget projections are rarely right on the mark, and the further out they are made, the farther off the mark they are likely to be. For an advance appropriations mechanism to function effectively, it must be linked to a forecasting model that is both reliable and accurate, to the extent possible. VA's principal forecasting model is the Enrollee Health-Care Projection Model.

The Enrollee Health-Care Projection Model, or VA Model, is a comprehensive enrollment, utilization, and expenditure-projection model. It was originally developed in 1998 in partnership with Milliman, Inc. Through the past 11 years of periodic updates and continuous refinement, VA and Milliman have developed a strong partnership that has resulted in a powerful modeling tool. VA guides the overall development of the VA Model and ensures that it meets the needs of stakeholders. VA program staff provide expertise on the unique needs of Veterans, patterns of practice in the VA health-care system, and how the system is expected to evolve over the next 20 years. Milliman brings specialized expertise, access to extensive amounts of health-care utilization data, and excellent research to the overall modeling effort.

The VA Model produces multi-year projections to inform the VHA budget process, estimate the impact of proposed policies, and support strategic and capital planning. For each year, the VA Model projects:

- the number of Veterans expected to be enrolled;
- the priority level, age, gender, and geographic location of enrolled Veterans;
- the total health-care demand for enrolled Veterans across 58 health-care services;
- the portion of that care enrollees are likely to receive from VA versus other health-care providers; and
- the expenditures associated with the projected utilization.

The enrollment modeling process begins with comprehensive and accurate Veteran population data developed by VA's Office of the Actuary using a "VetPop" model. The Office of the Actuary projects Veteran populations over 30 out-years using data from the Census Bureau and the Department of Defense, and mortality and supplemental data to develop refined estimates of the current Veteran population and projected future levels. In 2005, independent verification and validation of the VetPop model by the Institute for Defense Analysis found the baseline Vet-

eran population estimate to be accurate in providing baseline estimates broken out by demographic characteristics such as age and gender. Additionally, VA completes a detailed validation annually to assure confidence in the VetPop output. This includes extensive peer review of our methodology and assumptions for parameters as well as of our programs, logs and output lists. All results are examined for consistency and compared with previous data and Census estimates. It should be noted the accuracy of the total Veteran population is unlikely to change significantly over the short term because the Veteran population changes little over the short term. The accuracy of the long-term forecast is largely dependent on the accuracy of the projections of deaths and military separations.

Projections for health-care services VA offers that are comparable to the private sector, including inpatient, surgical, and ambulatory care, are based on private-sector benchmarks, which are adjusted for the demographics of the Veteran enrollee population and the VA health-care delivery system. Private-sector benchmarks used in the VA Model come from the Milliman Health Cost Guidelines, which are updated and expanded annually. These guidelines are a combination of consultants' expertise, research, and actuarial judgment; they also represent the health-care utilization of over 60 million Americans. The guidelines have been validated and used extensively by private-sector health plans. The guidelines also provide extensive information on the impact of age and gender, changes in health-care benefits, and changes in copayments on health-care utilization. The enormous volume of data allows VA to develop projections at a very detailed level. Projections for services that are unique to VA, such as blind rehabilitation, and services where VA has a unique practice pattern, such as prosthetics, are developed based on analyses of historical VA data.

The VA Model is supported by in-depth analyses of VA data, including enrollment rates, enrollee mortality, morbidity, and reliance on VA versus other health-care providers, and VA's level of health-care management. An annual VHA Survey of Enrollees provides data on enrollee insurance coverage, income, period of service, and self-reported health status. The 2008 Survey included new questions developed to identify the key drivers of Veterans' decisions to enroll and use VA health care.

The VA Model uses utilization and cost trends to project modeled services forward 20 years into the future from the most recently completed fiscal year, or base year. Assumptions about future trends are developed by a workgroup of VA staff and Milliman experts on health-care trends. The workgroup reviews VA historical trends and historical and estimated future trends in the broader health-care industry in developing the assumptions. While there are differences between VA's closed-panel, integrated system and the fee-for-service environment in Medicare and the private sector, the broader health-care industry trends serve as a frame of reference for how future changes in the provision of health care will impact VA. These trends include expected changes in medical-care practice and custom. For example, gall bladder surgery is now routinely performed on an outpatient basis, so trends and projections now include a reduction in inpatient surgery utilization rates based on this shift.

The projections are developed at a very detailed level and then aggregated to provide national projections. Projections are developed by 13 priority levels and by five-year age bands. Projections are also developed separately for enrollees who used VA health care before eligibility reform since they have unique demographic and utilization patterns. Geographically, the projections are developed at the sector level, which is the lowest geographic area for which credible projections can be developed at the level of detail used in the model. A sector consists of one or more complete counties and is fully contained within a single submarket. Over 3,100 counties are mapped into 506 sectors. Sector-level projections are then aggregated into 103 submarkets, 80 markets, 21 Veterans Integrated Service Networks (VISNs), and the national level.

The VA Model has evolved significantly since 1998 and continues to evolve. Plans for future model enhancements are developed through an assessment of the predictive capability of various model components or the identification of new data sources. For example, we recently assessed the accuracy of the 2008 enrollment and patient projections from the 2006 Model, which supported the 2008 Budget. The 2006 Model projected Veteran enrollment to within 0.3 percent, or 26,607, of actual 2008 enrollment, while it over-projected patients by 161,166, or 3.3 percent. In the last five fiscal years, the average variance between the VA Model's projection of enrollees and the actual enrollee population was 0.54% under-forecast. In other words, slightly more Veterans enrolled than were projected. In the same five years, the average variance between the VA Model's projection of Veteran patients and actual patients was 1.7% over-forecast. In other words, slightly fewer patients were actually seen in Veterans Health Administration than projected.

Regarding the latest generation of Veterans with service in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or other theaters, VA initially had difficulty modeling this population because we did not have estimates of the total force expected to be deployed in these conflicts. However, since 2007, VA has used a future force deployment scenario developed by the Congressional Budget Office to estimate the number of future OEF/OIF Veterans. We have conducted extensive analyses of the enrollment and health care utilization of this population, and with each additional year of data, we gain more insight into their unique characteristics. The VA Model reflects the fact that OEF/OIF enrollees have exhibited significantly different VA health-care utilization patterns than non-OEF/OIF enrollees. For example, OEF/OIF enrollees have an increased need for dental services, physical medicine, prosthetics, and outpatient psychiatric and substance use disorder treatment. Alternatively, OEF/OIF enrollees seek about half as much inpatient acute surgery care from VA as non-OEF/OIF enrollees.

The VA Model addresses many but not all areas of the health care budget. Approximately 16 percent of VA's health care budget is developed through alternative models and estimates, and each present challenges in projecting future costs.

Long-Term Care (both institutional and non-institutional) estimates are developed in accordance with the VA's Long-Term Care Strategic Plan and historical cost and workload trends. VA will continue to focus its long-term care treatment in the most clinically appropriate and least restrictive setting by providing more non-institutional care than ever before and making more care available to Veterans closer to their homes.

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the Foreign Medical Program, the Spina Bifida Program, and Children of Women Vietnam Veterans estimates are based on the current benefit structure, the mix of users, and workload estimates that reflect historical trends.

Readjustment Counseling estimates reflect historical trends and the establishment of new Vet Centers and provide for the three major functions of direct counseling for issues related to combat service, outreach, and referral.

Non-Veteran health-care cost estimates reflect collateral care, consultations and instruction for spouses, reimbursable workload from affiliates (such as sharing agreements with the Department of Defense), humanitarian care, and preventive health occupational immunizations for VA employees. They are based on historical workload and cost trends adjusted to reflect the current benefit structure.

As noted earlier, while VA's methodology for health-care budget development is sound, we recognize the realities of economic, policy and other uncontrollable factors which alter the requirements for care and the ultimate costs of it. This limitation should be recognized in any proposal to implement an advance appropriations process. Any such proposal should provide flexibility for near-term changes in workload or performance needs.

VA supports the intent of S. 423 and is committed to working with Congress to provide our Veterans with the timely, accessible, and high-quality care that they expect and deserve. We also believe that close consultation between Congress, the Administration, and other stakeholders is necessary to develop the details in overcoming the challenges for the implementation of an advance appropriations proposal.

S. 498 "DENTAL INSURANCE FOR VETERANS AND SURVIVORS"

Similar to the pilot program proposed in section 217 of S. 252, S. 498 would require the Department to provide a dental insurance plan for Veterans enrolled under section 1705 of title 38 and the dependents of Veterans eligible for medical care under section 1781. The bill provides the Secretary the discretion to define the benefits appropriate for such a dental insurance plan and makes enrollment in the insurance plan voluntary. Enrollment would be for a period of time as established by the Secretary, who would also establish premiums adjustable on an annual basis. The legislation would not impact the Department's obligations to provide dental care to Veterans under section 1712. VA opposes this bill as it would establish an entirely new and dramatically different role for VA. The cost estimate for this proposal would be $10 million in the first year, $18 million over five years, and $29 million over ten years. All costs for premiums and deductibles would be borne by Veterans or dependents.

S. 699 "FAR SOUTH TEXAS VETERANS MEDICAL CENTER ACT OF 2009"

The proposed bill would allow the Secretary to carry out the construction of a major medical facility project in Far South Texas consisting of a full service Depart-

ment of Veterans Affairs hospital. The bill authorizes appropriation for fiscal year 2009 such sums as such may be necessary for the project.

VA does not believe that a full-service hospital is the best approach to providing medical care and treatment to Veterans in Far South Texas. VA projections illustrate that this region will see a continued increase in the outpatient workload but low levels of inpatient care. VA's Fiscal Year 2008 Appropriation (Public Law 110–161), included authorization for a Major Lease to construct a build-to-suit Health Care Center (HCC) in Harlingen, Texas, in collaboration with the University of Texas (UT), Harlingen. The HCC will provide primary care, specialty care, mental health services, ambulatory surgery and expanded diagnostics and imaging in approximately a 120,000 square foot facility. Agreements will be made with the local hospital and UT to provide the required inpatient services. VA has entered into a 20-year lease for the HCC pursuant to the authorization provided by Congress.

S. 772 "HONOR ACT"

Section 2 of the Honor Act of 2009 would require the Secretary to establish a scholarship program for qualifying Veterans pursuing a graduate or post-graduate degree in behavioral health sciences. Veterans would qualify for this scholarship if: (1) during service on active duty in the Armed Forces, they served in a theater of combat or during a contingency overseas operation; (2) they were retired, discharged, separated or released from service on or after a date not earlier than August 2, 1990, as specified by the Secretary; (3) at the time of application to the program, they hold an undergraduate or graduate degree that qualifies them for pursuit of a graduate or post-graduate degree in behavioral sciences; and (4) they meet other qualifications as established by the Secretary. The scholarship is to include tuition, reasonable educational expenses, a stipend and an obligation of service to the Department of Veterans Affairs, the Department of Defense, or some combination of both agencies.

This provision links two important but independent concepts: enhancing educational opportunity for returning soldiers and providing mental health care to Veterans. However, it is not clear that linking these two distinct ideas has merit, as the proposed program would entail substantial costs over a long time period while producing few tangible benefits.

It takes an average of two to seven years to become a behavioral specialist suitable for employment in VA. This is a long lead time to wait for behavioral specialists and we have no way of knowing that there will be a need for these behavioral health graduates by the time they complete their degrees. Assuming that each Veteran student already has an undergraduate degree, the time estimates for each discipline are summarized below.

- VA facilities, under the guidance of VHA's Office of Mental Health Services, only hire behavioral health specialists with advanced degrees. In particular, VA relies on doctoral level psychologists, masters level social workers, psychiatric nurses, and nurse practitioners to provide the high quality care Veterans deserve.
- Clinical practice in VA in psychology requires admission into an accredited graduate program, four to six years of graduate education, one year of full time supervised internship before receipt of the doctoral degree, and another year of supervised clinical practice before becoming license eligible in most states. VA estimates the duration of a scholarship is between six and eight years.
- Clinical practice as a masters-prepared social worker would require a two year masters program, followed by clinical experience. VA estimates the duration of a scholarship between two and three years.
- Clinical practice as a master's prepared behavioral health nurse or nurse practitioner requires a one to two year master's program, followed by certification. VA estimates the duration of a scholarship between two and four years.

VA has had success recruiting internally from VA training programs and externally from the private sector for its mental health staffing needs. Over 3,800 additional mental health workers have been hired in the past three years. VA has also developed several successful recruitment resources including expanded funding for mental health training. Seventy-three percent of current VA psychologists participated in VA training programs.

Costs for this proposed program, both direct and indirect, would also be substantial and it is not clear that VA would receive a return on investment from this proposal. Specifically, VA estimates section 2 would cost $5.9 million in fiscal year 2010, with a five-year total of $32.6 million and ten-year total of $65.2 million.

Section 3 of the Honor Act of 2009 would require the Department of Defense to carry out a program to employ and train qualifying former members of the Armed

Forces as psychiatric technicians and nurses. VA defers to the Department of Defense for views on this section.

Section 4 would reinstate provisions originally contained in the initial Vet Center legislation (Public Law 96–22, June 13, 1979) that were repealed in October 1996 (Public Law 104–262). This section is similar to section 402 of S. 252. Reinstatement of these provisions would give Vet Centers the latitude to help Veterans with problematic discharges, deemed by Vet Center staff to be related to war trauma, through referral to services outside VA and referral for assistance with discharge upgrades when appropriate. This provision would give Vet Centers the authority to assist a new generation of combat Veterans in resolving problems with the character of their discharge. VA estimates that the total number of Veterans this section would affect is small, so the costs of the provision would be negligible.

Section 5 would authorize the Secretary to provide mental health services through Vet Centers to members of the regular component of the Armed Forces and readjustment counseling and mental health services to members of the reserve component. It would require any provider who determines the servicemember is a threat to himself or herself or others to notify an appropriate official of a military medical treatment facility, and would require that official to inform the servicemember's chain of command.

VA generally supports this provision as it would augment the existing eligibility for Vet Centers to include active duty and reserve component servicemembers who served in a combat theater of any era. However, we are very concerned by the use of the term "mental health services" in proposed sections (f)(1)(A) and (B) as Vet Centers provide readjustment counseling but do not provide medical services, to include mental health services. Veterans in need of these services are referred to other facilities. We recommend that the proposed subsection (f)(1) be amended to read:

> The Secretary shall, upon the request of a member of the Armed Forces, furnish the member through a center the following:
>
> (A) In the case of a member of a regular component of the Armed Forces, readjustment counseling authorized to be provided under this section.
>
> (B) In the case of a member of a reserve component of the Armed Forces, readjustment counseling authorized to be provided under this section.

By implication the primary target population for Section 5 is OEF/OIF combat Veterans; however, combat Veterans of all eras would be eligible. This provision would promote early access, education, prevention, and services to combat Veterans in a confidential setting that would greatly assist in overcoming the effects of stigma and promote access to care. Vet Centers provide services in a community-based environment that does not carry the stigma sometimes associated with some other mental health or readjustment care. Many servicemembers want to avoid the perception of having a mental illness that could affect readiness and their careers. The Vet Center program promotes early intervention and makes every effort to reduce the stigma of seeking assistance.

This provision would also make confidential Vet Center services available to active duty and reserve component servicemembers through the Vet Center Combat Veteran Call Center being implemented in FY 2009. The Call Center will be staffed 24/7 by combat Veteran peers to provide confidential support and referral information for Veterans and family members regarding the full range of readjustment issues following service in a combat zone.

VA estimates section 5 would cost $3.7 million in FY 2010, with a five-year total of $20.2 million and ten-year total of $44.9 million. Our support of this provision is contingent upon finding offsets within the 2010 funding level requested by the President.

Section 6 would require that the suicide of certain former members of the Armed Forces that occurs during the two-year period beginning on the date of separation or retirement from the Armed Forces be treated as a death in line of duty of a servicemember on active duty in the Armed Forces 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 are "[b]urial benefits," Survivor Benefit Plan benefits under subchapter II of chapter 73, 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 6, 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. It appears that this last provision (subsection (d)(2)) is intended to provide the date of death for determining

the effective date of an award or amount of benefits, although this is not clear from the bill's language. Essentially, under section 6 the suicide of a covered individual would be treated as a service-connected death for VA benefit purposes.

VA does not object to section 6. Because it would essentially deem a suicide under the specified circumstances a service-connected death, it would, for cases falling within its ambit, relieve VA of the administrative burden of having to obtain a medical opinion to determine whether a suicide is due to a service-connected mental disorder. Survivor benefits would be payable based on these suicides the same as they would based on any other suicide that DOD determines was in line of duty. This amendment would facilitate the expeditious provision of needed benefits to Veterans' survivors at a very difficult time in their lives.

However, we would like to note that this provision may have an unintended implication for veterans suffering from depression, PTSD, or other mental disorders. It is conceivable that a Veteran whose judgment is clouded by severe depression could conjecture that more Federal financial assistance would be provided under this provision than he or she could provide alive, and thus might perceive that the Government was offering a perverse incentive to suicide. We ask that the Committee consider the potential risk of this misperception along with the potential benefits of the provision.

We have several technical concerns with section 6. 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 provision's language whether the adjective "combat-related" is meant to modify PTSD and TBI as well as mental health condition. In addition, subsection (c)(1) identifies "[b]urial benefits" as one of the covered benefits, but fails to specify from which Federal department or agency. 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. Furthermore, an ambiguity would remain even if subsection (c)(1) is intended to refer to VA burial benefits. It is unclear whether that term refers only to burial benefits under chapter 23, title 38, United States Code, or includes benefits such as burial in a national cemetery, provided by chapter 24, title 38, United States Code. The bill language could be clarified to address these ambiguities.

Because under current law VA is likely to determine that a suicide under the circumstances described in section 6 is a service-connected death, albeit after more development of the claim, requiring the provision of service-connected benefits, VA estimates no benefit cost associated with this provision if enacted. There also would be no additional administrative costs.

S. 793 "DEPARTMENT OF VETERANS AFFAIRS VISION SCHOLARS ACT OF 2009"

S. 793 would establish a new scholarship program for individuals who are accepted for enrollment, or currently enrolled, in a program of study leading to a degree or certificate in visual impairment or orientation and mobility. In exchange for the scholarship assistance, participants would incur a three year service obligation to the Department to be fulfilled within the first six years after their graduation. The bill would limit to $15,000 the total amount of assistance that a participant who is a full-time student could receive during an academic year. It would establish a maximum cap of $45,000 on the total assistance that VA could provided to any participant. S. 793 would also require the Secretary to establish terms of participation for the program. Participants who fail to meet their service obligations would be subject to repayment terms, as established by the Secretary.

VA appreciates the importance of Blind Rehabilitation Services, as is evident by its investment of $50 million to enhance its nationwide continuum of rehabilitative care for Veterans and active duty military personnel with visual impairments. VHA is the first health care system to completely integrate such services for patients with visual impairments into comprehensive health care benefits. This continuum of care will establish 55 new outpatient clinics targeting those who are beginning to experience functional loss from visual impairment. New programs also include: 22 new Intermediate Low Vision Clinics; 22 new Advanced Ambulatory Low Vision Clinics; and 11 new Outpatient Hoptel Blind Rehabilitation Clinics. The goal of this initiative is to provide rehabilitation services that keep visually impaired Veterans and active duty personnel functioning as independently as possible, and integrated with their families and communities.

The Department is committed to ensuring that appropriate staffing of blind rehabilitation outpatient specialists and visual impairment professionals is maintained to support this important continuum of care; however, VA must oppose S. 793 because it is unnecessary. The Veterans Health Administration (VHA) analyzes data

concerning recruitment and retention of health care disciplines annually. The results of this analysis are published each year in the Succession and Workforce Development Plan. This plan provides a detailed, evidence-based analysis that identifies the categories of health professions that could, or should, be targeted with recruitment or retention incentives, including scholarship programs. As part of the succession planning efforts, VHA has funded technical career field interns in the blind rehabilitation occupation. In 2007, nine interns were funded, in 2008, 20 interns and again in 2009, 20 interns will be funded. We feel continued support in the technical career field program will meet the needs of the Department and the objectives of the legislation. We do not believe creation of an entirely separate scholarship program would be cost effective.

It is also important to note that under the bill participants would be treated far more leniently than participant's in VA's existing scholarship program in the event they breach their service obligations. Participants in VA's Education Incentive Scholarship Program (EISP) risk other forms of liability depending on the type of breach committed by the participant, including failure to accept the scholarship money, failure to complete the program, or failure to obtain licensure. This bill does not address the other scenarios covered under the EISP.

VA estimates the total cost of implementing S. 793 to be $521,000 in fiscal year 2010, $2.72 million over five years, and $5.7 million over a 10-year period.

S. 801 "FAMILY CAREGIVER PROGRAM ACT OF 2009"

VA's opposition to S. 801 was detailed in the April 22, 2009, testimony. The costs for each section of the bill are outlined below.

Section 2 would amend 38 U.S.C. § 1784 to allow for waiver of charges for hospital care or medical services provided to certain family members of Veterans receiving VA health care. We project that this provision would cost approximately $330,000 in 2010, $2 million over five years, and $5.3 million over ten years.

Section 3 addresses family caregiver assistance. VA has identified 65,798 Veterans with a serious injury incurred on or after September 11, 2001, that would be eligible for this program during its first two years. It is expected that an additional 1,440 Veterans would become eligible each subsequent year. VA estimates that this provision would cost $5.056 billion in fiscal year 2010, $26.859 billion over five years, and $62.8 billion over 10 years. Note that these costs do not include Veterans severely injured prior to September 11, 2001, that may become eligible for this program after the first two years.

Section 4, Lodging and Subsistence for Attendants, would amend 38 U.S.C. § 111 to allow for travel, including lodging and subsistence, for the period consisting of travel to and from a treatment facility and the duration of the treatment episode for certain family members of certain Veterans receiving VA health care. We estimate the cost of this provision to be $8.6 million in 2010, $57.7 million over five years, and $163 million over ten years.

S. 821 "PROHIBITION ON COLLECTION OF CERTAIN COPAYMENTS FROM VETERANS CATASTROPHICALLY DISABLED"

This bill would amend 38 U.S.C. 1710 to prohibit a Veteran who is catastrophically disabled from making any payment for the receipt of hospital care or nursing home care provided pursuant to section 1710.

VA has no objection to this proposal. However, we note it is unclear if this proposal is intended to eliminate nursing home co-payments since the legislation refers to only section 1710 of title 38, while authority for VA nursing home care falls under section 1710A of title 38. We believe any co-payment requirements under this provision would remain in place. We further note the bill does not address pharmacy co-payments.

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

Thank you again Mr. Chairman, for the opportunity to provide VA's views on these bills.

Sincerely,

ERIC K. SHINSEKI.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO U.S. DEPARTMENT OF VETERANS AFFAIRS

S. 801

Question 1. In written testimony, the Department expressed concern "that the provision of humanitarian care could become a primary factor in designating a caregiver rather than the person's ability to assist the Veteran." Since the legislation states that the designated caregiver receives waived charges for emergency medical care in the sole instance he or she is accompanying the Veteran, the likelihood of the caregiver receiving health care benefits is very small. Please elaborate as to why VA has a reservation with this provision?

Response. Given the extensive list of persons eligible to be the Veteran's caregiver, the Veteran may elect to designate, or be under pressure to designate, as their caregiver someone who has need for medical care and would benefit greatly from the Department of Veterans Affairs' (VA) providing that care. This person may not be the best choice to assist the Veteran with their daily needs. Moreover, the legislation does not provide for limits on the number of times or how frequently the Veteran may change caregivers. Potentially, a number of persons could receive needed medical care by being designated as caregiver.

Question 2. The Department objects to section 3 of S. 801 because of a concern that it will force VA to create preferential benefits for one group of Veterans. Yet, the legislation allows VA to extend this benefit to "include the largest number of Veterans possible." Please explain, in detail, why the Department raises an objection to this provision?

Response. The number of Veterans meeting the eligibility of section 3 for the first 2 years of enactment is small compared to eligible Veterans from previous generations. VA believes that any program that would benefit one cadre of combat Veterans over another is inequitable, whether for a 2-year period or permanently.

VA has been working on the family caregiver issue for some time and believes that the newly developed Veteran directed-home and community-based service (VD-HCBS) creates a workable infrastructure for family caregivers to be paid for the relevant service they provide. The VD-HCBS program provides Veterans of all ages the opportunity to receive home and community based services in a consumer-directed fashion that enables them to avoid nursing home placement and continue to live in their homes. The VD-HCBS program addresses the home care needs for Veterans of all ages, allowing services to be provided to younger, seriously-injured and Traumatic Brain Injury (TBI) Veterans. This program will also help address the demand for paid family caregivers in a comprehensive and structured manner.

We would be pleased to discuss this program and other alternatives to section 3 of S. 801 with Members of the Committee staff. VA is committed to working with the Congress to create a viable family caregiver program.

S. 734

Question 3. VA's testimony states that section 2 "could result in significantly higher educational awards, but would mean significantly fewer people could participate." According to a March 2009 CRS report, VA currently provides an average of $38,000 per award, which is less than the statutory maximum. Is there a problem with funding the Educational Debt Reduction Program?

Response. Funding for the educational debt reduction program (EDRP) is budget driven. There is always a greater demand for EDRP funding than the amount available through centralized funds. Local leadership has the option to further fund EDRP awards from its own budget, but that allocation is budget driven as well at the local level. EDRP is a reimbursement program, meaning that VA provides awards to employees at the end of the year covering their out-of-pocket payments on their loans. As a result, the amount that is reimbursed to employees each year is limited not only by the amount awarded but also by the amount of loan repayment the employees can reasonably pay themselves. VA generally awards amounts below the statutory maximum to ensure a greater number of applicants will receive awards. If the award amounts are not limited, fewer applicants will receive them, thus limiting the recruitment benefits of the program.

Centrally, $20 million annually is allocated for EDRP. Because the pay-out is over a 5-year period, the amount of funding for new awards authorized each year is approximately $3,000,000 to $3,500,000. This amount is divided among the 21 networks. In addition to these centralized funds, all Veterans Integrated Service Networks (VISN) and medical centers are also able use local funds for EDRP. VISNs and medical centers have already committed $883,918 for fiscal year (FY) 2010 out of their local budgets to support EDRP awards.

In addition, Veterans Health Administration (VHA) is not solely reliant on EDRP and also uses other recruitment and retention incentives as appropriate. For example, in FY 2007, VHA invested over $66 million in recruitment incentives outside of EDRP including over $44 million in retention Incentives and $3.3 million in relocation Incentives.

Question 4. VA's testimony states the following: "EDRP is a reimbursement program, meaning that VA provides awards to employees at the end of the year covering their out-of-pocket payments on their loans. In many situations, employees would be unable to bear the cost of higher per year awards." Section 7683(b)(1) of title 38 provides that "The Secretary may make education debt reduction payments to any given participant in the Education Debt Reduction Program on a monthly and annual basis, as determined by the Secretary." Does this not accord the Department the discretion to determine when such payments are made?

Response. Reimbursements for EDRP are required to be paid after the loan payment is made by the employee, whether reimbursed monthly or annually. With the number of participants and payments being made, monthly reimbursement would be onerous on both the employee (having to provide monthly evidence of loan payment prior to reimbursement) and VA in certifying monthly payments and processing reimbursements. Additionally, as there is no statutory minimum service period for EDRP awards, providing reimbursement at the conclusion of each annual service period improves retention and is a benefit to VA and Veterans served as it encourages employees to remain in service.

Question 5. VA testimony states that funds proposed to be transferred to the Department of Health and Human Services Corps utilization could be better used to support VA's recruitment and retention programs. Please describe in detail the ways in which VA's current programs provide superior financial recruitment and retention incentives to those found in the National Health Service Corps.

Response. It is our understanding that simply providing $20 million in funding to the Department of Health and Human Services (HSS) for use in the National Health Service Corps (NHSC) program will offer no direct benefit or return on investment for VA. VHA health care facilities do not meet the criteria for participation in NHSC as the criteria include accepting Medicare, Medicaid, and indigent patients (not just Veterans as indigent patients). Federal correctional institutions and Indian health care systems are specifically included as eligible in the HSS program language while VHA facilities are not.

The employee incentive scholarship program for current VA employees was designed following the model provided by HHS as was the now inactive scholarship program under title 38 health professionals educational assistance program.

S. 252 includes language that will re-authorize this scholarship provision giving VHA the ability to operate a program similar to the NHSC with a direct service obligation to VA. VA fully supports this provision of the bill.

Question 6. VA's testimony states that section 6(a) is not required because VA is already carrying out a program of teleconsultation for remote mental health assessments. Please provide information that demonstrates that this process is in place at all VA facilities "that are not otherwise able to provide such assessments without contracting with third-party providers or reimbursing providers through a fee basis system."

Response. The provision of mental health services using teleconsultation fits into the uniform mental health services package (UMHSP). The UMHSP ensures that the balance between VA-provided in-person care, telemental health and contracted care is appropriate to ensure the mental health care needs of patients are equitably met. VHA has a nationwide framework whereby telemental health care is provided and VA facilities can adopt this to comply with the UMHSP. In FY 2008, 149 VA medical centers (VAMC) and 353 community-based outpatient clinics (CBOC) were actively using teleconsultation capabilities, with 108 VAMCs and 307 CBOCs specifically providing mental health services. This use resulted in a total of 63,598 telemental health consultations nationally. Additionally, VA has readily available capability to provide this care directly to Veterans in their homes with 781 home mental health teleconsultation visits occurring in FY 2008.

Thus, VA is currently able to substantially meet its telemental health requirements. A current limitation relates to inadequate telecommunications bandwidth and ensuring suitable space for teleconsultation in clinics. These limitations relate equally to any approaches that would seek to contract out telemental health services.

Question 7. VA's testimony states that "VA does not support these provisions as we believe our obligation is to ensure Veterans receive the highest possible standard of care, regardless of where that care is provided." Please explain how fee basis pro-

viders are presently evaluated and how VA ensures that such care is of the highest quality.

Response. VA is committed to assuring the highest possible quality of care for Veterans, regardless of how and where their care is delivered. This means care consistent with evidence-based practices and proper coordination to assure continuity.

VA would like to point out that such challenges are not easily met, in part because of well-recognized barriers to coordination in community practices. Additionally, few community physicians have the infrastructure to electronically capture and report the clinical variables that VA relies on to ensure quality care. Finally, unless a community site meets certain minimal volume thresholds (the statistical rule of thumb is approximately 30 unique cases per reporting period), performance metrics will have too great an error margin to be usable.

Recognizing these challenges, a standard set of quality measurement tools for both fee basis and contracted care is under development. At present, however, because of the wide range of community capabilities, VHA's approach to evaluation is based on contractually mandated performance elements that are tailored to meet specific local requirements. Project HERO, which represents one of VA's first efforts at managing and consolidating contracted care, has allowed us to develop and test combinations of metrics, such as facility accreditation, provider credentialing, access measures, timeliness, patient safety incident evaluation, clinical documentation submission, patient satisfaction, and others. In addition, the parent VAMC currently provides local quality oversight which includes review of selected clinical records, to ensure outside care meets our own standards.

S. 252

Question 8. I appreciate VA's technical comments on expanding authority for the Secretary to move more positions into hybrid status. What is meant by occupations which "would not otherwise be available to provide medical care and treatment for Veterans?"

Response. The statement is related to the availability or ease to hire those who provide medical care to Veterans. Currently, if title 5 occupations are vacant, the facility must go through the process of requesting and waiting for a certificate of eligible candidates from a delegated examining unit, versus immediate recruitment locally. Additionally, pay flexibilities associated with hybrid title 38 makes it easier to pay wages set to be reflective of and competitive with the health care market.

Question 9. In VA's testimony regarding EDRP program, it is noted that "it takes more than six months for employees to become aware of this very helpful recruitment and retention program." How is this program a recruitment tool if your employees are unaware of its existence until more than six months after the beginning of their employment?

Response. The offer of EDRP is explained in the announcement or advertisement posted for eligible positions. Many times new employees, coming on board, may have overlooked the information or not fully understood requirements to immediately apply and fill out the paperwork. The way the program is structured now, if the application for EDRP is not submitted within the first 6-months of employment, they lose their eligibility. This rule also does not allow for flexibility in using the EDRP as a retention tool. If a practitioner, who may have a student loan, is planning on leaving employment and was not offered EDRP when hired, it can be offered to retain the employee. As the statute is written now, it does not allow for use for retention of employees.

Question 10. According to VA's testimony, section 302 is "unnecessary" because VA initiated a planning and implementation program in September 2008 to evaluate and enhance the care of women Veterans. Please provide the Committee with a copy of this plan.

Response. The Women Veterans Health Strategic Health Care Group (WVHSHG) developed a women's comprehensive health implementation planning (WCHIP) tool to assist facilities in analyzing their own current health care delivery for women Veterans and plan for care delivery enhancement. Every facility was requested to put together a multidisciplinary planning and implementation team to address comprehensive primary care for women Veterans.

The WCHIP tool outlines a "care gap" analysis, a market analysis, and a needs assessment, which facilitate the development of a business plan. This plan includes resource needs, goals, timelines, budgets, training needs and program evaluation metrics to deliver comprehensive health care to women Veterans.

A final facility-based implementation plan based on a completed WCHIP tool is due to the Deputy Under Secretary for Health for Operations and Management by

August 1, 2009. VA will provide the Committee with a copy of that plan when it is available for release.

Question 11. VA's testimony argues against section 304's requirement for staffing standards, noting that retaining the flexibility for staffing related determinations "is essential to permit VA and individual facilities to respond to changing needs and available resources." How often do individual VAMCs conduct evaluations of staffing needs regarding mental health professionals working with Veterans who experienced MST?

Response. In response to the issuance of the Uniform Mental Health Services Handbook last year, VAMCs are currently evaluating their staffing needs and programming related to a wide variety of mental health services, including care for conditions related to military sexual trauma (MST). More broadly, assessment of staffing needs occurs on an ongoing and as needed basis, depending on local needs and resources.

The Office of Mental Health Services' MST support team also issues an annual report summarizing the number of Veterans screening positive for MST at each VA facility and the amount of care they subsequently receive for conditions related to MST. Facilities are instructed to use these data to assess the adequacy of their current staffing and services.

Question 12. What specialized training do mental health care professionals receive regarding MST? The testimony refers to annual four-day training provided to 30 clinicians. Who are the 30 clinicians, and how are they selected to receive this training?

Response. On a monthly basis, the MST support team hosts the MST teleconference training series, which cover a variety of topics related to MST. Typically, around 120 telephone lines are used, often with more than one listener on each line. Recent topics have included overviews of several commonly used evidence-based treatment protocols.

The MST resource homepage is a Web site that serves as a clearinghouse for a variety of MST-related resources such as: patient education material; sample training presentations, provides educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. The Web site hosts discussion forums that allow providers to share information and engage in conversations related to screening and treatment of MST.

Another major training resource available to VA staff is an independent study training course on MST developed by the Veterans health initiative.

Information on MST has been included in each of the national rollouts of evidence-based therapies conducted by the Office of Mental Health Services. The MST support team encourages MST coordinators to attend this training.

Finally, the MST support team hosts an annual, multi-day training program focused on providing clinical care to MST survivors and MST-related program development. During the first 2-years of the training, attendees were MST coordinators selected by VISN leadership based on the training needs of the VISN. Each VISN had at least one attendee. This year the number of trainees will be expanded to 50. Each VISN will now have two attendees, some of whom may be clinicians only. As in previous years, a number of slots will be available for staff from Vet Centers.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO DR. GERALD M. CROSS, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Women Vets – Study

Question 1: Dr. Cross, in your testimony, you stated that the VA does not think it is feasible to implement Section 101 of my Women Veterans Healthcare bill (S.597), which calls for a comprehensive assessment on barriers to care for women veterans, until the VA has completed and fully analyzed its own National Survey on Women Veterans. Can you tell me when you expect the National Survey to be fully analyzed?

Response: Because the Department of Veterans Affairs (VA) is very committed to addressing barriers for women Veterans accessing services, VA supported a large scale survey of 3500 women Veterans in 2007. This telephone-based survey included women who use VA for health care services and many who do not. This national survey of women Veterans was completed on September 1, 2009, and is being reviewed within the Veterans Health Administration (VHA). This survey addresses issues of barriers to care, how women Veterans access all health care, and their needs and perceptions of VA health care. The initial analyses and review will require approximately 90 days.

Women Vets – Plan to Improve Services

Question 2: Dr. Cross, you stated in your testimony that the VA initiated a planning and implementation program in September to improve the provision of healthcare services of women veterans. Can you tell me how this plan to improve services will work when you haven't even completed the National Survey on Women Veterans?

Response: Following the guidelines set forth in the *VA Under Secretary's Report on the Provision of Primary Care to Women Veterans* (November 2008), VHA evaluated health care for women Veterans at every VA medical center including community based outpatient clinics (CBOC), and developed improvement plans with full resource requests. These plans were submitted to the Veterans integrated service networks (VISN) and the Assistant Deputy Under Secretary for Health Operations and Management in August 2009. Based on an analysis of these plans, resources for fiscal year (FY) 2010 will be distributed to the field facilities. Mechanisms are currently being developed to launch evaluation of this rollout, including tracking and accountability for resources. In addition, results of the national survey of women Veterans will guide further strategic planning and development of services for women at the facility level.

Women Vets – Assessment on Services to Women Vets

Question 3: Dr. Cross, you stated that the VA will only support Section 102 of my Women Veterans Healthcare bill, if the mandated follow up plan to improve the provision of healthcare services for women was done by a contractor entity. Can you tell me why you have conditioned your support of this provision in this way?

Response: VA believes the expertise needed for such work is best accomplished by a contractor who has the requisite training and support staff. The evaluation will include a national assessment of services to women Veterans, and will require a cadre of staff to conduct the assessment. The reliability and validity of this evaluation is enhanced by having expert, independent personnel through the contract process.

Women Vets – Child Care Pilot

Question 4: Dr. Cross, you stated that the VA opposes the provision in my women veterans' bill that would authorize a two year pilot to subsidize the cost of child care for a limited number of qualified veterans. The rationale you gave was that the pilot, which would cost $3 million over two years, would divert resources from medical care. Even if you buy into this flawed zero-sum game logic - which I don't – the VA's simple opposition to this provision completely ignores the fact that the lack of childcare is a significant impediment to veterans receiving critical healthcare services. Dr. Cross, if you knew that the funding of this pilot program would not divert resources from medical care, would you then support the creation of this child care pilot, or is there some other reason behind the VA's opposition to the childcare pilot that is not included in your written testimony?

Response: Our concern of diverting resources from medical care is not as much an issue of financial concern, but rather our ability to ensure we devote our attention to those barriers that have the greatest impact to Veteran's access, including women Veterans. VA remains committed to addressing all types of barriers that could keep Veterans from accessing health care services. Our current focus has been to eliminate geographic barriers for rural Veterans through the expansion of outpatient clinics, telehealth programs, and mobile clinics.

GPE Transfer Provision

Question 5: Dr. Cross, you are opposing Section 404 of S.252, which would transfer $5 million to set up a special component of the HHS Graduate Psychology Education Program to train psychologists in the treatment of Veterans with PTSD, TBI and other combat-related disorders.

> "Our intention is to strengthen the safety net for Veterans and their families in underserved areas – folks who will be seen in community health centers and other community based clinics, in non-VA programs. Last year's well publicized RAND study on the invisible wounds of war concluded that "a major national effort is needed to expand and improve the capacity of the mental health system to provide effective care to service members and veterans. The effort must include the military, veteran and civilian health care systems, and should focus on training more providers to use high-quality, evidence- based treatment methods and encouraging service members and veterans to seek needed care."

Doesn't the VA have an obligation to spend a modest amount to help train psychologists who will unavoidably be treating veterans in the civilian care setting?

Response: VA does fully recognize the need for enhanced psychology training and VHA has taken significant internal steps to expand psychology internship and post-

doctoral training opportunities. As of FY 2008, training opportunities have been expanded by 160 positions for a total of 635 funded training positions in psychology. The $5.3 million cost of this expansion will recur annually; all newly funded positions in FY 2008 were also funded for FY 2009, and are anticipated to be funded in FY 2010. VA continues to explore mechanisms for expansion of psychology internship and post-doctoral fellowship training to focus on VA identified areas of critical importance in keeping with the Secretary's and the President's transitional goals for VA. These will include efforts to train psychologists for effective functioning within interdisciplinary health care teams in primary care, supporting the medical home model, and efforts to expand training to include greater focus on needs of and services to Veterans in rural settings. Many graduates of VA Internship training programs do not become VA employees and instead choose to practice in community settings.

VA recognizes that there are training needs at the graduate level that would better prepare psychology graduate students for VA internships and post-doctoral fellowships, as well as eventual VA employment. However, rather than fund graduate programs indirectly in a manner that would not necessarily result in Veteran-relevant, high quality curricular changes, or increased numbers of VA qualified psychologists, VA will work to support initiatives that result in direct benefits for Veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO DR. GERALD M. CROSS, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1: Mr. Cross, in your testimony, you state that the VA already has authority to contract for outreach services that Senator Feingold and I are looking to support through the pilot program we developed in Section 211 of Chairman Akaka's legislation S.252. Can you tell the Committee how many times in each year 2003-2008 the VA contracted with outside organizations to provide one or more of the outreach services described in Section 211 to service members, veterans, or their families? Please describe the type of outreach services and who the work was contracted to. What number of veterans was contacted through this work?

Response: Although VA has the authority to contract for outreach services, we have not exercised that authority. VA appreciates the support provided by this bill for contracting outreach services, and the flexibility to enhance its alternatives in this manner. However, the expansion of the Vet Center program over the last 2 years, and ongoing into FY 2010, will provide for the additional outreach capacity needed to assure early access to care for the new generation of combat veterans. Starting with 209 vet centers in 2006, VA currently has 232 vet centers, and is projecting a total of 299 vet centers by the end of FY 2010. Additionally, vet center outreach services are provided primarily by combat Veteran peers, resulting in immediate rapport with fellow Veterans and relaxation of the stigma characteristic of combat Veterans. Since the beginning of hostilities in the Middle East, the vet centers have provided outreach services to over 285,000 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans.

Section 211 addresses using community-based organizations and local and State government entities in the following areas:

"(1) To increase the coordination of community, local, State, and Federal providers of health care and benefits for Veterans to assist Veterans who are transitioning from military service to civilian life in such transition";

Vet centers are community–based facilities, designed by statute to provide outreach and readjustment services to combat Veterans and family members. Successful accomplishment of this mission requires vet centers to develop partnerships with other community agencies to provide education about combat Veterans' post deployment service needs, and to establish referral linkages throughout the community via local, county, State and other community organizations and Veteran service organizations.

Vet centers also partner with State National Guard Adjutant General Offices and Reserve component units. Since the onset of hostilities in Afghanistan and Iraq, the vet centers have provided substantive outreach services to over 285,000 OEF/OIF returning combat Veterans and counseling services to over 95,000 within the vet centers.

"(2) To increase the availability of high quality medical and mental health services to Veterans transitioning from military service to civilian service life";

Vet centers have contracts for fee programs with mental health centers, private sector mental health agencies and qualified mental health professionals for the direct provision of readjustment counseling and mental health services. Readjustment Counseling Service (RCS) contract programs are located to promote access to services for under served Veterans living in more rural areas. RCS has approximately 175 active contract programs that served over 4,000 Veterans in FY 2008. Veterans' family members can also be referred to contract providers when essential for the Veterans' readjustment. Vet centers also refer thousands of Veterans each year to VA medical facilities for medical and mental health services.

"(3) To provide assistance to families of Veterans who are transitioning from military service to civilian life to help such families adjust to such transition";

Vet centers serve families for war-related problems that impair the Veteran's readjustment. Within the vet center mission, family adjustment is considered central to the Veteran's readjustment. All vet centers have the capacity to provide family members with education about combat related readjustment problems, and to conduct family assessments and referrals. Those vet centers with a qualified family counselor on staff provide family readjustment counseling. In FY 2008, vet centers provided family services to 12,466 Veterans and 120,487 visits.

"(4) To provide outreach to Veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs".

Vet centers are actively involved in providing outreach services to inform Veterans about available services and promote early access to care. Vet center outreach is primarily a Veteran peer activity that helps to overcome the stigma common to combat Veterans. The *New England Journal of Medicine* (July, 2004) published an article by Charles W. Hoge et. al. on OEF/OIF warriors while on combat duty status. The study

researched the reporting mental health symptoms and barriers to their accessing mental health care. In the study, these Army researchers identified a substantial number of Veterans who had mental health symptoms and reported that they would not access care due to the stigma of receiving mental health services. The self perception is that accessing mental health services will affect active duty military status/job, is contrary to the warrior ethos of self reliance/readiness and that they would be labeled as weak, sick, or "crazy." The effects of stigma are well documented in the research and the Vet Center program is VA's response to providing access to confidential care in a safe setting by peer services. Vet center OEF/OIF Veteran outreach specialists attend every post-deployment health reassessment (PDHRA) event, and meet returning Veterans at Active, Military demobilization, National Guard and Reserve sites some of which are coordinated via the VHA OEF/OIF Outreach Office. Vet centers also provide outreach services at all community events frequented by Veterans and family members such as the Yellow Ribbon programs and other activities. Since the beginning of hostilities in the Middle East, the vet centers have provided outreach services to over 285,000 OEF/OIF Veterans. Vet centers do not contract for outreach services.

Question 2: Mr. Cross, can you tell me how many full time staff the VA has that focus solely on outreach to veterans, service members, or their families? Can you tell me what numbers of veterans were contacted through this work in years 2003-2008?

Response: VHA does outreach through a variety of programs and facilities. We are unable to quantify the number of full-time staff dedicated to this mission since it is decentralized throughout the organization. VHA does have an OEF/OIF Outreach Office with 11.0 full time employee equivalent (FTEE) dedicated to VHA outreach initiatives.

VHA's Health Resource Center (HRC) took over activities from the previous contractor and now provides support for the combat call center initiative which began in May 2008. The HRC has 15.0 FTEE assigned that focus solely on outreach to Veterans, service members, or their families. The primary objectives of the call center initiative was to inform Veterans about VA benefits and services and offer assistance where needed with VA-related issues. Call center statistics are listed below:

- Called 676,093 Veterans
- Made contact with 504,189 Veterans
- Spoke with 165,094 Veterans
- Sent 36,651 information packages to Veterans

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO DR. GERALD M. CROSS, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1: In your testimony, you state that the VA administration DOES not OPPOSE, Section 2 of S.658 (Rural Veterans Health Care Improvement Act of 2009), a provision that establishes the beneficiary travel allowance for mileage at a rate of 41.5 centers per mile. You state legislation is unnecessary because Public Law 110-387 gives the VA Secretary authority based on availability of funds, to prescribe a rate higher than the federal employee rate. Given this fact(s), the rate never changed between 1977 and 2007, and was only raised after Congress pushed the VA to do

it...*without legislation (if left to the Administration) how would you ensure rate increases are provided in a timely, responsive manner without prompting from Congress?*

Response: VA remains committed to providing the best medical care available to our Nation's Veterans including assisting eligible Veterans in offsetting their travel costs when receiving VA authorized health care. We understand the unique challenges that travel presents to Veterans and that it is often noted as a significant barrier to receiving quality and timely VA health care. The challenges VA faced in raising this rate were due in large part to the fact that beneficiary travel funding comes directly from the medical care appropriation and must compete with VA's direct delivery of medical services to Veterans. We appreciate recent Congressional support in providing funding specifically targeted towards furnishing a greater travel reimbursement for Veteran travel. The increased visibility of this program, combined with VA's expanded emphasis on delivery of care to rural Veterans will help to ensure a continued focus on the beneficiary travel program. VA is committed to continually review and adjust this rate based upon changes in the cost of travel and availability of VA's appropriations to ensure our Nation's Veterans are appropriately reimbursed for their travel expenses while helping to assure their access to VA health care.

Question 2: The VA OPPOSES my legislation to create Centers of Excellence and Demonstration Project stating they are duplicative of services and projects previously/already established by VA. Frankly, I have never been able to get a clear explanation of what the VA is doing. I have repeatedly asked for a breakdown of how demonstration project money is being spent, yet have never received an answer. Additionally, we have not seen an explanation of how dollars are being spent, no evidence that the VA's current research centers are providing any material benefit to the VA. *Would you care to comment further on these matters? Will you commit to provide me a detailed briefing within the next 30 days on where and how this money is being spent?*

Response: VA understands "Centers of Excellence" to be a network of health care facilities selected for specific services based on criteria such as experience, outcomes, quality, efficiency and effectiveness. The "Centers of Excellence" proposed in this provision are duplicative of the Veterans Rural Health Resource Centers (VRHRC) established by the Office of Rural Health (ORH) in 2008. VRHRCs were established to create regional satellite offices to support ORH and VHA efforts to enhance health care delivery to Veterans residing in rural and highly areas. The vision of the VRHRCs is to become nationally recognized collaborative centers focused on improving access and quality of care for rural Veterans, as well as premier centers for the dissemination of information that impacts the health of rural and highly rural Veterans.

The VRHRCs have four primary functions:

1) Conduct policy-oriented studies and analyses on rural issues, synthesize the results into reports that are easy to understand by both technical and non-technical policy audiences, and develop and disseminate products in consultation with the ORH.
2) Develop and execute pilot projects based on studies and analysis findings and field based requests. This includes providing consultation and technical

assistance to the field to develop additional pilot projects, as well as oversight of projects and reporting of outcomes. Support extends to all VISNs within their region, and may include collaboration at the National level.

3) Serve as regional rural health experts to organize and facilitate execution and dissemination of ORH efforts, engage other VHA entities in rural activities, consult as rural health experts, and share information within and *across* VISN boundaries.
4) Serve as a repository for rural information and facilitate information dissemination at both the identified region and National levels.

ORH selected three VRHRCs based on the research proposals, business plans, program portfolios, capabilities, organizational arrangements and budget submitted as part of the VRHRC selection process. The three selected sites, and their respective VISNs, are listed below:

- Western Region, based in Salt Lake City, Utah, covers VISNs 18-22.
- Central Region, based in Iowa City, Indiana, covers VISNs 11-12, 15-17 and 23.
- Eastern Region, based in White River Junction, Vermont, covers VISNs 1-10.

The attached map illustrates how the three centers divide the country regionally and provides further detail on exactly which States (or portions of a particular State) are covered by each VRHRC.

The projects conducted by VRHRCs cover a wide range of health care issues relevant to rural and highly rural Veterans, including access, quality, collaboration strategies, telehealth and technology, education and training, mental health, workforce and long-term care, which are broken into three types of categories: studies and analysis, pilot projects, and dissemination and educations. Appendix A, attached, provides a list of current VRHRC projects by region. Some sample expected outcomes include:

- Identify opportunities for the VA to improve on aspects of the patient centered medical home model that are not currently being addressed in order to influence the development of additional policies to benefit rural Veteran populations.
- Improve care for rural Veterans suffering from diabetes, hypertension, or chronic pain.
- Determine methods to improve the rates of colon cancer screening for rural Veterans and provide a tested model for other clinics to follow.
- Improve care to Vietnam-era Veterans through development of a "best practices" manual outlining the most efficient method for locating and maintaining contact with Veterans living in rural towns and communities.

The budget of each VRHRC is approximately $2 million annually and each year the VRHRCs develop a portfolio of projects that is reviewed to ensure proposed projects meet ORH's goals.

Question 3: Again, the VA OPPOSES my legislation that would provide mental health support to veterans in rural areas stating it would be duplicative and "blur the distinction between the readjustment counseling services and mental health services currently provided by the VA." I strongly support continuity of care provided by the VA, and would prefer that the VA would provide these services, however, reality in rural areas – is

different. There is a clear need for a "surge capacity" of providers, fellow veterans and anyone else who is capable to lend a hand to help veterans in need. We should be using every possible tool in the toolbox. There are only two Veterans Centers in Montana – a state equal in size to the entire Northeast corridor. *How would you propose we adequately reach these veterans based on the current lack of services and providers in Montana?*

Response: VA and ORH remain committed to increasing access to health care for our Nation's Veterans. ORH is currently working with and will support the Office of Mental Health Services in the execution of Public Law (P.L.) 110-387, which specifically requires the implementation of a pilot program to address peer outreach services, peer support services (including mental health services) and readjustment counseling.

In May 2009, as part of the execution of P.L. 110-329, appropriating $250 million to support the establishment and implementation of new rural health outreach and delivery initiatives for Veterans in geographically remote areas, ORH awarded the following programs, which will increase access to mental health care for rural and highly rural Veterans in Montana:

- *VISN 19 Primary Care for Rural Veterans Telehealth – Outreach Clinic Expansion Initiative*. This project will establish several primary care telehealth outreach clinics that will provide primary and mental health care, among other services, via telehealth technology to eligible rural and highly rural service area populations. One clinic will be located in Northeast Montana, and another clinic will be located in Hamilton, Montana, both operating under the Montana Healthcare System. ORH awarded $7.3M to this project.

- *VISN 19 General Telehealth – Specialty Services*. This project will expand care coordination general telehealth tele-specialty services to rural and highly rural Veterans by collaborating with existing facilities across VISN 19, including Montana. Services will include telemental health care with an emphasis on post-traumatic stress disorder (PTSD). ORH awarded $3.7M to this project.

- *VISN 19 Extended Education and Wellness Strategies for Veterans in Rural Communities*. This project will use telehealth technology to expand access to and continuity of care for rural and highly rural Veterans with chronic conditions, including depression and PTSD, throughout VISN 19, including Montana. ORH awarded $1.7M to this project.

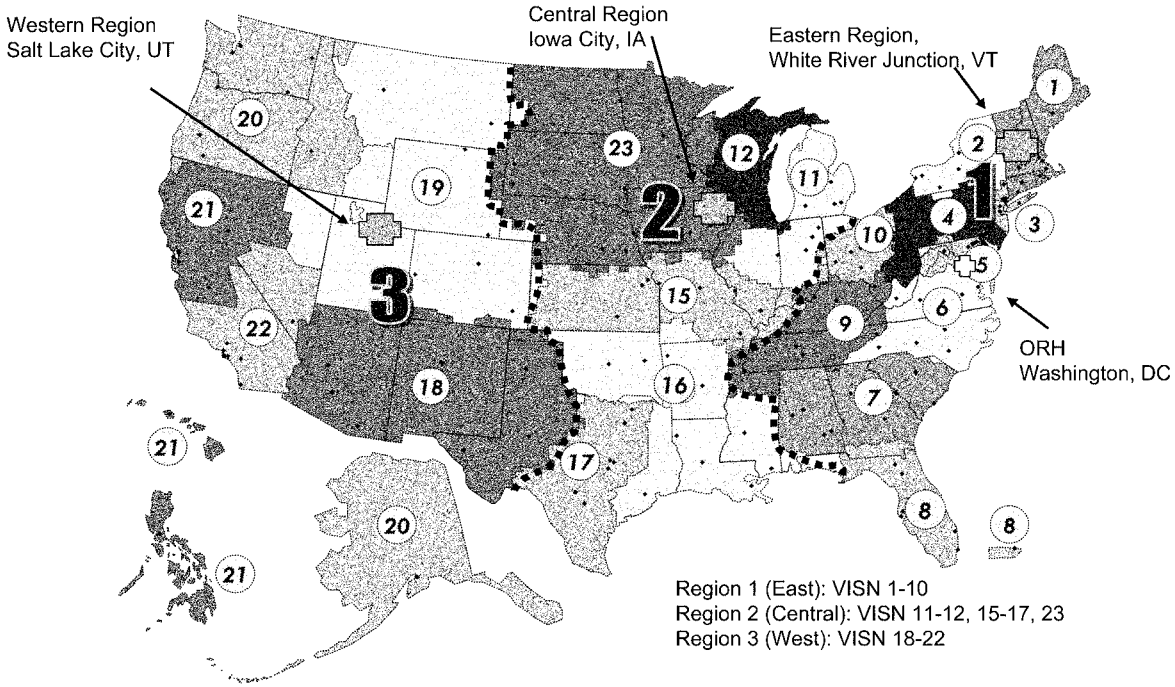
In addition, ORH awarded $5.5M for a nationwide mental health initiative with VA's Office of Mental Health Services (OMHS). This project, *Community-Based Mental Health Services for Veterans in Rural Areas*, will expand intensive case management services for Veterans with serious mental illness and outreach services for homeless Veterans living in rural and highly rural areas. The project marks an expansion and integration of VA's existing *Rural Access Network for Growth Enhancement (RANGE)* program, the health care for homeless Veterans programs, and the collaborative Department of Housing and Urban Development and VA Supportive Housing (HUD-VASH) program. OMHS is selecting sites to execute this initiative.

In addition to initiatives being taken by ORH in collaboration with VA Mental Health, VA is implementing a Vet Center program expansion to establish 39 new vet centers by the end of calendar year 2009. The criterion used for selecting the new sites was Veteran population. The primary objective is to ensure that all counties nation-wide having a population of 50,000 or more Veterans have at least one vet center. No county in Montana met the Veteran population threshold of 50,000 for a new vet center. However, VA has conducted another assessment to determine how to provide services to Veterans in less densely populated areas, to include two locations in rural Montana. VA plans to establish two new vet centers in Montana in 2010, one in Flathead County and the other in Cascade County.

VA has also deployed a fleet of 50 mobile vet centers nation-wide to strategic vet center sites throughout the country. The two existing Montana vet centers, located in Missoula and Billings, have each been assigned one of the 50 vehicles. The placement of the 50 mobile vet centers was designed to cover a national network of designated Veterans service areas (VSA), and not to augment the services at any particular vet center. Every county in the State will be covered by the VSA of one of the two mobile vet centers assigned to Montana. The mission of the vehicles will be to promote outreach to hard-to-reach Veteran populations and ease of travel to outlying outreach events.

In addition, the two Montana vet centers together have a total of nine contracts with private sector readjustment counseling providers. The Missoula Vet Center has nine readjustment contract providers located in the following communities: Hamilton, Great Falls, Kalispell, Thompson Falls, Polson, Libby and Anaconda/Butte. The Billings Vet Center has contracts with a provider in Bozeman/Belgrade and in Miles City with Eastern Montana Mental Health. The latter contractor has 12 additional satellite locations located in Glendive, Colstrip, Forsyth, Sidney, Glasgow, Plentywood, Scobey, Wolf Point, Backer, Malta, Broadus, and Poplar.

Location of VRHRCs



Note: The color scheme is only used to illustrate the VISN boundaries.

Appendix A: Veterans Rural Health Resource Centers (VRHRC) Project Summaries

Eastern Region

Longitudinal health-related quality-of-life and survival among rural versus urban Veterans (ER-1) – Amy Wallace MD, MPH, White River Junction (WRJ) Veterans Affairs Medical Center (VAMC) and Dartmouth Institute for Health Policy and Clinical Practice (DIHPCP)

Using data from the survey of health experiences of patients (SHEP) for 2002 to 2006, investigators will examine rural/urban disparities in SF-12 health related quality of life scores among VA users. It is anticipated the work will contribute to the understanding of findings from earlier work. Investigators will employ three methods of analyses:

a) Sequential, cross sectional, unadjusted comparison of rural to urban results. This is most meaningful for VAMC managers, who must treat all comers, and for policymakers who might consider revision of Veterans equitable resource allocation (VERA) to accommodate health care needs, as reflected by health related quality of life scores.
b) Sequential, cross sectional, adjusted comparison of rural to urban results. This is most meaningful for researchers who want to know, after adjusting for differences in demographics of rural and urban Veterans- who might have different ages, rates of employment, and imputed incomes: Is rural dwelling status independently associated with lower (worse) health-related quality-of-life scores?
c) Longitudinal analysis. By chance, a number of rural and urban Veterans were repeatedly sampled over time. We will use repeated measures analysis to determine whether any disparities we see are changing over time, within a cohort of rural and urban Veterans and to compare the risk-adjusted survival rates of rural and urban Veterans.

Examination of VA's urban/rural/highly rural designations (ER-2) —Alan West, PhD, WRJ VAMC and Dartmouth Medical School

The goal of this project is to develop a crosswalk that assigns each ZIP code in the file to an urban, Rural, or highly rural designation based on frequency of occurrence, comparing the urban/rural/highly rural system to other commonly used urban – rural classification systems, such as the rural urban commuting area system. Using planning systems support group (PSSG) most recent geo-coded Veterans Health Administration (VHA) enrollment file (for the end of fiscal year (FY) 2007), a crosswalk will be developed assigning each ZIP code in the file to an urban, rural, or highly rural designation based on frequency of occurrence; followed by an assessment of how accurately this ZIP code based approximation assigns enrollees to PSSG's original designations. This project will also explore the implications of the dispersion of enrollees among categories for developing rural health care policy in different Veterans Integrated Services Network (VISN), specifically, assessing whether urban, rural, and highly rural enrollees differ with respect to other demographics in addition to travel times to VA care.

Health care utilization and costs of VA patients in national surveys of the general population (ER-3) —Alan West, PhD, WRJ VAMC and Dartmouth Medical School

This study is a follow-up to a recently completed Health Services Research and Development (HSR&D) grant to study health care use and costs in 9 recent years of medical expenditures panel survey data, comparing Veterans who use any VA care to other Veterans or non-Veterans nationwide. It will focus on time trends since the beginning of VA's reorganization, assessing changes in Veteran reliance on VA versus non-VA care, and consider differences related to the type(s) of care obtained, health care insurance coverage, and urban versus rural dwelling. The study will elaborate on a preliminary finding that rural Veterans younger than 65 have become increasingly reliant on VA care, more so than other Veterans, and this greater reliance is related to having less private insurance coverage. The study is a retrospective cohort study of survey data related to longitudinal patterns of utilization behavior, insurance coverage, rurality of residence, and other covariables of interest.

Rural Veterans' perceptions of access to care (ER-4) — Pamela Lee, PhD, WRJ VAMC and Dartmouth Medical School

This project includes a survey of rural Veterans and focus groups with VA personnel. In a collaboration with co-investigators from Claremont Graduate University, we are interviewing rural Veterans to understand how far they travel to obtain either VA or non-VA medical care, how their travel burdens may vary with age, income, and health condition, how they perceive or experience obtaining health services through information technology media (i.e., Internet, telephone), and their willingness to adopt new technologies to help overcome spatial barriers. Researchers are also conducting focus groups with VA personnel for their perspectives on the use of information technology to access health services and the potential for new technologies to mediate barriers related to access to health services.

Telephone care as a substitute for routine psychiatric medication management (ER-5) —Amy Wallace, MD, MPH, WRJ VAMC and DIHPCP

Through an HSR&D funded investigator-initiated research (IIR), researchers are nearly finished conducting a randomized, controlled trial of telephone versus routine care in psychiatric medication management to answer the following questions:

a) Does substituting brief, scheduled, clinician-initiated telephone calls (telephone care) for routine psychiatric medication management visits reduce overall health care utilization?
b) Is substituting brief, scheduled, clinician-initiated telephone calls (telephone care) for routine psychiatric medication management visits as effective as routine care?

Clinical practice intensity: comparing VA to private sector physicians in rural and urban settings (ER-6) —Brenda Sirovich, MD, MS, WRJ VAMC and Dartmouth Medical School/DIHPCP

Medical practice patterns vary widely across the U.S. Extensive work using Medicare claims has shown many-fold variations in the use of specific services and procedures between different, even neighboring communities. Underlying the wide variation is a poorly understood characteristic called clinical practice intensity – the tendency of individual providers to order tests, referrals and treatments. Practice intensity is important not only because it is a powerful determinant of health care costs, but also of health care outcomes. VA in particular needs to understand practice intensity. Because resources are constrained relative to the private sector, there is reason to believe VA providers may behave differently. This study will survey VA physicians about practice intensity using standardized clinical vignettes, and to assess their perceptions of their practice environment. We will expand a currently funded HSRD IIR which aims to describe VA primary care physicians' practice intensity and assessment of their VA practice environment by comparing practice intensity and assessment of practice environment between VA physicians and their private sector counterparts across rural and urban practice settings.

Ethics of rural health care practice (ER-7) —Alan West, PhD, WRJ VAMC and Dartmouth Medical School

There are special ethical considerations inherent to clinical practice in closely-knit, tightly interdependent rural communities. Ethical issues are especially relevant when the health issue is stigmatizing, as is the case with mental illnesses, drug abuse disorders, and infectious diseases. Solutions for complex ethical dilemmas in a rural context may differ from those derived in urban areas where more diverse health resources permit greater role separation and clearer personal and professional boundaries. Resources and training for rural clinicians confronted with complex ethical dilemmas are limited, and rural clinicians have expressed concerns about professional ethics guidance and ethical standards of practice that appear most applicable to resource-enriched, less interdependent urban settings and do not recognize the special problems associated with life in small communities.

Access factors affecting VA enrollees' use of non-VA medical care (ER-8) —Alan West, PhD, WRJ VAMC and Dartmouth Medical School
This HSR&D-funded project involves acquiring several recent years of hospital discharge data for any non-VA hospitalizations obtained by VA health care enrollees living in any of nine different States, then integrating these non-VA data with any VA hospitalizations these enrollees may have had during the same years. Additional data will include hospital use and cost data from national surveys of health care consumers that include VA users. Subjects will be separated by age group and urban-rural residence, and analyses will compare utilization, health status, and payment information for major diagnostic and service categories, exploring trends over time and accounting for the influences of age, VA priority status, Medicare or other insurance coverage, income, urban-rural residence, and distance to care. This study will yield information about how much VA enrollees rely on private sector inpatient care for different major diagnostic or service categories, and how this reliance is affected by urban-rural residence and distance to VA or non-VA care.
Variations and opportunities in end of life care of Veterans (ER-9) —Yinong Young-Xu, PhD, Dartmouth Medical School
Though substantial research has been conducted on end-of-life (EOL) care for non-Veteran populations, there has been little study of EOL care for Veterans. Research on the Medicare populations has consistently shown that EOL care varies dramatically across regions in the U.S., including disparities between rural and urban areas.
Access to treatment and outcomes for Veterans with substance use disorders (SUD) (ER-10) — Steve Pizer, PhD, Boston VAMC
HSR&D funding began June 2009 in this retrospective study of secondary data to assess the effects of access to treatment on outcomes for urban versus rural Veterans with substance use disorders. The results of this study will help inform VA policy regarding the establishment of mental health and substance abuse treatment resources in community based outpatient clinics. Data sources will include VA, Medicare, and Medicaid utilization and claims records as well as VA waiting time data from 2001 to 2005, supplemented by data from the VA drug and alcohol program survey from 2000, 2003, and 2006. Access will be measured by waiting times, distance to VA facilities, and variation in local supply of non-VA treatment. Study will look at trends in fiscal, supply, utilization and outcome variables of substance abuse treatment for both VA and non-VA providers, assess risk-adjusted mortality and preventable hospitalization rates, and identify rural-urban and distance to care differences in access to VA substance abuse care. Concurrent examination of VA and non-VA utilization date will allow VA to estimate the relationship between fiscal variables, the supply of treatment, and use of VA and non-VA treatment. Finally, study will examine the relationship between access to local treatment, health outcomes, and mortality for Veterans with SUD diagnoses.

Access to evidence-based treatments for neurologically impaired rural Veterans (ER-11) — Paul Hoffman, MD, Gainesville VAMC

The Multiple Sclerosis Centers of Excellence (MSCoE) was established in 2001, with Baltimore VAMC (MSCoE-East) and Seattle-Portland VAMC (MSCoE-West) as coordinating sites. A major goal is to improve the quality of and access to multiple sclerosis (MS) specialty care for Veterans diagnosed with MS. The MSCoE model for the delivery of MS care is a hub and spoke system where hub sites with comprehensive clinical care programs are established regionally and are linked to and support spoke sites which may have the capacity to treat and follow some MS patients, but lack the resources to deliver comprehensive MS care. At present there are 30 potential hub sites within the MSCoE network of VISNs 1 to 11, including Gainesville and Togus. Researchers have established collaboration with the MSCoE-East to study access to care for Veterans with MS in the area east of the Mississippi.

The most fundamental indicator of quality of care of patients with MS is the requirement of an annual MS-specialty visit (with a MS-specialty provider) to chart disease progression, evaluate and modify current therapy, and make appropriate and timely referral to other specialties and services. However, a major barrier in the delivery of MS care is the fact that the majority of Veterans with MS seen in the VA system have some degree of mobility limitations and many patients are located in rural areas. This can make access even to hub sites difficult, or even prohibitive in some cases. Indeed, even a distance of 30 miles can be prohibitive for an MS patient to travel for an annual evaluation.

This study will examine differences in access to comprehensive MS care across rural to urban settings, and will examine locations of MS specialty care, compare patients' access to comprehensive programs, and evaluate patient outcomes, as compared to the standard multiple clinic referral paradigm. Telehealth for exercise prescription transmission to groups of MS patients in rural areas. This pilot study proposes to extend physical therapy expertise to rural areas through the use of video conferencing. The transmitting therapist would be an MS expert and the attendant therapist could either be a certified physical therapy assistant or a knowledgeable caregiver. The result will lead to the creation of a program that will deliver MS specialty services to Veterans who need care in urban, suburban, rural and highly rural areas. Successful strategies could guide policymakers in considering its use in rural patients with other neurological impairments including spinal cord injury and traumatic brain injury.

Decision aid for patients with post traumatic stress disorder (PTSD) (ER-12) — B. Vince Watts, MD, MPH, WRJ VAMC and Dartmouth Medical School

The treatment of PTSD should be based on evidence of effectiveness and in conjunction with patients' wishes. Decision aids, which are designed to help patients make better informed treatment decisions consistent with their values, have been applied to many medical conditions but not to mental health conditions. Working in collaboration with the National Center for PTSD and the Dartmouth Institute for Health Policy and Clinical Practice, this study involves developing a decision aid for PTSD treatment that will help Veterans choose evidence-based treatments consistent with their needs and expectations. Researchers will seek to determine whether use of the decision aid leads to patients making better quality decisions about PTSD treatment, using evidence-based treatments more often, and being more satisfied and treatment-adherent.

Using a randomized clinical trial design, researchers will compare patients who view a decision aid just after presenting for care with patients receiving the usual treatment. Baseline knowledge, satisfaction, and decision certainty measures will be collected, and patients will then be followed for 6 months to access their use of evidence-based treatments and overall PTSD symptoms.

This intervention could supply VA providers with an important tool for the treatment of PTSD. Conducted in a rural setting, this project will not only help demonstrate that policy relevant research can be completed in rural settings, but also will develop a web-based tool that will help Veterans across the nation choose PTSD care that is consistent with their stated values– a first step toward addressing unwarranted variation in preference-sensitive care.

Military, family, and community networks helping with reintegration (ER-13) —Laurie Slone, PhD, Dartmouth Medical School

Social support is vital and local efforts are the most effective way to reach service members and their families with the support they need. Social capital is especially valued in rural communities, and the availability of pre-existing social networks in rural communities may assist returning soldiers in reintegration. This program is intended to make the most of existing resources and services and to simplify access to them by building networks between the providers who make these services available. This will help to simplify the process of receiving services for all troops and their families because no matter where they turn, someone will be able to provide support and point them to the assistance that they need.

Using a pre-post survey design, the study proposes to evaluate (1) the internal functioning of the collaborative network, and (2) the effectiveness of this type of community network on community coordination, collaboration, support, communication, and satisfaction; level of involvement in community; and respondents' self-efficacy regarding knowledge of: reintegration issues following deployment and how to obtain information and care. It is anticipated that this project will serve as a national model for network development to enhance reintegration of Veterans in rural settings.

Adequacy of the physician workforce in rural settings: augmentation of primary care with emergency capabilities (ER-14) — James Geiling, MD, WRJ VAMC and Dartmouth's New England Center for Emergency Preparedness

Dr. Geiling, an expert on disaster planning for medical facilities and systems, will produce a publishable report on "lessons learned" from multiple disaster exercises in which he participated, with a focus on how telemedicine with rural Veterans would play out in the event of a large-scale event such as a pandemic, and with recommendations for next steps, including a potential pilot project to test innovative arrangements.

Quality improvement, VAMC chiefs of staff perceptions of rural access to care (ER-15) — Pamela Lee, PhD, WRJ VAMC and Dartmouth Medical School/ National Center for Patient Safety

Chiefs of staff from all VAMCs were invited to participate in a brief telephone interview regarding healthcare needs of rural Veterans, programs/services offered to rural Veterans at their facility, effectiveness of program/service, private sector partnerships, collaborations with other Federal agencies, patient safety issues, ethical issues, facility strengths and barriers to providing care to rural Veterans, and awareness of Office of Rural Health (ORH). Themes and responses will be compiled into a report for ORH. The report will include recommendations for future evaluations/demonstration projects, etc. This is intended to be an internal report and will not be submitted for broader or peer-reviewed publication.

Care improvement for rural Veterans CIRV online newsletter (ER-16) — Yinong Young-Xu, PhD, Dartmouth Medical School

A newsletter for the VRHRC —*Care Improvement for Rural Veterans (CIRV)* —will be developed and will contain summaries of clinically and policy relevant information and publications for improving rural health. The summaries will be presented in brief format with links to the full article, when available. VA is prepared to widen the scope to include peripheral issues such as transportation, telephone and internet service, and community service. In terms of clinical practice, low-cost and low-technology but highly effective patient care will be emphasized. The immediate audience will be personnel who work for or who are associated with the VRHRC. However CIRV summaries are also likely to be of relevance to physicians, researchers, administrators and policymakers within and outside VA. VA plan to circulate it by posting it on the Web. When fully implemented, it will be published 4 times a year.

Rural Veterans research repository (ER-17) — Yinong Young-Xu, PhD, Dartmouth Medical School
Though much work as been done nationally in the area of rural health care as it relates to Veteran issues, there is no central clearinghouse for all of the various studies and evaluations. This Web-based program will link to the CIRV but also be a stand-alone repository for Veterans rural health research and evaluation, made available initially to all VRHRC sites and eventually to a larger audience of VA and non-VA clinicians and administrators.
National telehealth inventory (ER-18)
Expansion of telehealth programs within VA has been a significant national effort since the early years of this decade. There has not yet been any formal inventory of how prevalent telehealth use is across the Veterans integrated service networks (VISN), as well as what modalities are being used. This inventory will initially separate out the Eastern Region VISNs (1-10), and quantify the volume and type of telehealth used. This will become the springboard for future telehealth studies and demonstration projects. The final product for this project will be a program evaluation toolkit including a repository of measures, surveys, etc. that can be accessed from a Web site and used by other centers for studies.
Utilization of mobile clinics as an alternative care delivery model for rural areas (ER-20) — Lesley Mansfield, MD, FACP, Togus VAMC
In 1988, VHA funded six mobile health clinics (MHC) in an effort to improve access to VA health care for rural Veterans. The goal was to bring VA primary care services to Veterans who lived at least 100 miles from a VA health care facility, and one of the original sites was in Maine. An evaluation of that project (Wray et al., 1999) found that the MHC did increase access to VA health care (defined as increased enrollment) and provided a flexible method of assessing the actual need for services when establishing a fixed site was not immediately feasible. The VA ORH funded four new MHCs in 2008, including one in Maine that will become operational in 2009. The goal of this rural MHC project is to increase access to VA health care for rural Veterans. To improve access to the underserved North Central area of Maine, the Togus VAMC will implement a mobile clinic model for enrollment, screening and delivery of primary and mental health care. Building on prior experience, the Maine MHC will operate from an oversized tractor trailer through a circuit of the major towns in remote Somerset and Piscataquis counties.
Evaluation of ORH-approved access points as a means to increase rural access (ER-21) —VAMC Togus, New England Healthcare System of University of New England, Maine Institute for Human Genetics and Health
Maine has opened three outreach clinics to increase access for rural Veterans in the state--Ft. Kent in 2004, Lincoln in 2006 and Houlton in 2008. The intention of these projects was to improve accessibility and desirability of VA primary care services for non-enrolled but eligible Veterans as well as for enrolled Veterans who were traveling substantial distances for services. The Ft. Kent and Houlton outreach clinics are open 1 day per week, and Veterans need to travel to a supporting community based outpatient clinic (CBOC) or to Togus for services at other times. The Lincoln Outreach Clinic is open 5 days per week on a schedule that parallels the availability of primary care services at CBOCs. Evaluation of the outreach clinic model is needed to further understand the effect on new enrollment, existing enrollment, 1-day versus 5-day clinic availability and veteran use of supporting or local medical services. VA enrollment and appointment data and a convenience survey of Veterans using the outreach clinics will be used to analyze these outcomes.
Community-based facilities to provide VA telemental health (ER-22) — Andrew Pomerantz, MD, WRJ VAMC
Rural access to psychiatric care is often limited and may be especially restrictive for returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) combatants. Partnering with local community health centers, this pilot project seeks to establish telepsychiatry for this population, with Veterans physically located inside an existing community health center and care provided via video conference hookup back to professional staff at the WRJ VAMC. Evaluation of this project will identify the utility of this care delivery model in improving access and outcomes.

Central Region
Potentially preventable hospital readmissions among rural Veterans (CR-1) —Marilyn Klug, PhD, University of North Dakota and Fargo VAMC
This project will examine the potential utility of preventable readmission rates as a useful marker of hospital quality and fill an important gap in understanding of the prevalence and nature of hospital readmissions in facilities serving largely rural Veteran populations. Methodology will include logistic regression to predict which patients are most likely to be readmitted. The project will measure geographic variation in preventable readmission rates across VA hospitals and assess how hospital and patient attributes affect potentially preventable readmission rates.
Are CBOCs improving care for chronically ill rural Veterans? (CR-2) – Ira Moscovice, PhD, University of Minnesota and Minneapolis VAMC
This project will assess the extent to which CBOCs are improving primary care for rural Veterans in VISN 23. The purpose of the project is to compare evidence-based quality of care, patient satisfaction and access indicators for rural Veterans with chronic health conditions who receive care from CBOCs and VAMCs in VISN 23, and to assess the policy implications of any identified differences between CBOCs and VAMC and across CBOCs. Methodology will include multivariate analysis of CBOC characteristics.
Creating patient-centered medical homes (PCMH) for rural Veterans (CR-3) – Keith Mueller, PhD, University of Nebraska and Nebraska/Western Iowa VAMC
Researchers will seek to build on the medical home concept through creation of a rural Veteran focused approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, and coordinated, health care delivery are all goals associated with the creation of a medical home. Currently, the literature review portion of the project is complete reconciliation of PCMH, VA PCMH, Dartmouth PCMH, and Wagner PCMH is underway.
Telephone-based Telehealth intervention for diabetes, hypertension, and chronic pain (CR-4) – Carolyn Turvey, PhD, Iowa City VAMC
This 3-year study will test a telephone intervention for patients with hypertension and diabetes receiving care in CBOCs in VISN 23. The intervention will be based on a telephone intervention using nurse case managers that was shown in our prior work to reduce heart failure readmissions. This intervention was selected because of its lower resource requirements and its ability to be delivered by nurses in a centralized location relying on the availability of patients' electronic health records. The intervention will be sequentially implemented in randomly selected patients in the 48 CBOCs in VISN 23 who meet eligibility criteria.
Western Region
Partner with 3 rural communities for development of outreach clinical with telehealth supportive care and community collaborations (WR-1) – Randall Rupper, MD, Salt Lake City (SLC) VAMC and University of Utah
The study will include a complete review of the Elko Outreach Clinic model and will seek input from VISN advisory committee about potential sites. An implementation plan will be developed.
4 Corners telehealth conference (WR-2) – Jay Shore, MD, University of Denver
With supplemental funding from the Department of Defense, Western Region will convene a telehealth conference to address the rural health needs of Veterans within Colorado, Utah, Arizona, and New Mexico. A survey will be developed and distributed to attendees. From the results, a conference agenda will be planned for the 4 Corners telehealth conference for decision makers.

Baseline survey assessing health care needs, perceived barriers to service, and service disparities in rural Utah and Montana (WR-3) – Vaughn Call, MD, SLC VAMC and Brigham Young University
A baseline survey assessing health care needs, perceived barriers to service, and service disparities in rural Utah and Montana will be conducted to determine the healthcare needs and barriers to service in specific rural areas.
Clinical demonstration: Internet based caregiver support program for caregivers of cognitively impaired elderly Veterans (WR-4) – Randall Rupper, MD, SLC VAMC and University of Utah
Researchers will develop and implement an internet-based caregiver support program for caregivers of Veterans with dementia.
Telepsychiatry clinics for American Indian Veterans on rural reservations (WR-5) – Jay Shore, MD, University of Denver
This Clinical Demonstration Pilot program (CDPP) will establish telepsychiatry clinics for American Indian (AI) Veterans on reservations will identify and recruit clinical replacements and develop a transition plan. Once a clinician is in place researchers will create a manuscript on the new clinics, which will be reviewed by ORH before submission. Residents will be recruited for 2009-2010 and consultation provided for the clinics to assist in developing tele- family focused therapy (FFT) and tele-geriatric care. The final product will be data gathered from the clinic creation process to be used for mental health (MH) guidelines.
Creation of an infrastructure for native focus (WR-6) – Jay Shore, MD, University of Denver
This project will examine the current health care policies for rural Native Veterans and provide recommendations for further policy development. The study will review health care policies and prioritize issues to make health care policy recommendations and conduct a gap analysis, and present three detailed health care policy benchmark reports concerning rural AI populations, rural Alaskan Native (AN) populations and rural Pacific Islander (PI) populations. For each rural native population, report will discuss next steps for policy development for health care for rural native populations and prioritized recommendations for further work.
Creation of a Web site for rural Veterans as end users (WR-7) – Bob Hill, PhD, SLC VAMC and University of Utah
The goal of this project is to create a Web site that assists rural Veterans in connecting to VA resources and information. The Western Region web design team will obtain the necessary space and recruit the necessary expertise to develop an interactive, consumer-focused Web site. They will populate the Web site with material that is emerging from the VRHRC and then test the Web site with focus groups to assess its effectiveness. The Web site will be updated monthly for a 3 month period to refine and improve the site, and additional groups will be encouraged to become members of the site to get updates about ORH and the 3 VRHRCs.
To create an Web site about the VRHRCs (WR-8) – Bob Hill, PhD, SLC VAMC and University of Utah
The goal of this project is to create a Web site that will disseminate information on the VRHRCs to policymakers, Veterans and service providers. The web design team will develop the public Web site and will place the Web site on a server that can address large viewership demand and beta test the Web site before populating it with VRHRC information. They will build a resource section to the site specific to rural veteran populations with an emphasis on target projects and populations (geriatrics, AI/AN). This site will be created by the Western Region web design team, with content provided by each VRHRC.

Develop focus group protocols (WR-10) – Vaughn Call, PhD, SLC VAMC and Brigham Young University
The objective of this study is to create focus group protocols for Veterans' health population studies. In this study, a sample of rural Veterans and non-Veterans will be contacted and focus groups will be conducted by rural community type. Based on their results, a standardized protocol on how to conduct needs assessment surveys in rural communities will be developed. As part of the development process, a list of key concepts and constructs and focus group methodology will be examined. Final products will include a report on "best practices" and the finalized versions of the protocols.
To disseminate products that highlight and describe findings from VRHRC projects (WR-11) – Bob Hill, PhD, SLC VAMC and University of Utah
This project will disseminate knowledge gained through the VRHRC projects, demonstrations and research. Domain leaders will discuss and produce a concrete taxonomy and provide input on the different areas of reports/information/scholarship/practical products. This will include work completed as well as planned activities. The taxonomy will be loaded on the Intranet to be populated, and progress reports will be instituted to track the Web site. An annual conference will be held where findings from research and from implementation projects from rural communities will be presented. ORH and VRHRCs will be invited to participate in this conference. An annual report will be generated that will include a prospective plan for products for the upcoming year.
Dissemination of symptom based home telehealth protocols to national sites (WR-12) – Randall Rupper, PhD, SLC VAMC and University of Utah
The purpose of this project is to evaluate the necessary elements of a symptom-based telehealth program and develop a toolkit based on the results. Additionally, the project will support ongoing evaluation of factors leading to successful participation in the symptom based program, outcome effects, office of care-coordination assistance with marketing of toolkit, direct marketing to remote sites, and provide implementation support and consultation.
Funding of new pilot programs (WR-13) – Jay Shore, MD, University of Denver
This project will collaborate with a pilot project designed to increase access or quality of care to AN/PI/AI populations. Currently, the Western Region has suspended this project pending guidance from ORH. The PPG will work with Western Region to assure consistency with the ORH pilot project request for proposal.
Guidelines for design and implementation of AI/PI/AN telemental health clinics (WR-14) – Jay Shore, MD, University of Denver
The purpose of this project is to provide guidelines for design and implementation of American Indian Veteran telemental health clinics. This project will examine service utilization, cost and semi-structured interview data to assess the programmatic outcomes achieved by telepsychiatry clinics, with a particular emphasis on the clinics' feasibility, sustainability and cost. This project will further examine factors influencing the diffusion and adoption of telepsychiatry by tribal, state, and federal organizations. Guidelines and recommendations for developing similar programs will be disseminated at the end of the first project year. During the third project year, project lead will assess the inclusion of these guidelines by the VA and Indian Health Services (HIS) policy bodies. Final products resulting from this project will be a manuscript, conference presentations, as well as Web dissemination of results.
Survey of Vietnam-era Veterans (WR-15) – Vaughn Call, PhD, SLC VAMC and Brigham Young University
This study will survey Vietnam-era Veterans to assess health care needs and barriers to service. A sample of Vietnam-era war Veterans will be located and surveyed to assess health care needs and barriers to service, with an annual longitudinal follow-up for 5 years. The final product will be a policy brief on implications of Veteran and structural assessments in four States and sample of Vietnam-era Veterans, as well as web reports on mobility patterns of Vietnam-era Veterans and their impact on rural communities and recommendations for application of findings and procedures to other centers.

Taxonomy of community types and associated characteristics (WR-16) – Vaughn Call, PhD, SLC VAMC and Brigham Young University
Common definitions of rural communities based on distance generally do not consider commute times to health care providers, economic conditions, social and cultural differences, the level of informal services or telehealth infrastructure. The aim of this project is the development of a taxonomy capturing community type and associated characteristics. Researchers will use literature on definitions of rural and highly rural communities, collaborate with other centers, and obtain census and state data on economic and social conditions in western states to facilitate taxonomy development. While a single definition may not meet all policy needs, a more comprehensive taxonomy of rural places is required to tailor policies that serve the healthcare needs of rural Veterans living in different types of rural communities. A more comprehensive taxonomy will be developed by incorporating additional factors using multiple sources of available data. This new taxonomy will provide utility to studies using multilevel analysis to disentangle community effects from family and individual factors.
Telehome care for rural Veterans with PTSD (WR-17) – Jay Shore, MD, University of Denver
Researchers will design a telemental health program to address PTSD in rural and American Indian Veterans as an adaptation and service demonstration project. Final products will include a clinical manual, the dissemination of American Indian experiences, results, and satisfaction levels. Further, it is hoped ideas for future implementation and expansion will result from this project.
Investigation and analysis of transportation policies for rural Veterans (WR-18) – Randall Rupper, MD, SLC VAMC and The University of Utah
Researchers will investigate current VA practices and policies relating to transportation for rural Veterans in an effort to reduce experienced barriers. This program will include a pilot needs assessment, pilot implementation program to address multiple coordination issues, and an evaluation to determine options for innovative national programs to address rural transportation issues. The result of this project will be a policy brief submitted to ORH.
Understanding Veterans service options and utilization patterns for PTSD and TBI (WR-19) – Jay Shore, MD, University of Denver
This goal of this project is two-fold. First, researchers will determine how service location and type affects the detection of PTSD among Veterans, as well as their use of mental health services. To perform this task, data will be examined to determine what characteristics are present in high and low users of VHA mental health services. The use of geographic information systems mapping software will aid in this effort by creating visual spatial representations of existing clinic locations in relation to patient residence. Second, existing administrative and patient data will be reviewed to determine which individual factors affect Veterans' use of behavioral health care for PTSD. The information gathered in this project will help to increase access to care for Veterans in need of PTSD services, and has special potential for Veterans living in rural areas. Final products will include both a manuscript for publication and a presentation at a national conference.

Chairman AKAKA. I will now turn to Ranking Member Senator Burr for his questions. Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

Dr. Cross, I can't let you get by without asking about this testimony. I take for granted that the inability to meet the deadline was because the Administration didn't return the testimony. Is that correct?

Dr. CROSS. Senator, that is not how we want to phrase it. I take responsibility and I appreciate the Chairman's comments earlier and apologize for the tardiness.

Senator BURR. Did you or did the VA have it in its possession before last night when it was turned in?

Dr. CROSS. Walter, help me—

Senator BURR. Listen, this is not the first time I have been on this cabbage truck, and it has been in Republican Administrations and now it happens to be a Democratic Administration and the likelihood is your testimony sat at OMB, and OMB ignored the rules of the Committee. Let us all concede that fact. When you got your testimony back, how different was it than what you sent?

Dr. CROSS. Sir, I am not here to point fingers at anyone else. I will take responsibility for what I did.

Senator BURR. Dr. Cross, I appreciate that. I am trying to figure out what you wanted to tell the Committee and what the Administration instructed you through the changes in your testimony you were going to say to the Committee, but we will forego that.

Mr. Hall, as Assistant General Counsel, did you inquire with OMB as to whether we would get the testimony so that you could meet the rules of the Committee?

Mr. HALL. Yes, sir. This is, of course, an Administration position. We work closely with the Office of Management and Budget and other agencies to formulate the Administration's views.

Senator BURR. Did they express any concern that they weren't allowing you to meet the rules of the Committee from the standpoint of the timeliness of testimony?

Mr. HALL. Sir, we worked as hard and fast as we could to address the many issues that were before us.

Senator BURR. Let us switch to the Second Amendment issue. I am disappointed that the VA has not taken a position on this. Let me ask you, do you agree with the Justice Department's request of the VA that they continue to submit names? Dr. Cross?

Dr. CROSS. Sir, the position that we have coming to you is the same as what we put in the written testimony, that we have reviewed the proposals and we have deferred officially to the Department of Justice.

Senator BURR. Well, I didn't ask about your comments on my legislation. I asked, do you agree with the Justice determination that VA should be obligated to provide those names, yet other agencies that have people that meet the same legitimate threshold do not?

Dr. CROSS. I would like to ask my colleague, the General Counsel, to comment on that.

Senator BURR. Mr. Hall?

Mr. HALL. Yes, sir. That is the—the Department of Justice administers the Brady Bill. It is their responsibility to determine who it is that is required to be reported, the names that are required to be reported, and we comply with that—with those instructions.

Senator BURR. Mr. Hall, do you believe in your opinion of the jurisdiction of the Justice Department. Do they have the ability to reverse this decision on their own, or does it require legislation?

Mr. HALL. My understanding of the law is that it says the requirement to report is a "may report." They "may determine."

Senator BURR. So one would conclude from that that the Justice Department today has the ability to say——

Mr. HALL. Sir, I would defer entirely to the Department of Justice as to the interpretation of that law, which they are responsible for administering, and they are the——

Senator BURR. I am not a lawyer, but please tell me this. Is there a significant difference between the word "may" and "shall" from a legal standpoint? When you see the word "may," are you compelled?

Mr. HALL. You may be.

Senator BURR. You are using "may" again. [Laughter.]

The truth is, the Justice Department could—and this is the new Justice Department—they could look at this request that they have made of VA and they could say, you know, this has been grossly misinterpreted; and they could, on their own, pull back the request.

Mr. HALL. I think that is entirely within the Department of Justice to——

Senator BURR. See, I knew if we worked at this, we were going to agree on something.

Dr. Cross, the Committee has heard from veterans, family caregivers, Veterans Service Organizations, that we need to provide more support to family caregivers caring for veterans. In your testimony, you mentioned that the Department currently contracts for caregiver services with home health agencies and those agencies, in turn, are employing family members. Specifically, how many family members are currently employed by home health agencies?

Dr. CROSS. Sir, I don't know that number, but I am concerned that the number is quite small. I think that we need to address that. I think that is a real issue that we have to bring forward. We think the mechanism is sound, to use those agencies that are already existing or have expertise in this area to help us with this challenge which is so very important. But I don't know the number of family members that are currently hired, and I am concerned that it is small. I think that we need to address that and find some way to increase that number.

Senator BURR. Do you have any idea of the number of family members serving as caregivers, whether they are hired or not?

Dr. CROSS. Specifically, no, sir.

Senator BURR. I hope you understand, these are significant things that we need to know the numbers on if, in fact, we suggest—and I think your testimony suggests that the way the VA currently has it structured is working, and that is that we have home health agencies that turn around and hire family members to serve as caregivers. And I think what we are going to find out is that it rarely happens. Where it does happen, it is probably not with the best agreement up front, that the majority of caregivers would prefer not to go through a third party. As a matter of fact, most of them that supply the service today are doing it because of their family member—that they believe can only have the level of care if, in fact, they commit to do it. Why we would not provide a similar incentive for them to do this, versus to work through a third party, is somewhat a mystery to me.

Has the VA done an assessment to make sure that the arrangements that are currently out there, meaning home care-hired family caregivers, work?

Dr. CROSS. The way that it works right now is that the care managers interact with the veteran to make sure that they are being cared for properly. You have raised a very important point, though, in regard to the family members, and actually, we have asked the staff to look into the possibility of whether or not we can even create a preference when we work with those agencies in the community—to have a preference for those family members.

I think, though, that you can understand that there might be some challenges for us if we made those family members directly employees of the VA, in essence. It would put us, at times, in a difficult position between that situation and the welfare and care of that veteran—a primary responsibility itself. Our primary responsibility is, in fact, the care of the veteran. We have to hold people responsible for that. Holding a family member responsible for that

could be a challenge for us. We are much more comfortable at this time having these community agencies train and oversee this.

But I think that you have raised a significant issue as to how many family members are actually able to take advantage of this.

Senator BURR. I thank you for your testimony. I have run over my time. If I could say to the Chair, I would like my colleagues to know that the father, the sister, and the brother-in-law of Eric Edmundson are in the audience today. His father has cared for him since the day he took him out of a VA facility. I think it is—those that have met Eric understand the challenges he has gone through. I know without his dad's commitment to take care of him as a caregiver, Eric would not have made the progress he has today; and we all have great hope that he can continue to make progress. That would not have happened if it hadn't been for a family that basically dropped everything and really made it their life's commitment to serve their son as a caregiver. So I want to thank Edgar and Anna and Roger for coming up and taking the time to come to Washington today.

Thank you, Madam Chair.

Senator MURRAY [presiding]. Thank you very much.

Dr. Cross, I recently held a press conference on women's veterans issues, and in attendance were several female veterans who were part of a group that is known as Team Lioness. The Army has sent these female soldiers to serve in a support role for Marine ground combat troops in Iraq. And the members of Team Lioness were exposed to some of the bloodiest counterinsurgency battles during their service. All of this was done, of course, despite the current prohibition on women serving in combat.

Now, I am told that many members of Team Lioness have not had their combat service recorded in their DD–214, which, of course, impacts their ability to get compensation or any other ancillary benefits that they earned. In fact, a female veteran who served as the mechanic in Team Lioness told me that the VA claims adjudicator she went to see about her PTSD claim didn't believe that she could have any psychological health issues because her military records didn't show any record of combat service. So this is a real issue for these women.

Now, I recognize that this is a DOD problem. But I was hoping you could tell me if the VA itself is exploring any options to ensure that its compensation and pension staff and its medical staff are aware of the combat roles that many women veterans have played in Iraq.

Dr. CROSS. Thank you, Senator. I believe the group that you are referring to actually came over and made a presentation at VACO headquarters.

Senator MURRAY. Oh, great. I am glad they did.

Dr. CROSS. I am looking forward to learning more about them. One organization where we do have some options to support them, even in that process, is our Vet Centers—for any combat veteran returning—to also help them work with DOD or help them work with VBA to resolve issues regarding their DD–214. I think that would be a very appropriate place for them in our Vet Centers. But we can address that systematically with DOD and VBA, as well. We are quite willing to do that.

Senator MURRAY. OK. I think it is important to address that with DOD and I appreciate that. But I also think, meanwhile, it is important to let VA personnel know that there are women out there that did serve in combat so that they don't hear, well, you can't, it is not on your form, because they did.

Dr. CROSS. Agreed.

Senator MURRAY. OK. I have a number of questions I want to submit for the record. As you know, Senator Akaka, our Chairman, had to leave for a short while. We are going to pass the gavel up here among members and I appreciate everybody's patience as we do that, and I am going to turn the gavel over to Senator Sanders.

Senator SANDERS [presiding]. Thank you. We should put the clock on, if we could.

I want to get to the issue of outreach. My understanding is that the VA has opposed legislation that Senator Feingold and I introduced—Section 211 of the broader bill. What we believe very strongly is that it is terribly important to have aggressive outreach; that there are many veterans who do not know what they are entitled to. As I said earlier, it doesn't matter what you have if people don't know about it.

And so what we have proposed is that community, local, State, and Federal providers of health care be enlisted in an outreach effort in the form of a pilot program. I say this because my recollection—and somebody can correct me if I am wrong—but I think in the early 2000s, maybe 2003 or so, an actual memo went out from the VA to halt outreach efforts. I think the VA has never been particularly aggressive, in general, in outreach efforts. They actually stopped it. I brought forth an amendment when I was in the House to undo that.

So I think that, especially in rural areas, it is very important that every veteran know the benefits they are entitled to. I think the VA, in general, is doing better now than they used to. But it is no great secret nor will it shock anybody in this room when I say that for many years the VA basically did not want veterans to know what they were entitled to. Am I right? Because if they don't know what they are entitled to, they can't take advantage of it and we save money. It is a great way to do business. That is no secret. Everybody knows that.

But, I happen to believe that if we pass legislation and veterans are entitled to certain benefits, they should know about it, period. That is what it is about. That has not always been the case. So we want to expand upon what the VA is doing, getting other groups involved in it. Dr. Cross, why is that a bad idea? Why aren't you supporting it?

Dr. CROSS. Senator, let me be very clear. We strongly support outreach, and I will list a couple of things that we are doing that I think are very consistent with what you are proposing. The bill itself and Section 211 itself was opposed because it appeared to be duplicative of what the Vet Centers, case managers, and other outreach we are currently doing, which I will elaborate on in just a moment.

We are doing so many other things right now that I want to make sure that you are aware of and that you are proud of. We were concerned that coming back from OEF and OIF, a number of

veterans had not contacted us, had not come to a VA medical center. We put in place a contract to call every single one of them, and we are doing that by the hundreds of thousands and saying, hey, how are you doing? Is there something we can do for you—

Senator SANDERS. I am aware of that. We spoke to Dr. Peake about that. I think that is an excellent step forward. And I do—I am aware, as I said a moment ago, that we are doing better.

Let me just suggest to you, and you tell me this, that you have somebody coming back from Iraq with PTSD in rural Vermont. What we are doing now in our State is we have people actually going out and knocking on his or her door. I think we have got to be a lot more aggressive. As I said, I think you are making progress, but tell me the problem about why we would not want to be even more aggressive, bringing different groups in?

Dr. CROSS. I don't think necessarily there is any problem with being more aggressive, and I think we all support that. There were technical problems, I think, with the language in the bill and how it relates to the Vet Centers that we have. The Vet Centers have been tremendously successful.

Senator SANDERS. Vet Centers help. Why don't we do this? I am the first to happily concede that we have been making some progress. But you will recall, literally, not so many years ago where the VA—am I right on that, Dr. Cross?

Dr. CROSS. Senator, I think we——

Senator SANDERS [continuing]. Didn't VA actually send out a memo telling VAs all over the country to stop doing outreach?

Dr. CROSS. That may have been before my time, but we agree that we made progress.

Senator SANDERS. My recollection is that is exactly——

Dr. CROSS. And the progress was needed.

Senator SANDERS. OK. So we are making some progress. I want to make more progress and I look forward to working with you if there are any technical problems in the bill, to see how we can work that out.

Dr. CROSS. And sir, we will make our staff available to meet with your staff, to work through any of those issues at any time you would like.

Senator SANDERS. We look forward to working with you.

Senator Begich?

Senator BEGICH. Thank you very much. I will have a few questions, but I am busily trying to read your testimony. I am not going to try to get into why or whatever. I was a mayor once and I understand how the process goes with OMB. Sometimes it is painful for an agency, but I will leave it at that. Yet it is frustrating, because I am trying to figure out very quickly where you are on certain pieces of legislation, where you are not on certain pieces of legislation. So I have a couple questions and then I will probably go to some early parts of the testimony, because that is all I have gotten through so far.

And I may be wrong on this, but I am just trying to remember my visit to Alaska. I just came back Monday, but I was there for a couple of weeks. If you are a doctor—and I will use Alaska—and you are a certified physician and you are going to do contract work for the VA, does the VA put you through another certification proc-

ess? I guess the question is, why; because if the medical care I am getting—I am not a veteran—from that same doctor, I think I am getting pretty good quality. Why duplicate that? Why not just get them into the process? Why do we waste the time? I mean, you have gotten my answer to the question from my perspective by my statement, so——

Dr. CROSS. I appreciate that, and quite frankly, the process they have to go through and that I had to go through when I came in is a bit cumbersome.

Senator BEGICH. Why do we do it?

Dr. CROSS. Think back to Marion—Marion, Illinois—and what happened there a couple of years ago. We believe very strongly that the additional safeguards that we have to put in place are very important for the safety and welfare of our veterans. Not everyone in the community who is practicing and working in the community is someone that we would want working in the VA.

Senator BEGICH. Is there a way to figure out how to streamline it by working with the local agencies that do the board certification already, rather than create a whole new system?

Dr. CROSS. One thing that we have done is contract with an organization to do reports about individual physicians automatically for us. We started that in November 2008, to identify any problem cases. But quite frankly, that is only for those who are already employed by us.

Senator BEGICH. So it is not the recruitment of new contract doctors or doctors.

Dr. CROSS. I think there is more that we could do to streamline that process.

I was thinking about your situation in Alaska and the individuals who fly often to the very rural areas that you mentioned——

Senator BEGICH. Right.

Dr. CROSS [continuing]. And I have asked my counsel sitting next to me if there was a technique that we might be able to use to address those, by making them something called WOCs. We will look into that. I don't know the answer at this point.

Senator BEGICH. That would be great. I would be very interested in that.

The second thing is—again, if my information is wrong, just correct me—but the contract periods that you can do for contract services for doctors or other professionals is 1-year increments with renewals, basically. Am I close on that? [Dr. Cross nods affirmatively.]

OK. Here is the complaint I hear, It is too short. What do we need to do to extend that, yet still give you the flexibility if the contractor is not performing to the levels that you prefer or need? I mean, the reality is in 1 year you are not even getting into the depths of what potentially is available out there because people just don't want to do it for 1 year. They want more security, up to 3 years. Besides the appropriation issue, what can we do here to fix this problem?

Dr. CROSS. Now, I am not briefed on that, but I agree with you on what you are telling me, that the 1 year is too short. I just got my privileges renewed at the Washington VA Medical Center where I keep mine. It is for 2 years.

Senator BEGICH. Well, that is a change. That is good. So could you get me some information on that?

Dr. CROSS. Yes, sir.

Senator BEGICH. I mean, that is a complaint I have heard. There are professionals that want to do it but they think of this 1-year increment and decide it is not worth it for what they have to go through to get there, and then they are not sure if it extends beyond. We all recognize part of it is budgetary and so forth, but more security in that arena, I think, would help ensure a more stable workforce. That is just a thought.

Dr. CROSS. I agree, sir. Thank you. We will look into it.

Senator BEGICH. Thank you. I have just a few more seconds left and I would just ask this general question. I think it was in your earlier—in the very front pages of the testimony. I know the issue is about reimbursement. How do you deal with folks who you want to get into the system, recognizing it could be 6 or 7 years before they are actually finally into it? The specialty they are going for may not be worthwhile at that time. But isn't it true you could go back 10 years and you could probably pick the half-a-dozen certain types of professional classifications that you always have shortages?

You can say, OK, this is a group we are going to focus on, knowing there is—like there is right now—a high demand for mental health professionals. Five years ago, it was different. But we know there is at least a half-a-dozen or more classifications that we want to dive into to figure out how to recruit, knowing that it may take 7 years, but we are going to need them anyway, because there has been no time you have had a surplus of physicians. I mean, that is a rare occasion——

Dr. CROSS. Yes.

Senator BEGICH [continuing]. You have a surplus of physicians or nurse practitioners in the business of health care.

Dr. CROSS. I am going to ask my colleague, Joleen, to comment on that. But first, let me say, becoming a physician is about a 14-year process—pre-medicine, medicine, residency, fellowship, all of those kinds of things. When I was going through that process, I changed my mind about three or four times as to what specialty I wanted to go in. So if we targeted one of those specific specialties, it may not be what comes out at the other end of the pipe, so to speak.

Joleen?

Senator BEGICH. Can I add, and no disrespect to the Doctor, but 67 percent of the care is nurses, physician assistants, which are shorter periods of time, 18 months to 36. I know this because we have one of the top nursing schools in the country in Alaska, in Anchorage. So, no disrespect to physicians, but there is also a huge gap in this other area. So that is——

Dr. CROSS. Right.

Senator BEGICH [continuing]. So there is a shortage that you can supply quickly.

Ms. CLARK. We have a couple of things that we are doing, but S. 252 does reinstate that scholarship program and we are hoping that that will help us to be able to expand past just physicians and help us with nurses and physicians. Also, the VA Nursing Academy

has just expanded to five additional universities this year and we are hoping that that helps us to educate more nurses so that we can hire additional nurses. In the last 5 years, we have been able to hire—because of the flexibilities that the legislation that has been approved by these committees has allowed us—we have been able to hire 10,000 additional nurses in the last 5 years, 4,000 additional physicians. The physician pay bill helped us tremendously with that. And the legislation in——

Senator SANDERS. Does that mean that we have 10,000 more nurses in the VA?

Ms. CLARK. Yes. We had approximately 37,000 5 years ago. Right now, actually, we have 49,000. We had 47,000 at the end of the year—or, excuse me——

Senator SANDERS. And 4,000——

Ms. CLARK. Yes, 47,000. Yes.

Senator SANDERS. Four-thousand more physicians?

Ms. CLARK. Four-thousand more physicians actually on board, yes. So we have been able to do tremendous things. We know there are certain areas—especially the rural areas—that we have work to do. We have a pilot program going on for recruiters, especially in rural areas, to try to target some of those positions that are hard to recruit, like the scarce specialty in physicians, some of those nurses that are critical care positions and nurses. So, we do realize there are going to be those areas that are always harder to fill and that we really need to target those specifically. We are working on trying some pilots out to see how to best do that.

Senator BEGICH. Great. Thank you.

Senator SANDERS. Thank you, Mr. Begich. If that is the span of your questioning——

Senator BEGICH. I will stop now.

Senator SANDERS. All right. Thank you, and let me thank the panelists and welcome our second panel.

OK. I am delighted to welcome our witnesses from Veterans Service Organizations and advocacy groups to the second panel. I appreciate your being here today and we look forward to your testimony.

First, I want to welcome Adrian Atizado, Assistant National Legislative Director for the Disabled American Veterans. Next, I welcome Ammie Hilsabeck, R.N., of the Iron Mountain, Michigan, VA Medical Center, representing the American Federation of Government Employees. Thanks for being here.

Mr. J. David Cox, R.N., was scheduled to appear today but could not because of a death in his family, so please extend our deepest condolences to him and his family when you see him.

We also welcome Hilda Heady, former President for the National Rural Health Association. Thank you very much for being here.

We welcome Ralph Ibson, Health Policy Senior Fellow for the Wounded Warrior Project. Thank you very much for being here, and a familiar face for this Committee.

Last, we welcome Blake Ortner, Senior Associate Legislative Director for Paralyzed Veterans of America.

We thank all of you for joining us today and your full statements will appear in the record of the Committee.

Let us begin with Mr. Atizado. Again, we thank you very much for being here.

STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Thank you, Senator. I would like to thank the Committee for inviting me to testify at this legislative hearing. We appreciate the opportunity to present our views on the 19 bills on today's agenda. Of course, at the Committee's request, I will limit my oral statements to a select few of these important bills.

Mr. Chairman, the DAV and allies in the partnership for veterans' health care budget reform believe that S. 423 proposes a reasonable alternative to achieve sufficient, timely, predictable, and transparent funding for VA medical care. The bill would authorize Congress to appropriate funding for veterans' health care 1 year in advance and provide greater transparency to VA's health care budget formulation process. Equally important, after enactment, Congress will retain its oversight authority and full discretion to set actual appropriated funding levels for each fiscal year.

We are delighted to know that this important bill is being considered by the Committee today and we thank the 35 Senators whose cosponsorship made this a bipartisan bill, including the ten Members of this Committee. We are encouraged by the Senate action on April 3 when it passed a budget resolution that allows advance appropriations for VA medical care, and on April 9, when President Obama and VA Secretary Shinseki publicly reaffirmed their support for advance appropriations legislation, as well as in VA's testimony today. We urge the Committee to approve this bill because its passage in the 111th Congress would address DAV's highest priority in VA health care.

Mr. Chairman, the DAV recently had occasion to help organize and sponsor a Capitol screening of the independent documentary film "Lioness" that Senator Murray had mentioned. This is to be shown on PBS on June 2. The story is of five Army women who served in Marine ground combat teams in Fallujah and Ramadi. Their role was to assist in offensive operations by providing body weapon searches of Iraqi women and children. These women were mechanics and clerks, as the Senator had mentioned, who found themselves fighting in some of the most violent counterinsurgency combat in this war.

Now, I mention this because it serves as a reminder that a significant new women veteran population is beginning and will continue to present certain needs that VA has likely not seen before and will now need to address. Women veterans are a dramatically growing segment of the veteran population, and as mentioned, according to VA, the number of women veterans utilizing VA health care will likely double in the next 5 years.

We believe the Women's Health Care Improvement Act of 2009 will allow VA to effectively meet the needs of women veterans. This bill is fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women's health, the VA's Advisory Committee on Women Veterans, the Independent Budget, and the DAV. Our organization was proud to work with Senator Murray and the original cosponsors of the bill

in crafting the proposal. DAV strongly supports this measure and urges its approval.

We also commend the decision to include an earlier version of the bill in S. 252, the Omnibus Health Proposal, and we trust that the Committee staff and Senator Murray's staff will work out any differences between these excellent bills.

With regards to the two bills proposing a caregiver support program, the DAV would like to thank both Chairman Akaka and Senator Durbin on their leadership in this very sensitive matter. We are also appreciative of the efforts by Congressional staffs who worked with our organization and sought our views in crafting both bills. These bills seek to address those informal caregivers of severely disabled veterans who today remain untrained, unpaid, unrecognized, undercounted, and exhausted by their duties. The DAV supports both measures, given that our national resolution calls for legislation to provide comprehensive support services to caregivers of severely injured veterans.

We believe S. 801, the Family Caregiver Program Act of 2009, proposes a more comprehensive program and we ask for the Committee's approval of that legislation. I would like to note, though, that S. 543, as well as the provisions in S. 252, contain worthwhile sections and provisions that we hope will be considered by this Committee as it finalizes the authorization of this new VA caregiver program.

Mr. Chairman, this concludes my testimony. I would like to ask the Committee to refer to my written testimony for the DAV's position and comments on the other bills that I did not include in my remarks. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: Thank you for inviting the Disabled American Veterans (DAV) to testify at this important hearing of the Committee on Veterans' Affairs. DAV is an organization of 1.2 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

Mr. Chairman, the DAV appreciates your leadership in enhancing Department of Veterans Affairs (VA) health care programs that many service-connected disabled veterans rely upon. At the Committee's request, the DAV is pleased to present our views on nineteen (19) bills before the Committee today.

S. 423—VETERANS HEALTH CARE BUDGET REFORM AND TRANSPARENCY ACT OF 2009

Mr. Chairman, while great strides have been made to increase the level of VA health care funding during the past several years, there is a long history of significant delays in actually receiving those funds. Notwithstanding notable improvements over the past two years, including passage of a regular appropriation on September 30, 2008, VA has received its annual funding for veterans' health care late in 19 of the past 22 years. Unlike Medicare's mandatory trust funds, the VA must rely on Congress and the President to pass a new discretionary appropriations law each year to provide VA hospitals and clinics with the funding they need to treat sick and disabled veterans.

Due to the late and unpredictable budget process, VA is increasingly challenged to properly treat the physical and mental scars of war for all veterans needing care. Further, not knowing when or at what level VA will receive funding from year to year—or whether Congress would approve or oppose the Administration's proposals—hinders the ability of VA officials to efficiently plan and responsibly manage VA health care.

Broken financing causes unnecessary delays and backlogs in the system: hiring key staff is put off, or just not done, while injuries like PTSD or Traumatic Brain Injury (TBI) are too often not diagnosed or treated in a timely manner. Since 2001, the number of VA patients has grown by two million—a 50 percent increase—and our newest generation of veterans has increasingly complex mental and physical health care needs that will require a lifetime of care. Moreover, a 2007 report by the VA's Office of Inspector General concluded that 27% of the injured veterans seeking treatment at VA facilities had to wait more than 30 days for their first appointments.

For the past decade, the DAV and its allies in the Partnership for Veterans Health Care Budget Reform—a coalition of nine veterans service organizations with a combined membership of eight million veterans—have sought to fundamentally change the way veterans health care is funded. While mandatory funding has been the focus over the past several years, the Partnership helped develop and fully endorsed S. 3527, the Veterans Health Care Budget Reform Act, introduced in the 110th Congress. This legislation was endorsed by The Military Coalition, comprised of 35 organizations representing more than 5.5 million members of the uniformed services—active, reserve, retired, survivors, veterans—and their families.

We believe this legislation, the successor to S. 3527, proposes a reasonable alternative to achieve the same goals as mandatory funding, by authorizing Congress to appropriate funding for veterans' health care one year in advance, and by adding more transparency to VA's health care budget formulation process. With the goal of ensuring sufficient, timely, and predictable funding through advance appropriations, Congress retains full discretion to set actual appropriated funding levels for each fiscal year. The legislation does not eliminate, reduce or diminish, but rather enhances, Congress's ability to provide strong oversight over VA programs, services and policies.

We at DAV are delighted to know this important VA health care funding reform bill is being considered by the Committee today. We thank the 32 Senators who have given this bill co-sponsorship on a bipartisan basis, including ten of the 15 Members of this Committee. Also, only in recent days have we confirmed in a meeting with President Obama and Secretary Shinseki that both the President and the VA Secretary fully endorse the Senate's decision to make provision for advance appropriations for VA health care funding for Fiscal Year 2011 in the Fiscal Year 2010 Senate budget resolution. We hope the Committee would approve, that the Senate and House would pass, and that President Obama would sign S. 423 into law.

Passage of the Veterans Health Care Budget Reform and Transparency Act in the 111th Congress would address DAV's highest priority in VA health care; thus, we urge its enactment.

S. 597—WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009

Title I, Section 101 would require the Secretary to submit a report to Congress on existing stigma and other barriers that impede or prevent women from accessing health care and other services from VA. The bill would require an assessment of its existing health care programs for women veterans, and an evaluation of the needs of women who are currently serving, and women veterans who have completed service, in OIF/OEF.

Section 102 would require VA to contract with a non-VA entity to study the health consequences is women veterans from environmental and occupational exposures while serving in OIF/OEF.

Section 103 would require the VA to report to Congress on whether there is at least one established full-time women veterans program manager at each VA medical center.

Title II, section 201 requires the Secretary to identify available services, personnel and other resource requirements to develop a plan and make recommendations to appropriately meet the future health care needs, including mental health care needs, of women who served in OIF/OEF.

Section 202 would make improvements in VA's ability to assess and treat veterans who have experienced military sexual trauma (MST) by requiring a new training and certification program to ensure VA health care providers develop competencies and the use of evidence-based treatment practices and methods in caring for these conditions consequent to MST. The Secretary would be required 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 202 would also require VA 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 Sec-

retary 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 203 would establish a non-medical model pilot program of counseling in retreat settings for recently discharged women veterans who could benefit from VA establishing off-site counseling to aid them in their repatriation with family and community after serving in war zones and other hazardous military duty deployments.

Section 204 would require recently separated women veterans to be appointed to certain VA advisory committees.

Section 205 would authorize a two-year pilot program in at least three VISNs of providing subsidies 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 subsidizing expenses.

Section 206 would amend title 38, United States Code to authorize a period of not more than seven days of VA-provided or authorized contract care for the newborn infant child of a woman veteran.

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. According to VA, the number of women veterans utilizing VA health care will likely double in the next 2 to 4 years. We expect they will undoubtedly use other VA benefits in addition to health care. 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 prepare to receive a significant new population of women veterans in future years, who will present needs that VA has likely not seen before in this population.

We recently had occasion to help organize and sponsor a Capitol screening of the independent documentary film *Lioness*, to be shown on the Public Broadcasting System on June 2, 2009. It is the story of five Army women who served in Iraq, in regular military occupational specialties, but who were pressed into service in Marine ground combat teams in Fallujah and Ramadi, Iraq, to assist in offensive operations providing body weapons searches of Iraqi women and children, to ensure the safety of the Marines and other Iraqi civilians. These women, who were not trained as infantry combatants, were exposed to some of the most violent counterinsurgency combat hazards in this war.

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. 1210) on a bipartisan basis by Representatives Herseth Sandlin and Representative Moran of Kansas. DAV strongly supports this measure and urges the Committee to approve it and move it toward enactment.

FAMILY CAREGIVER SUPPORT SERVICES

S. 543—VETERAN AND SERVICEMEMBER CAREGIVER SUPPORT ACT OF 2009

This legislation would establish a pilot program at six locations, with one required to be conducted at a VA facility in a rural area and another at a qualified private rehabilitation facility. The proposed pilot program would provide support services and financial assistance to family caregivers of veterans or members of the military seriously injured in the line of duty since September 11, 2001. VA would provide training and certification of family caregivers, and of an alternate caregiver to relieve a primary caregiver, if deemed necessary. Once trained and certified, family caregivers would receive payments for the care they provide.

In addition, the bill would require VA and DOD to make available to caregivers, mental health and support services, on the assumption that the need for services would be related to their role as caregivers. VA would be required to conduct a survey of family caregivers to better understand the value of the services they provide

and to assess and report to Congress on the effectiveness of these pilot programs. Furthermore, if the pilot programs are successful, they could be expanded nationwide.

While we support the spirit of this bill, appreciate Senator Durbin's leadership in introducing it, and would not object to its passage, we believe a number other provisions are necessary to underwrite a more fully developed caregiver support program.

S. 801—FAMILY CAREGIVER PROGRAM ACT OF 2009

Section 2 of this bill would amend Section 1784, title 38, United States Code, to require VA to waive any charges for emergency medical care provided on a humanitarian basis to family caregivers while accompanying certain severely injured veterans. This provision would only apply to family caregivers of those veterans whose injury was sustained on or after September 11, 2009, and such injuries meet a prescribed level of severity.

Section 3 of this bill would create a new VA program for family caregivers or personal care attendants of severely injured veterans. The goal of this program would be to allow eligible veterans to reside in their communities and maintain their quality-of-life with caregiver assistance. We note that veterans, or servicemembers awaiting discharge for their injuries sustained on or after September 11, 2001, and in need of personal care services, would be the first categories to be eligible for this program. The DAV believes the program proposed in this bill would be beneficial to all disabled veterans, and we thank the Chairman for including a provision in the bill to address this matter. Specifically, for all other veterans, the Secretary would be required to make a determination two years following enactment of this bill to "include the largest number of veterans possible" in this program.

Taking on the role of a family caregiver is a personal choice made by the family member and the veteran affected. We believe this bill would respect the privacy of this decision, and recognizes the contributions caregivers make to the health and well being of severely injured veterans. Under this program, more than one caregiver could receive basic instructions. In addition, only one caregiver would be certified by VA as the primary personal care attendant of a veteran after completing basic instructions provided by VA and any additional training identified by an evaluation of the veteran's needs. To assist in completing the required training and certification, this bill would require VA to provide for necessary travel, lodging, and per diem to the caregiver, and respite care to the veteran as needed during such caregiver training and certification.

To support and sustain caregivers, the bill would provide ongoing assistance such as mental health counseling, eligibility for the Civilian Health and Medical Program of Veterans Affairs (CHAMPVA), payment of a stipend, and other critical services such as respite care. Even though most family caregivers take great pride in providing care to their loved ones so that these veterans can remain at home, the physical, emotional and financial consequences can be overwhelming for them without support, with respite services being a good example thereof. Research has shown that providing respite for caregivers can have a positive effect on the health of the caregiver as it provides the much needed temporary break from the often exhausting challenge imposed by constant attendance of a severely disabled person. Currently, VA's system for providing respite care is fragmented and inflexible, governed by local policies for Community Living Center (formerly VA Nursing Homes) and Adult Day Care programs. As part of the ongoing assistance this bill proposes, VA would be required to provide no less than 30 days annually, including 24-hour respite care. The DAV is hopeful this provision will encourage VA to establish clearer policies expecting every Community Living Center and Adult Day Care Program to provide priority for age-appropriate respite care for severely injured veterans.

The DAV believes that family caregivers are motivated by empathy and love, but they are also often dealing with guilt, anger and frustration. The very touchstones that have defined their lives—careers, love relationships, friendships, and their personal goals and dreams—have been sacrificed, and they face a daunting lifelong duty as caregivers. Put simply, family caregivers of severely disabled veterans, who are vital for VA's patient-centric care provided in the least restrictive settings, must not remain untrained, unpaid, unappreciated, undercounted, and exhausted by their duties.

DAV Resolution No. 165 was passed by the delegates to our most recent national convention. That resolution calls for legislation that would provide comprehensive supportive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to immediate family member caregivers of veterans severely injured, wounded or ill from military service. Accordingly, the DAV supports this measure. We thank Senator

Akaka for introducing this bill and congressional staffers for working with DAV to address the unmet needs of caregivers of severely injured veterans.

This bill is an important measure and DAV urges the Committee's approval. In addition, we believe S. 543, as discussed above, contains worthwhile provisions that we hope will be considered by this Committee as it finalizes the authorization of these new benefits.

S. 658—RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009

Section 2 of this bill would amend Section 111, title 38, United States Code, to insert a fixed rate of 41.5 cents for the purposes of VA's travel beneficiary program. Reimbursement at this rate may exceed the cost of travel by public transportation regardless of medical necessity. We note section 401 of Public Law No. 110–387, enacted October 10, 2008, amended the federal veterans' benefits provisions to repeal a requirement that the Secretary of Veterans Affairs adjust the amounts deducted from payments or allowances made by the VA for beneficiary travel expenses in connection with health care whenever the payment or allowance is adjusted. It required the Secretary to use the same mileage reimbursement rate in beneficiary travel as for government employees use of privately own vehicles on official business as authorized in title 5, United States Code. A report is required no later than 14 months upon enactment of the Act.

Section 3 of this bill would require VA to establish at least one and no more than five Centers of excellence for rural health research, education, and clinical activities.

Section 4 would require the Secretary to establish a transportation grant program to veterans service organizations to allow for other transportation options to assist veterans residing in highly rural areas to travel to VA facilities.

Section 5 would require the VA's Office of Rural Health to conduct demonstration projects with the goal of expanding care in rural areas.

Section 6 of the bill would require the VA to establish a contract care program through community mental health centers and other "qualified entities" for the provision of certain readjustment, mental health, peer counseling and similar services to OIF/OEF veterans and their dependents in rural and remote regions. The program would be restricted to areas determined by the Secretary to be inadequately served by direct VA services.

Section 7 of the bill would establish a Native American health care coordination function in the 10 VA medical centers that serve the greatest number of Native Americans per capita, with specification of the duties associated with the new function. Also, the bill would require the Secretary and the Secretary of the Interior to execute a memorandum of understanding that would ensure the health records of Indian veterans may be transferred electronically between the Indian Health Service and the Veterans Health Administration (VHA).

Section 8 would require an annual report to Congress as a part of the President's budget on a variety of matters concerned with rural veterans.

The conference report accompanying the Consolidated Appropriations Act of 2008, specified that $125 million of the funds provided for Veterans Medical Services should be used to increase the travel reimbursement rate. The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009, provided an additional $133 million to increase the beneficiary travel reimbursement mileage rate to 41.5 cents per mile, while freezing the deductible at current levels. Subsequently, the Veterans' Mental Health and Other Care Improvements Act of 2008 revised VA's beneficiary travel program to establish a mileage reimbursement rate equal to that for Federal employees when a government vehicle is available, but the individual chooses to use their own vehicle. Further, Public Law 110–387 changed the mileage deductible to $3 for each one-way trip; $6 per round trip; with a calendar month cap of $18 as specified in title 38, United States Code, section 111(c)(1) and (2) for travel expenses incurred on or after January 9, 2009.

The DAV appreciates Senator Tester's leadership in improving health care for veterans residing in rural areas. We support enactment of this bill as consistent with our DAV Resolutions 159 (on beneficiary travel policy) and 177 (on access to rural health care), adopted by our membership at DAV's 2008 National Convention.

S. 404—VETERANS' EMERGENCY CARE FAIRNESS ACT OF 2009

This bill would amend subparagraph (b)(3)(C) of section 1725, title 38, United States Code, by striking the words "in whole or in part" where they appear in current law. The bill would also add new language to clarify Congressional intent that VA would be required to assume responsibility as payer of last resort in a case in which an otherwise eligible veteran has private insurance coverage that pays a portion or part of the cost of an episode of emergency care in a private facility. Under

the bill, VA would pay the remainder of the veteran's obligation, less any required copayments under the associated private insurance coverage.

While the bill also provides the date of the enactment as the effective date, many veterans have been adversely affected by the VA's non-reimbursement for emergency treatment under the current law. This bill provides VA discretionary authority to reimburse veterans for emergency treatment provided prior to the date of enactment who have been financially harmed under the VA's current non-reimbursement policy.

DAV supports the purposes of this bill and appreciates the sensitivity of the Committee leadership in developing an effective solution to a nagging problem plaguing both service-connected and nonservice-connected veterans who rely on VA to meet their primary health care needs, but who find themselves confronted by medical emergencies.

S. 252—VETERANS HEALTH CARE AUTHORIZATION ACT OF 2009

Sections 101, 102, and 103. These provisions would aid VA in retaining health care professionals in the VA system, and clinical executives in facilities and in VA Central Office; would limit VA's use of overtime, clarify policies on weekend duty and use of alternative work schedules for nurses; and, would improve VA's educational assistance programs. DAV provided detailed testimony during the 110th Congress on these matters in S. 2969, from which its sections 2, 3, and 4 were incorporated as sections 101, 102, and 103 in this bill.

Mr. Chairman, DAV has no resolution adopted by our membership addressing these specific matters, but we are strong supporters of VA as a preferred Federal employer. We believe these provisions in general would be supportive of that goal; therefore, DAV would not object to their enactment. Nevertheless, we note that our colleagues in the VA labor community appear to be deeply concerned about ceding additional authority to the Secretary to expand the "hybrid" title 5—title 38 appointment authority without further authorization by Congress. Labor has made the point strongly that VA should first be held accountable for disclosing the manner by which the Department has carried out prior authority in dealing with hybrid appointments across more than 20 career fields. Based on VA's apparent struggle to establish qualification and classification standards for some of the occupational classes already included in the hybrid appointment authority, we believe Federal unions may have a valid basis for those concerns. Therefore, we defer to their expertise in this case and ask the Committee's further consideration of those matters in sections 101, 102 and 103 in Title I of the bill in recognition of the concerns of labor.

Section 104. DAV provided testimony in the past Congress on S. 2377, Section 2 thereof which has been incorporated as Section 104 of this bill.

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 S. 2377 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.

Section 201. At the Chairman's request, DAV provided testimony in the 110th Congress on Title III of S. 2984, which has in part been incorporated as Sections 201 through 206 of this bill. Although DAV has no resolutions specific to the matters entertained in S. 2984, we were generally supportive of the provisions in that bill with the exception of those matters in section 304 (now in section 201 of this bill). We believe in both instances of its knowledge of, and oversight in, VA practices with regard to compensating nursing personnel and in conducting long-term strategic planning, that these reporting requirements should be retained. We are particularly concerned at the prospect of VA's discontinuing its construction-related reporting with the Committee relying primarily on VA's annual 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 contained

in the annual budget for a given year. We believe both Congress and the community of veterans service organizations, in properly representing and protecting veterans' interests, need to continue receiving comprehensive reports on VA's strategic plans, including its major construction planning.

Sections 202–206. DAV takes no positions on these matters, but offers no objections to their enactment.

Sections 207–208. These sections would establish health care quality management officers and new functions nationally, regionally and locally in the VHA, and would require a series of reports to document progress in quality management. DAV provided testimony in the 110th Congress on S. 2377, section 3, which has been incorporated as Sections 207 and 208 of this bill. DAV has no adopted resolution from our membership on these specific issues; however, we expressed our appreciation and strong support the intent of S. 2377 and do so again with respect to these provisions. While it seems clear that additional oversight is necessary given the VA Office of Inspector General's January 2008 report documenting unacceptable practices at the VA Medical Center Marion, Illinois, that served in part as an impetus for section 207 in this bill, we trust that the new reporting, State licensure and certification requirements in the bill would not serve to dampen future physicians' interest in considering VA careers.

Sections 209 and 210. These provisions would establish training and certification pilot programs, an innovative respite program for family caregivers, and new health care trainees in caring for severely brain-injured veterans. DAV provided testimony in the past Congress in support of Sections 2 and 3 of S. 2921, which have been incorporated as Sections 209 and 210 of this bill.

Section 211. DAV provided previous testimony in the past Congress on S. 2796, which has been incorporated as Section 211 of this bill. This section would establish a five-site pilot program to facilitate veterans' use of community-based organizations to ensure they receive the care and benefits they deserve in transitioning from military to civilian life. The program would be conducted through VA grants to community-based organizations with the goal of providing information, outreach, mental health counseling, benefits, 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 concerns about VA becoming 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 this section 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 section.

Section 212. DAV provided previous testimony last Congress on S. 2889, which has been incorporated as section 212 of this bill. Section 212 would provide VA a 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. DAV Resolutions 161 and 164, adopted by our members at our 2008 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 suffer from TBI. Again, we ask the Committee to consider broadening the eligibility for this new contract residential rehabilitation care option in Section 212 of the bill to any veteran with a service-incurred TBI.

Section 213. This section was incorporated from Section 6 of S. 2889 from the 110th Congress. This section 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). DAV does not have a resolution from our membership on this matter; therefore, DAV takes no position on this provision.

Section 214. This section would require VA to contract with the Institute of Medicine for an expanded study related to veterans' health-related exposures from participating in Project Shipboard Hazard and Defense ("Project SHAD"). DAV does not have a resolution from its membership on this matter. However, the DAV believes this is a worthwhile provision in light of our policy regarding environmental expo-

sure of sick and disabled Persian Gulf War Veterans and in recognition of DAV Resolution 022, adopted at our 2008 National Convention, which opposes any rule or provision that would authorize use of servicemembers for human experimentation without their knowledge and informed consent.

Section 215. DAV provided previous testimony during the last Congress on Section 4 of S. 1233, which has been incorporated in part in Section 215 of this bill. We note that in passing Public Law 110–181, the National Defense Authorization Act for Fiscal Year 2008, Section 1703 did not follow the language contained in Section 4 of S. 1233 of the last Congress. We believe Section 215 of this measure would clarify that veterans with Traumatic Brain Injury have a right to access community-based rehabilitation, but only when VA cannot provide the care and when the non-VA provider is accredited and adheres to appropriate VA clinical and rehabilitation standards. We support Section 215 of this measure which contains the same two key implied presumptions that we supported in Section 4 of S. 1233 in the 110th Congress: (1) that the VA must have the capacity to be the provider of choice, and (2) that proximity to care is a key component to ongoing rehabilitation and community reintegration for the traumatically brain-injured veteran.

Also, we support the implicit goal of this section to give VA an incentive to further develop its capacity to provide high quality specialized care. VA's four lead Polytrauma Rehabilitation Centers have achieved and maintained, without qualification, accreditation from the Commission on the Accreditation of Rehabilitation Facilities for acute inpatient TBI rehabilitation programs; however, to date and to our knowledge not a single VA facility has achieved accreditation for outpatient, home-based, residential or community based TBI rehabilitation. We urged this Committee then, as we do now, to encourage VA to seek such accreditation at Level II and Level III poly-trauma sites.

Section 216. This section would make federally-recognized tribal organizations eligible to participate in VA's State extended care grant programs, including the treatment of existing beds in tribally-owned health facilities as State veterans home beds for purposes of the per diem subsistence program administered by VA.

DAV does not have a resolution from its membership on this specific matter, but as a part of the *Fiscal Year 2010 Independent Budget*, DAV has expressed concerns about the status of the State extended care construction grant program, and in particular, with respect to the fact that nearly $1 billion in backlogged construction, new home and renovation grants are pending in VA Central Office, affecting existing State veterans homes in nearly every State. Given this backlog and Congress's inability to appropriate sufficient funding annually to properly maintain this system, we are concerned that adding as many as 500 tribal organizations to the competition for these severely limited funds will only serve to diminish the existing State home program. Therefore, we ask that the Committee withhold approval on this section to enable our staffs to work toward an acceptable compromise to enable tribal organizations to participate more directly in this unique VA-State partnership.

Section 217. We appreciate the intent of the bill which would require VA to contract with a dental insurer to administer a new dental plan provided under a three-year pilot program. Moreover, each individual covered by the dental insurance plan would be required to pay the entire premium for coverage under the dental insurance plan, in addition to the full cost of any copayments. DAV Resolutions 167 and 172 support legislation to amend title 38, United States Code, section 1712, to provide outpatient dental care to all enrolled veterans, but without any additional costs to be borne by the veteran or their survivors and dependents.

Title III—Women Veterans Health Care. For Title III of this measure, sections 301–309, we refer this Committee to our views on S. 597, the Women Veterans Health Care Improvement Act of 2009, contained herein. We believe the small differences in the two bills can be worked out by your able staffs. We strongly support improved services for women veterans, are deeply grateful to the Chairman and Members of this Committee for their interest in women's health, and urge the Committee to report an appropriate compromise bill during this session.

Sections 401 and 402. DAV provided previous testimony during the last Congress on Sections 2 and 3 of S. 2963, which have been incorporated as Sections 401 and 402 of this bill. While DAV has no resolutions from our membership supporting the specific matters entertained by these sections, 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 these sections and would have no objection to their enactment.

Section 403. DAV provided testimony during the last Congress on Section 3 of S. 2899, which has been incorporated as Section 403 of this bill. DAV has no adopted resolution from our membership dealing specifically with suicides in the veteran

population. However, we agree that full and accurate data on the issue of suicide is crucial to VA's ability to reduce veterans' suicides. Also, and more importantly in our view, DAV believes strongly that improving, expanding and enhancing VA's mental health programs across the board, including those dealing with depression, adjustment disorders, PTSD, mild-to-moderate Traumatic Brain Injury, marital and family relations (including readjustment from long deployment separations), and substance-use disorders—particularly with early interventions, will not only provide more effective care but can stem suicidal ideation in untreated or poorly treated populations.

Section 404. We note that Public Law 110–329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, includes provisions (Section 227) very similar to Section 404 of this measure, so we are concerned that this provision may be unnecessary or duplicative of current law. Nevertheless, DAV does not have a resolution from our membership on this specific matter; therefore, we take no position.

Title V—Homeless Veterans. DAV provided testimony during the last Congress on S. 2273, which has been incorporated as Title V of this bill. The *Independent Budget* for Fiscal Year 2010 included a series of recommendations that are consistent with the five sections under this title; therefore, we support its purposes and urge its enactment.

Title VI—Nonprofit Research and Education Corporations. DAV provided previous testimony last Congress on S. 2969, which has been incorporated as Title VI of this bill. While DAV has no adopted resolution on this particular matter, DAV is a strong supporter of a robust VA biomedical research and development program. We believe enactment of this Title would be in that program's best interest, and therefore, we urge its enactment.

Sections 701 and 702. These sections are derived from Sections 401 and 402 of S. 2984 from the 110th Congress. These provisions would expand certain authorities set out in title 38, United States Code, relating to VA police officers so as to better reflect the current scope of their duties and responsibilities, and would modify the authority of VA to pay an allowance to VA police officers for the purchase of police uniforms. DAV has no resolution from its membership on this specific matter; therefore, we have no position on this measure.

S. 821—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO PROHIBIT THE SECRETARY OF VETERANS AFFAIRS FROM COLLECTING CERTAIN COPAYMENTS FROM VETERANS WHO ARE CATASTROPHICALLY DISABLED, AND FOR OTHER PURPOSES.

Mr. Chairman, thousands of veterans survive catastrophic traumas in civilian life. Some of them have been able to surmount the tremendous challenges imposed on them by accidents or disease, and have been able to rejoin the workforce to be productive citizens. We believe they should not face the double jeopardy of catastrophic disability and an additional financial penalty of paying VA copayments in order to access VA health care and services. These veterans, many permanently wheelchair bound and spinal cord injured, already spend thousands of their own dollars annually on health-related supports and services that able-bodied veterans do not need to bear, or even think about. If a catastrophically ill or spinal-cord injured veteran succeeds in the daunting personal quest to remain in, or re-join, the labor force, we believe the government where possible ought to provide that veteran proper incentives to remain employed, in this case by forgiving VA copayments.

In conjunction with DAV's national resolution from our membership calling for legislation to repeal all copayments for military retirees and veterans' medical services and prescriptions, and as a partner organization constituting *Fiscal Year 2010 Independent Budget*, the DAV fully supports this provision. It matches the Independent Budget's recommendation that veterans designated by VA as being catastrophically disabled for the purpose of enrollment in health care eligibility priority group four (4) should be made exempt from health care copayments and other fees. We note this legislation was passed by the House in the past Congress but was not considered by the Senate. We urge this Committee to approve and move this provision to enactment during this Congress.

S. 793—DEPARTMENT OF VETERANS AFFAIRS VISION SCHOLARS ACT OF 2009

This measure would direct the Secretary of Veterans Affairs to establish and carry out a scholarship program of financial assistance for individuals who: (1) are accepted for, or currently enrolled in, a program of study leading to a degree or certificate in visual impairment or orientation and mobility, or both; and (2) enter into an agreement to serve, after program completion, as a full-time VA employee for three years within the first six years after program completion. It would set max-

imum assistance amounts of $15,000 per academic year and $45,000 in total per participant. The legislation would require pro-rata repayment for failure to satisfy education or service requirements, while allowing the Secretary to waive or suspend such repayment whenever noncompliance is due to circumstances beyond the control of the participant, or when waiver or suspension is in the best interests of the United States.

DAV has no resolution on this issue adopted by our members; however, the *Independent Budget* for Fiscal Year 2010 contains a series of recommendations for VA improvements in its vision care programs. One such recommendation urges VA to require its health care networks to restore clinical staff resources in inpatient blind rehabilitation centers and increase the number of full-time Visual Impairment Services Team coordinators. This measure would improve recruitment for these positions. On that basis, DAV fully supports the intent of this bill.

S. 772—HONOR ACT OF 2009, A BILL TO ENHANCE BENEFITS FOR SURVIVORS OF CERTAIN FORMER MEMBERS OF THE ARMED FORCES WITH A HISTORY OF POST TRAUMATIC STRESS DISORDER OR TRAUMATIC BRAIN INJURY, TO ENHANCE AVAILABILITY AND ACCESS TO MENTAL HEALTH COUNSELING FOR MEMBERS OF THE ARMED FORCES AND VETERANS, AND FOR OTHER PURPOSES.

This bill would create a scholarship program within VA to produce graduate-level behavioral sciences practitioners among qualified veterans, in exchange for specified obligated Federal service in either the VA or the Department of Defense health care systems. It would also create a Defense program of employment, training and deployment of combat veterans as psychiatric technicians and nurses, to serve in future combat zones as determined by the Secretary of Defense. The bill would reauthorize Vet Centers to refer former military servicemembers with character of discharges that make them ineligible as veterans, to community resources for counseling and other mental health services, and it would specifically authorize serving members of the Armed Forces to be eligible for counseling and related mental health services at VA's Vet Centers. The bill would deem certain post-deployment suicides among combat veterans to have been deaths in the line of duty. Finally, this bill would require a series of reports to Congress dealing with its provisions.

DAV has no resolution adopted by our membership specific to these issues; however, we believe this to be a helpful bill, particularly with respect to the Vet Center related provisions. Therefore, we would offer no objection to its enactment.

S. 498—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO AUTHORIZE DENTAL INSURANCE FOR VETERANS AND SURVIVORS AND DEPENDENTS OF VETERANS, AND FOR OTHER PURPOSES.

This measure is similar to Section 217 of S. 252 with the exception that under this measure the provision of dental insurance by VA would not be a pilot program with respect to duration and location of availability. As discussed in our views on section 217, we appreciate the intent of this bill. However, DAV Resolutions 167 and 172 support legislation to amend title 38, United States Code, section 1712, to provide outpatient dental care to all enrolled veterans but without any additional costs to be borne by the veteran or their survivors and dependents.

S. 669—VETERANS 2ND AMENDMENT PROTECTION ACT

Under the terms of this bill, in absence of a judicial determination of mental incompetency, VA would be prohibited from reporting an individual veteran's identity or competency status to any authority that could restrict that veteran from his or her Second Amendment rights to bear arms.

The DAV has no resolution from its membership on this issue and, therefore, we take no position on this bill.

VHA WORK FORCE

S. 246—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.

Mr. Chairman, this bill is very similar to S. 2377, introduced in the 110th Congress. 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 in physician appointments 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.

We noted in testimony on May 21, 2008 to the Senate Committee on Veterans' Affairs on S. 2377, the predecessor version of this bill, VA raised a number of valid concerns with respect to State licensure limitations this bill would impose on VA physicians. We ask the Committee to take those concerns into account as you consider the merits of this bill.

S. 362—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, AND FOR OTHER PURPOSES.

Mr. Chairman, this bill would restore bargaining rights for clinical care employees of the VHA that were eroded over the past eight years by the former Administration. A similar version of the bill was introduced in both bodies in the 110th Congress but did not advance.

DAV does not have an approved resolution from our membership on the specific VA labor-management dispute that prompted the introduction of this bill. However, we believe labor organizations that represent employees in recognized bargaining units within the VA health care and benefits systems have an innate right to information and reasonable participation that result 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, 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 staffs within these bargaining units. We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have 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 local 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 who receive care from VA's physicians, nurses and others can be negatively affected by that environment.

We believe this bill, which would rescind VA's refusal to bargain on matters within the purview of section 7422, through striking of subsections (b), (c) and (d), and that would clarify other critical appeal and judicial rights of title 38 appointees, is an appropriate remedy, and would return VA and labor to a more balanced bargaining relationship on issues of importance to VA's professional workforce. VA clearly has indicated vigorous disagreement with the intent of the measure, but has not to date been willing to compromise its position in refusing to bargain across a wide group of issues that are dubiously defined by VA as "direct patient care." Given the stalemate, our only recourse is to endorse the intent of the bill, yet continue to hope that VA and Federal labor organizations can find a basis for compromise.

S. 734—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE CAPACITY OF THE DEPARTMENT OF VETERANS AFFAIRS TO RECRUIT AND RETAIN PHYSICIANS IN HEALTH PROFESSIONAL SHORTAGE AREAS AND TO IMPROVE THE PROVISION OF HEALTH CARE TO VETERANS IN RURAL AREAS, AND FOR OTHER PURPOSES.

Section 2 of this bill would enhance VA's existing education debt reduction program by removing the current dollar limitation ($44,000 per participant) and equating it to the actual level of debt and interest payable by individual employees of the Department, with amended procedures for offers and acceptances of such debt reduction employment incentives. Section 3 of the bill would include certain VA medical facilities, located in health professional shortage areas, in the list of facilities eligible for assignment of participants in the National Health Service Corps scholarship program administered by the Department of Health and Human Services (HHS). The section would require VA to transfer to HHS $10 million to carry out the purposes of the section. Section 4 of the bill would require VA's Office of Rural Health to develop and submit to Congress a five-year strategic plan, with specifications of the content of this report.

Section 5 of the bill would enhance VA's Vet Centers to meet needs of veterans of OIF/OEF through the establishment, training and deployment of volunteers, paraprofessionals and veteran-students to provide counseling and other mental health services to OIF/OEF veterans in established Vet Centers. Section 6 of the bill would establish a new section 1709, title 38, United States Code, to establish consultation and teleretinal imaging functions in the VHA, including the establishment of clinical and technical standards to carry out these programs; and amendments to VA's internal allocation (VERA) and workload reporting data systems to accommodate and give creditable resources to VA facilities conducting such programs.

Section 7 of the bill would improve oversight and administration of contract and fee basis care authorized by the Department. It would require VA to consolidate contracting for community-based outpatient clinics (CBOC) at the VHA Network (VISN) level to the maximum extent practicable; establish rural outreach coordinators at each CBOC with a majority of enrolled veterans who reside in "highly rural" areas; establish incentives to obtain accreditation of participating fee-basis private providers, and to encourage these providers to participate in VA's peer review system. Section 8 of the bill would amend section 111, title 38, United States Code, to provide reimbursement for airfare and other actual necessary expenses to certain enrolled veterans when air travel is the only practical way for such veterans to gain access to direct VA health care, with conforming changes to section 111.

Section 9 of the bill would establish a pilot program wherein full-time VA physicians would be authorized to assume attending responsibilities for primary care or mental health services at community hospitals located in health professional shortage areas, with financial incentives for them to assume these responsibilities, and including establishment of a series of rules to govern and control such participation.

Mr. Chairman, this bill largely conforms with recommendations of the *IB* for Fiscal Year 2010, particularly in respect to the provisions related to rural health, continuity of care, innovations, quality of care, and improving access to direct VA health care. Also, it comports with the *IB* recommendations with respect to better coordinating and improving the quality of contract and fee-basis care. On this basis, DAV fully supports the intent of this bill and urges the Committee to approve it.

VHA FACILITIES

S. 226—TO DESIGNATE THE DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC IN HAVRE, MONTANA, AS THE MERRIL LUNDMAN DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC.

This is a local matter, and DAV takes no position on this bill.

S. 239—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO ENSURE THAT VETERANS IN EACH OF THE 48 CONTIGUOUS STATES ARE ABLE TO RECEIVE SERVICES IN AT LEAST ONE FULL-SERVICE HOSPITAL OF THE VETERANS HEALTH ADMINISTRATION IN THE STATE OR RECEIVE COMPARABLE SERVICES PROVIDED BY CONTRACT IN THE STATE.

Mr. Chairman, while the bill is a general mandate that every state have a "full-service" VA medical center within its borders, the circumstances surrounding the bill make clear that its intent is to restore the VA Medical Center in Manchester, New Hampshire. As such, this is a local matter, and DAV takes no position on this bill.

S. 509—TO AUTHORIZE A MAJOR MEDICAL FACILITY PROJECT AT THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, WALLA WALLA, WASHINGTON, AND FOR OTHER PURPOSES.

This is a local matter, and DAV takes no position on this bill.

S. 699—TO PROVIDE FOR THE CONSTRUCTION OF A FULL SERVICE HOSPITAL IN FAR SOUTH TEXAS BY THE SECRETARY OF VETERANS AFFAIRS.

This is a local matter, and DAV takes no position on this bill.

Mr. Chairman, this concludes DAV's testimony. We appreciate the opportunity to have provided our views on these bills. I will be pleased to respond to any questions that you or other Members of the Committee may have.

Senator SANDERS. Thank you very much.

Ms. Hilsabeck?

STATEMENT OF AMMIE HILSABECK, R.N., OSCAR G. JOHNSON VA MEDICAL CENTER, IRON MOUNTAIN, MICHIGAN, ON BEHALF OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Ms. HILSABECK. Mr. Chairman and Members of the Committee, my name is Ammie Hilsabeck and I am a Registered Nurse at the Oscar G. Johnson Iron Mountain VA Medical Center in the Upper Peninsula of Michigan. It is a great honor for me to be here to testify on behalf of S. 362 on behalf of my union, the American Federation of Government Employees, and also the veterans that I take care of each and every day.

In Iron Mountain, I am a union steward for the AFGE Local 2280 and I work the evening shift in the emergency room. I am also the evening NOD, or the nursing officer of the day. I provide direct patient care to the veterans who come into the emergency room. I also manage additional services that are needed to take care of these veterans. I work with the nurses and the doctors within the entire hospital, making sure that all units are properly staffed on the evening shift. I handle a wide range of duties and tasks from within the hospital, and calls from veterans from the outside of the hospital.

The AFGE greatly appreciated the chance to meet with Secretary Shinseki on this issue 2 days ago. The Secretary gave us his commitment that he would look into the issue and continue the dialog with us through a future meeting before finalizing his position. Therefore, it was especially disappointing to read the VA's testimony for today's hearing and see all the inaccurate statements about how bargaining rights work and how we want to use them are back again.

All we are saying is that Title 38 employees deserve equal rights to voice their concerns in the workplace. To accuse us of wanting to use these rights to interfere with patient care is unfair and not based on law or fact. To accuse us of wanting to block supervisors from quickly removing employees who are abusing patients from the workplace is also unfair and not based on law or fact.

I can't deny the fact that I provide patient care. That is my job. I take care of veterans every day. So, of course, every concern I have about doing my job relates to patient care in some way, but that is not interfering with direct patient care. That is not telling management how to treat diabetes or PTSD or which specialist to hire or how much to spend on a new imaging machine. Collective

bargaining is about resolving labor-management disputes about conditions of employment.

The right to a grievance is not a temporary restraining order forcing immediate action by supervisors or absolute right for employees to walk off the job. It is only the right to require management to come to the table to discuss what is already happening in the workplace, or a policy that has been proposed, or to hear the employee's side of the story if he or she has been accused of improper conduct or poor performance.

All we are saying is that it makes no sense to treat one part of the VA health care workforce differently than another. If a psychologist can bargain over these issues, why can't a psychiatrist? If an LPN can negotiate over these issues, why can't a Registered Nurse? If military hospital nurses or physicians can file grievances on employment matters that impact patient care, why can't we at the VA have these rights when we do the same jobs?

I want to tell you what it is really like to work without a voice and without a chance to address concerns when you are caring for veterans in an emergency room every day and why we could provide better care for our veterans if management was willing to sit down and negotiate over employment issues.

My managers recently made a decision that critically ill veterans would no longer be stabilized in our critical care unit but rather in the emergency room where I work. They would not negotiate, however, with us about what the ER nurses would need to take care of these veterans and the amount of responsibility in terms of training the emergency room nurses, equipment that was needed, medications, and supplies. We were also kept in the dark when management decided that our imaging reading services would sometimes be contracted out and sometimes not be contracted out, which means delayed care for our veterans. All we want is to negotiate things like this so we can meet our guidelines and provide the right care in a timely manner.

Dr. Cross complains that we want to negotiate over what constitutes an emergency for mandatory overtime. He suggests that we would use the grievance process to stop managers from responding to emergencies with extra nurse coverage. All we wanted was VA central office to define "emergency" in advance of future emergencies and with one national definition so that over time, policies did not vary from hospital to hospital. Over a dozen States have that definition, so why won't the VA protect the safety of its veterans in the same way?

VA's testimony also states that if we have the right to negotiate over management policies on compressed work schedules, which means three 12-hour days a week, which is common in other hospitals, that we are once again interfering with shift changes needed for medical emergencies. We can't prevent urgent shift changes, but we could be able to plan in advance with management about shifts that will make our nurses want to stay at the VA.

Speaking of wanting to stay at the VA, things have changed a lot since I arrived in 2002. We are no longer—

Senator SANDERS. If you could please wrap up.

Ms. HILSABECK. OK. We are no longer treated like professionals whose views on anything matter. We are always in fear of arbi-

trary and unfair discipline or terminations. We are seeing doctors and nurses get hired by the VA and leave within 1 week. I would like to stay at the VA; yet, me and my colleagues have so many pressures—to care for veterans without adequate support, coupled with hostile managers telling us Section 7422 does not let us speak up about anything—it is becoming harder and harder not to leave.

[The prepared statement of Ms. Hilsabeck follows:]

PREPARED STATEMENT BY AMMIE HILSABECK, REGISTERED NURSE, OSCAR G. JOHNSON VA MEDICAL CENTER, IRON MOUNTAIN, MICHIGAN, ON BEHALF OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Mr. Chairman and Members of the Committee: The American Federation of Government Employees (AFGE) appreciates the opportunity to testify today on pending health-related legislation. AFGE represents nearly 160,000 employees in the Department of Veterans Affairs (VA), more than two-thirds of whom are Veterans Health Administration (VHA) medical professionals on the front lines treating the physical and mental health needs of our veteran population.

S. 362

Overview

AFGE strongly supports S. 362 to amend the law that provides Title 38 medical professionals with collective bargaining rights: Section 7422 of Title 38 (hereinafter "Section 7422"). Bargaining rights enable labor-management disputes over matters that affect working conditions to be resolved efficiently through grievances, arbitrations and negotiations.

S. 362 is needed to clarify which workplace issues are covered by Section 7422. VA human resource policy interprets Section 7422 to deprive Title 38 employees of the same bargaining rights used every day by other VHA employees covered by Title 5 bargaining rights law.[1]

For example, registered nurses currently have far fewer bargaining rights than licensed practical nurses (LPN) and nursing assistants (NA) working at the same facility; psychiatrists cannot grieve over routine working conditions while social workers and psychologists working at the same mental health clinic can do so.

S. 362 also would give VA registered nurses, doctors and dentists the same bargaining rights as registered nurses, doctors and dentists performing the same type of work at military hospitals and Federal prison facilities, who are covered by Title 5 bargaining rights.

Last year, VHA testified before this Committee that enacting this legislation would "jeopardiz[e] the lives of our veterans." We believe that what jeopardizes patient care is arbitrarily preventing certain clinicians from speaking up about working conditions that impact the quality and safety of patient care. What hurts patient care is management's unfettered discretion to ignore laws recently enacted by Congress to improve VHA recruitment and retention of registered nurses and physicians, especially in the face of growing national shortages. (In 2008, VHA ranked RNs and physicians as the top two "mission-critical occupations for recruitment and retention.")

VHA policy did not always single out Title 38 employees for unequal treatment. In fact, in 1996, labor and management entered into an agreement about how to interpret Section 7422 to limit the number of disputes over what matters could be negotiated. They agreed to interpret "direct patient care" narrowly and allow grievances over routine matters such as nurse schedules and pay surveys. During that period, VHA also recognized the importance of affording full collective bargaining rights to all employees. In a 2002 VHA directive, that "applie[d] to all categories of employees in VA," the agency stated that collective bargaining "safeguards the public interest" and "facilitates and encourages the amicable settlement of disputes between employees and their employers involving conditions of employment." A year

[1] Most VHA employees are covered by one of three major personnel systems:

- Title 38 covers eight positions: registered nurses (RN), physicians, dentists, physician assistants, optometrists, chiropractors, podiatrists and expanded duty dental auxiliaries.
- Title 5 covers the most VHA positions and includes nursing assistants and medical technicians. All Title 5 employees at VHA have full bargaining rights.
- Hybrid Title 38, the newest system, applies Title 38 rules to hire and appoint employees and Title 5 rules to bargaining. Therefore, hybrids, including psychologists, social workers, LPNs and pharmacists have full bargaining rights.

later, the new administration began singling out Title 38 employees and severely curtailing their bargaining rights.

We agree with VHA that collective bargaining is a valuable safeguard. AFGE urges passage of S. 362 so that access to this safeguard and effective dispute resolution tool does not depend of which personnel system applies, or whether the patients are veterans, active duty personnel or Federal prisoners. In addition, this legislative change will ensure the use of consistent personnel policies even when administrations change. (Opponents of this legislation have not expressed objection to the other two bill provisions. Section 2 of the bill would provide Title 38 employees with the right to appeal arbitrator decisions to court and Section 3 would strengthen their right to a hearing transcript following agency personnel hearings.)

Exceptions to Title 38 Bargaining in Current Law

Current VA policy severely limits Title 38 bargaining rights by applying the three exclusions to bargaining in Section 7422 very broadly: direct patient care, peer review, and compensation.

Contrary to Congressional intent, since 2003, VHA has applied an overly broad interpretation of the "direct patient care" exception to prohibit bargaining over a wide range of indirect patient care matters related to routine working conditions such as scheduling and assignments. Congress clearly intended to narrowly define the "direct patient care" exception as limited to medical procedures physicians follow in treating patients. In contrast, Congress 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).)

VHA's interpretation of the compensation exception is also overly broad and contrary to Congressional intent. VHA applies this exception not just to negotiation over the setting of pay scales (which is clearly prohibited already by Title 5 for all Federal employees), but also entitlements to "additional pay" such as overtime, weekend pay and retention pay that Congress has specifically enacted to ensure a fair and desirable workplace.

How collective bargaining rights are used in the healthcare workplace

Collective bargaining is an efficient dispute resolution process that requires management and labor to participate in grievance hearings, arbitrations and negotiations over conditions of employment. For example, collective bargaining requires labor and management to participate in grievance hearings about nurse overtime pay is paid according to law, and negotiations over training for new computer systems. Otherwise, management can simply walk away, leaving employees with no recourse to resolve a dispute, even when it involved a matter that could hurt patient care, such as excessive mandatory nurse overtime or assignment of nurses to new hospital units without adequate training.

Contrary to what opponents have contended, collective bargaining cannot be used to:

- Require management to negotiate over disputes related to the agency's mission such as medical procedures or the qualifications of medical professionals;
- Prevent the employer from removing an unfit employee from the workplace;
- Allow employees to "walk off the job" and abandon patients in order to participate in a grievance hearing or negotiation session.

VHA "7422" Policy Wastes Health Care Dollars on Unnecessary Disputes

The ambiguous exceptions in Section 7422 need to be eliminated. They are unnecessary because Title 5 already clearly prevents Title 38 employees from interfering with management's mission. This policy also wastes patient care dollars because it results in many costly, time-consuming and demoralizing labor-management disputes. Opponents point to the number of Undersecretary of Health (USH) decisions published each year. They fail to point out that the actual number of disputes is far greater for two reasons. First, not every USH decision is published. Second, even though the USH has the sole authority to make these determinations, local human resource personnel regularly make unauthorized decisions denying employees their rights to grieve and negotiate. (The fact that VHA has not curbed this widespread, unauthorized practice is also troubling.) Many employees never challenge decisions made at the facility level because they are discouraged by the unlikelihood of success. The USH ruled in favor of management in 100% of the published cases in 2003, 2005, 2006 and 2007, and in all but two cases in 2004.

Employees and their representatives are also discouraged from seeking USH review because of the lengthy process required. Many cases take several years to reach the USH. VHA waited seven years to invoke Section 7422 to block a challenge

by Asheville, North Carolina operating room nurses over unfair policies on weekend pay.

Opponents of S. 362 contend that Title 38 employees will use their expanded bargaining rights to interfere with patient care, but they have not, and cannot, point to a single example of attempts to interfere in this matter or in the setting of pay scales. A review of all published USH decisions since 2003 reveals that the vast majority involve routine disputes over matters such assignments, schedules and noncompliance with pay rules, and none relate to medical procedures or pay scales.

Elimination of the exclusions in Section 7422 will not result in employee interference with patient care or setting of pay scales because Title 5 already sets clear limits on the scope of bargaining for all VHA employees, as discussed shortly. Section 7106(a) (which also covers Title 38 employees) clearly states that management rights—the determination of the agency mission, budget and organization—are not subject to bargaining. Similarly, employees cannot interfere with pay rates; Chapters 53 and 71 of Title 5 have always barred all Federal employees from bargaining over the setting of pay scales. In contrast, Section 7103(a)(14) of Title 5 makes it clear that Federal employees can only bargain over "conditions of employment."

Multiple decisions by the Federal Labor Relations Authority (FLRA) confirm that Title 5, standing alone, would prohibit Title 38 employees from interfering with direct patient care. More specifically, the FLRA has ruled that the union cannot require negotiations on even when services are to be provided to the public for "mission" reasons. It follows that Title 5 prevents a union from forcing negotiations over the substance of patient care.

Collective bargaining increases accountability and improves patient care

Current policy prevents RNs, physicians and other Title 38 employees from challenging workplace policies that lessen the quality and safety of patient care. For example, research on nurse overtime has clearly shown that exhausted nurses are more likely to make medical errors. In 2004, Congress enacted legislation to limit mandatory overtime except in cases of emergency. When local directors invoked the "emergency" exception to cover up for poor staffing policies, AFGE tried to negotiate with VHA for a nationally uniform definition of the term, but VHA refused.

Bargaining rights play a valuable role in agency innovation. A decade ago, VHA implemented two new health care information technology (IT) systems: Computerized Patient Record Systems and Bar Code Medication Administration. These health care IT innovations helped transform the VA into a world-class health care system and national model. When these systems were introduced, labor used its bargaining rights to negotiate over training and IT support to ensure that Title 38 nurses could provide patient care effectively and without interruption during computer breakdowns. Sadly, under current VHA policy, these negotiations would be prohibited as interfering with "direct patient care." Full bargaining rights for VHA doctors and nurses will allow them to once again make valuable contributions as the new administration undertakes major IT changes.

In contrast, nurses and doctors who work at Department of Defense (DOD) and Bureau of Prison (BOP) healthcare facilities have been able to use their full rights to positively impact patient care. For example, physician assistants (who would fall under Title 38 at the VA) participated in negotiations over all 19 BOP health services program statements currently in effect, including "Health Services Quality Improvement," "Infectious Disease Management," and "Health Information Management."

In summary, AFGE urges this Committee to support S. 362 to provide all VHA clinicians with the same bargaining rights. This legislation will vastly reduce the number of wasteful, demoralizing labor-management disputes at medical facilities and allow all of VHA's dedicated clinicians to make positive contributions to health care delivery.

S. 252

Overview

AFGE thanks Chairman Akaka for his leadership in introducing legislation again this year to address the needs of front-line VHA nurses for more competitive pay and schedules, increased loan assistance and equal rights for part-time nurses, and we urge passage of these provisions. However, we strongly oppose the provision to expand the Hybrid Title 38 personnel system, and therefore urge the Committee to strike this language from the bill and substitute a provision for further study of this poorly functioning, nascent personnel system. Age's objections to other provisions in this bill are discussed below.

Section 101(a): This provision would immediately transfer over 11,000 nursing assistants from Title 5 to Hybrid Title 38 status, and allow the Secretary to transfer over 20,000 more Title 5 employees to Hybrid status. Further expansion of this broken system could be disastrous. Therefore, we urge lawmakers to strike Section 101 (a) from the bill and substitute language to request a comprehensive study of the Hybrid Title 38 system to determine if and how can be fixed prior to further expansion.

The Hybrid Title 38 personnel system has failed to meet its top objective: flexible, expedited hiring of healthcare personnel at the facility level. The system is currently plagued by so many delays during the initial boarding process and ongoing hiring and promotion processes that VHA has had to hire additional staff just to deal with current backlogs and problems. For example, it took more than four years for social workers and some psychologists to be "boarded" (transferred to the Hybrid system from Title 5). VHA social workers report that it can take more than six months to hire new social workers. Hiring is so cumbersome and slow that in many cases, it is still faster to hire under Title 5. Proponents of Hybrid expansion contend that the Title 5 hiring process is too slow, but it is worth noting that the VA recently hired 4,000 new Title 5 disability claims processors without delay.

In addition, veterans' employment rights appear to be weaker under Hybrid Title 38 than under Title 5, depriving hundreds of veterans employed by VHA of the ability to enforce their rights through the Merit System Protection Board and Labor Department. Further study is needed to clarify the scope of veterans' preference under different VHA personnel systems prior to placing more employees under the Hybrid system.

Promotion policies are less equitable under the Hybrid system as well, which impacts VHA recruitment and retention. Currently, Hybrid Title 38 employees have little or no recourse if management refuses to allow them to go before professional standards board to be considered for promotion "above the journeyman level." Even when promotion is recommended, management can refuse to promote. This has greatly impacted social workers and psychologists, among others.

In summary, AFGE urges further study of the Hybrid Title 38 system prior to further expansion, to determine if and how the system can be improved, or whether Title 5 (and possibly new Title 5 streamlined procedures) would better serve VHA's workforce needs. It will also be worthwhile to examine how VHA recruitment and retention of specific professions is faring under the Hybrid system, for example, mental health providers, licensed practical nurses and pharmacists.

Section 101(b) and (c): AFGE strongly supports these provisions. Part-time VA registered nurses (RN) have "fallen through the cracks" of Title 38 for too long. Under current law, a RN hired on a full-time basis can become a permanent employee after two years. In contrast, RNs who are hired as part-time can never obtain personnel rights and benefits associated with permanent status. It is equally unfair that RNs who worked for years on a full-time basis lose all their rights when they convert to part-time, for example, to start a family or care for elderly relatives. These provisions provide a simple, equitable fix: After the equivalent of two years of work, part-time nurse achieve the same status as their full-time counterparts, and nurses who have already achieved permanent status retain it when they change to a part-time schedule.

Section 101(d)–(f): AFGE takes no position on these provisions

Section 101(g): AFGE opposes this provision to pay $40,000 recruitment and retention bonuses to pharmacist executives. These large bonuses should only be put into law after a showing of clear evidence of a national recruitment and retention problem for all VHA pharmacist positions (including pharmacists and pharmacist techs working directly with patients). For example, this Committee recently relied on a comprehensive study of recruitment and retention problems for Certified Registered Nurse Anesthetists to support pay adjustments for them. We estimate that this proposed pay increase change would allow a pharmacy executive in Washington State to earn over $173,000 and a pharmacy executive in Salem, Virginia, to earn $183,000.

Section 101(h): We take no position on Section 1(h)(1) on non-foreign COLAs.

We object to Section 1(h)(2) that would allow VHA to set the market pay differently for management physicians and dentists than practitioners providing hands-on care. We see no justification for exempting no practicing physicians and dentists from the same peer-based compensation panel system used by practitioners providing direct care. Congress enacted this elaborate system in 2004 (Pub. L. 108–445) specifically to ensure that market pay was set fairly and at a level that was competitive with pay offered by other local health care employers. Exempting management clinicians from this statutory pay process will undermine Congressional intent and increase pay decisions based on favoritism rather than market conditions.

We urge the Committee to strike this provision and instead, conduct oversight of the 2004 law prior to making any further amendments to it.

We strongly object to Section 1(h)(3) that would allow pay reductions based on changes in board certification or reduction of privileges. The board certification provision will disproportionately impact newer physicians and dentists who are required to qualify for renewal of their board certification every ten years (unlike older practitioners whose board certification is permanent). VHA should create new incentives, not disincentives, to recruit and retain new clinicians. Many VA clinicians have difficulty securing the leave to renew their certification in a timely manner. Therefore, this will also disproportionately impact clinicians in rural hospitals and other facilities that are short-staffed. Similarly, we object to tying pay to privileges as they are completely within management's discretion. Currently, management can provide themselves with full privileges even though they do not see patients, but arbitrarily restrict or deny privileges of hands-on physicians and dentists in retaliation for voicing their concerns through avenues such as union grievances, lawsuits and complaints to the Inspector General.

Sections 101(l) and (n): AFGE supports this provision to adjust the pay caps for Cranes (as already discussed) and Lens (whose modest wages often hit the pay cap when annual Federal pay raises are provided).

Sections 101(j) and (l): AFGE opposes these provisions to provide significant increases in base pay and retention bonuses ("special pay") to nurse executives. This represents a 400 percent increase over five years. (In 2004, Congress enacted a $25,000 ceiling on nurse executive retention bonuses.) We estimate that in North Carolina, this would allow some nurse executives to earn almost $240,000, and in Washington State, $243,000. AFGE opposes such a large increase absent sufficient evidence of a national recruitment and retention problem for VHA nurse executive positions.

Section 101(k): AFGE supports this provision to provide additional director training on the RN third party locality pay survey process. This will assure that surveys are conducted properly and will result in VHA pay that is competitive with the private sector. Providing employees and their representatives with survey data about their own pay is also a common-sense fix that will lead to greater accountability.

Sections 101(m): AFGE supports this provision to "fine tune" the rules for overtime and shift differential pay of all VHA nurses to ensure fair and consistent payment of additional pay, and keep VHA competitive with other employers applying similar rules.

Section 102 (a–b): AFGE supports this provision to provide clearer language to limit mandatory overtime for RNs and extend this limit to other nursing positions, as well as protect against retaliation for refusal to work a prohibited schedule. The definition of "emergency" is consistent with state nurse overtime laws that already protect other nurses from excessive mandatory overtime. AFGE notes, however, that under current VHA policy on Title 38 collective bargaining, RNs will not be able to enforce their rights to refuse to work prohibited schedules (but Lens and NAs with Title 5 bargaining rights will be able to seek enforcement through grievances).

Section 102(c): AFGE supports this provision to encourage greater use of alternative work schedules (AWS) by VHA. AWS is valuable nurse recruitment and retention tool as it is widely offered in the private sector. AFGE notes, however, that under current VHA policy on Title 38 collective bargaining, RNs will be unable to enforce their rights to AWS if VHA continues to refuse to offer it (in contrast to LPNs and NAs with full bargaining rights.)

Section 103: AFGE supports these improvements to VHA loan assistance programs including greater access to this assistance by current employees seeking additional training.

Section 104: AFGE generally supports strong standards for physician appointments but notes that most of these proposed requirements are already in practice at VHA. AFGE opposes VISN approval of physician appointments: this will bog down an already slow hiring process and further impede the VA's ability to hire physicians. AFGE calls for further study of the impact of tying performance to board certification prior to implementing this provision; it could have an adverse impact on VHA's ability to recruit physicians without enhancing quality of care. More generally, as already discussed, AFGE urges the Committee to conduct oversight of a broad range of physician issues, including implementation of the base, market and performance pay provisions in the 2004 physician and dentist pay bill, the "24/7" rule and other scheduling matters, panel sizes, continuing medical education reimbursement and board certification.

Section 201: AFGE strongly opposes elimination of this modest annual reporting requirement that holds VHA accountable to Congress for its nurse locality pay policies. We see no benefit, and only problems, with allowing VHA to conduct critical

nurse recruitment and retention policies in secrecy, especially given the need for highly effective pay policies during this growing national nursing shortage. More generally, the process of setting front-line nurse locality pay or nurse executive retention bonuses should be far more transparent.

Sections 202–214: AFGE takes no position on these sections.

Section 215: AFGE supports increased access to TBI care but is concerned about the minimal oversight provisions in this section. Therefore, AFGE urges the Committee to conduct regular oversight into all contract care arrangements, including the ongoing Project HERO pilot operating in four VISNs, to ensure that veterans' needs are well served by non-VA providers in terms of quality of care, coordination of care, timeliness of care and geographic accessibility. In addition, oversight of all contract care arrangements should include consideration of the impact of diverting patients and patient care dollars on the VA's capacity and budget for providing in-house care, a comparison of the cost and quality of patient care with care provided through increased in-house capacity and providing care through VHA's extensive telehealth system. The long range impact of contract care on the VA's role as a leading researcher and training ground for practitioners across the country should also be evaluated.

Section 216: AFGE has not taken a position on this section

Section 217: AFGE opposes this provision to pilot a contract dental care program. AFGE supports instead VA-provided outpatient dental care to all enrolled veterans without imposing additional costs on them or their families.

Title III: AFGE takes the same position on Title III of this bill and S. 597. We fully support provisions to improve and expand health care services to women veterans and their families.

Title IV: AFGE has not taken a position on this section.

Title V: AFGE has not taken a position on this section.

Title VI: AFGE has not taken a position on this section.

Title VII: AFGE supports these provisions for VA police officers. AFGE also recommends the additional language providing that in the event that an offense takes place in the presence of the officer while off Department property, he or she may take appropriate action to—protect life, and may exercise any authority authorized by an express grant of authority under applicable Federal, State or local law.

S. 821

AFGE supports this legislation to eliminate copayments from veterans who are catastrophically disabled.

S. 801

AFGE supports this legislation to provide assistance to family caregivers.

S. 793

AFGE supports this legislation to increase tuition assistance for individuals training for positions to care for the visually impaired.

S. 772

AFGE has not taken a position on this bill.

S. 734

AFGE supports this bill, including much needed provisions to increase oversight of contract care. As already discussed (see Section 215 of S. 252), AFGE urges the Committee to conduct comprehensive oversight of all contract care arrangements and should coordinate activities under this program with oversight of Project HERO that already operates in four VISNs.

S. 699

AFGE has not taken a position on this bill.

S. 658

AFGE supports this legislation to improve access to health care for rural veterans. In Section 6, AFGE urges greater oversight of contract care consistent with our recommendations in our comments on Section 215 of S. 252 and S. 734.

S. 597

AFGE supports this legislation to improve health care services for women veterans and their families.

S. 543

AFGE has not taken a position on this bill.

S. 509

AFGE supports this bill for construction of new facilities and other improvements at the Walla Walla, WA VAMC.

S. 498

AFGE has not taken a position on this bill.

S. 423

AFGE supports this legislation to authorize advance appropriations for VA health care.

S. 404

AFGE supports this legislation to expand eligibility for emergency medical care.

S. 246

AFGE has not taken a position on this bill.

S. 239

AFGE has not taken a position on this bill.

S. 226

AFGE has not taken a position on this bill.

Senator SANDERS. Thank you very much.

Ms. Heady?

STATEMENT OF HILDA R. HEADY, MSW, ASSOCIATE VICE PRESIDENT OF RURAL HEALTH, ROBERT C. BYRD HEALTH SCIENCES CENTER, WEST VIRGINIA UNIVERSITY, AND PAST PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION

Ms. HEADY. Thank you. I am thrilled to be able to present to the distinguished members of the panel. I am the Associate Vice President for Rural Health at the Robert C. Byrd Health Sciences Center at West Virginia University and I was honored last summer to have been appointed by former Secretary Peake to the National Advisory Committee on Rural Health in the VA.

NRHA is the rural voice for 62 million Americans who call rural their home; and NRHA has focused on the issue of rural veterans and studied policy matters since 1997. We particularly want to address some of the measures in S. 734 and S. 658 today.

Rural Americans have responded every time the country has gone to war. I am from a very small rural Southern community and a family that can trace its generations in American wars all the way back to the American Revolutionary War, and with the exception of the War of 1812 and the Spanish-American War, I have had members in all of these combats.

One of my uncles served with General Patton in World War II and stormed the beaches of Normandy, returned home to become a sharecropper in Northern Alabama, and died of a heart attack at the age of 41 as a rural veteran who never received VA benefits.

He left a young widow and five children. If Senator Akaka's bill, S. 734, had been the law of the land in those years following World War II, perhaps access to health care would have been closer to his small rural community and perhaps high-quality trained primary care physicians, whose training was supported by the incentives in the bill such as the National Health Services Corps, the Education Debt Reduction Program, and training in post-deployment health issues, may have enabled a physician to detect his heart disease and prevent his premature death, and perhaps his children would not have grown up with a single mother struggling to provide for them.

In brief, NRHA supports the increase of access and building on the current successes of the CBOCs, mobile clinics, and outreach clinics, and certainly the Vet Centers. We need more rural outreach coordinators in each VISN that serve high numbers of rural veterans, as pointed out in this bill, because these individuals are involved in contracting fee-for-services with existing rural providers. And we need to focus special efforts on recruiting existing rural providers in these areas to work under these contracts with the VA.

Linking quality of VA services with quality rural civilian services just simply makes sense, and as long as quality standards of care and evidence-based medicine guide the treatment for rural veterans, then we strongly support these collaborations with community health centers, critical access hospitals, other rural hospitals, and rural health clinics.

We need to increase the access to mental health care services, particularly for those with PTSD and Traumatic Brain Injury. We need more TBI case managers. The current load of TBI case managers do not adequately address those individuals who are in rural areas. Rural areas suffer from very limited health care professionals, and where 75 percent of primary care HPSAs are located in rural areas, 85 percent of our shortage areas in mental health are in rural areas. The provisions of S. 734 that call for the increases in training of mental health providers and volunteer counselors would go a long way to helping in that area.

Travel reimbursement will also address some critical needs, especially air service for those individuals that are in highly rural areas.

We also call for an increase in the collaboration around research that will look at non-enrolled veterans. Most of the research that is currently done by the VA is only done on secondary databases of veterans who are enrolled, and since we know that the VA only serves 39 percent of veterans, then we are leaving out 61 percent of those veterans, and we know that a number of those individuals are in rural areas. This would be a natural tie-in to the Centers of Excellence that are called for in Senator Tester's bill, S. 658.

I want to commend Senator Murray for introducing the women veterans bill and I think that we need to point out that among the 15 percent total number of women that are in the military service right now, 37.5 percent of those women are African-American women and we need to pay special attention to this population as they become veterans and in need of our services.

Thank you very much for the legislation. This is a huge agenda, and with very little exceptions, the National Rural Health Association is very pleased to support most of these efforts. Thank you.

[The prepared statement of Ms. Heady follows:]

PREPARED STATEMENT OF HILDA R. HEADY, MSW, ASSOCIATE VICE PRESIDENT OF RURAL HEALTH AT THE ROBERT C. BYRD HEALTH SCIENCES CENTER, WEST VIRGINIA UNIVERSITY, NATIONAL RURAL HEALTH ASSOCIATION, PAST PRESIDENT

Chairman, Akaka, Ranking Member Burr, and Members of the Senate Committee on Veterans' Affairs: Thank you for the honor and the opportunity to speak to you today about the health care needs of our rural veterans. I am Hilda Heady, Associate Vice President of Rural Health at the Robert C. Byrd Health Sciences Center at West Virginia University, a committee member of the VA Veterans Rural Health Advisory Committee, and past president of the National Rural Health Association (NRHA). The NRHA provides leadership on the issues that affect the health of the 62 million Americans who call rural home and has long focused efforts on improving the physical and mental health of our rural veterans.

Since our Nation's founding, rural Americans have always responded when our Nation has gone to war. Whether motivated by their values, patriotism, or economic concerns, the picture has not changed much in 230 years. Simply put, rural Americans serve at rates higher than their proportion of the population. Though only 19% of the Nation lives in rural areas, 44% of U.S. Military recruits are from rural America. And, sadly, according to a 2006 study of the Carsey Institute, the death rate for rural soldiers in our current war in Iraq is 60% higher than the death rate for those soldiers from cities and suburbs. Given this great commitment to service from our rural communities, we need to do more to resolve the health care barriers that face rural veterans.

There is a national misconception that all veterans have access to comprehensive care. Unfortunately, this is simply not true. Access to the most basic primary care is often difficult in rural America. Access for rural veterans can be daunting. Combat veterans returning to their rural homes in need of specialized care due to war injuries (both physical and mental) will likely find access to that care extremely limited. Scarcity of mental health and family counseling services is also a problem for rural veterans in need of these services.

Simply put, because there are a disproportionate number of rural Americans serving in the military, there is a disproportionate need for veteran's care in rural areas. While the VA has increased the number of Community Based Outpatient Clinics (CBOCs), Outreach Health Centers, Home Based Care, or other outreach service programs in rural communities, it is not reasonable to expect that the VA can put a CBOC or one of these other services in every community where our rural and highly rural veterans live. We can, however, increase access to approved sources of care to overcome the difficulty rural veterans experience in attempting to receive timely, appropriate care.

In West Virginia, more than half of all our veterans live in rural areas. Veterans represent over 14% of our population and that is growing: the state of West Virginia supports a military complex of Army and National Guard, Army and Air Reserve Components, plus Navy and Marine Reserve Units. Many of our soldiers in these units are serving their second or third tour of duty in Iraq or Afghanistan, but hopefully will return home soon. A vast number will return home to rural communities scattered across the state, often several hours' drive from veteran health care facilities. Many will simply forego care because this access is so difficult.

The NRHA strongly supports specific solutions to meet the challenges of providing quality care to our rural veterans. The NRHA believes that improving access to care for our Nation's rural veterans must be a priority for both the Administration and Congress, and submits the following recommendations:

1. Increase Access by Building on Current Successes

Community Based Outreach Centers (CBOCs) open the door for many veterans to obtain primary care services within or close to their home communities. Additionally, Outreach Health Centers and mobile clinics meet the needs of many rural veterans. NRHA applauds the success of these programs as well as recent increases in Federal appropriations. Expansion of these critical services is needed.

2. Increase Access by Collaborating with Non-VHA Facilities

Approximately 20% of veterans who enroll to receive health care through the VHA live in rural communities. In addition, the VA currently serves only 39% of all veterans, so we know that a number of rural veterans rely upon their local, civilian

health care system for services and some may not receive any care. With an ever-growing number of veterans returning home to their rural communities after military service, these rural health care systems must be prepared to meet their needs. While CBOCs and Veteran Outreach Centers provide essential points of access, there are not enough of these facilities in rural communities. Furthermore, CBOCs do not provide a full range of care and the low volume of veterans in some communities may never be able to support one of these centers. Simply put, more providers, specifically trained in post-deployment health conditions and care, are needed to serve the increasing number of rural veterans. Collaboration with existing rural health care facilities provides a cost-effective, timely and quality solution to this problem.

Linking the quality of VA services with rural civilian services can vastly improve access to quality health care for rural veterans. Our goal is not to mandate care to our veterans, but to provide them a choice, a local choice. As long as quality standards of care and evidence-based medicine guide treatment for rural veterans, the NRHA supports collaboration with:

• *Community Health Centers.* These centers serve millions of rural Americans and provide community-oriented, primary and preventive health care. More importantly, FQHCs are located where rural veterans live. A limited number of collaborations between the VHA and Community Health Centers already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. These successful models should be expanded to reach all of rural America.

• *Critical Access Hospitals and other rural hospitals.* These facilities provide comprehensive and essential services to rural communities and are specific to rural states. If these facilities are linked with VHA services and models of quality, access to care would be greatly enhanced for thousands of rural veterans.

• *Rural Health Clinics.* These clinics serve populations in rural, medically-underserved areas and comprise a vital piece of the safety-net system. In many rural and frontier communities, RHCs are the only source of primary care available.

The above rural health facilities are the cornerstone of primary and preventive quality health care in rural America. Each is required to meet Federal requirements for quality, provider credentialing and the use of health information technology. Current collaborations with the VHA in Wisconsin, Missouri and Utah are strong examples of success. Expanding the levels of collaboration will vastly increase access to care in a cost-effective manner.

The NRHA is pleased that the Rural Veterans Access to Care Act was signed into law last October. This act establishes a three-year pilot program in several rural regions of the country to allow the most underserved rural veterans to take advantage of existing quality rural health providers, such as Critical Access Hospitals, community health centers and rural health clinics. The pilot project is relatively small and requirements to qualify are rigid a veteran must live at least 60 miles from a VA primary care facility like an outpatient clinic, 120 miles from a VA hospital or 240 miles from a VA specialized-care facility when seeking that care. Despite these defects, this legislation is an important step in the right direction, but so much more must be done.

S. 658, the Rural Veterans Health Care Improvement Act, is an important next step because it will allow even greater access to care or rural veterans. Specifically, one section authorizes the Office of Rural Health to improve or expand care for rural veterans through a series of demonstration projects that includes coordination with Community Health Centers, Critical Access Hospitals and Indian Health Services. We thank Senator Tester for introducing this bill and for this Committee's examination of it.

Additionally, S. 734, the Rural Veterans Health Care Access and Quality Act of 2009, is yet another crucial step. This Act establishes a pilot project that would provide financial incentives for physicians who serve in a Health Professional Shortage Area to provide primary care or mental health services to rural veterans. Such a program could go far in improving access to care for rural veterans, especially meeting the great unmet mental health needs of our Nation's veterans. The NRHA applauds Chairman Akaka for introducing this important bill. Care must be taken that laudable efforts to increase provider care for our veterans does not exacerbate the current provider shortage in rural areas. Because access to primary care in rural America is at crisis levels for all both civilian and non-civilian patients, it is also important to be mindful that any incentives do not inadvertently reduce providers at non-VA facilities.

3. Increase Access to Mental Health and Brain Injury Care

Currently, it appears that Traumatic Brain Injury (TBI) will most likely become the signature wound of the Afghanistan and Iraqi wars. Such wounds require highly

specialized care. The current VHA TBI Case Managers Network is vital, but access to it is extremely limited for rural veterans—expansion is needed.

Additionally, mental health needs of combat veterans deserve special attention and advocacy as well. Access to mental health services is a problem in many small rural communities. In fact, 85% of all mental health shortages are found in rural America. A lack of qualified mental health professionals, shortage of psychiatric hospital beds and the negative stigma of mental illness, often result in many rural residents not getting the care they so desperately need. These problems are exacerbated for veterans who live in rural communities—too often members of our military return home to a civilian community where the cultural expectation is self-reliance and to solve one's own problems. In a civilian health care system where few may understand military experience or the special needs of combat veterans, we need to do more to prepare our primary care providers who will serve these veterans.

Although Vet Centers provide mental health services, they are not consistently available at the local, rural level. More resources are needed in order to contract with local mental health providers, hire additional mental health providers and/or contract with Critical Access Hospitals (CAHs) and other small rural hospitals. The provisions in S. 658 that give the VA the clear authority to contract-out mental health services for certain rural veterans is strongly supported by the NRHA. However, without addressing the national need for more mental health providers in rural areas and include post-deployment and/or combat related mental health disorders, the greater impact of S. 658 may be hampered.

4. Target Care to Rural Veterans

A. *Needs of the Rural Family.* Rural veterans have an especially strong bond with their families. Returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transitions back into civilian life. The Vet Centers do a tremendous job of assisting veterans, but their resources are limited. The NRHA supports increases in funding for counseling services for veterans' and their families.

B. *Needs of Rural Women Veterans.* More women serve in active duty than at any other time in our Nation's history. And more women are wounded or are war casualties than ever before in our Nation's history.

Targeted and culturally competent care for today's women veterans is needed. Rural providers should also be trained to meet the unique needs of rural, minority, and female veterans.

5. Improving the VA Office of Rural Health

The NRHA calls on Congress and the VA to fully implement the functions of the newly created VA Office of Rural Health to develop and support an ongoing mechanism to study and articulate the needs of rural veterans and their families.

Additionally, efforts to increase service points for rural veterans have, in large part, not been fully supported by the VA Administration itself. The VA has not consistently supported attempts to collaborate with rural health. It is my hope that with a new Administration and the newly formed VA Rural Health Advisory Committee, previous barriers will be eradicated and the VA Office of Rural Health will lead the way in expanding access options for rural veterans. Furthermore, the NRHA strongly encourages greater coordination between the Rural Health Consultants housed in each VISN and state-level rural health officials in their region. Specifically, quarterly meetings with State Office of Rural Health and State Rural Health Association officials would be prudent.

S. 734 provides important direction for the VA Office of Rural Health. The requirement of establishing a strategic plan to implement specific workforce recruitment and retention goals is imperative for increasing access to care for rural veterans. However, we must again be mindful that any strategic plan to increase providers at VA facilities does not inadvertently increase the current shortage crisis at non-VA facilities. To this end, collaboration between the Federal Office of Rural Health Policy within HRSA and the VA Office of Rural Health is critical and must be established to best take advantage of the many efforts to reduce provider shortages in rural areas already underway within HRSA.

6. Explore ways to coordinate benefits for dual eligible veterans

As the veteran population ages, a growing number of veterans are eligible for both VHA health benefits and Medicare. The combination of two partial benefits packages should ensure the best possible care for our veterans, but the co-payments and Medicare Part D requirements may not be affordable for many veterans. Coordination of benefits would allow veterans to utilize the different resources offered to them effectively to receive high quality care close to home.

7. Increase research on defining the rural veteran population

Without good research about the rural veteran population, we cannot possibly expect to ensure their good health. Epidemiological studies are needed to identify the locations and populations of veterans in various rural areas of the country. These studies must provide information about race, gender, place of residence, health care needs, service-related health issues and service utilization. With only 39 percent of veterans enrolled in VA health care benefits, and most VA research conducted on secondary bases of enrollees, we know that non-enrollees who may be rural, less than honorably discharged, and other veterans in need, are not included in this research. We need to broaden avenues for quality research which would provide information about how to best serve the veteran population who are currently not enrolled. The NRHA would encourage the VA to collaborate with the six Federal Office of Rural Health Policy/HRSA-funded Rural Health Research Centers to explore this research.

CONCLUSION

While many opportunities for improvement exist in providing care to veterans in rural communities, the VA is to be commended for the excellent service provided in many of its facilities. However, we must never forget that many veterans forgo care entirely because of access difficulties to VA facilities. Providing health care in rural communities requires unique solutions, whether it is to veterans and their families or the general population. Additionally, we must all be mindful of long-term needs and costs of our sailors and soldiers. The wounded veterans who return today won't need care for just the next few fiscal years; they will need care for the next half century.

Both S. 734 and S. 658 are crucial pieces of legislation that will vastly improve the access to health care for our Nation's rural veterans. Adopting the legislation and other strategies referenced in this written testimony will vastly improve the lives of the millions of veterans who live in rural America. Their service to their Nation affords them no less.

Thank you again for this opportunity.

Senator BEGICH [presiding]. Thank you for your testimony. The Chair keeps rotating, so you have to bear with us.

Mr. Ibson, please.

STATEMENT OF RALPH IBSON, SENIOR FELLOW FOR HEALTH POLICY, WOUNDED WARRIOR PROJECT

Mr. IBSON. Thank you. Mr. Chairman and Members of the Committee, thank you for inviting Wounded Warrior Project to testify about pending legislation, particularly S. 801, a measure that would direct VA to develop a nationwide comprehensive wounded warrior family caregiver program; and S. 543, which calls for a pilot program to assess the feasibility of providing such support.

Both bills recognize the extraordinary burdens being shouldered by family caregivers. Like wounded warriors themselves, family caregivers must adjust to a new normal in taking on what may be a lifetime of committed care.

Wounded Warrior Project knows firsthand the challenges these family members face and believes the time has come to create a comprehensive nationwide program to sustain that caregiving. The establishment of such a program is our top legislative priority and we offer our overwhelming support for S. 801, the Family Caregiver Program Act of 2009.

We applaud Chairman Akaka's leadership in taking up this important issue and working so closely with Ranking Member Burr to craft this strong bill.

S. 801 incorporates all the elements we believe are essential to helping families sustain the caregiving needed by our wounded warriors. We have reached that view based on exhaustive research

on family caregiving needs documented in a paper we would like to submit for the record. [Please find "Sustaining Family Caregiving for Wounded Warriors: The Need for a Comprehensive Caregiver Program" after Mr. Ibson's prepared statement]

S. 543, also before the Committee, would provide some of the supports we view as critical, but the measure falls short, in our view. It would not provide the full range of needed supports and is limited in scope to a 2-year pilot involving relatively few facilities. We believe the time for pilot programs is long past.

Family caregivers are a vital link in the rehabilitation of severely wounded warriors, but these families have no assurance of ongoing governmental support. That lack of support threatens to take its toll. Studies show that family caregivers experience an increased likelihood of stress, depression, and mortality as compared to their non-caregiving peers. Caregiving takes an economic toll, as well.

Let me share just two examples from among the many caregivers with whom we have worked closely. Jennifer was forced to leave her teaching job to care for her husband, who was struck by an IED in Iraq in 2005. His injuries resulted in total blindness and severe TBI and he is on medications to control seizures and many other problems. In her 3 years of full-time caregiving, Jennifer has received no training of any kind and no supplemental income. She had not been made aware of any VA respite care program when we interviewed her recently.

Charlene, another caregiver, lost her job after 2 months of caring for her wounded warrior son, who sustained severe TBI in 2003 and requires full-time care. She has health care coverage, but only through her husband's health program, and they pay significant premiums for that care, having gone from a two-income to a single income family. Charlene recently underwent a heart biopsy and heart catheterization and states plainly that her caregiving activities are extremely stressful.

Without ongoing support, many of these family caregivers will simply find themselves unable to cope. The ultimate cost of failing to address their urgent needs is surely to increase the risk of veterans being needlessly institutionalized at great cost.

I was struck, and perhaps others of you on the Committee were, as well, that VA expresses its opposition to S. 801 in part on the ground that it would, quote, "divert from the primary mission of treating veterans and training clinicians." I can think of no higher calling in law or policy than the care, rehabilitation, and well-being of wounded warriors. That is the essence of what S. 801 is about and it is disappointing that the Department's testimony misses that point.

Further, the Department offers as a solution a position that I think Senator Burr ably demolished, but a position articulated last September in hearings on the House side, proposing that caregivers might be employed by home health agencies. Senator, as you ably pointed out, the VA has no evidence to show that that is a workable solution. In the months since last September, nothing has changed and no evidence was put on the table to suggest that this is at all plausible. It simply isn't a mechanism by which to support family caregivers. S. 801 is just such a mechanism and it has our full support.

We would welcome the opportunity to discuss the elements of the bill in greater detail, including what some families see as a need for somewhat greater flexibility in the bill's oversight provisions. But above all, we urge the Committee to make enactment of S. 801 a top priority.

Thank you for taking up this important issue. I would be pleased to address any questions you might have.

[The prepared statement of Mr. Ibson follows:]

PREPARED STATEMENT OF RALPH IBSON, SENIOR FELLOW FOR HEALTH POLICY, WOUNDED WARRIOR PROJECT

Chairman Akaka, Ranking Member Burr, Members of the Committee: Thank you for inviting Wounded Warrior Project (WWP) to testify about pending legislation, particularly S. 801, a measure that would direct the Department of Veterans Affairs to develop a nationwide, comprehensive wounded warrior family caregiver program, and S. 543, which calls for a pilot program to assess the feasibility of providing such support.

Both bills recognize the extraordinary burdens being shouldered by family caregivers of our Nation's latest generation of wounded warriors, and both seek to support these critical stakeholders in the rehabilitative process. Family caregivers, like their wounded warrior, often must adjust to their own "new normal" as they embark on what may be a lifetime of committed care for their veteran. The time has surely come to create a robust, nationwide wounded warrior family caregiver program to address the urgent needs of these family members. The establishment of such a program is Wounded Warrior Project's top legislative priority, and we offer our overwhelming support for S. 801.

Wounded Warrior Project knows firsthand the challenges these family members face. We work daily with thousands of our alumni to ensure they become the most successful and well adjusted wounded warriors in the Nation's history. Through our nationwide family caregiver outreach and retreat program, Wounded Warrior Project is gathering vital data needed to more appropriately support family caregivers in the rehabilitation of their wounded warriors. This program provides these caregivers much needed respite, counseling, and training. Family caregiver retreats are comprised of participants facing similar challenges based on their unique family roles and experiences. Separate retreats are organized for wives, mothers, and fathers of wounded warriors. Also, we will be holding a caregiver summit in Washington, DC, in late June, and we expect that our family caregivers will visit many of you on the Committee.

WOUNDED WARRIOR PROJECT SUPPORTS S. 801

WWP strongly supports S. 801, "The Family Caregiver Program Act of 2009." This bill reflects a keen understanding of the needs of both severely wounded warriors and the devoted loved ones who selflessly care for them. That understanding is reflected in the establishment of a program that would fully address the long unmet needs of family caregivers while ensuring the well-being of our most profoundly wounded warriors. Mr. Chairman, we applaud your leadership in taking up this important issue and working with the Ranking Member to craft this strong bill. Not only does S. 801 meet a dire and well-established need, but it builds on an array of services—some of which are already provided at many, but not all, VA facilities. These services are simply not currently integrated in a comprehensive manner to support family caregivers.

The Department of Veterans Affairs (VA) has mounted a number of pilot programs to assist family caregivers, and various elements of the VA system already provide many of the services family caregivers need. Thus, there already exists a strong foundation to take the next logical step and establish a nationwide program of comprehensive support. S. 543, "The Veteran and Servicemember Caregiver Act of 2009," would provide some of the supports we view as critical to sustain family caregiving. But the measure falls short. It would not provide family caregivers the full range of needed supports (providing simply for study with regard to needed respite and health care), and it is limited in scope to a two-year pilot program to be carried out at not fewer than six facilities. We believe that the time for pilot programs is past.

S. 801, in contrast, proposes just the type of comprehensive solution Wounded Warrior Project recommends and fully supports. Our wounded warriors and those family members who care for them have compelling needs. S. 801 meets those needs

head on. We commend the Chairman, the Ranking Member, and all the Committee co-sponsors for introducing this urgently needed legislation.

The Need for Family Caregiver Support

While many wounded warriors substantially recover from their wounds and are able to live independently, some have sustained such profound injuries that they will likely need ongoing personal care and assistance for a very long time. These individuals usually want to return to, or remain in, their homes, and strongly resist being institutionalized. In-home care by a loved one also affords the wounded warrior greater access to community-based care, a right that has already been affirmed by the Supreme Court in its *Olmstead* v. *L.C.* decision. Most warriors want to be cared for by their loved ones, if possible, rather than by agency personnel. Most families want the same for their wounded warrior. But the extraordinary demands of caregiving invariably take a toll on family caregivers—physically, psychologically, emotionally, and financially.

Our research makes one thing abundantly clear—very little institutional attention is being paid to family caregivers though they are a vital link in the veteran's rehabilitation process. The President's Commission on Care for America's Returning Wounded Warriors, the Dole-Shalala report, provided powerful data on the nature and magnitude of the problem. Among its findings, the Commission reported that:

- Among OEF/OIF servicemembers surveyed, "33% of active duty, 22% of reserve component and 37% of retired/separated servicemembers report that a family member or close friend relocated for extended periods of time to be with them while they were in the hospital."
- Among OEF/OIF servicemembers surveyed, "21% of active duty, 15% of reserve component, and 24% of retired/separated servicemembers say friends or family gave up a job to be with them or act as their caregiver."

The Well-Established Burden on Family Caregivers

The impact of long-term caregiving on the families of severely disabled individuals in the general population has been extensively studied. These findings underscore the need wounded warrior family caregivers have for the array of services provided for in S. 801.

Studies indicate, for example, that proper caregiver training can reduce the chances of injury for both the caregiver and the recipient. They show further that well-trained caregivers are less likely to use costly, formal supports.

Highlighting the need for access to counseling and other health care services, the studies also show that family caregivers experience an increased likelihood of stress, depression, and mortality as compared to their non-caregiving peers. Those who provide care 36 hours or more per week are more likely than non-caregivers to experience depression and anxiety. Women who provide that level of care to a disabled spouse are six times more likely to experience symptoms of depression and anxiety. Studies also suggest that with each incremental increase in assistance with activities of daily living (ADLs), spousal caregivers experience a greater risk for serious illness. Caregivers report poorer levels of perceived health, more chronic illnesses, and poorer immune responses to viral challenges.

Finally, economic issues associated with caregiving cannot be ignored. The literature suggests that informal (unpaid) caregiving is incompatible with full-time employment. Research shows that even small reductions in work hours to provide unpaid care can result in significant lost wages and a reduction in the caregiver's future pensions and retirement savings. Also, while not specifically addressed in the research, a reduction in long-term wages will obviously result in a reduction in future social security benefits.

Wounded Warrior Project works closely with the family caregivers of our wounded warriors and sponsors frequent caregiver retreats. We have learned firsthand that our caregivers experience the same profound challenges so thoroughly documented in the literature.

Let me share just two examples from among the many with whom we work closely. In late 2005, one of our alumni was struck by an Improvised Explosive Device while serving in Iraq. He was permanently and totally blinded, has severe TBI, and is on medications to control seizures and a host of related issues. His wife was forced to leave her teaching job permanently to care for her husband. She is assisted daily by her mother. In the three years she has been a full-time caregiver, she has received no training of any kind, no supplemental income, and has health care coverage only because she is covered by TRICARE which does not extend to her mother. She was completely unaware of any VA respite care program when we interviewed her. She lives 90 miles from the nearest VA facility.

The mother of one of our alumni lost her job after two months of caring for her son, a severely wounded warrior injured in April 2003, who requires full-time care. She only has health care coverage because she is covered by her husband's health care program, but they pay significant premiums for that care. They have gone from a two-income family to a one-income family. She has had a heart biopsy and heart catheterization done recently and states plainly that her caregiving activities are extremely stressful. She worries about their finances and health care coverage.

The impact on family members such as these of having to care for severely wounded veterans for extended periods of time—and in many cases, for life—can be overwhelming. From the moment one or more family members meet their returning wounded warrior, they come face-to-face with their "new normal."

From the moment they are injured, the wounded warrior and their family members are forced to make decisions about who will provide routine, daily care. While the decision to care for a loved one—a commitment vital to that wounded warrior's recovery—may come easily, the burden of caregiving itself can take an enormous toll on the family. Family caregivers may be forced to take extended leaves of absence or permanently leave their jobs, losing retirement plans, health care plans, savings plans, and benefits plans in the process. In many cases, the wounded warrior requires personal assistance around the clock and may need specialized, daily care which the family caregiver is neither trained nor emotionally equipped to handle. At present, few family caregivers receive training, and they have no formal support network. Many have no access to health care, respite care, counseling, or a way to replace lost income.

The High Cost of Doing Nothing

These family caregivers are, in many cases, the "first responders" to wounded veterans in need. They are often the first ones to detect new challenges to the veteran's rehabilitation and the ones most capable of implementing a positive response to those challenges. Without an appropriate level of support, many of these family caregivers will simply find themselves unable to cope. Over the long-term, such a tragic outcome will ultimately result in an enormous cost to our wounded warriors, their families, and to the health care system which will likely be called upon to care for them.

Setting aside the obligation we owe these warriors and their loved ones, the ultimate cost of failing to address the urgent needs of wounded warrior family caregivers is almost certainly much greater than the cost of establishing a comprehensive wounded warrior family caregiver program for all who need ongoing support. S. 801 clearly recognizes this reality.

There is Currently no Comprehensive, Nationwide Wounded Warrior Family Caregiver Program

While S. 801 envisions a comprehensive nationwide program, it is important to note that many VA medical centers already provide some of the very services and supports proposed in the bill, including respite care and family education and counseling. But none provide all of these services. Nor do they focus in a comprehensive, coordinated way on family caregivers. Family caregivers need more than piecemeal services and support. They have a profound need for the kind of robust national program proposed in S. 801. Based on the experience of our wounded warriors, we believe such a program would contribute enormously to the recovery and rehabilitation of severely wounded warriors. Moreover, we believe it would avert what is otherwise likely to be a growing need for long-term institutional care. In short, establishing a comprehensive family caregiver program such as the one envisioned by S. 801 is not only the right thing to do for our wounded warriors, but a fiscally prudent one.

Given the handful of very limited and inconsistent wounded warrior family caregiver programs and support services now available, families are coping largely on their own. VA testified last year that it provides home health services to veterans in many areas through contract arrangements with some 4,000 home health agencies. But many of the families of our newest generation of wounded warriors consider such services—even if they are available locally—a poor alternative to the care provided by a devoted parent, sibling, spouse, or friend. Local services vary greatly in both quality and quantity. There is no nationwide training standard and no cultural training for local agencies addressing the unique needs of young, severely wounded veterans, particularly those with TBI, PTSD or other psychological health issues. Additionally, for family caregivers who need financial support to enable them to care for their wounded loved ones, VA has no answer other than to refer them to these same local agencies for possible employment.

Legislation is now urgently needed to avert foreseeable family tragedies through creation of a nationwide, comprehensive wounded warrior family caregiver program

such as the one proposed in S. 801. At its core, this legislation would meet a vital need for those seriously wounded warriors who require extensive personal care. This legislation would provide an option not now available to many severely injured veterans whose families cannot meet or sustain their loved ones' caregiving needs.

S. 801 Provides the Kind of Comprehensive Support that Family Caregivers Need

Informed by the experience of our wounded warriors and their families, Wounded Warrior Project enthusiastically supports passage of S. 801. It lays a comprehensive and needed foundation for a VA-administered family caregiver program comprised of three basic elements: training and certification, provision of support services, and a modest monthly allowance. Participation would be predicated on an objective, clinical determination of a veteran's need for extensive daily caregiving, and the family caregivers' capacity to provide the needed assistance.

Under S. 801, an individual who, with the veteran's assent, agrees to serve as the veteran's Primary Personal Care Attendant, and who successfully undergoes training and achieves certification, would be provided the support and services needed to sustain that role. This support and these services would include counseling and needed mental health services; technical support, including access to a Web portal linked to a wide range of nationwide family caregiver support services; 30 days of annual respite care; CHAMPVA health care coverage; and a modest monthly allowance. Other family members can also receive basic family caregiver training, and, upon certification, have access to counseling and technical assistance.

S. 801 provides the full array of support needed by family caregivers while establishing a framework that balances the needs of the wounded warrior and the family caregiver. The legislation provides VA the needed latitude to design and administer the program, but also directs VA to consult with wounded warriors, family caregivers, VSO's and other pertinent organizations during the design and initial implementation phases.

We anticipate that VA would employ an interdisciplinary process to determine the need for caregiving assistance. Such a process would include an objective assessment of the veteran's need for caregiving assistance in performing such routine activities of daily living as feeding, dressing, bathing and other personal hygiene needs. This assessment and a VA family caregiver recommendation would in no way obligate the family. It would simply provide the veteran and family an additional option where feasible and appropriate.

VA would provide all training and certification at no expense to the servicemember or designated family caregiver. VA's responsibility to these family caregivers would not end with training and certification. S. 801 sets the framework to provide direct technical support, including information, assistance, and counseling, and to address routine, emergency, and specialized caregiving needs in a timely manner.

To be effective and sustaining, a family caregiver program design must address the intense burden of daily caregiving. S. 801 does so by including such program elements as respite care of not less than 30 days annually, to include 24-hour per day respite, tailored to meet each Primary Personal Care Attendant's needs.

A viable program must also provide a means of protecting the health of a family caregiver who undertakes the weighty commitment of providing ongoing primary care of a wounded warrior. S. 801 meets that important need by making Primary Personal Care Attendants eligible for medical care under the CHAMPVA program.

Finally, cognizant that many family members must forego employment and often relocate to provide care to a loved one, the authors of S. 801 have met a critical need by providing the Primary Personal Care Attendant a modest monthly stipend based on the level of daily care provided. S. 801 would direct VA to establish a schedule of allowances tied to the amount the Department would pay a commercial home health care agency to provide a commensurate level of personal, daily care authorized for that veteran.

We should note that our focus on the importance of family caregiver assistance outlined in Section 3 of S. 801 does not, in any way, indicate a lack of support for the other provisions of S. 801. Section 2 waives charges for humanitarian care provided to family members accompanying certain severely injured veterans receiving care at a VA, VA-contracted, or "fee-basis" facility. Section 4 authorizes VA to pay lodging and subsistence to attendants who travel with a disabled veteran to receive treatment at a VA facility. These additional proposals serve as logical, additional components of a nationwide family caregiver program, and have our full support.

We welcome the opportunity to discuss the elements of S. 801 in more detail, including what some families see as a need for greater flexibility in the bill's oversight provisions. But, above all, we urge the Committee to make enactment of S. 801, "The Family Caregiver Program Act of 2009," a top priority.

Thank you for your interest in this important issue. I'm pleased to address any questions you or other Members of the Committee have at this time.

[The paper referenced by Mr. Ibson follows:]

Sustaining Family Caregiving for Wounded Warriors: The Need for a Comprehensive Caregiver Program

Prepared by:

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Wounded Warrior Project: Washington
February 20, 2009

The Problem: Long after their wounds have healed, many severely injured veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) depend on family members for daily caregiving. For those who can no longer carry out all the basic activities of daily living, family caregiving often represents the difference between the veteran's residing at home and being cared for in an institution. The ongoing demands of daily caregiving take a toll on the caregiver. Without reliable support and basic services – currently unavailable to most families of wounded veterans – it is unlikely that this fragile family-support system can sustain itself, with resultant risk to the veteran's well-being.

Wounded Warrior Project (WWP) Solution: WWP proposes that Congress enact legislation establishing a comprehensive program through which a family member of a severely wounded veteran can receive VA training, certification, and an array of ongoing support services needed to sustain daily caregiving. Such needed support services include counseling, respite, a family allowance, and health coverage.

WWP Rationale:

Summary: Family caregiving can be critical to the successful recovery, rehabilitation, and reintegration of the wounded warrior to the community. Veterans who have experienced polytrauma and other profound wounds may need long-term assistance, supervision or protection in performing activities of daily living, and are necessarily turning to family or significant others for that personal care. VA's fundamental obligation to the wounded veteran makes it imperative that the Department ensure that his or her daily caregiving needs are met. When that care will be furnished by family or a significant other, VA must provide needed training and ongoing support services to ensure that family caregivers can sustain that demanding undertaking and the veteran receive optimal care.

Family caregiving has been the subject of extensive study, illustrating the toll that caretaking can have on the caretaker, as well as the beneficial impact of governmental programs supporting family caregiving. The literature and rich body of experience documenting the value of caregiver support programs has relevance to family caregivers of veterans, as the circumstances and needs of those caregivers (and those cared for) differ little from those in other populations.

This paper outlines five key points about family caregiving that provide the evidence-based rationale to support Wounded Warrior Project's recommendations. The paper also includes policy recommendations.

Key Points:

1. **Family caregiving exacts a toll (economic, psychological, health) on the caregiver, and lack of adequate ongoing support heightens the risk that needed caregiving will not be sustained, with adverse implications for the patient's well-being.**

There is little debate in the literature: caring for a relative with physical or cognitive impairments is stressful and can take an emotional and even physical toll on the caregiver. Indeed, the stress of caregiving can produce physiological reactions that can disrupt sleep and healthy eating habits

and may compromise a caregiver's immune response.[1] Studies clearly show that caregivers experience an increased likelihood of stress,[2] depression,[3] and mortality[4] as compared to their non-caregiving peers. Family caregivers who provide care 36 hours or more per week are more likely than non-caregivers to experience depression and anxiety. Women who provide that level of care to a disabled spouse are six times more likely to experience symptoms of depression and anxiety.[5] Studies also suggest that with each incremental increase in assistance with activities of daily living (ADLs), spousal caregivers experience a greater risk for serious illness.[6] Caregivers report poorer levels of perceived health,[7] more chronic illnesses,[8] and poorer immune responses to viral challenges.[9]

Caregiving can be so stressful that it can become unsustainable. Research shows that family members who are unhappy with the burdens of providing care to a loved one with a combat-related disability are often reluctant to provide support. There is also an association between a cohabitating partner's increased social withdrawal due to that unhappiness and an increased intensity of the patient's injury-associated symptoms.[10] While the wounded warrior adjusts to a new disability and its challenges, the spouse tends to assume all or almost all the responsibilities for child care, the family's finances and the psychological well-being of all family members. Without needed support, the spouses of veterans often become caught in a "compassion trap," sacrificing their own needs for those of the family and increasing the risk that the pressures on the caregiver become too great to continue.[11]

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[1] Martin Pinquart and Silvia Sorensen, "Correlates of Physical Health of Informal Caregivers: A Meta-Analysis," *Journal of Gerontology* 62B, no. 2 (2007): pg. 127.

[2] Martin Pinquart and Silvia Sorensen, "Differences Between Caregivers and Noncaregivers in Psychological Health and Physical Health: A Meta-Analysis," *Psychology and Aging* 18, no. 2 (2003): 254.

[3] Nadine Marks, and James Lambert, "Transitions to Caregiving, Gender, and Psychological Well-Being: A Prospective U.S. National Study," February 1999, working paper no. 82, Center for Demography and Ecology, University of Wisconsin-Madison, pg. 15.

[4] Richard Schultz and Scott Beach, "Caregiving as a Risk Factor for Mortality," *Journal of the American Medical Association* 282, no. 23 (1999): 2218.

[5] C. Cannuscio et al, "Reverberation of Family Illness: A Longitudinal Assessment of Informal Caregiver and Mental Health Status in the Nurses' Health Study," *American Journal of Public Health* 98, no. 8 (2002): 305-1311.

[6] W. S. Shaw, T. L. Patterson, S. J. Semple, S. Ho, M. R. Irwin, R. L. Haugler et al., "Longitudinal Analysis of Multiple Indicators of Health Decline among Spousal Caregivers," *Annals of Behavioral Medicine* 19 (1997): 105.

[7] R. Schulz, A. T. O'Brien, J. Bookwala and K. Fleissner, "Psychiatric and Physical Morbidity Effects of Dementia Caregiving: Prevalence, Correlates, and Causes," *Gerontologist* 35 (1995):771–791, as referenced in Thomas Patterson and Igor Grant, "Interventions for Caregiving in Dementia: Physical Outcomes," *Current Opinion in Psychiatry* 16 (2003): 629-630.

[8] R. A. Pruchno and S. L. Potashnik, "Caregiving Spouses: Physical and Mental Health in Perspective," *Journal of American Geriatric Society* 37 (1989): 697–705, as referenced in Thomas Patterson and Igor Grant, "Interventions for Caregiving in Dementia: Physical Outcomes," *Current Opinion in Psychiatry* 16 (2003): 630.

[9] R. Glaser, J. K. Kiecolt-Glaser, "Chronic Stress Modulates the Virus-Specific Immune Response to Latent Herpes Simplex Virus Type I," *Annals of Behavioral Medicine* 19 (1997): 78–82, as referenced in Thomas Patterson and Igor Grant, "Interventions for Caregiving in Dementia: Physical Outcomes," *Current Opinion in Psychiatry* 16 (2003): 630.

[10] M. Sherman, F. Sautter, J. Lyons, G. Manguno-Mire et al., "Mental Health Needs of Cohabitating Partners of Vietnam Veterans with Combat Related PTSD," *Psychiatric Services* 56 (2005): 1152.

[11] B. Arzi, Z. Solomon and R. Dekel, "Secondary Traumatization among Wives of PTSD and Post-Concussion Casualties: Distress, Caregiver Burden, and Psychological Separation," *Brain Injury* 14 (2000): 726.

Notably, there is evidence that the heightened risks associated with caregiving can be diminished substantially by providing education and supports. One study found that caregiver intervention programs that focus on alleviating caregiver burden and depression, increasing general subjective well-being, and increasing caregiving ability and knowledge are generally beneficial, with most effects persisting even seven months after the intervention concludes. Interventions that focused on caregiver ability and knowledge produced an immediate and significantly stronger effect than the effects seen by other interventions.[12] In general, however, the study found that providing caregivers with multicomponent programs that include psychoeducational interventions and supportive therapy is the most effective way to immediately improve caregiver well-being.[13]

Caregiving can also be physically demanding, especially for caregivers who help with ADLs. The literature suggests that proper caregiver training, such as appropriate lifting techniques for transferring the care recipient between a chair and a bed, can reduce the chances of injury for both the caregiver and the recipient. Well-trained caregivers are also less likely to use costly, formal supports.[14]

Evidence suggests that respite care also provides relief from stress because it enables caregivers to attend to their own needs.[15] Similarly, study has shown that training focused on psychoeducational skills was successful in decreasing caregiver burden and in reducing negative reactions to a care recipient's potentially disruptive behaviors.[16]

Economic issues associated with caregiving cannot be ignored. The literature suggests that informal (unpaid) caregiving is incompatible with full-time employment.[17] And even small reductions in work hours to provide unpaid care can result in significant lost wages and a reduction in the caregiver's future pensions and retirement savings.[18]

For many of those wounded during OIF/OEF, family members have become informal full-time caretakers, shouldering enormous burdens while often suffering financial consequences from loss of employment and benefits in order to care for their loved ones. Evidence shows that state programs providing formal home- and community-based care (as opposed to institutional care) to disabled individuals tend to provide such care only in the *absence* of an available family

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[12] S. Sorensen, M. Pinquart and P. Duberstein P, "How Effective Are Interventions with Caregivers? An updated meta-analysis," *Gerontologist* 42 (2002): 360.
[13] Ibid., 369.
[14] G. Smith, P. Doty and J. O'Keefe, "Supporting Informal Caregiving," in *Understanding Medicaid Home and Community Services: A Primer* (Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2000). As referenced in *The Older Americans Act National Family Caregiver Support Program (Title III-E and Title VI-C): Compassion in Action* (Washington, DC: U.S. Department of Health and Human Services, Administration on Aging, 2004), 7.
[15] E. Ann Mohide, "Caregivers Described How an Alzheimer's Disease Respite Programme Gave Them Time to Attend to Their Own Needs," *Evidence Based Mental Health* 5 (2002): 32-33.
[16] K. W. Hepburn, J. Tornatore, B. Center and S. K. Ostwald, "Dementia Family Caregiver Training: Affecting Beliefs about Caregiving and Caregiver Outcomes," *Journal of the American Geriatric Society* 49 (2001): 454.
[17] R. W. Johnson and A.T. Lo Sasso, *The Trade-Off between Hours of Paid Employment and Time Assistance to Elderly Parents at Midlife* (Washington, DC: The Urban Institute, 2000), 25.
[18] Ibid., 27-28.

caregiver.[19] One analyst suggests that such state policies unfairly "lock available family members into caregiving roles."[20] Without needed support, many family caregivers of this generation of wounded warriors see no choice but to provide the care, no matter how potentially devastating the consequences. The combination of the physical, psychological, economic, and emotional burdens of caregiving often weaken the family unit which, in turn, can have a long-term damaging impact on the disabled veteran's quality of life.

2. Successful models for supporting family caregiving have emerged from programs established and funded by Congress that have targeted other vulnerable populations, particularly low-income older Americans and other Medicaid beneficiaries.

Over a period of years, federal policy has placed great reliance on home- and community-based care for older Americans and for people with disabilities and chronic illnesses, as preferable alternatives to institutional care. The Department of Health and Human Services (DHHS) has emphasized the need to alleviate the burden placed on informal caregivers, "Home- and community-based services that are essential to strengthening informal caregiving include, but are not limited to, personal assistance; respite; home and vehicle modifications; assistive devices; caregiver training; education and support; day care; and consumer-directed services."[21] As will be discussed, DHHS program precedents also include payment to informal caregivers through consumer-directed services.

Furthermore, as reflected in measures like The Older Americans Act Amendments of 2000, which authorized the creation of the National Family Caregiver Support Program, Congress has recognized that policies focused on home- and community-based care place a heavy burden on families who assume the demands of informal family caregiving. Hence, Congress has previously recognized that such caregivers need support.[22]

Longstanding Programmatic Support for Home Caregiving: Congress has long recognized the importance of in-home non-medical assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for people who need it. With the Medicaid program, established in 1965, Congress authorized states under a Personal Care Services (PCS) option, to cover paid attendant services in order to help qualified individuals with such ADLs as bathing, dressing, transferring, toileting, and feeding, as well as IADLs such as housekeeping, cooking, shopping and laundry.[23] (Medicaid covers low-income individuals who are disabled,

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[19] N. Muramatsu, Y. Hongjun, R.T. Campbell, R.L. Hoyem, M.A. Jacob, and C.O. Ross, "Risk of Nursing Home Admission among Older Americans: Does States' Spending on Home- and Community-Based Services Matter?" *Journal of Gerontology: Social Sciences* 62B, no. 3 (2007): S174.

[20] Meredith Lilly, Audrey Laporte and Peter Coyte, "Labor Market Work and Home Care's Unpaid Caregivers: A Systematic Review of Labor Force Participation Rates, Predictors of Labor Market Withdrawal, and Hours of Work," *Milbank Quarterly* 85, no. 4 (2007): 677.

[21] G. Smith, P. Doty and J. O'Keefe, "Supporting Informal Caregiving," in *Understanding Medicaid Home and Community Services: A Primer*, (Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2000). As referenced in *The Older Americans Act National Family Caregiver Support Program (Title III-E and Title VI-C): Compassion in Action* (Washington, DC: U.S. Department of Health and Human Services, Administration on Aging, 2004), 3.

[22] Public Law 106-501 section 316.

[23] According to Federal Register, vol. 62, no. 176, pg. 47896, "Although not specifically mentioned in section 1905(a) of the [Social Security] Act, personal care services could be covered under section 1905(a)(22) of the Act

blind, or the caretaker relatives of children from low-income families.)[24] The PCS option under Medicaid originally barred family members from receiving payments for caregiving, but subsequent developments under the Medicaid program have enabled states to substantially augment the nature and scope of family caregiver support, including payment to family caregivers.[25]

Experimentation Spawns Successful Models: In 1981, Congress gave individual states greater flexibility under Medicaid to provide in-home supports to individuals at risk of institutionalization by establishing the Medicaid home- and community-based services (HCBS) waiver program.[26] Under that program, states operating under a waiver of otherwise applicable Medicaid requirements could provide a wider range of in-home personal care services than provided by previous state options, and could target particular populations.[27] Additionally, the waiver provision requires states to build a plan that "[i]s developed through a person-centered process that is directed by the individual…and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual…"[28] This latitude given to states under the waiver authority to develop meaningful home-based programs for different populations—while remaining mindful of the vital familial role in long-term care—resulted in program demonstrations that validated the benefits of providing family caregiver supports.

Of particular note, states have experimented with consumer-directed models of long-term care under the Medicaid waiver program. Medicaid consumer-directed care initiatives have enabled care recipients to choose who will provide care, including family members. For example, Florida, Arkansas, and New Jersey experimented with a Cash and Counseling model of consumer-directed care, where beneficiaries hire and pay workers directly. Under the program demonstration, beneficiaries who were eligible for personal care services under their state Medicaid plan were given a monthly allowance which they could use to hire their choice of caregiver or spend on services or goods needed for daily living. Notably, a waiver of federal regulations permitted care recipients to hire "legally responsible" relatives (spouses, parents of minors, and legal guardians who are ordinarily responsible for the consumers' safety and welfare).[29] A study of the program found that when participants were given the opportunity to choose their care provider, a majority chose a relative. The study concluded that the Cash and

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(redesigned as section 1905(a)(25) of the Act on November 5, 1990), under which a State may furnish any additional services specified by the Secretary and recognized under State law. In regulations at 42 CFR 440.170(f), the Secretary specified that personal care services may be covered." Available from http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?position=all&page=47896&dbname=1997_register. Accessed 26 January, 2009.

[24] Title XIX of the Social Security Act as amended, Public Law 89-97 section 1901.

[25] 42 U.S. Code section 1396d.

[26] The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35 section 2176.

[27] Pamela Doty, *Cost-Effectiveness of Home- and Community-Based Long-Term Care Services* (Washington, DC: U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy, 2000). Available from http://aspe.hhs.gov/daltcp/reports/costeff.htm. Accessed 26 January, 2009.

[28] 42 U.S. Code section 1396n.

[29] Stacy Dale, Randall Brown, Barbara Phillips and Barbara Carlson, *Experiences of Workers Hired Under Cash and Counseling: Findings from Arkansas, Florida, and New Jersey, Final Report* (Princeton, N.J.: Mathematica Policy Research, Inc., 2005), 5. Available from http://www.mathematica-mpr.com/publications/pdfs/3stateworkers.pdf. Accessed 28 December, 2008.

Counseling model was highly successful in meeting the long-term care needs and goals of beneficiaries.[30] Directly hired workers were satisfied with their work arrangements, compensation and relationship with the care recipient.[31] The positive results of the Cash and Counseling model demonstrated that family members are the favored choice of home-based long-term care providers, and that providing cash benefits to family caregivers results in satisfied care recipients and providers.

California's In-Home Supportive Services (IHSS) program is another example of a successful program that pays family caregivers for their services. Beneficiaries of the IHSS program are permitted to hire, fire, schedule, train and supervise their own personal assistance providers, or choose to be assigned an agency home health aide. A study of the IHSS program found that, compared with the assistance from agency aides, the assistance provided by the consumer-directed model "consistently yielded superior results on client satisfaction with services, empowerment and quality of life."[32]

In empowering the consumer to choose where and by whom care is provided, these state Medicaid demonstration programs established an important precedent: permitting federal funding to support family caregiving as a matter of patient choice. The demonstrations also affirmed that care recipients would rather rely on family caregivers than anyone else to provide care. Additionally, by providing payments to family caregivers, these demonstration programs represented a critical step in attempting to relieve the financial challenges of informal caregiving.

Paralleling these developments, a 1999 Supreme Court decision, Olmstead v. L.C., gave new impetus to states to provide home-based long-term care tailored to individual needs. The Court in Olmstead held that the Americans with Disabilities Act requires states to provide community-based treatment (rather than institutional care) to individuals with disabilities when such a placement is appropriate.[33] The Olmstead decision, which emphasized that all reasonable efforts should be made to enable persons with disabilities to live in the least restrictive setting appropriate, provided the underpinning for a Presidential policy statement, the "New Freedom Initiative,"[34] and an Executive Order directing federal agencies to "remove barriers" to community living for people with disabilities. The Order also directed agencies to "swiftly" assist states in implementing the Olmstead decision.[35] Taken together, Olmstead and the federal policies it spawned accelerated an already evolving idea that family caregiving provides a vehicle enabling disabled individuals to live successfully at home.

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[30] Ibid., 31.
[31] Ibid., ix.
[32] Ibid., 5.
[33] Olmstead V. L. C. (98-536) 527 U.S. 581 (1999).
[34] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *New Freedom Initiative: Overview,* online document, n.d. Available from http://www.cms.hhs.gov/NewFreedomInitiative/01_Overview.asp#TopOfPage. Accessed 29 January, 2009.
[35] Executive Order 13217, Federal Register, vol. 66, no. 120 (21 June, 2001). Available from http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=fr21jn01-98.pdf. Accessed 29, January, 2009.
[35] Olmstead V. L. C. (98-536) 527 U.S. 581 (1999).

Family Caregiving and the Law: One year after Olmstead, Congress passed the first federal law that created a program specifically to support family caregivers, the National Family Caregiver Support Program (NFCSP).[36] NFCSP targets family caregivers of older adults, grandparents and relative caregivers (over age 60) of children 18 years of age and younger. Under NFCSP, Congress authorized grants to states and sub-state agencies to provide eligible family caregivers "multifaceted systems of support" with five basic requirements:[37]

- Information to caregivers about available services;
- Assistance to caregivers in gaining access to the services;
- Individual counseling, organization of support groups, and caregiver training in making decisions and solving problems relating to their caregiving roles;
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- Supplemental services, on a limited basis, to complement the care provided by caregivers.

While NFCSP was designed to assist the needs of a specific segment of the caregiver population, the program established a flexible infrastructure that could meet the needs of other caregiver populations. The architects of NFCSP designed it with the view of expanding the population of caregivers to be covered as additional resources become available.[38]

Congress took another significant step toward improving family caregiver supports in the Deficit Reduction Act of 2005 (DRA). Building on the overwhelmingly positive results of the consumer-directed Cash and Counseling demonstration programs, Congress in section 6087 of the DRA authorized states to provide self-directed personal assistance services to individuals otherwise eligible for personal care services.[39] This new option allows states to mount self-directed care programs without requiring waivers of Medicaid law, which are subject to budgetary requirements and are temporary in nature.[40] Under this new state option, a beneficiary can hire people to provide needed services, and Congress further specified that if the state permits, the beneficiary may elect to pay a family caregiver for covered services. Specifically, the law provides that *"[a]t the election of the State—a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services…"*[41]

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[36] Public Law 106-501 section 373.
[37] Ibid.
[38] U.S. Department of Health and Human Services, Administration on Aging, *The National Family Caregiver Support Program: Resource Guide* (Washington, DC: Department of Health and Human Services, n.d.), 192. Available from http://www.lewin.com/content/publications/2479.pdf. Accessed 20 January, 2009.
[39] Public Law 109-171 section 6087.
[40] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *CMS Issues Proposed Rule to Empower Medicaid Beneficiaries to Direct Personal Assistance Services,* press release, 14 January, 2008. Available from http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2832&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cb. Accessed 20 January, 2009.
[41] The Deficit Reduction Act of 2005, Public Law 109-171 section 6087.

While Congress has clearly provided a framework for supporting family caregivers of low-income disabled and elderly individuals needing long-term care, it has not to date focused specifically or comprehensively on family caregiving to meet the long-term care needs of veterans. It does bear noting that Congress amended the Family and Medical Leave Act (FMLA) in 2008 to provide family members the job-protected right to take up to 26 workweeks of leave to care for an active-duty service member undergoing medical treatment, recuperation or therapy.[42] This extended leave benefit can be vital. However, it does not address the ongoing, long-term needs for caregiving that face many of the most seriously wounded and their families.

In contrast, the National Family Caregiver Support Program and Medicaid home and community-based care programs have helped fund and sustain an extensive number of programs across the county that have supported family caregiving. These programs have provided families an array of services that have included training, counseling, respite and other supports, and, in some instances, cash payments. In short, federal law and other federally-supported programs provide rich precedent for Congress to recognize the needs of those providing ongoing care to wounded warriors, and to enact legislation to ensure they can sustain that needed caregiving.

3. While caregivers of wounded veterans face burdens comparable to those supported through other public programs, VA – despite recognizing the importance of informal caregiving – is not now adequately meeting the needs of family caregivers of wounded warriors.

Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) have been characterized by historically high survival rates of combat-injured service members. Additionally, repeated deployments, extended deployments, the wide use of "stop-loss" directives, and a heavy reliance on the National Guard and Reserves have heightened the long-term impact of such signature wounds of these conflicts as traumatic brain injury (TBI) and polytrauma. The high survival rate and need for caregiving for many who sustained severe injuries have placed a heavy burden on the family caregivers of returning wounded warriors.

Scope of Need: Given the national focus on improving programs and services provided directly to wounded warriors, it is perhaps not surprising that the needs of family caregivers would escape significant attention. Yet the President's Commission on Care for America's Returning Wounded Warriors, the so-called "Dole/Shalala" report, suggests the nature and magnitude of what has become a growing problem. The Commission conducted a random sample national survey, and found that of those 1,730 OIF/OEF veterans surveyed, 21% of active duty, 15% of reserve component, and 24% of retired/separated service members have a family member or friend who has been forced to leave a job to care for the veteran full-time. Additionally, 33% of active duty, 22% of reserve component and 37% of retired/separated service members reported that a family member or close friend relocated for extended periods of time in order to spend time with the wounded warrior while he or she was in the hospital.[43]

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[42] Public Law 110-181 section 585.

[43] President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify*, report prepared by Bob Dole and Donna Shalala, Co-Chairs, 110th Cong., 2007, 9.

In spite of the sudden, potentially overwhelming toll that family caregiving can exact, family caregivers of this current generation of wounded warriors are finding that they have no choice but to shoulder the burden. Furthermore, this generation of service members faces a high risk of exposure to an adverse event that could render them in need of life-long care. Unprecedented numbers of those who have served in Iraq and Afghanistan sustained wounds of such severity and complexity that they will require lifelong support with ADLs and IADLs. According to DoD, as of January 31, 2009, there were 33,696 military personnel wounded in action in support of OIF/OEF.[44] In a February 2008 pamphlet, VA reported that thirty-four percent of all OIF/OEF veterans had been deployed multiple times.[45] Multiple deployments increase the chances of injury and the burden on the family even before the wounded warrior returns home. Upon returning home newly disabled, many veterans need intense, ongoing personal care that is often provided at great personal sacrifice by family members.

The unique demographics of OIF/OEF soldiers contribute to a desperate situation for family members who suddenly find themselves *without any further support* as the sole provider for the warrior's dependents, and caregiver to a newly disabled loved one who may no longer be able to contribute to familial obligations. The majority of those wounded in support of OIF/OEF are younger than 25 years old.[46] This younger demographic may be less likely to have a spouse when they get wounded and retire from military service. In 2006 almost half (45%) of all active duty members were not married.[47] Should the wounded warrior require long-term care, the relative or friend who might step in to the caregiver role would not have the access that a spouse would to military health insurance or other benefits. Sixty three percent of all active duty members reported children as family members,[48] with an average of two children per service member.[49] As many within this generation of wounded warriors are likely to have been very young, single, and/or to have had dependent children at the time they were injured, the need to support their family caregivers is especially compelling.

VA and the Informal Caregiver: Informal family caregiving provides critical support to VA in carrying out its health care mission, but one sees very little evidence of significant institutional attention being given to family caregivers as vital links in the rehabilitation process. As a system, VA has no family caregiver program targeted at wounded warriors. Furthermore, the experience of caregivers associated with Wounded Warrior Project, albeit a non-scientific representation of current caregivers, is that of wide variability in VA support.

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[44] Department of Defense, *U.S. Military Casualties Wounded in Action,* online fact sheet for OIF/OEF. Available from http://siadapp.dmdc.osd.mil/personnel/CASUALTY/castop.htm. Accessed 10 February, 2009.
[45] Department of Veterans Affairs, online pamphlet (Washington, DC: National Center for Veterans Analysis and Statistics, February 2008). Available from http://www1.va.gov/vetdata/docs/Pamphlet_2-1-08.pdf. Accessed 10 February, 2009.
[46] Department of Defense statistics as cited in Michael McGeary, Morgan Ford, Susan McCutchen, and David Barnes, eds., *A 21st Century System for Evaluating Veterans for Disability Benefits* (Washington, DC: The National Academies Press, 2007), 55.
[47] Department of Defense, *Profile of the Military Community: DoD 2006 Demographics* (Washington, DC: Office of the Deputy Under Secretary of Defense (Military Community and Family Policy), n.d.), 31.
[48] Ibid., 44.
[49] Ibid., 50.

However, there is keen recognition within VA of the important role informal caregiving plays, and the importance of VA's supporting these caregivers. An internal VA publication advises, for example, that:

- "Without a caregiver, many veterans would not have the continuity of care or the quality of life they desire."[50]
- "We all recognize the benefits to our veterans when their informal caregivers are healthy, engaged and coping well. However, we must also recognize the impact on the veteran when caregivers are struggling because of their limitations. As clinicians, it is our responsibility to support caregivers when possible and permissible within existing VHA rules, regulations, resources and capacity."[51]
- "There are several reasons why caregiver assessments should be completed. In clinical practice, caregiver assessments are necessary to determine caregiver needs, and eligibility for appropriate caregiver support services so ways of assisting them can be incorporated into the veteran's care plan. In helping the family feel heard and better understood, we can build and strengthen the therapeutic alliance. By making family and caregivers an essential component of the treatment team, we can empower these key individuals to continue in their care giving role by reinforcing that their contributions are recognized, supported, valued and needed by both the veteran and the healthcare team."[52]

While VA guidance advises clinicians of the internal resources available to support caregivers, clinicians are also encouraged to refer families to community resources for additional services, or services not available at all VA facilities.[53]

As illustrated by the following VA research perspective, there is also evidence of recognition within VA that more can be done, and that investing more to support family caregivers, and particularly those of veterans with traumatic brain injury and polytrauma, would likely produce substantial dividends:

> "Informal caregivers provide supportive assistance to patients with disabilities which reduce formal healthcare costs. Providing supportive services to caregivers will most likely help reduce the care costs for patients with TBI/PT as they will require less use of emergency care, institutionalization, and VHA services, while also improving caregiver and patient outcomes. In addition to providing direct informal care and assistance to TBI/PT patients, caregivers are a key link in navigating and coordinating the VA and community services and benefits that, together, promote successful rehabilitation and community integration. Since the availability and quality of informal care can reduce institutionalization rates, diminish utilization of urgent care services, and improve efficient coordination of community services and benefits with VA services and benefits,

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[50]Carla Anderson, Susan Bass, Nancy Campbell, Pam Canter, Wendy Hamlin, Betsy Helsel, Judith Jensen, Rita Kobb, Jeff Lowe, Laural Traylor and Mary Anne Zapor, *Supporting Veterans' Caregivers: A Frequently Asked Questions Guide* (Department of Veteran Affairs, Office of Care Coordination, 2006), 3. Available from http://www.queri.research.va.gov/chf/docs/Supporting_Veterans_Caregivers_FAQs.pdf. Accessed 20 January, 2009.
[51] Ibid.
[52] Ibid., 11.
[53] Ibid., 12.

interventions that support and enhance family members' ability to assist the TBI/PT patient are likely to be highly efficient for VHA."[54]

4. VA's position to date on meeting the caregiving needs of the wounded warrior has been flawed and shortsighted.

At-best Limited Support: To date, the VA has acknowledged the importance of family caregiving, but has proposed only a very limited Departmental effort. In 2006, VA reportedly awarded grants totaling $5 million to support eight Caregiver Assistance Pilot Programs, to include training, respite care and counseling.[55] Later, in its medical care budget for fiscal year 2009, the VA proposed a modest $8 million program to provide education, training, counseling and psychological services for one year to family caregivers.[56]

However, in testifying on legislation that would have required VA to establish a more far-reaching family-caregiver program that would have included provision of financial assistance, Dr. Gerald Cross, the Department's Principal Deputy Under Secretary for Health, stated last year that, "VA supports using family members as caregivers for these veterans, but believes VA's current home healthcare program already accomplishes this in a more efficient and effective manner....We strongly urge the Congress to allow VA to continue to obtain caregiver services under the Home Healthcare Program, which uses a third party to provide for the training and payment of personal care attendants."[57] VA's testimony suggests that it makes wide use of home health agencies to provide caregiving services to veterans in their homes. However, if a family member prefers instead to be the primary caregiver, VA testified that "[i]n situations where a veteran will require long-term or lifetime care or assistance in the requirements of daily living," the Department "will provide counseling and training to family members and other caregivers who are capable and willing to take on this responsibility."[58] In short, VA's position appears to be that it will provide that family only limited short-term assistance, but the family must shoulder the long-term home-care responsibility on its own. The only suggestion VA offered at this hearing for family members who need help over the long term in providing care to a wounded warrior is for the family member to attempt to secure employment with a home health agency.[59]

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[54] Joan Griffin, "Understanding and Meeting the Needs of Informal Caregivers to Improve Outcomes for Traumatic Brain Injury Patients with Polytrauma" [VA Health Services Research and Development study, Quality Enhancement Research Initiative, SDR 07-044, funding period April 2008-March 2011], n.d., Available from http://www.queri.research.va.gov/projects/abstracts.cfm?Project_ID=2141698653&UnderReview=no. Accessed 29 December, 2008.

[55] Statement of Mahdulika Agarwal, M.D., MPH, Chief Officer, Patient Care Services, Veterans Health Administration, Department of Veterans Affairs, before the Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, United States House of Representatives, 13 March, 2008. Available from http://www.va.gov/OCA/testimony/hvac/soi/080313MA.asp. Accessed 18 January, 2009.

[56] U.S. Department of Veterans Affairs, *Fiscal Year 2009 Budget Submission*, Vol. II, February 2008, 1A-13, 14. Available from http://www.va.gov/budget/summary/2009/Volume_2-Medical_Programs_and_Information_Technology.pdf. Accessed 4 February, 2009.

[57] Congress, House of Representatives, Committee on Veterans Affairs, Subcommittee on Health, *Legislative Hearing on H.R. 3051, H.R. 6153, and H.R. 6629*, 110th Cong., 2nd Sess., 9 September 2008.

[58] Ibid.

[59] Ibid.

We do not minimize the value of training, counseling, and psychological services, but in situations where a veteran will require long-term or lifetime care or assistance in the requirements of daily living, there is little foundation for believing that training and a few weeks or months of counseling can sustain a lifetime of caretaking.

Lack of Real Choice: With the stance it has taken, VA offers the veteran and his or her family only a very limited caregiving choice (and no choice whatsoever for those residing in rural or other areas where there is no agency to provide services under contract arrangements). The VA-offered "choice" is in essence: "Do it our way – have a stranger provide intimate care to your loved one, or do it on your own!" That posture robs the veteran and family of real choice. (In that regard, VA's approach is both paternalistic and fundamentally out of step with a federal policy of giving individuals with disabilities meaningful choice about their living arrangements and more control over the services they receive.[60]

Ultimately, such a position would fail those families who feel they can best meet the needs of their loved one, but who need ongoing support to do so. At a time that the veteran and his or her family need support and stability, lack of long-term support creates uncertainty and heightens vulnerability. In offering only initial training and counseling to those families who elect to be primary caregivers, VA's position suggests that the family is on its own thereafter. Without continuity of support, the caregiver and veteran's well-being appears to be at greater risk.

VA has certainly dedicated resources to certain modes of supporting veterans in their homes as an alternative to institutionalization. Most notably, the Department spent an estimated $144.6 million in Fiscal Year 2008 to provide agency-furnished homemaker/home health aide services to some 6680 veterans.[61] However, its failure to mount, or support, an ongoing family caregiver program runs the risk that fragile family-provided home care will break down, and that some wounded warriors will require institutional care at vastly greater cost to the VA.

Contract workforce limits: VA's reliance on contracting with home health aide agencies may be misplaced as societal demand for home-based long-term care services appears likely to outpace supply.

Demand for long-term care can be expected to increase as the first of the "baby boom generation" will reach 65 years of age in 2011. Between 2010 and 2050, the over 65 age group is expected to increase from 40 million (13% of the overall population) to 88 million (20%).[62] Those aged 85 or over are the most likely to need long-term care.[63] This age group will double

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[60] Executive Order 13217, *Community-based Alternatives for Individuals with Disabilities*, 18 June, 2001. Available from http://www.whitehouse.gov/news/releases/2001/06/20010619.html. Accessed 4 February, 2009. U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *New Freedom Initiative: Overview*, online document, n.d. Available from http://www.cms.hhs.gov/NewFreedomInitiative/01_Overview.asp#TopOfPage. Accessed 29 January, 2009.

[61] Department of Veterans Affairs, *Fiscal Year 2009 Budget Submission*, Vol. II, 1H-11.

[62] U.S. Census Bureau, Population Division, "Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12)," Release Date August 14, 2008.

[63] Lisa Alecxih, *Nursing Home Use by "Oldest Old" Sharply Declines* (The Lewin Group, 2006), 4. Available from http://www.lewin.com/content/publications/NursingHomeUseTrendsPaperRev.pdf. Accessed 4 January, 2009.

from 2% of the population in 2010 to 4% in 2050, swelling from 6 million to 19 million people.[64] But as the population most likely to rely on long-term care services is rapidly expanding, nursing home use rates are dropping as people turn more to community- and home-based long-term care services.[65] The baby boom generation is expected to show the same preferences for home- and community-based care, possibly to a greater extent, placing even greater demand on home-based long-term care services.[66] Analysts predict that baby boomers faced with long-term care decisions will be more willing and able to purchase formal services than today's retirees, which will increase the demand for formal long-term care services over the next 30 years.[67] The paraprofessional workforce that provides the largest share of the low-tech personal care and ADL assistance includes nursing assistants, home health and home care aides, personal care workers and personal care attendants.[68] Analysts project that the paraprofessional workforce will not grow at the rate needed to meet the demand for home health services.[69] The Department of Health and Human Services estimates that informal caregiving will continue to be the largest source of direct care as the baby boomer generation retires, and the country will face "considerable challenges" in finding an adequate supply of paid and unpaid long-term care workers.[70] Consequently, labor shortages could make it tenuous for VA to place such heavy reliance on contracting for home health services.

Quality of Care Issues Associated with Contract Home Health Services: VA's seeming reliance on contracting for home health care for wounded warriors may not take account of the changes in that market, and the impact those changes may have on the care provided wounded warriors. Anticipated labor shortages raise the prospect of a decline in standards in this workforce, with potentially dramatic impact on the quality of caregiving to meet a wounded warrior's most basic needs.

In assisting with ADLs, such as bathing, dressing, toileting, eating, and managing medications, home health workers have intimate personal interaction with patients in areas that are central to their quality of life and care.[71] The literature documents that low wages, high turnover rates, lack of benefits such as health insurance,[72] and staff shortages[73] associated with personal

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[64] U.S. Census Bureau, Population Division, "Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12)," Release Date August 14, 2008.
[65] Lisa Alecxih, *Nursing Home Use by "Oldest Old" Sharply Declines* (The Lewin Group, 2006), 7. Available from http://www.lewin.com/content/publications/NursingHomeUseTrendsPaperRev.pdf. Accessed 4 January, 2009.
[66] Ibid., iii.
[67] Robyn Stone, *Long-Term Care Workforce Shortages: Impact on Families*, Policy Brief no.3, Family Caregiver Alliance, commissioned by the Robert Wood Johnson Foundation, October 2001, pg. 4.
[68] Ibid., 2.
[69] H.S. Kaye, S. Chapman, R. J. Newcomer and C. Harrington, "The Personal Assistance Workforce: Trends in Supply and Demand," *Health Affairs* 25, no. 4 (2006): 1118-1119.
[70] Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, the Centers for Medicare and Medicaid Services, Health Resource and Services Administration, Department of Labor's Office of the Assistant Secretary for Policy, Bureau of Labor Statistics and Employment and Training Administration, *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation* (Washington, DC: Department of Health and Human Services and Department of Labor, 2003), 3. Available from http://aspe.hhs.gov/daltcp/reports/ltcwork.pdf. Accessed 2 January, 2009.
[71] Robyn Stone, "The Direct Care Worker: The Third Rail of Home Care Policy," *Annual Review of Public Health* 25 (2004): 522.
[72] H.S. Kaye, S. Chapman, R. J. Newcomer, and C. Harrington, "The Personal Assistance Workforce: Trends in Supply and Demand," *Health Affairs* 25, no. 4 (2006): 1118.

assistance jobs have contributed to serious concern over the future availability of these frontline workers. Personal assistance workers typically change jobs every 2.5 years.[74] This high turnover rate can disrupt not only continuity of care but also the close bonds formed between the care recipient and the provider. Staff shortages may further limit the amount of personal attention that aides can provide to their clients. A study of the Pennsylvania frontline long-term care workforce found that more than half of all home health agencies report staff shortages.[75] Qualitative studies suggest that problems with attracting and retaining direct care workers may mean poorer quality care, unsafe care, major disruptions in the continuity of care, and reduced access to care.[76] At the very least, these factors cast doubt on a VA strategy that would rely heavily on contracting for home health aide services to avoid institutionalization and to meet veterans' long-term care needs. At worst, as one analyst suggests, reliance on contracting for home health services could adversely affect care recipients' physical and mental health.[77]

VA has an obligation to afford the highest quality care to those wounded in service. A strategy that relies on contracting to meet the home health care needs of vulnerable, severely wounded warriors is risky in light of workforce trends and the limitations of the home health care workforce. Wounded warriors – whose families can provide home care if provided adequate support – should not have to bear those risks.

5. A wounded warrior family caregiving program must be comprehensive and provide ongoing supports and services, including training, counseling, respite, a family allowance, and health coverage.

Based on research studies and the experience of wounded warrior caregivers, an effective family caregiver program must provide training (as determined necessary), ongoing support services (to include counseling and respite), modest income-support and health coverage. The program should be available to wounded veterans across the country, without regard to their proximity to VA facilities. We discuss the program elements, and the mechanisms through which they might be mounted, in more detail below.

Discharge Planning/Assessment. As part of the planning for hospital discharge and eventual return to the community, a multi-disciplinary team would routinely assess the veteran's needs following hospitalization. That discharge planning process would necessarily consider a range of possible options, and would readily lend itself to considering a need for family caregiving.

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[73] Robyn Stone, "Long-Term Care Workforce Shortages: Impact on Families," Policy Brief no.3, Family Caregiver Alliance, commissioned by the Robert Wood Johnson Foundation, October 2001, pg. 5.
[74] H.S. Kaye, S. Chapman, R. J. Newcomer, and C. Harrington, "The Personal Assistance Workforce: Trends in Supply and Demand," *Health Affairs* 25, no. 4 (2006): 1118.
[75] J. Leon, J. Marainen and J. Marcotte, *Pennsylvania's Frontline Workers in Long-Term Care: The Provider Organization Perspective* (Jenkintown, PA: Polisher Geriatric Institute at the Philadelphia Geriatric Center, 2001), as referenced in Robyn Stone, "Long-Term Care Workforce Shortages: Impact on Families," Policy Brief no.3, Family Caregiver Alliance, commissioned by the Robert Wood Johnson Foundation, October 2001, pg. 4.
[76] G.S. Wunderlich, F. Sloan and C.K. Davis, eds., *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (Washington, DC: Natl. Acad. Press, 1996), as referenced in Robyn Stone, "The Direct Care Worker: The Third Rail of Home Care Policy," *Annual Review of Public Health* 25 (2004): 525.
[77] Robyn Stone, "Long-Term Care Workforce Shortages: Impact on Families," Policy Brief no.3, Family Caregiver Alliance, commissioned by the Robert Wood Johnson Foundation, October 2001, pg. 6.

Wounded Warrior Project anticipates that among the tools planners' would use in evaluating a need for such caregiving would be one of the widely used standardized instruments for assessing an individual's ability to perform such routine ADLs as feeding, dressing, bathing and other personal hygiene needs, and such IADLs as housekeeping, cooking, shopping and laundry. Many returning warriors have sustained profound "invisible wounds" that do not necessarily limit them physically. Individuals with traumatic brain injury, for example, may be capable of performing activities of daily living, but neurological impairment may compromise their ability to live independently and safely without caregiver assistance. To illustrate, symptoms associated with traumatic injury can include difficulty in concentrating or thinking; difficulty understanding speech; loss of memory; impulsiveness, irritability, and difficulty controlling urges; loss of balance; depression; and anxiety.[78] Accordingly, the discharge team should determine the extent of caregiving need (full-time or part-time, for example) based not only on the extent of the veteran's functional impairment, but capacity to live independently and safely without assistance. Consistent with the veteran's preference(s), the team should also assess the willingness and capability of family members or others to provide that needed caregiving (as well as the appropriateness of the home setting to meet the veteran's needs). The assessment would in no way obligate the family; it would simply provide the veteran and family an option, where feasible and appropriate.

Training and Certification. Given the burdens inherent in long-term caregiving and the implications for the veteran, discussed above, VA's responsibility to these Personal Care Attendants cannot end with training and certification. An individual who completes training and certification, and commits to serve as the veteran's primary caregiver must be provided the support needed to carry out that role effectively. We envision a system under which VA would provide these caregivers with routine and emergency support. Organizationally, the design of such a support system could take different forms. But, functionally, VA should provide direct technical support, including information and assistance to timely address routine, emergency, and specialized caregiving needs. One component of such a system could be a caregiver support Website. An Internet portal could provide caregivers a range of online tools, including interactive email access to all VA caregiver program offices, emergency hotline assistance, monitored support chat rooms and forums, current caregiver program news, a library of national caregiver resources, and a caregiver program benefits section to help caregivers understand the benefits available to them and to help caregivers file claims.

To be effective and sustaining, the program design must also recognize the intense burden of daily caregiving. Among critically needed supports, VA should also provide caregivers and wounded warriors access to needed family and individual counseling (to include marriage counseling), whether in-person, by telephone, or online. Similarly important, the caregiver program should include provision for respite care of not less than 30 days annually. Such care could be provided either through contract arrangements for appropriate home health services or community placement, or in VA facilities that are appropriate to the needs of the veteran.

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[78] Neurology Channel, "Traumatic Brain Injury: Signs and Symptoms," A physician- developed and monitored-website resource, last reviewed by Dr. Stanley Swierzewski, December 2007. Available from http://www.neurologychannel.com/tbi/symptoms.shtml. Accessed 20 February, 2009.

Support. VA's responsibility to these Personal Care Attendants cannot end with training and certification. An individual who completes the training and receives certification, and, with the veteran's agreement, commits to serve as the veteran's primary caregiver must be provided the support needed to carry out that role effectively. We envision a system under which VA would provide these caregivers with routine and emergency support. Organizationally, the design of such a support system could take different forms. But, functionally, VA should provide direct technical support, including information and assistance to timely address routine, emergency, and specialized caregiving needs. (One component of such a system could be a caregiver support Website. An Internet portal could provide caregivers a range of online tools, including interactive email access to all VA caregiver program offices, emergency hotline assistance, monitored support chat rooms and forums, current caregiver program news, a library of national caregiver resources, and a caregiver program benefits section to help caregivers understand the benefits available to them and to help caregivers file claims.)

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Protecting the Caregiver. Family caregiving is not only vital to enabling a severely wounded veteran to rebuild a life in the community, but it relieves the VA of providing what could otherwise be much more costly institutional care for that individual. To illustrate, VA spent an estimated $2.99 billion in Fiscal Year 2008 to provide skilled nursing home care in its facilities to some 11,000 veterans at an annual cost of more than $270 thousand for each patient.[79] A family caregiver program should be designed to insure against the risk that foreseeable burdens of caregiving overwhelm the caregiver, and suddenly shift caregiving responsibility onto the VA. Given studies showing the health risks and economic challenges of family caregiving, Wounded Warrior Project believes a family caregiver program must provide both a means of protecting the caregiver's health and a modest level of ongoing income support for that caregiver.

The VA has long administered a program under which certain dependents and survivors of veterans receive health benefits. That program, CHAMPVA, authorized under section 1781 of title 38, U.S. Code, is a ready mechanism for providing medical care to certified family caregivers who are not otherwise eligible for medical care under TRICARE. Given that Congress has authorized CHAMPVA benefits for spouses and children who are survivors or dependents of veterans who were killed or severely disabled in service,[80] a modest expansion of that program to cover certified caregivers of severely wounded veterans would be appropriate.

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[79] U.S. Department of Veterans Affairs, *Fiscal Year 2009 Budget Submission*, Vol. II, February 2008, 1H-11. Available from http://www.va.gov/budget/summary/2009/Volume_2-Medical_Programs_and_Information_Technology.pdf. Accessed 4 February, 2009.

[80] 38 U.S. Code section 1781(a).

Finally, given that many family members must forego employment and often relocate to provide care to a loved one, and that economic stability is vital to sustaining a viable caregiving arrangement, it is critical that the program provide a level of income support. We propose that caregiver legislation make provision for VA payment of a monthly personal caregiver allowance to certified personal care attendants. We envision that VA could establish a schedule of allowances tied to the amount the Department would have paid to a commercial home health care agency to provide the level of personal, daily care authorized for that veteran.

Congress should close gaps in current law: Provisions of current law lay the underpinning for what *could* be a family caregiver program, though there remain gaps. The primary function of the VA health care system is to provide for the medical care and treatment of veterans.[81] While Congress has enacted a body of law focused on the veteran's care, there is broad recognition that the family can be integral to that care, and that the family's needs not only merit recognition but services and support. Section 1782 of title 38, U.S. Code, for example, directs the Secretary to provide education, training, professional counseling and mental health services to the immediate family (or an individual with whom the veteran lives) when necessary in connection with treating a veteran for a service-connected condition (and authorizes the provision of such services as necessary to the care of other health conditions).[82] VA may furnish respite care of limited duration to a chronically ill veteran (directly or through contract arrangements) to enable that veteran to continue residing primarily at home. [83] Under section 1720C of title 38, VA may furnish medical, rehabilitative, and health-related services (including case-management services) in non-institutional settings for veterans who would otherwise need nursing home care.[84] Case-management services are defined to include coordination and facilitation of all services furnished to a veteran, including assessment of needs, planning referral, monitoring, reassessment and follow-up.[85] (The term "health-related services" is not defined, but could conceivably include services that support a family caregiver so long as they are also services that are "for the veteran".[86]) Under current law, Congress has also authorized VA to provide medical benefits for the spouses of certain profoundly disabled veterans: namely the spouse (or child) of a veteran who is totally and permanently disabled as a result of a service-connected condition.[87]

In all, were VA to establish a family caregiver program, most of the elements of a comprehensive program are already in place. In requiring VA to establish a comprehensive family caregiving program, as proposed, Congress can build on an already broad foundation and close the limited gaps in current law.

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[81] 38 U.S. Code section 7301.
[82] 38 U.S. Code section 1782.
[83] 38 U.S. Code section 1720B.
[84] 38 U.S. Code section 1720C.
[85] Ibid.
[86] Ibid.
[87] 38 U.S. Code section 1781(a).

Conclusion:

Since VA already has the infrastructure and key program components in place to mount a comprehensive family-caregiver program, Congress -- by enacting family caregiver legislation, as proposed -- can readily ensure that wounded warriors' critical need for caregiving will be met.

Were VA to set out to establish a family caregiver program, most of the elements of a comprehensive program are already in place.

In proposing that Congress enact legislation to establish a family caregiver program for veterans wounded during Operation Iraqi Freedom and Operation Enduring Freedom, Wounded Warrior Project is not proposing a dramatic change in VA mission or far-reaching changes in law. Our proposal aims simply to ensure optimal care for the wounded veteran in a setting that best advances that individual's recovery, rehabilitation, and opportunity to achieve the fullest life in the community. Rather than proposing a completely new initiative with vast new staffing commitments, our legislation would build on existing law and task the Veterans Health Administration (VHA) to weave together already established program elements. Importantly, the component elements of a family caregiver program are largely already in place. VA medical centers already routinely conduct need-for-personal-care assessments; educate family members in caregiving; conduct formal training programs; provide individual and group counseling; operate respite care programs; monitor patient care and health status by telephone; and provide health care to family members. VHA is spending nearly $150 million annually to provide personal care to veterans in their homes.[88] It is simply not dedicating resources in those instances when those personal care needs are being provided by a family member or another caregiver selected by the veteran. Congress can feel confident that in enacting caregiver legislation, as proposed above, it is tasking VA's health care system with responsibilities it can carry out.

Family caregivers are a vital resource to the successful recovery, rehabilitation and reintegration of wounded warriors to the community. In the past, Congress has authorized programs that provide critical supports to family caregivers that include training, counseling, respite, cash payments and other supports. The success of these precedents is encouraging, and it offers a clear path toward developing a similar comprehensive family caregiver program for veterans. VA has a fundamental obligation to the wounded veteran to ensure that his or her daily caregiving needs are met. In order to meet this obligation, VA must lift the burden that family caregivers are informally and unselfishly shouldering with detrimental consequences.

After extensive study and discussion with family caregivers of OIF/OEF veterans, Wounded Warrior Project believes that the most comprehensive solution involves Congress enacting legislation to establish a comprehensive program through which a family member of a severely wounded veteran can receive VA training, certification, and an array of ongoing support services needed to provide daily caregiving. Such needed support services include counseling, respite, a family allowance, and health coverage.

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[88] Department of Veterans Affairs, *Fiscal Year 2009 Budget Submission*, Vol. II, 1H-11.

Senator BEGICH. Thank you very much, Mr. Ibson.

Mr. Ortner, before you start, I want to say I enjoyed playing in the poker tournament the Paralyzed Veterans Association had. I am glad I came in second. [Laughter.]

Mr. ORTNER. Well, we were glad to have you there.

Senator BEGICH. It was a pleasure to be there. Please, your testimony.

STATEMENT OF BLAKE C. ORTNER, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. ORTNER. Paralyzed Veterans of America would like to thank Chairman Akaka, Ranking Member Burr, and Members of the Committee for the opportunity to present our views on pending legislation before the Committee. Due to the number of bills today, I will limit my remarks to only a few, but want to assure the Committee that we are interested in all legislation dealing with our Nation's veterans.

First, on behalf of Paralyzed Veterans of America and our 20,000 members, I want to thank the Chairman, Ranking Member Burr, and other Members of the Committee for introducing and cosponsoring S. 423, the Veterans Health Care Budget Reform and Transparency Act of 2009. This legislation will reform the VA budget process by providing advance appropriations for veterans health care, ensuring timely and predictable funding for VA. We look forward to working with you to pass this critical legislation.

PVA supports S. 821 to prohibit the Secretary of VA from collecting copayments from catastrophically disabled veterans, legislation critical to PVA members, many of whom receive 85 to 90 percent of their care from VA. As Senator Sanders mentioned, PVA worked hard to ensure that those veterans with catastrophic disabilities were allowed to enroll in Priority Group 4, even though their disabilities were non-service-connected and regardless of income. However, unlike Category 4 veterans, they would still be required to pay fees and copayments. PVA believes this is unjust.

VA recognizes these veterans' unique specialized status on the one hand by providing specialized service for them in accordance with its mission to provide for special needs. Unfortunately, these veterans are not casual users of VA health care. Because of the nature of their disabilities, they require a great deal of care and a lifetime of services. In most instances, the VA is the only and the best resource for a veteran with spinal cord injury. Because of the amount of care required, these copays rapidly add up.

In the last Congress, a House bill received unanimous support from Republicans and Democrats as well as VA. Unfortunately, the Senate never took action on the measure and the legislation was never enacted. On March 5, 2009, Mrs. Halvorson introduced legislation in the House, H.R. 1335, that will again attempt to remove this burden. Together with S. 821, we hope to finally resolve this issue during the 111th Congress.

Regarding family caregiver services, we applaud the introduction of both S. 801, the Family Caregiver Program Act of 2009, and S. 543, the Veteran and Servicemember Caregiver Support Act of 2009, and strongly support this legislation. This training and assistance is a critical aspect of preparing caregivers to care for a family member. The only concern that PVA would like to address is the significant use of the word "may" instead of "shall" in requirements of the Secretary. Our fear is that if VA is faced with the budget challenges that inevitably will occur, the value of the caregiver programs may be lost as they fall under the budget axe.

There are approximately 44 million individuals across the United States that serve as caregivers on a daily basis. Their contributions are invaluable economically as they obviate rising costs of traditional institutional care. The services rendered by caregivers are also priceless socially and emotionally as they allow ailing and disabled veterans to live more independently and often in their comfort of their own homes with friends and family.

Many of the pieces of legislation being considered today have to do with increasing the number of health care professionals in the VA system, in particular, those in hard-to-serve areas. PVA's primary concern and the basic reason for our existence is the health and welfare of our members and our fellow veterans. The thousands of VA health care professionals and those individuals necessary to support their efforts are the core of VA's primary mission.

PVA appreciates the comprehensive nature of S. 252 and supports the overall provisions of the legislation. It clearly outlines multiple approaches to increasing the competitiveness of VA for hiring health care providers. These programs will provide incentives for new hires or to keep already skilled employees in the VA system.

Contributing to the problem for veterans is the need for care in rural America. Forty percent of nearly two million VA health care users reside in rural areas and 44 percent of newly returning veterans from OEF and OIF live in rural areas. PVA supports the provisions of S. 246, S. 734, and S. 658.

Finally, the number of rural veterans is increasing, but in addition, there has been a dramatic increase in the number of women veterans now using VA facilities. PVA fully supports S. 597, the Women's Veterans Health Care Improvement Act of 2009, language that has been incorporated into S. 252. Women have played a vital part in the military service throughout our history and current estimates indicate that there are 1.8 million women veterans, comprising nearly 8 percent of the U.S. veterans population. VA must act now to prepare to meet the specialized needs of women who have served.

PVA sincerely appreciates the opportunity to provide our views on this important legislation and would also like to point out that much of the legislation presented today is discussed in greater detail in the current edition of the Independent Budget.

This concludes my testimony. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Ortner follows:]

PREPARED STATEMENT OF BLAKE C. ORTNER, SENIOR ASSOCIATE 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 present our views on pending legislation before the Committee. We hope that the Senate Committee on Veterans' Affairs will take our concerns under consideration as it moves its legislation forward in the 111th Congress. Mr. Chairman, we appreciate the legislative successes that veterans have realized under your leadership and we look forward to continued success in the future. PVA continues to work on issues important to our members, veterans with spinal cord injury or dysfunction, specifically, and to all veterans.

S. 423—THE "VETERANS HEALTH CARE BUDGET REFORM AND TRANSPARENCY ACT OF 2009"

Chairman, Akaka, on behalf of PVA and our 20,000 members, I want to thank you and the other Members of the Committee, for introducing S. 423, the "Veterans Health Care Budget Reform and Transparency Act of 2009," that will reform the Department of Veterans Affairs (VA) budget process by providing advance appropriations for veterans' health care. Your legislation was developed in consultation with the Partnership for Veterans Health Care Budget Reform (the Partnership)—a group that consists of nine major veterans service organizations, including Paralyzed Veterans of America. For more than a decade, the Partnership has worked to achieve a sensible and lasting reform of the funding process for veterans' health care. While the Partnership has long advocated converting VA's medical care funding from discretionary to mandatory funding, there has been virtually no movement in Congress in this direction.

The Veterans Health Care Budget Reform and Transparency Act would ensure that the goals of the Partnership—sufficient, timely, and predictable funding—are met. Historically, advance appropriations have been used to make a program function more effectively, better align with funding cycles of program recipients, or provide insulation from annual partisan political maneuvering. By moving to advance appropriations, veterans' health care programs will accrue all three of these benefits.

To enhance the budget process even further, the legislation includes provisions to add transparency and oversight to VA's internal budget forecasting model. Due to the complex nature of VA's actuarially-based Model, S. 423 will require GAO to conduct an annual audit and assessment of the Model to determine its validity and accuracy, as well as assess the integrity of the process and the data upon which it is based. GAO would submit public reports to Congress each year that would assess the Model and include an estimate of the budget needs for VA's medical care accounts for the next two fiscal years. Providing Congress with access to the Model and its estimates of VA health care's resource needs, would create greater confidence in the accuracy of advance appropriations for veterans' medical care, as well as validate future requests for emergency supplemental appropriations.

Additionally, the Senate budget committee agreed with the value of advance appropriations for VA and included language in their recent budget resolution calling for advance appropriations for the VA medical care appropriation. Moreover, President Obama recently reaffirmed his support for advance appropriations. PVA strongly supports S. 423.

S. 821—ELIMINATION OF CO-PAYMENTS FOR PRIORITY GROUP 4 VETERANS

PVA supports S. 821, to prohibit the Secretary of VA from collecting co-payments from catastrophically disabled veterans and we applaud Senator Sanders for introducing this important and overdue legislation. This legislation is critical to PVA members, many of whom receive 85 to 90 percent of their care from the VA.

In 1985, Congress approved legislation which opened the VA health system to all veterans. In 1996, Congress again revised that legislation with a system of rankings establishing priority ratings for enrollment. Within that context, PVA worked hard to ensure that those veterans with catastrophic disabilities would be placed in a higher enrollment category. To protect their enrollment status, veterans with catastrophic disabilities were allowed to enroll in Priority Group Four even though their disabilities were non-service-connected and regardless of their incomes. However, unlike other Category Four veterans, if they would otherwise have been in Category Seven or Eight, due to their incomes, they would still be required to pay all fees and co-payments, just as others in those categories do now for every service they receive from VA.

PVA believes this is unjust. VA recognizes these veterans' unique specialized status on the one hand by providing specialized service for them in accordance with its mission to provide for special needs. The system then makes them pay for those services. Unfortunately, these veterans are not casual users of VA health care services. Because of the nature of their disabilities they require a lot of care and a lifetime of services. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury, and yet, these veterans, supposedly placed in a higher priority enrollment category, have to pay fees and co-payments for every service they receive as though they had no priority at all.

We were pleased that the House Committee on Veterans' Affairs approved and the House of Representatives eventually passed legislation—H.R. 6445—to eliminate this financial burden placed on catastrophically disabled veterans during the 110th Congress. In fact, the House bill received unanimous support from Republicans and

Democrats as well as the VA. Unfortunately, the Senate never took action on the measure and the legislation was never enacted. On March 5, 2009, Mrs. Halvorson introduced legislation in the House of Representatives, H.R. 1335, that will again attempt to remove this unjust burden. Together with S. 821, we hope that with your leadership, we will finally be able to resolve this issue during the 111th Congress.

S. 801—THE "FAMILY CAREGIVER PROGRAM ACT OF 2009"

S. 543—THE "VETERAN AND SERVICEMEMBER CAREGIVER SUPPORT ACT OF 2009"

Regarding family caregiver services, we applaud the introduction of both S. 801, the "Family Caregiver Program Act of 2009" and S. 543, the "Veteran and Servicemember Caregiver Support Act of 2009" and strongly support the legislation. While we believe S. 543 certainly expands caregiver assistance opportunities, we prefer the provisions of S. 801 because it is more broadly focused. This training and assistance is a critical aspect of preparing caregivers to care for a family member. PVA would like to thank the congressional staffs for their work on both S. 801 and S. 543 to insure these critical issues are properly addressed. The only concern that PVA would like to address in the legislation is the significant use of the word "may" instead of "shall" in areas identifying requirements of the Secretary. Our fear is that if VA is faced with the budget challenges that inevitably will occur, will all the value of the caregiver programs be lost as they fall to the budget ax. This must not be allowed to happen.

There are approximately 44 million individuals across the United States that serve as caregivers on a daily basis. The contributions of caregivers in today's society are invaluable economically as they obviate the rising costs of traditional institutional care. The services rendered by caregivers are also priceless socially and emotionally, as they allow ailing and disabled veterans to live more independently and often in the comfort of their own homes with their friends and family.

As the veteran community is aware, family caregivers also provide mental health support for veterans dealing with the emotional, psychological, and physical effects of combat. Many PVA members with spinal cord injury also have a range of co-morbid mental illnesses, therefore, we know that family counseling and condition specific education is fundamental to the successful reintegration of the veteran into society. Providing education and training to family caregivers will pay dividends in care well beyond any costs associated with the program.

The aspects of personal independence and quality care are of particular importance to veterans with spinal cord injury/dysfunction. Paralyzed Veterans has over 60 years of experience understanding the complex needs of spouses, family members, friends, and personal care attendants that love and care for veterans with life long medical conditions. As a result of today's technological and medical advances, veterans are withstanding combat injuries and returning home in need of medical care on a consistent basis. Such advances are also prolonging and enhancing the lives and physical capabilities of injured veterans from previous conflicts. No matter the progress of modern science, these veterans need the health-care expertise and care from a health team comprised of medical professionals, mental health professionals, and caregivers. As a part of the health care team, caregivers must receive ongoing support to provide quality care to the veteran. It is for this reason, we are happy to see that S. 801 includes provisions for conducting caregiver assessments that identify the needs and problems of caregivers currently caring for veterans. The VA must also work to enforce and maintain an efficient case management system that assists veterans and family caregivers with medical benefits and family support services.

Our experience has shown that when the veteran's family unit is left out of the treatment plan, the veteran suffers with long reoccurring medical and social problems. However, when family is included in the health plan through services such as VA counseling and education services, veterans are more apt to become healthy, independent, and productive members of society.

S. 772—THE "HONOR ACT OF 2009"

PVA supports this legislation and would like to thank Senator Bond for his introduction of S. 772, the "Honor Act of 2009." Mental health issues continue to be a growing problem for those who have witnessed the horrors and traumatic events of war. Evidence continues to show that the prevalence of mental illness is high in veterans who have served in Iraq and Afghanistan. Combat exposure coupled with long and frequent deployments are associated with an increased risk for Post Traumatic Stress Disorder (PTSD) and other forms of mental illness. In fact, the VA reports that Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) vet-

erans have sought care for a wide array of possible co-morbid medical and psychological conditions, including adjustment disorder, anxiety, depression, PTSD, and the effects of substance use disorder.

The impact of a veteran's mental illness is far reaching and obviously has serious consequences for the individual veteran being affected, but perhaps less obvious are the serious consequences, stemming from a veteran's mental illness, that confront his or her spouse, their children and other family members. With this in mind, Paralyzed Veterans believes that Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family and non-family caregivers of severely injured and ill veterans.

The scholarships and other provisions of S. 772 create opportunities to increase the number of mental health professionals to provide for veterans with mental health challenges. Additionally, we applaud provisions expanding Vet Center opportunities for those who would not be authorized counseling services. But PVA believes that Vet Centers should also increase coordination with VA medical centers to accept referrals for family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation; improve reintegration of combat veterans who are returning from deployment; and provide information on identifying warning signs of suicidal ideation so veterans and their families can seek help with readjustment issues. PVA believes that an effective mental illness family counseling and education program can improve treatment outcomes for veterans, facilitate family communication, increase understanding of mental illness, and increase the use of effective problem solving and reduce family tension.

S. 669—THE "VETERANS 2ND AMENDMENT PROTECTION ACT"

Regarding S. 669, the "Veterans 2nd Amendment Protection Act," PVA has not taken a position on this legislation.

S. 252—THE "VETERANS HEALTH CARE AUTHORIZATION ACT OF 2009"

S. 246—THE "VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT"

PVA's primary concern, and the basic reason for our existence, is the health and welfare of our members and our fellow veterans. The thousands of VA healthcare professionals and all of those individuals necessary to support their efforts are at the core of VA's primary mission. These individuals serve on the front line every day, caring for America's wounded veterans from Iraq and Afghanistan and seeing to the complex medical needs of our countries older veterans from previous wars. PVA believes that VA's most important asset is the people it employs to care for those who have served our Nation. By the number of bills today regarding the subject of staffing of VA, we can see it is of concern to the Committee as well.

Mr. Chairman, PVA appreciates the comprehensive nature of S. 252, the "Veterans Health Care Authorization Act of 2009" and supports the overall provisions of the legislation. It clearly outlines multiple approaches to increasing the competitiveness of VA for hiring health care providers including changes to pay computation, exemptions from limitations on competitive pay and opportunities for additional nurse pay. In addition, changes to educational assistance programs and employee retention programs will provide incentives to keep those already skilled employees in the VA system.

Given the Veterans Health Administration's (VHA) leadership position as a health system, it is imperative that VA aggressively recruit health care professionals and work within established relationships with academic affiliates and community partners to recruit new employees. In order to make gains on these needs, VA must update and streamline its human resource processes and policies to adequately address the needs of new graduates in the health sciences, recruits, and current VA employees. Today's health care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, and generous educational benefits. VA must actively address the factors known to affect current recruitment and retention, such as fair compensation, professional development and career mobility, benevolent supervision and work environment, respect and recognition, technology, and sound, consistent leadership, to make VA an employer of choice for individuals who are offered many attractive alternatives in other employment settings.

The United States is currently in the tenth year of a critical nursing shortage which is expected to continue through 2020. The shortage of registered bed-side nurses and registered nurse specialists is having an impact on all aspects of acute and long-term care. America's nursing shortage has created nurse recruitment and

retention challenges for medical care employers nationwide and is making access to quality care difficult for consumers.

VA's ability to sustain a full complement of highly skilled and motivated personnel will require aggressive and competitive employment hiring strategies that will enable it to successfully compete in the national labor market. VA's employment success within the VHA will require constant attention by the very highest levels of VA leadership. Additionally, Members of Congress must understand the gravity of VA personnel issues and be ready to provide the necessary support and oversight required to ensure VA's success. The legislation presented today demonstrates without doubt that the Committee understands these issues.

PVA is concerned about the VA's current ability to maintain appropriate and adequate levels of physician staffing at a time when the Nation faces a pending shortage of physicians. Recent analysis by the Association of American Medical Colleges (AAMC) indicates the United States will face a serious doctor shortage in the next few decades. The AAMC goes on to say that currently, "744,000 doctors practice medicine in the United States, but 250,000—one in three are over the age of 55 and are likely to retire during the next 20 years." The subsequent increasing demand for doctors, as many enter retirement, will increase challenges to VA's recruitment and retention efforts.

Contributing to the problem for veterans is the need for care in rural America. The tremendous increase in veterans due to the wars in Afghanistan and Iraq is leading to greater numbers of veterans located in rural areas where only 10 percent of physicians practice. Additionally, those living in rural areas generally are more likely to live below the poverty line.

Because 40 percent of nearly 2 million VA health care users reside in rural areas, including 80,000 who live in highly rural areas, they often have worse physical and mental health quality-of-life. Exacerbating the problem is that 44 percent of newly returning veterans from OEF/OIF live in rural areas. While VA may be working in good faith to address its shortcomings in rural areas, it clearly still faces major challenges and hurdles.

PVA supports the provisions of S. 246, including loan repayment, tuition reimbursement and other incentives, if fully implemented, should help alleviate some level of this challenge by providing incentives to physicians to accept service in hard-to-fill positions. We applaud Senator Durbin for his far reaching initiative to provide for all veterans, even though they may live far from our urban centers.

Mr. Chairman, we also applaud the inclusion of language from S. 246 in S. 252 to insure the disclosure of certain physician information before their appointment to VA regarding lawsuits and civil actions against the individual for medical malpractice. Physicians providing care to our honored veterans must be of the highest quality. PVA understands that in this era of often frivolous medical lawsuits, physicians may be challenged and may settle lawsuits for which there was no medical wrongdoing. PVA believes the best way to guarantee the highest quality of physician in the VA system is to be forthright with information and allow the full examination of the record to prevent any future doubts. Additionally, the establishment of Quality Management Officers as outlined in both S. 252 and S. 246 should help insure the highest quality of care is provided to our veterans.

PVA strongly supports provisions of S. 252 regarding Nonprofit Research and Education Corporations. This legislation will 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. 252 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.

S. 597—THE "WOMEN VETERAN HEALTH CARE IMPROVEMENT ACT OF 2009"

As stated above, the number of rural veterans is increasing, but in addition, there has been a dramatic increase in the number of women veterans now using VA facilities. PVA fully supports S. 597, the "Women Veterans Health Care Improvement Act of 2009," language that has been incorporated into S. 252. Women have played a vital part in the military service throughout our history. In the last 50 years their roles, responsibilities, and numbers have significantly increased. Current estimates indicate that there are 1.8 million women veterans comprising nearly 8 percent of the United States veteran population. According to Department of Defense (DOD) statistics, women servicemembers represent 15 percent of active duty forces, 10 percent of deployed forces, 20 percent of new recruits, and are a rapidly expanding segment of the veteran population.

Historically, women have represented a small numerical minority of veterans who receive health care at VA facilities. However, if women veterans from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) continue to enroll at the current enrollment rate of 42.5 percent, it is estimated that the women using VA health care services will double in two to four years.

As the population of women veterans undergoes exponential growth in the next decade, VA must act now to prepare to meet the specialized needs of the women who served. Overall the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young working women with childcare and eldercare responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men.

This legislation is meant to expand and improve health care services available in the VA to women veterans, particularly those who have served in 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 S. 597 would authorize a number of studies and assessments that would evaluate the health care needs of women veterans. Furthermore, these studies would also identify barriers and challenges that women veterans face when seeking health care from the VA. Finally, the VA would be required to assess the programs that currently exist for women veterans and report this status to Congress. We believe each of these studies and assessments can only lead to higher quality care for

women veterans in the VA. They will allow the VA to dedicate resources in areas that it must improve upon.

Title II of the bill would target special care needs that women veterans might have. Specifically, it would ensure that VA health care professionals are adequately trained to deal with the complex needs of women veterans who have experienced sexual trauma. Furthermore, it would require the VA to develop a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services to recently separated women veterans in a retreat setting. Additionally, the legislation calls for the inclusion of recently separated women veterans on advisory committees to allow them to provide their unique perspective as veterans issues are considered. This together with programs to subsidize child care for certain women veterans receiving health care and those receiving maternity care, will provide an excellent environment that considers the unique needs of 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 fully supports the Chairman's decision to include the language of S. 597 within S. 252. 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. Finally, we would encourage the Committee to review the extensive policy section in the FY 2010 edition of *The Independent Budget*—"Women Veterans' Health and Health Care Programs."

S. 793—THE "DEPARTMENT OF VETERANS AFFAIRS VISION SCHOLARS ACT OF 2009"

As in previous bills, S. 793, the "Department of Veterans Affairs Vision Scholars Act of 2009," provides increased services for an additional at-risk group, veterans with vision impairments. PVA has consistently supported the protection of specialized services and supports S. 793. As with other specialty fields, VA suffers from a shortage of blind rehabilitation specialists. The scholarship program proposed in this legislation should encourage individuals to enter this field to provide rehabilitation services to veterans with visual impairments. However, it is critical that the provisions of the legislation concerning outreach and the publication of the program be aggressively pursued. Those who may take advantage of the scholarship program will be unable to if they do not know about it.

S. 362—TO IMPROVE COLLECTIVE BARGAINING RIGHTS AND PROCEDURES

PVA supports S. 362 introduced by Sen. Rockefeller that will more quickly resolve adverse actions and set deadlines for final decisions.

S. 734—THE "RURAL VETERANS HEALTH CARE ACCESS AND QUALITY ACT OF 2009"

S. 658—THE "RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009"

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. As discussed previously regarding S. 246, 40 percent of nearly 2 million VA health care users reside in rural areas, with 44 percent of newly returning veterans from OEF/OIF living in rural areas.

PVA supports S. 734, the "Rural Veterans Health Care Access and Quality Act of 2009," and its provisions to increase the number of health care professionals in rural areas. Enhancement of the education debt reduction program at VA for those who accept placement in rural areas is an efficient method, though it is only one method. In addition, the pilot program on incentives for physicians who assume inpatient responsibilities may also encourage health care professionals to locate in rural areas. But these are short term fixes. For this reason we welcome the legislation's call for a five-year strategic plan by VA with goals for recruitment and retention of health care personnel in rural areas. The challenge of this problem must be met by multiple solutions. The inclusion of legislative provisions to expand teleconsultation and telemedicine can help to provide services that may not be generally available to rural communities.

PVA supports S. 658, the "Rural Veterans Health Care improvement Act of 2009," which includes additional methods for improving rural health care. The creation by VA of Centers of Excellence for rural care research, education and clinical activities may help shed light on how best to provide services in rural areas. PVA supports the oversight of these centers by the Director of the Office of Rural Health (ORH) and encourage close coordination among the centers and the ORH if more than one center is established. The most important provision may be to develop and implement innovative clinical activities and systems of care for veterans in rural areas. In addition, demonstration projects on alternatives for expanding care may be beneficial. While all these ideas are welcome, the greatest need still is for qualified health care providers to be located in rural settings. Only significant incentives and opportunities for these professionals will bring them to these often remote areas.

PVA also supports the provisions of S. 658 dealing with our Native American veterans by establishing Indian Veterans Health Care Coordinators as well as provisions for a program of readjustment and mental health care services to veterans who have served in Operation Iraqi Freedom and Operation Enduring Freedom.

S. 404—THE "VETERANS' EMERGENCY CARE FAIRNESS ACT OF 2009"

Mr. Chairman, PVA strongly supports S. 404, the "Veterans' Emergency Care Fairness Act of 2009" which will remove an unfair burden on our veterans. The legislation will expand eligibility for emergency medical care for some veterans. Currently, veterans who have a third-party insurance provider that pays a portion of medical expenses in the event of an emergency, do not have the balance of their medical expenses covered by the VA. Having the VA function as a secondary payer should eliminate that situation. It will prevent the VA from denying payment for emergency service at non-VA hospitals when a veteran is partially covered by their third-party insurance.

S. 498—AUTHORIZE DENTAL INSURANCE FOR VETERANS AND SURVIVORS AND DEPENDENTS

Regarding S. 498, legislation to authorize dental insurance for veterans and survivors and dependents of veterans, PVA recommends caution in pursuing this legislation. We are concerned with the provisions which appear to establish VA as an insurance company, with the Secretary providing dental insurance, identifying dental benefits and treatment, establishing premium rates and managing enrollment and disenrollment. S. 252 includes similar language, but establishes the program as a pilot. This is a direction that PVA believes is inappropriate for VA. If this need is sufficiently significant for VA to establish an insurance program, PVA recommends that existing VA facilities and capability be expanded to meet this need.

S. 239—THE "VETERANS HEALTH EQUITY ACT OF 2009"

The intent of S. 239, the "Veterans Health Equity Act of 2009," is to ensure veterans receive care close to their homes to avoid the time and health hazards of traveling long distances for care. Though the idea of contract care for those displaced from VA facilities appears like the simple and obvious choice, there are many drawbacks with the use of VA contracting authority.

VA already has contracting ability, but it is generally limited to care VA cannot provide at its facilities. Allowing an expansion of this authority to provide for general care has the potential to result in the decline of VA as a system of care for veterans as more and more locations seek to provide care closer to the veteran and away from VA facilities. PVA believes that while this may be useful for some veterans, those with the greatest need for VA care, those with catastrophic spinal cord injuries and disease and other specialized services that depend on a well funded VA system, will see reduced availability of services provided most effectively by VA.

While PVA is seriously concerned about the ability of VA to continue providing high quality specialized services, we also recognize the serious challenges faced by veterans in states with limited VA facilities. PVA acknowledges something must be done, and it is VA's responsibility to determine what steps should be taken to address this problem. Mr. Chairman, we would encourage VA to examine possible alternatives to provide care that will not damage or interfere with the care system and services currently provided to veterans. Though PVA believes that any outside contract care which meets the standard of VA services will be more expensive, an examination of this option, with appropriate coordination of care to ensure veterans are receiving the best care possible, may be an option for a future program. However, any pilot or demonstration program implemented by VA should use separately designated and appropriated funds outside of VA's normal budget and must ensure

coordination with VA to maintain a continuity of records between contract care providers and VA to protect veterans when they return to a regular VA care facility.

In a time of tight budgets and increasing need due to returning Afghanistan and Iraq combat veterans, the pressures on VA to find less expensive and more widely available methods to provide care for these veterans can become overwhelming. But any modifications to VA care must ensure that veterans most in need of the specialized care provided best by VA do not suffer from any changes made to the system.

S. 226—MERRIL LUNDMAN DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC

S. 509—AUTHORIZE MEDICAL FACILITY IN WALLA WALLA, WASHINGTON

S. 699—FAR SOUTH TEXAS VETERANS MEDICAL CENTER ACT OF 2009

PVA has no position on these proposed bills. All deal specifically with local issues or needs and we believe they should be considered within the local needs for facilities and the ability to provide veterans' services. PVA believes naming issues should be considered by the local community with input from veterans organizations within that community. For construction projects and the authorization of new facilities, PVA believes that if a demonstrated need exists, VA should establish facilities that will provide the best care for veterans in the area.

Mr. Chairman, PVA sincerely appreciates the opportunity to provide our views on this important legislation and would be pleased to provide any additional information. We would also point out that much of this legislation is discussed in much greater detail in the 23rd edition of *The Independent Budget*.

This concludes my testimony and I will be happy to answer any questions you may have.

Senator BEGICH. Thank you very much.

Senator Burr, do you want to start with questions?

Senator BURR. Thank you, Mr. Chairman.

I would like to thank all of our witnesses on the second panel for your valuable testimony and the insight that all bring to the table on the issues. I am going to focus on two areas very quickly, and I am going to pick on you, Adrian. I could ask the guys at the end of the table down here, but I am going to spare them.

Does the DAV think it is appropriate that the names of service-disabled veterans are sent to NICS when Social Security recipients aren't for the same circumstances?

Mr. ATIZADO. Well, sir, I appreciate the question in light of my colleagues at the end of the table. In our testimony, if you will note that we don't have a resolution on this issue. Whether or not our organization would support or oppose a bill really depends on what our membership passes at our national convention, and since we don't have a resolution on this specific matter, we can't take a position on the bill, Senator.

Senator BURR. And I appreciate that. I know how the member organizations operate up here—let me just say for the benefit of all three—because there were no positions from any.

I think that when you have a population that entrusts you with the issues that are of great importance to them, when you have one that I think is a constitutional question, I think you have to go above and beyond to sell to the members why their voice should be heard. I am not sure that there is any veteran of the 117,000 that are out there that are sitting at home saying, "You know what? This was appropriately applied to me." And I am not sure that members of all the organizations aren't sitting at home saying, "I hope that never happens to me." I am not sure that anybody is wishing this to happen.

This needs to be reversed. It does. And I think that every organization that represents veterans should look at this as a potential

loss of their individual rights and engage their membership. Granted, it is not number 1 on everybody's list; I understand that. But I don't think we have the ability to pick and choose which ones we are going to be engaged in and which ones we are not. So, I hope you will take it back to the annual meeting and propose that you do take a position as strongly as you can. And Blake, also with you; and Ralph, if appropriate, with you.

If I didn't miss anything, I think most of you were supportive of the Family Caregiver Act and I believe that this is vitally important that we move forward.

I will defend the VA for a little bit. They had many more responsibilities and they have got to make sure that the overall architecture that they set up continues to work and function. And I think that it puts a higher threshold on the Chairman and me to work with VA to make sure that what we are attempting to do works within that framework, and I pledge to them to continue to do that.

But I also pledge to you that at the end of the day, we are going to have a caregiver program that provides for those family members that choose to take care of their loved ones. I think it is in the best interest of those veterans who have been injured. It is in the best interest of the family that feels the closest to them and desires the most—as much of a recovery that they possibly can have. And clearly, since we offer this to other populations in America—typically that care is extended through Medicaid in different fashions determined by States—I don't know why the Veterans Administration should be excluded from it.

So, I appreciate the comments all of you have made. Where you still have issues that are thorny or rough, I look forward to working with you on any language where we might need to make changes to smooth that out. Once again, I thank you.

Senator BEGICH. Thank you very much, Senator Burr.

I have a 4:30, so I am going to ask a couple of questions, and then, Senator Burr, I will come back to you for any additional questions; and then I will close it off.

I do have a couple of questions that the Chairman wanted to ask, so I am going to ask them on his behalf. The first one is to Mr. Ortner. The PVA testified in 2007 against the VA partnering with the Centers for Medicare and Medicaid Services to utilize critical access hospitals. Does the organization still object to that or have they modified their position, or are you aware of that?

Mr. ORTNER. I am not aware. I would be happy to take that for the record and I will go back and we will get an answer for the Chairman.

Senator BEGICH. That would be great. That was a couple of years ago and there may have been a change since then. But if you could follow that up and give it to the Committee, that would be fantastic.

Mr. ORTNER. And I wasn't present at PVA at the time that was testified.

Senator BEGICH. I love it. We newbies. I get to say, that all happened last year; I wasn't here. So I am with you on that. But thank you very much.

[Response to the request follows:]

PARALYZED VETERANS OF AMERICA,
Washington, DC, May 20, 2009.

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

DEAR MR. CHAIRMAN: Thank you for the opportunity to respond to questions from Paralyzed Veterans of America's (PVA) April 22, 2009 testimony on pending legislation before the Committee.

Regarding Mr. Begich's question on your behalf in reference to PVA's 2007 testimony against VA partnering with the Centers for Medicare and Medicaid Services to utilize critical access hospitals, PVA would like to offer the following response for the record.

I believe the Chairman was referring to PVA's June 14, 2007, testimony to the House Committee on Veterans' Affairs Subcommittee on Health. PVA expressed its concerns about demonstration projects between VA and the Centers for Medicare and Medicaid Services. PVA believed that congressional legislation may have been "jumping the gun" and getting ahead of the Office of Rural Health's ability to assess demonstration projects.

PVA's position has not changed. The Office of Rural Health (ORH) was established to develop policies and identify and disseminate best practices and innovations to improve health-care services to veterans who reside in rural areas. This is a noble goal and ORH is now established and working its mandated activities, but it is still relatively new and at the threshold of tangible effectiveness. But more specifically, PVA does not believe it is the proper role of Congress to legislate specific solutions to rural health problems. It is much more critical that Congress provide aggressive oversight to ensure VA is providing the high quality of care veterans are due, regardless of their location. It is not simply enough to increase the access to care. VA increasing its fee based care will provide greater access, but at what long-term cost to the veteran.

ORH must concentrate on its coordination role. Public Law 109–461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006," which established the Office of Rural Health and its mission requirements, in Section 213 of the law requires VA to work at the local level with, among other institutions, critical access hospitals located in rural areas. The intent was to increase the awareness of veterans and their families of the availability of VA health care and how they can access such care from VA. Congress should emphasize this coordination role and demand from ORH specific examples of its success or progress toward success. This is where Congress can provide the greatest overall impact on rural care.

Additionally, the Office of Rural Health should have the opportunity to develop programs that will help provide high quality health care to the rapidly increasing number of rural veterans. Congress needs to provide the stringent oversight to insure ORH is meeting the goals of policies and practices on care which is of the same quality or better than that provided at VA facilities. ORH must not only disseminate the practices and innovations, but should monitor that its recommendations are being implemented and if not, why.

The Office of Rural Health has a daunting mission. With over 40 percent of veterans living in rural areas and almost 80,000 living in "highly rural" locations, VA must develop new and innovative techniques to care for these veterans. But these challenges in no way permit providing lesser quality care than these deserving veterans would receive from any other VA facility. This must be ORH's first mission.

More information on the concerns of PVA and other VSOs regarding rural health care issues is contained in *The Independent Budget* for Fiscal Year 2010 produced by AMVETS, Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars.

Sincerely,

BLAKE C. ORTNER,
Sr. Associate Legislative Director.

Senator BEGICH. Mr. Ibson, many of the VA's current caregiver pilot programs do not include—and I know some of you already testified on this, but I want to put his question on the record so the answer is crystallized here. Current caregiver pilot programs do not include financial support for the caregiver—something you talked about as well as others. Can you tell the Committee why

caregivers need the monetary stipend in addition to counseling, training, and other forms of support? Specifically, why monetary is important, if you could add to that and then we put that into the record, that would be fantastic.

Mr. IBSON. Surely. I think the experience we have seen with caregivers is, as I indicated, that their lives have been completely irrevocably altered. Family members have left their jobs to be at the bedside of their loved ones and have not left that bedside. Economic concerns have been set aside in what becomes a self-sacrificing mode. Ultimately, that burden will take its toll, not only in terms of mental health, emotional health, overall health, but economically, as well. We see a need to sustain that caregiving, and in order to do so, it is our view that a broad array of services is needed to provide adequate supports—not simply emotional support, not simply respite, not simply counseling and training, but a financial stipend, as well—to sustain the caregiving.

Senator BEGICH. Thank you for that.

I will just give you 2 seconds here. I have a nephew who has spina bifida and Medicaid; I have another nephew who is his caregiver and gets a stipend. I just wanted to make sure the Chairman had his question, but I also am very sensitive to the issue and making sure that the economic opportunities are there because it does put lots of stress for all the reasons you have just said.

Let me ask, if I can, just one more. I will not do well with your name. I will do my best. Mr. Atizado and also Ms. Hilsabeck, this is for both of you. The Chairman noted your testimony, which indicates the DAV's and the AFGE's full support of S. 743, the Rural Veterans Health Care Access and Quality Act of 2009, in part because it improves oversight of contract and fee-based care. Could you comment on why you see the need to improve oversight in this area? If you could be just brief, but just again emphasize a little bit of your testimony, again, crystallizing it for this question, either one of you.

Ms. HILSABECK. Thank you for the question, but I wouldn't be really prepared to answer that. I would have the AFGE—the union—get that information.

Senator BEGICH. OK. That would be fair. If you can get that information to the Chairman, that would be fantastic.

Ms. HILSABECK. OK.

Senator BEGICH. Thank you.

[Response to the request follows:]

RESPONSE TO REQUESTS ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

At the April 22, 2009 hearing, Senator Begich requested that AFGE elaborate on the statement in its written testimony on S. 734 about the need for oversight of VA contract and fee basis health care, especially the Project HERO pilot project,

Generally, AFGE is deeply concerned about the lack of adequate oversight of all VA contract health care arrangements, in terms of

- Lack of cost effectiveness;
- Inferior quality of care for specialized veterans' needs;
- Lack of coordination between contract providers and VA providers; and
- Long range impact on contract care on VA's internal capacity to meet veterans' health care needs through direct care, research and academic affiliations.

I. FEE BASIS CARE

With regard to fee basis care specifically, we believe that many VA medical facilities are over relying on fee basis care, in violation of the statutory requirement that these arrangements only be made when VA in-house care is "scarce" i.e. not available. Our members regularly report that managers at their facilities turn to costly fee basis care rather than make effective staffing plans or utilize the recruitment and retention tools enacted by Congress to fill nurse and physician vacancies (e.g. nurse locality pay and alternative work schedules, physician market pay and performance pay). Overreliance on fee basis care also threatens the quality of care: fee basis providers lack the expertise and specialization of VA providers who exclusively treat veterans within the VA system, and they are less familiar with unique combat related injuries such as Traumatic Brain Injury.

We have heard that a number of facilities are currently facing budget shortfalls—despite unprecedented budget increases from Congress—because they are providing and more of their care through expensive fee basis arrangements.

Recommendation: We urge Congress to conduct oversight into the current status of VA's fee basis program, including expenditures by each VA medical facility on fee basis care, credentials of fee basis providers, effectiveness of coordination between contract providers and VA providers, and the adequacy of VA personnel needed to arrange and oversee fee basis arrangements.

II. PROJECT HERO

Project HERO has been touted as the cure for all the woes of fee basis care. Nothing could be further from the truth. This pilot project was implemented without adequate Congressional authority.[1] It has been conducted in near secrecy. It is draining VA medical centers of substantial portions of their budgets and resulting in reductions of the very in-house personnel needed to effectively arrange and oversee contract care. It is costing the VA more than fee basis care arranged directly by VA personnel. It has not resulted in greater access for rural veterans and in fact, is impeding access for many veterans who are being forced to go to HERO providers and travel further when they prefer to receive their care within the VA.

The reach of Project HERO is enormous: the pilot covers 33 states in 4 VISNs (8, 16, 20 and 23) and by the VA's own admission, now covers thirty percent of all veterans enrolled in the VA.[2] Yet, on the HERO webpage, it describes HERO as "a pilot program that helps Veterans access the health care they need *when specific medical expertise or technology isn't available inside the VA health care system*" (emphasis added). Clearly, a 30% penetration rate is directly contrary to HERO's own stated goal of supplementing, not supplanting, VA's in-house services.

Based on reports from the field, it appears that HERO may not be consistently fulfilling other key commitments it made on its VA webpage:

- "When Veterans need care that's not available at their local VA medical center . . . Project HERO supplements VA care with credentialed quality medical and dental providers to quickly meet their needs."
- "HVHS (Humana Veterans Health Services) is committed to contacting Veterans for appointments within five days, and both HVHS and Delta Dental arrange for Veterans to see specialists within 30 days. Veterans also wait less than 20 minutes to see the doctor or dentist once they've checked in for their appointments."

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[1] The conference report for the 2006 VA appropriations law is the only source of authority for Project HERO. The following 196 words addressed the need for contract care management, and were never intended to serve as the basis for this vast pilot project:

Contract Care Coordination—The conferees support expeditious action by the Department to implement care management strategies that have proven valuable in the broader public and private sectors. It is essential that care purchased for enrollees from private sector providers be secured in a cost effective manner, in a way that complements the larger Veterans Health Administration system of care, and preserves important agency interest, such as sustaining a partnership with university affiliates. In that interest, the VHA shall establish through competitive award by the end of calendar year 2006, at least three managed care demonstration programs designed to satisfy a set of health system objectives related to arranging and managing care. The conferees encourage the Department to formulate demonstration objectives in collaboration with industry and academia, and the Secretary will report objectives to the Committees on Appropriations of both Houses of Congress within 90 days of the enactment of this Act. Multiple competitive awards and designs may be employed that may incorporate a variety of forms of public-private participation. The demonstrations, in satisfying the objectives to be enumerated, must be established in at least three VISNs, be comprehensive in scope, and serve a substantial patient population.

[2] See statement by VA National Program Manager Greg Eslinger in February 2009 news report. http://wcco.com/health/project.hero.veterans.2.939294.html

• "Veterans have peace of mind knowing their medical and dental records are returned to VA so their primary doctors and dentists can provide more informed, continuous care over time."

• "Veterans can trust VA is using resources wisely while maintaining high quality care. With Project HERO, HVHS and Delta Dental offer consistent, competitive pricing and they send invoices directly to VA for payment."

The VA has also not kept its commitment to keep labor organizations adequately informed about HERO, which it identifies as a "partner". They have not met AFGE's multiple requests for a face-to-face briefing, and at best, have supplied a few very general PowerPoint presentations to the AFGE VA Council leadership at group meetings. Our members on the front lines of health care have been given no role in overseeing or consulting on the use of HERO care.

We have brought our concerns to Senator Johnson, Chair of the Senate Mil-Con-VA Appropriations Subcommittee. South Dakota is also one of the states most heavily impacted by HERO to date. (Generally, the HERO pilot is VISN 23 is the most developed but we also are aware of HERO activity in VISNs 8, 16, and 20.)

Recommendation: The following are the questions that we have raised with appropriators. We hope this Committee will also conduct oversight to secure answers to these questions.

I. Source of funding for HERO

a. Which designated accounts are used to fund HERO administrative costs at each level (VA Central Office (VACO), VISN office and facility)?

b. Which accounts are used for payments to HVHS and Delta Dental for the services they arrange, related referral fees, etc.

c. Are fee basis dollars used to cover any HERO costs? If yes, what statutory authority does the VA rely on to use fee basis dollars?

II. Cost Effectiveness[3]

a. What is the fee arrangement between VA and contractors for different types of care, and how do these fees relate to the Medicare fee schedule?

b. What other costs are billed to the VA, e.g. referral fees?

c. Provide data on all payments to contractors since the inception of the pilot project.

d. Provide data on all administrative costs incurred at each level for the VA to operate this pilot project since HERO's inception.

III. Impact on Medical Center budgets[4]

a. For each facility participating in HERO, provide data indicating the percentage of the facility's budget that has been used to cover HERO fees, administrative costs and other HERO expenses.

b. For each facility participating in HERO, provide data indicating staffing levels for positions relating to care coordination (with HERO contractors and other contract care providers) including clinical care coordinators.

c. For each facility participating in HERO, provide data on staffing policies (e.g. hiring freezes), vacancies and other staffing changes since the date that the facility began participation in HERO.

IV. Impact on quality of patient care

a. Provide copies of all provider networks established by HVHS and Delta Dental to date.

b. What criteria are used to screen candidates for the HVHS and Delta Dental provider networks?

c. What if any complaints has the VA received regarding HVHS and Delta Dental providers?

d. What type of orientation is required for providers participating in HVHS and Delta Dental networks?

e. How does the VA (at each level) oversee the quality of care provided by HERO network providers?

f. What procedures are in place to ensure that contract providers make proper referrals (to the VA or outside the VA) when veterans need specialty care or other referrals?

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[3] AFGE has information that Humana may be charging the VA 105% of Medicare plus a referral fee per patient. In contrast, it is our understanding that when VA arranges its own contract ("fee basis" care) it pays the providers 100% of Medicare and there are no other fees involved.

[4] AFGE has received reports that several local facilities, including Minneapolis, Black Hills and Seattle have gone into budget shortfalls because of increasing costs for HERO and other contract care.

g. Provide data indicating the number and type of referrals, and provider name and address, for each referral made by contract providers since the inception of the pilot project.

h. Are the contractors required to provide the same level of care provided for equivalent services at the VA, e.g. physician or nurse, primary care or specialist?

i. What are the skill levels of personnel employed by the contractors who coordinate referrals and care with the VA?

V. Other care coordination issues

a. Provide a copy of procedures for sharing of medical records between the VA and the contractors, and their network providers.

b. What safeguards are in place to ensure that sharing of records protects veterans' personal health information?

c. Provide all reports received to date regarding problems with medical record exchanges between the VA and the HERO contractors.

d. Provide a copy of procedures used to ensure that contractors provide other medical services timely and properly, including prescriptions and prosthetics.

VI. Impact on access

a. What geographic criteria do contractors use to identify and recruit providers to their network?

b. What percentage of VA referrals have contractors been unable to fill due to lack of geographically accessible providers?

c. What percentage of VA referrals have contractors been unable to fill due to lack of appropriate specialists?

d. Provide data indicating travel times required for veterans using HVHS and Delta Dental providers, in comparison to travel times required to equivalent providers within the VA or fee basis providers contracting directly with the VA.

e. Provide data indicating the HERO contractors' success in meeting HERO's stated commitment of contacting veterans for appointments within five days, arranging for veterans to see specialists within 30 days and limiting the amount of time the veteran waits at the provider's office to less than 20 minutes after checking checked in for their appointments

f. What reports has the VA received of dissatisfaction by providers who contracted with HVHS or Delta, or evidence of reluctance by medical professionals or other providers (including dialysis facilities) to join the HVHS or Delta Dental networks?

g. What are the VA's criteria for determining which patients to refer to HVHS and Delta Dental, rather than treat in-house or refer to a fee basis provider arranged directly by the VA? Has the VA imposed any fixed quotas on facility directors as to the number of patients that must be referred to HERO contractors?

VII. Oversight and Evaluation

a. Describe all efforts by HVHS and Delta Dental to provide performance data and other information to lawmakers and partners (academic affiliates, VSOs and labor unions)? Provide all materials provided to lawmakers and partners.

b. What criteria were used to award the initial contract to HVHS and Delta Dental? Was the award made competitively? Provide a copy of first year contracts with HVHS and Delta Dental.

c. What criteria were used to award the second year contract to Humana and Delta Dental? Provide a copy of the second year contract.

d. What criteria were used to award additional specialty area contracts to Humana and Delta Dental during the first year? Provide copies of all such contracts.

e. Provide copies of all evaluations completed to date and all pending evaluations conducted by VA to determine the impact of HERO on the quality, timeliness and accessibility of veterans' care, patient satisfaction and cost effectiveness.

VIII. Patient Satisfaction

a. What information is provided to veterans regarding referrals to HERO contractors? Are they informed that they have a right to refuse an outside referral? Please provide copies of all documents provided to veterans about HERO and the referral process.

b. Have any veterans been told that if they refuse a referral to HVHS or Delta Dental, that they will be denied VA care? Are facilities permitted to impose this requirement?

c. What oversight has the VA conducted to ensure that veterans are fully informed of their rights in the referral process?

d. Provide data on the out-of-pocket medical costs incurred by all veterans using HERO providers who faced these additional costs.

e. What information is given to veterans about the safeguarding of their medical records when their cases are referred outside the VA?

XI. IMPACT ON RESEARCH: What evaluations has the VA done to determine the impact of HERO on VA's research capacity? Is HERO causing VA and academic researchers to lose volunteer patients needed for research programs?

XII. IMPACT ON ACADEMIC AFFILIATES: What evaluations has the VA done to determine the impact of HERO on VA's relationship with academic affiliates and opportunities for medical training? The impact on VA's medical school and other health professions training programs at the local level when a large portion of subspecialty work is diverted outside the VA and university systems? Is HERO causing medical schools and the VA to lose the very patients they need for teaching purposes.

Mr. ATIZADO. Senator Begich, thank you for the question. The DAV believes that oversight for VA's fee-basis program is needed simply because this program is fraught with problems: anywhere from the IT infrastructure or software that is utilized, the training of the people that run the fee-basis program; as well as the care that is purchased; the way it is not coordinated or lack of coordination. In fact, VA right now is conducting a project called Project HERO that is supposed to answer most of the concerns that we have about fee-based and contract care that VA currently does. We are learning more about that program, but if you would like, I can provide you a more detailed answer for the record.

RESPONSE TO REQUESTS ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Question. The Chairman noted your testimony, which indicates the DAV's and the AFGE's full support of S. 734, the Rural Veterans Health Care Access and Quality Act of 2009, in part because it improves oversight of contract and fee-based care. Could you comment on why you see the need to improve oversight in this area?

Response. Current law places limits on VA's ability to contract for private health care services in instances in which VA facilities are incapable of providing necessary care to a veteran: when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban with exception to Section 403 in Public Law 110–387, the Veterans' Mental Health and Other Care Improvements Act of 2008. This provision directs VA to conduct a three-year pilot program under which a highly rural veteran who is enrolled VA health care and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health care provider at VA expense.

According to VA, 41 percent (over 3.2 million) of its enrolled veteran population live in rural and highly rural areas, and approximately 40 percent of veterans receive some of their care from a non-VA health care provider. This represents a significant portion of the enrolled veteran population that has an identifiable need for expanded access to VA health care.

However, increased use of VA purchased care whether through contract and/or fee-base can silently shift the balance of clinical material that will result in unintended consequences for VA, unless carefully administered. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the specialized needs of combat wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for Post Traumatic Stress Disorder, as well as several others, would be irreparably impacted by the loss of veterans from those programs. Also, the VA's medical and pros-

thetic research program, designed to study and, hopefully, cure the ills of injury and disease consequent to military service, could lose focus and purpose were service-connected and other enrolled veterans no longer physically present in VA health care. Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when Public Law 104–262 was enacted in 1996. Unfortunately some of that capacity has dwindled.

We recommend the principles of our recommendations from the "Contract Care Coordination" section of the *Independent Budget (IB) for Fiscal Year (FY) 2010* be used as a guide for VA to develop an integrated program of contract care coordination for veterans who receive care from private health care providers at VA expense, while mitigating the aforementioned unintended consequences that diminish VA health care.

RURAL OUTREACH COORDINATORS

The DAV believes much can be done to improve the use of purchased non-VA care. For example, components of a coordinated care program should include a care and case management system to assist every veteran and each VAMC when a veteran must receive non-VA care. Notably, a provision in Section 7 of S. 734 would require VA to establish rural outreach coordinators at each CBOC with a majority of enrolled veterans who reside in "highly rural" areas.

Ostensibly, these rural outreach coordinators would fall under VA's Office of Rural Health (ORH), whose mission includes identifying and implementing new initiatives such as increasing mobile clinics, establishing new outreach clinics, expanding fee-based care, exploring collaborations with Federal and non-Federal community partners, operating the Rural Health Resource Centers, accelerating telemedicine deployment, developing workforce recruitment initiatives, developing web-based information delivery methods and funding innovative pilot programs. Notably, VA's budget submission for FY 2010 projects an increase in fee workload of 24 percent from 2008, and an increase in rural health spending through the ORH of $380 million from 2009.

As part of the IB, the DAV believes veterans who receive private care at VA expense and authorization should be required to participate in the care coordination program, with limited exceptions. This provision of S. 734 would require the coordinator at a clinic to be responsible for coordinating care and collaborating with community contract and fee-basis providers with respect to the clinic. We believe this is a good first step in care coordination for rural and highly rural veterans enrolled in the VA.

CONSOLIDATION OF COMMUNITY-BASED OUTPATIENT CLINIC (CBOC) CONTRACTING

As part of the IB, the DAV believes consolidated CBOC contracting offers VA a way to standardize the health care benefits to veterans served by individual VAMCs and provides greater efficiencies and cost savings to help meet the increasing health care needs of veterans in rural or underserved areas and areas not directly served by a VA medical facility.

Specifically, consolidated CBOC contracting would provide greater continuity of care and uniformity of benefit; simplify contract administration and oversight allowing for more efficiency; responsive capacity by sharing of health care providers based on demand; provide consistent and uniform medical care services; consolidate training on VA programs and procedures, including use of Veterans Health Information Systems and Technology Architecture (VistA); and standardized CBOC reporting. We invite the Committee to read more details on this issue in the *FY 2010 IB* article, "Community Based Outpatient Clinics."

ESTABLISH INCENTIVES TO OBTAIN ACCREDITATION OF PARTICIPATING FEE-BASIS PRIVATE PROVIDERS, AND TO ENCOURAGE THESE PROVIDERS TO PARTICIPATE IN VA'S PEER REVIEW SYSTEM

The DAV believes VA's health delivery system must promote and ensure health care quality and value, and protect veterans' safety. The Veterans Health Administration (VHA) has created a culture of quality by measuring important clinical outcomes, many of which fall within the domain of primary care. In addition, part of VA's quality of care includes the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health record and bar code medication administration. Loss of these safeguards, ones that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

An important tool to expand access to VA health care in rural areas is its use of fee care. Notably, sections 212(b) and (c) of Public Law 109–461 requires an extensive assessment of the existing VA fee-basis system of private health care, and eventual development of a VA plan to improve access and quality of mental health and long-term care for enrolled veterans who live in rural areas. To further such requirements, section 7 of S. 734 seeks to establish incentives to obtain accreditation of participating fee-basis private providers, and to encourage these providers to participate in VA's peer review system. Each VA rural outreach clinic is part of a VA network and maintains VA's quality standards. When conducted systematically and credibly, peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practice. Mr. Chairman, you mentioned VA currently has no standardized procedure in place to ensure non-VA purchased care veterans receive in the community are of equal or better quality than that which they would receive directly from VA. This provision is consistent with the principles of the recommendations from the "Contract Care Coordination" section of the *IB for FY 2010*.

Senator BEGICH. Very good. If you could do that, that would be great.

I just got a note that a vote has started, so I am going to just close it up and say thank you all again for your testimony, for both panels. Again, for information for all, the Committee's markup is scheduled for May 21 and it is the hope of the Chairman that at that time, we will move a number of these bills presented today.

For the Administration witnesses, we ask that you review all the bills that are going to be up for markup and submit your views no later than 1 week prior to markup—by May 14—especially after the Chairman's commentary today. I would even have it back by May 13—be 1 day early. That would be good. He would like your commentary on the bills prior to May 14.

I know many of you have submitted testimony for the record. We appreciate that. Again, markup will be on May 21 on several of these bills.

At this time, I will adjourn the meeting and thank you all for testifying.

[Whereupon, at 4:32 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF LT. JERRI GEER, USCG (RET.), SEATTLE, WA

Chairman Akaka, Ranking Member Senator Burr and Committee Members: I am LT. Jerri Geer, USCG (Ret.) and I am extremely grateful to be asked to speak with you today. I am honored to be here. Thank you.

I live in the Seattle, Washington, area and go to the Seattle VA Medical Center for my health care.

To begin, I live with the challenges of Bipolar Disorder. I have struggled with this disability for over thirty years and have always been responsible for my health and personal aspects of my life. Being Bipolar, I have had difficulties with my finances over the years, but have always been responsible for my debts and have never been late on my payments. I have always paid my debts in full. My FICO scores are between 783 and 785, which are considered excellent. However, in the fall of 2002, I was very afraid that I had gotten into a financial situation that I might not be able to handle. I thought I could trust my social worker and my psychiatrist at the Seattle VAMC, so I finally asked for help. This is when all the trouble started. They informed me about a program through the Seattle VA Regional Office that helps Veterans with their finances. After being told what I thought were all the facts about the program, I asked to be put in it. My psychiatrist wrote a letter to request this for me. A red flag immediately went up when I read the word incompetent in that letter. I asked my social worker what that meant and she said it was just a term the VA uses for this program; that it was unfortunate the VA couldn't find a better term for my situation. I asked her if this had any legal consequences outside the VA and she said no. Neither she, nor my psychiatrist, ever told me about the Brady Act—National Instant Criminal Background Check System (NICS). This letter is dated December 2, 2002. I really wanted to get help, so I signed the letter.

I didn't know about the Brady Act until I received my proposed rating letter of January 23, 2003, adjudicating me incompetent and I was to be assigned a fiduciary. In the letter it stated I was permanently barred from purchasing a firearm. Because I don't like guns, I didn't pay any attention to it. It took until May 2003 before I met my Field Investigator. During this time, I had read Suze Orman's books on finances and had actually regained control of my finances. When my Field Investigator saw what I had done, she said I really didn't need to be in the program and would recommend that to my psychiatrist. My psychiatrist didn't agree and wanted me to be on supervised pay and not have a payee. I only saw my Field Investigator twice: in the beginning, May 2003; and at the end, a year later in May 2004. During this period I managed my own affairs.

At my last meeting with my Field Investigator I was reminded once again I was permanently barred from purchasing a firearm. At that point, I realized I needed to know what that really meant. I received my competency rating November 19, 2004. I started researching the Brady Act later in January 2005. This is when I discovered the real ramifications and became concerned and angry that I was not told about this NICS when I volunteered to be put into the fiduciary system. I told my social worker and psychiatrist of my anger and fears. Apparently the VA Regional Office failed to inform the VA Medical Center about this NICS-Brady Act. If my psychiatrist had known, she would not have put me in this program. I was never incompetent and she knew I just wasn't the kind of person that should be in this NICS database. She apologized and said she was ignorant about this. I think she

was genuinely upset that she was not informed. Other patients had also been put in this system that were not incompetent. In my heart, I feel I was deceived, however unintentionally.

I decided this was an egregious miscarriage of justice. I spent at least three months researching on the internet and found information and misinformation concerning the Brady Act. Since I have no legal background, I tried earnestly to obtain information from the VA and the NICS, both of which kept pinging me back and forth between the two, saying the other could only remove my name from this database. I called the NICS for information three times and each time I received three different answers to the same question, "How can I remove my name from the NICS." They essentially told me the original agency that adjudicated me incompetent is the only one that can remove my name, which would be the VA.

I put a claim through the DAV to the Seattle VA Regional Office requesting they remove my name from the NICS in April 2005. I waited until June 2005 for a response, but none came. I decided to see Senator Patty Murray's staff member, Ms. Muriel Gibson in Seattle for help. She sent a Congressional Inquiry to the VA Regional Office in June 2005.

The VA responded in August 2005 to Senator Murray's Congressional Inquiry saying they could not remove my name, but sent a pamphlet giving me information on how to contact the NICS to remove my name. The pamphlet instructed how to appeal, but only after trying to purchase a firearm and the last paragraph indicated the original agency would be a key factor in the appeal. I felt the NICS appeal process was another path that would again put responsibility back on the original agency—the VA.

Therefore, Ms. Gibson and I decided to send a letter to the VA Judiciary Council asking them to remove my name from the NICS in August 2005. I waited until December 2005 for a response. None came. Ms. Gibson then contacted the VA Judicial Council which stated a reply had been sent in October 2005. Needless to say, I did not receive it. Ms. Gibson was faxed the response which again said the NICS was the only agency that can remove my name and only after I tried to buy a firearm. Since my stance of not wanting to buy a gun would be compromised, a letter was again sent to the VA Judiciary Council in December 2005 explaining my request. The VA sent another response dated March 2006 which denied my request once again to Senator Murray's office; however, I did not receive this letter until May 2007.

At this point, my spiritual needs were becoming serious and I turned to my Chaplain at the VA Medical Center. She called the attorney at the VA Regional Office and the attorney said she had never heard of this issue and referred my Chaplain to the Chief of Security at the VA Medical Center in Seattle.

Back in July 2005, I began to realize I seemed to know more about the NICS than the Federal Government. Even when a mistake has been made by the VA, a name cannot be removed. This, in my opinion, takes away my right to "due process" which is my Fifth Admendment Right and my Second Admendment Rights. So, I made a desperate move to write Chairman Craig on July 16, 2005. I also sent the same letter to the Chairman of the House Committee on Veterans' Affairs and Ranking Members of both the Senate and House of Representatives. Fortunately, Chairman Craig's staff member, Major David Buffaloe, USA, took the letter seriously and began researching this issue. He contacted me and told me that neither he nor other staff members knew about this and together we all began a journey that has led me to testify before you today.

I believe the Brady Act is not only an illegal act pertaining to veterans, but an ethical, civil rights, and privacy issue. I find it unbelievable that a Federal agency such as the Veterans Administration would make an agreement with another Federal agency without at least researching the various laws concerning the appropriateness of such an agreement. I feel the VA did little or no oversight and failed to protect the rights of veterans, their children and spouses. I later learned from Major David Buffaloe that the VA was also putting the names of veteran's children into the NICS when they became orphaned or for other reasons. This is unconscionable. Anyone with an ounce of sense would know the terrible ramifications of such

an act when these children become adults. It makes me believe that there is no one at the helm in the VA and the VA is derelict in its duties.

The Brady Act was not created to put innocent children's names in the NICS nor innocent adults. It is too broad, overreaching and is flawed. I do believe it was born out of fear, high emotions, feelings of not having control over the escalating violence in this country, ignorance, stereotyping and a belief system about the mentally ill that is vastly untrue and antiquated. It was well intended; however, it has cast a very wide net and innocent people have been swept into it, simply because they swim in the same ocean.

Before any citizen has their Constitutional Rights removed, it should be done only through a court of law and the right of legal council. Now, I do understand there are special circumstances, but it should always be done though a court of law. Right now felons have more legal rights than veterans.

After researching this issue, rbecame aware that this quest to remove my name from the NICS was not just about me, but about all veterans whose names are also sacred. This situation has been devastating to me. I feel my name has been stolen and my honor has been tainted. My whole sense of safety has been destroyed. I need my name removed from the NICS because I am not a "mental defect" and "a threat to public safety" and I was never "incompetent." This is very detrimental to my health. In the past, I have been open about my Bipolar Disorder, however, after this experience, of being plunged into the dark abyss of bureaucracy and indifference in the last four and a half years, I realize I have been putting myself at risk of being unjustly feared, judged and seen as a threat to public safety no matter who I shared my life with.

Mr. Chairman, in creating such a law as the Brady Act with its vast misunderstandings, I believe Congress has increased the potential violence with firearms. For who would want to subject themselves to the stereotyping, stigmatization, alienation, fear, loss of friends, family, jobs, and much more in voluntarily seeking Mental Health Care? It takes an immense amount of courage, responsibility and a wanting to be a positive member of society to seek this help. Instead of vilifying people who seek help, we need, as a moral society to make such people the pillars of society and, in a sense, heroes. Then, you will have a safer society. Otherwise, I fear we are only creating more Mr. John Hinckley's walking among us.

The irony of my situation is that I do support gun control and advocate for non-violence. I also understand the concerns of law-abiding citizens who enjoy or feel a need to own a firearm.

Mr. Chairman, I want to thank Senator Larry Craig while he was The Chairman of this Committee for his support, and his staff members, especially Major David Buffaloe, USA, for his exemplary work in researching this issue and helping me along the way. His kindness and compassion will always be with me.

I want to end by saying, "The benchmark of any society is its justice and there can be no freedom and honor without justice."

PREPARED STATEMENT OF MICHAEL BRENNAN, M.D., PRESIDENT, AMERICAN ACADEMY OF OPHTHALMOLOGY

Chairman Akaka and Ranking Member Burr: I am Michael Brennan, President of the American Academy of Ophthalmology. The Academy appreciates the opportunity to present its views on S. 252, the Veterans Health Care Authorization Act of 2009. The Academy is the largest national membership association of Eye M.D.s with more than 27,000 members, over 17,000 of which are in active practice in the United States. Eye M.D.s are ophthalmologists, medical and osteopathic doctors who provide comprehensive eye care, including medical, surgical and optical care. More than 90 percent of practicing U.S. Eye M.D.s are Academy members.

The Academy strongly supports Section 101 of the Veterans Health Care Authorization Act of 2009 which would authorize the Department of Veterans Affairs (VA) to extend Title 38, United States Code (U.S.C.), employment status to certain employees. We believe that this authority would enable the conversion of eye technicians within the Veterans Health Administration (VHA) from their existing non-specific health technician status into a Title 38 Hybrid Series specific for eye care tech-

nicians. The inclusion of eye technicians into the hybrid classification system would improve the ability of VA to recruit and retain qualified eye technicians by ensuring that personnel are hired based on knowledge, training and experience and to compensate eye technicians at a level more competitive with the private sector.

Improving VA's ability to recruit and retain qualified, experienced eye technicians is more crucial than ever today. Over the past decade, the eye care workload in the veterans' health care system has dramatically increased. Between 2001 and 2008, ophthalmology and optometry clinic visits and unique patients have increased 80 percent. In Fiscal Year (FY) 2008, there were 2.36 million eye clinic visits for 1.39 million veterans. As the veteran population ages, their complexity of care also increases. Diabetic retinopathy, macular degeneration, glaucoma, and cataracts are diseases that are highly prevalent in the aging veteran population.

The complexity of eye care will further increase as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans return home. According to the Office of VA Research, combat eye trauma is the second most common injury experienced by military personnel serving in Iraq and Afghanistan. Veterans with a history of ocular battle injuries are at high risk for developing retinal detachments, traumatic cataracts, and glaucoma. Delayed Traumatic Brain Injury (TBI) neurovisual complications can occur years after the initial injury. The ever increasing prevalence of combat eye trauma and TBI-related visual complications will place even greater demands on VA's eye care services for years to come.

Traditionally, eye clinics in the VA health care system have been staffed with untrained technicians who are hired as Title 5 employees under the Health Technician GS–0640 Series which covers a range of health care positions, including such diverse jobs as phlebotomist and laboratory technician. The ability of VA to recruit trained eye care personnel (including eye technicians, ophthalmic photographers and opticians), is hampered by a lack of an appropriate eye care personnel series and standards. There are no formal position descriptions for eye care personnel in the VA, leaving each medical center to create its own position description, which reduces consistency throughout the veterans' health care system. Moreover, there are no established salary ranges for eye care personnel in the VA system, making it difficult to recruit qualified applicants. Medical centers are forced to post an eye care professional position as a "health technician" and use convoluted language and special qualifications to avoid selecting an unqualified applicant. These constraints make it difficult for the VA to attract the most talented eye care technicians in the community.

Under Title 5 employment, positions are graded according to classification standards and employee pay is determined based on the position classification, not on the individual qualifications of the person occupying the position. This policy has hindered the VA from achieving the highest efficiencies of care as the addition of one trained technician to one eye care provider has been shown to have a positive impact on workload. For example, one technician improves the workload of an optometrist an average of 14 percent while one technician improves the workload of an ophthalmologist an average of 36 percent. In 2009, eye technicians are expected to have the knowledge, training and experience to perform highly technical, state-of-the-art, diagnostic procedures including:

- Ultrasonography;
- Digital computerized imaging and fluorescein angiography;
- Pachymetry;
- Optical coherence tomography;
- Scanning laser ophthalmoscopy; and
- Automated perimetry.

The addition of trained eye care technicians and photographers to an eye clinic is a relatively cost-efficient way to improve veteran access to eye care and increase productivity.

The Title 38 Hybrid Conversion Series was developed to help recruit and retain employees in highly competitive health care occupations. These positions are considered Title 38 positions but also retain some features of Title 5 positions. Under Title 38 Hybrid, the grade and salary of each position is based on the duties of the position and how the candidate's qualifications compare to the VA Standard. A profes-

sional standards board determines which candidates are qualified through a peer-review process. Education, training and experience all can be considered as qualifications. Several health care technical series have already been converted to the Title 38 Hybrid Series; many of these series involve diagnostic testing that is similar to ophthalmic technicians (ultrasonography, angiography, electrophysiological testing, etc.).

The demand for quality ophthalmic medical technicians is on the rise, and employment opportunities for these technicians are only expected to increase. In 2006, the Joint Commission on Allied Health Personnel in Ophthalmology, Inc (JCAHPO) applied to the U.S. Bureau of Labor and Statistics to list ophthalmic medical technicians as a separate occupational classification. Earlier this year, the Bureau of Labor and Statistics' 2010 Standard Occupational Classification (SOC) Committee recommendations included a new classification for ophthalmic medical technicians (Classification Number: 29–2057). This new classification recognizes the more advanced, clinical and overall medically detailed skills and knowledge of ophthalmic medical technicians and will increase the competitiveness of qualified technicians in the job market.

In closing, the Academy strongly supports the enactment of S. 252, the Veterans Health Care Authorization Act of 2009, because we believe it will provide the VA with the authority it needs to properly address the growing demand for eye care services. Once enacted, we would urge the Department of Veterans Affairs to use its new authority to convert eye technicians from their current classification to a Title 38 Hybrid classification as quickly as possible. Qualification standards for eye care technicians already have been developed for implementation by the VA through a joint ophthalmology/optometry collaboration. Creating a Title 38 Hybrid series for eye technicians in VA would enable VA to recruit and retain qualified eye technicians into the Veterans Health Care Administration and would increase the ability of VA to provide excellent, yet efficient eye care to our Nation's veterans.

Thank you for your consideration.

PREPARED STATEMENT OF IAVA SUBMITTED BY PATRICK CAMPBELL, CHIEF LEGISLATIVE COUNSEL, OPERATION IRAQI FREEDOM (2004–2005)

ADVANCE APPROPRIATIONS

S. 423, Veterans Health Care Budget Reform and Transparency Act of 2009 (Akaka)

IAVA strongly endorses this legislation. For nineteen of the last twenty-two years, the VA budget has been passed late, forcing the largest health care provider in the Nation to ration care. Imagine trying to plan for next month's bills without knowing your next paycheck. That's what we ask veterans' hospitals to do almost every year. Advance appropriations will ensure that the quality of care for veterans will no longer be compromised by budget delays. With the strong support of the President, bipartisan leadership in Congress, and the support of every major veterans organization, S. 423 can and must move forward this year.

MENTAL HEALTH

S. 658, Rural Veterans Health Care Improvement Act of 2009 (Tester)

We are pleased to offer support for S. 658. According to the GAO, more than 25 percent of veterans enrolled in VA health care live over 60 minutes driving time from a VA hospital. This legislation would implement a multi-pronged approach to delivering quality health care to rural veterans: creating rural centers of excellence, funding new transportation grants and demonstration projects, and authorizing the VA to build local peer outreach and support services. S. 658 would also expand current counseling capacity by allowing the VA to contract with local community health centers. With nearly one third of all returning veterans suffering from invisible psychological injuries, S. 658 will allow veterans to support one another and receive the counseling they need.

S. 772, Honor Act of 2009 (Bond)

S. 772 will address one of IAVA's top legislative priorities: ending the shortage of mental health professionals in the military and at the VA. This legislation provides incentives for retiring or separating military personnel and combat veterans to pursue an advanced degree in behavioral health. It will build a new generation of counselors with combat experience, and will help ensure that our men and women in uniform receive mental health care from personnel that understand military culture. The legislation also gives active-duty servicemembers the same access that veterans have to Vet Centers, expanding the pool of mental health care options available to our troops. In addition, the Honor Act takes a number of other innovative steps to address the mental health needs of troops and veterans. It allows servicemembers to present their records to the VA for screening, irrespective of their discharge, so that veterans do not fall through the cracks. The legislation also guarantees survivor benefits for any servicemember who commits suicide within 2 years of separation or retirement, provided they have a documented history of combat-related PTSD or TBI. Finally, by providing comprehensive training to educate troops on Post Traumatic Stress Disorder, the legislation will mitigate the confusion and stress that servicemembers feel when trying to identify mental health resources. For all of these reasons, IAVA wholeheartedly endorses S. 772.

S. 669, Veterans 2nd Amendment Protection Act (Burr)

Two years ago, this Committee considered critical suicide prevention legislation called the Joshua Omvig Suicide Prevention Act. When this desperately-needed bill came to the Senate floor for a vote, rumors spread that the legislation would cause veterans seeking help for PTSD to lose their Second Amendment rights. Although even the NRA stated that the Joshua Omvig bill would have no impact on gun rights, critical sections of the Suicide Prevention Act were watered down. Although there is still no danger a veteran will lose their right to carry a firearm for seeking treatment for PTSD, we offer our support for this legislation in the hopes it will quell any fears veterans might have about seeking treatment for mental health injuries.

FEMALE VETERANS

S. 597, Women Veterans Health Care Improvement Act of 2009 (Murray)

IAVA is honored to offer our full support for S. 597. By 2020, the proportion of women veterans using VA health care is expected to reach 15 percent. This vital legislation will assess barriers to VA care that women face; plan for women's future VA health care needs; ensure full-time women veterans program managers at every VA medical center; authorize the VA to care for the newborn children of female veterans; enhance Military Sexual Trauma (MST) training for VA mental health professionals; build a pilot program to evaluate providing child care subsidies to qualified veterans; and create a pilot program to study readjustment counseling for women veterans in group retreat settings.

FAMILY CAREGIVERS

S. 801, Family Caregiver Program Act of 2009 (Akaka)

IAVA is proud to put our full support behind S. 801, which will ensure that family caregivers who care for their injured loved ones receive compensation and benefits that honor their service to their wounded warrior. This bill will provide a living stipend, health care benefits, training, and support to family caregivers.

S. 543, Veteran and Servicemember Caregiver Support Act of 2009 (Durbin)

S. 543 is also a strong caregiver support bill. Like S. 801, it provides a living stipend and training to family caregivers, but offers a narrower scope of services than S. 801, and the legislation is limited to a 2-year pilot program. We support S. 543, but would prefer S. 801.

VA HEALTH CARE

S. 699, Far South Texas Veterans Medical Center Act of 2009 (Cornyn)

The Far South Texas Veterans Medical Center Act is a critical piece of legislation that will improve access to health care for many of our returning veterans. With more than 114,000 veterans residing in the South Texas area, and a high rate of deployment from the Texas National Guard and Reserve units stationed there, it is unconscionable that the nearest acute inpatient care facility is almost 6 hours away. The Capital Asset Realignment for Enhanced Services study found that fewer than 3 percent of its enrollees in the Valley-Coastal Bend Market of VISN 17 reside with-

in its acute hospital access standards. This bill will help correct this dire situation. Veterans in South Texas must be provided access to the care they were promised after fighting for this Nation.

S. 734, Rural Veterans Health Care Access and Quality Act of 2009 (Akaka)

IAVA is proud to support S. 734, enhancing retention within the Veterans Health Administration, expanding care at Vet Centers, and expanding VA health care in rural areas. S. 734 ensures that the VA recruits and retains the highest quality medical professionals by removing the cap on the Education Debt Reduction Program and making VA medical centers eligible for assignment in the National Health Service Corp Scholarship Program. Additionally, S. 734 expands the mental health services offered by the Vet Centers by allowing mental health care professionals to act as volunteer counselors for the VA. S. 734 also expands outreach to rural areas by allowing for expanded teleconsulting and treatment to veterans who are not able to travel due to distance or infirmary, and allows the VA to reimburse a veteran for airfare when ground transportation is not feasible.

S. 498, Establishing VA Dental Care for Veterans and their families (Burr)

IAVA is proud to support S. 498, extending VA dental care to veterans and their families by allowing them to purchase a VA dental insurance plan. Dental coverage has long been a gap in the benefits offered to veterans of the armed services, and IAVA fully supports allowing veterans and their families to take advantage of the high quality of care that is offered by their local VA.

STATEMENT FOR THE RECORD SUBMITTED BY THE NATIONAL ASSOCIATION OF VETERANS' RESEARCH AND EDUCATION FOUNDATIONS (NAVREF)

S. 252, "VETERANS HEALTH CARE AUTHORIZATION ACT OF 2009," TITLE VI, NONPROFIT RESEARCH AND EDUCATION CORPORATIONS (LEGISLATION TO UPDATE AND CLARIFY PROVISIONS OF THE LAW AUTHORIZING THE VA-AFFILIATED NONPROFIT RESEARCH AND EDUCATION CORPORATIONS, 38 U.S.C. §§ 7361–7366)

The National Association of Veterans' Research and Education Foundations (NAVREF) thanks Senator Daniel K. Akaka, Chairman of the Committee on Veterans' Affairs, for incorporating title VI, "Nonprofit Research and Education Corporations" in S. 252, the "Veterans Health Care Authorization Act of 2009" and for holding a hearing on this and other important health-related legislation. Upon enactment by Congress, title VI of this legislation will update and clarify provisions of the law authorizing the VA-affiliated nonprofit research and education corporations.

NAVREF is the membership organization of the 82 VA-affiliated nonprofit research and education corporations (NPCs) originally authorized by Congress under Public Law 100–322, and currently codified at sections 7361 through 7366 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 as well as interactions and advocacy with agency and congressional officials. Additional information about NAVREF is available on its Web site at www.navref.org.

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, 82 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.

The fundamental purpose of the nonprofits is to serve veterans by supporting VA research and medical education to improve the quality of care that veterans receive. For example, a seed grant provided by the Palo Alto Institute for Research and Education (PAIRE) 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*, is changing colonoscopy practices and may well lead to widespread earlier detection of a cancer that is preventable or curable through surgery. During 2008 PAIRE made nine similar awards to

VA Palo Alto investigators in the hope of equally significant research success down the road. Similarly, a few years ago funds administered by the Seattle Institute for Biomedical and Clinical Research (SIBCR) allowed a psychiatry clinician-investigator to test use of Prazosin, an inexpensive, already approved drug, for treatment of veterans with debilitating post-traumatic stress-related nightmares. The SIBCR funding allowed the investigator to accumulate positive preliminary data that then led to DOD and NIH awards to further test this promising treatment.

Last year, the NPCs collectively administered more than $250 million with expenditures that supported approximately 4,000 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.

Beyond administering research projects and education activities, these nonprofits support a variety of VA research infrastructure and administrative expenses. As described above, 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.

LEGISLATION WOULD ENHANCE AND CLARIFY NPC AUTHORITIES

The purpose of title VI of S. 252 is to modernize and clarify the 1988 statute after 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." VA's most recent annual report to Congress regarding the NPCs stated, "The VA-affiliated NPCs continue to make a substantial contribution to the VA research and education missions." This legislation will further enhance their value to VA.

The objectives of this legislation are consistent with the findings in the May 2008 VA Office of Inspector General (OIG) review of five NPCs and VHA's oversight of them. VHA is working hard to address the shortcomings in oversight that the OIG identified. NAVREF and the NPCs are working equally hard to ensure that NPCs have appropriate controls over funds and equipment (including strengthening the 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 NAVREF firmly believes that NPC boards and administrative employees strive to be conscientious stewards of NPC funds, NAVREF thanks the OIG for its thorough review of those five NPCs and for bringing to light these areas in need of improvement.

It is noteworthy that the OIG report cited no misuse of funds or instances of conflicts of interest, no dual compensation of Federal employees and no fraud. However, we take very seriously the OIG finding that these NPCs nonetheless may not have had adequate controls over some of the funds they manage. Two major provisions in title VI of S. 252 directly address this finding:

> First, section 601 allows voluntary formation of "multi-medical center research corporations." 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 provision—the centerpiece of the legislation—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 604(a)—"(e) Policies and Procedures"—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 prevent the possibility of imposing on NPCs conflicting requirements and to ensure that they remain independent "flexible funding mechanisms."

Title VI of S. 252 provides a number of other welcome enhancements to the NPC authorizing statute.

- Section 603(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 603(c) 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 standard currently applied to NPC board members, Federal conflict of interest regulations provide means of recusal as well as de minimus exceptions. Additionally, the current prohibition may be applied to any individual who has 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 604(a)—(a)(1)(C) 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.

• Section 604(a)—(a)(1)(D) 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. Although OGC is already obligated to review these agreements without reimbursement, the funds generated under this provision would help OGC to staff Regional Counsel offices to accommodate the substantial workload these agreements entail and to provide training for VA attorneys in CRADA requirements and related VA policies. The NPCs support making these reimbursements.

• Section 604(a)—(b)(2) of the legislation provides VA with authority 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.

• Section 604(a)—(b)(3) establishes explicit authority for VAMCs to accept funds provided by NPCs that may fall outside of VA's gift acceptance authority. It also allows VAMCs to retain such funds locally and to deposit them in the appropriate VA account without having to route them through the Treasury, necessitating cumbersome steps to get the funds to the right VA account. Finally, this provision makes these reimbursements "no year" money to give VAMCs needed flexibility in timing for use of the funds.

Although VA has broad authority to accept gifts (38 U.S.C. § 8301), many NPC payments to VAMCs are more accurately described as reimbursements to the VAMC or payments for services and may not be consistent with VA's gift acceptance authority. For example, NPCs typically reimburse VAMCs for the cost of clinical services provided exclusively for research purposes; VA employees' time spent on NPC-administered programs; and animal per diems. This clause also will allow VA to resolve longstanding VAMC uncertainty about how to treat such reimbursements and will let the VAMC that incurred the cost retain the amounts reimbursed. Currently, VAMCs must send such reimbursements to the Treasury and then the Fiscal Office must use a cumbersome process to bring the funds back to the VAMC.

Title VI of S. 252 also contains a number of useful clarifications of NPC status and purposes.

• Sections 601(b), (c) and (d) codify—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. Clause 601(c) 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, this legislation resolves longstanding differences of opinion among stakeholders, overseers and funding sources about the legal status of NPCs.

• Section 602(a)(1) of the legislation 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 appropriateness of NPC expenditures that support VA research and education generally, such as purchase of core research equipment used by many researchers for multiple projects, and enhances the value of NPCs to VA facilities.

• Section 604(a)—(c) 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 legislation 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 VA approval.

In addition to these enhancements and clarifications, title VI of S. 252 legislation 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. Other revisions are largely technical and conforming amendments.

PROPOSED LEGISLATION PRESERVES MEASURES PROVIDING OVERSIGHT OF NPCs

Title VI of S. 252 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 the amount of their prior year revenues, and they must submit to VA an annual report that includes the resulting audit report along with detailed financial information and descriptions of accomplishments.

In the wake of the Sarbanes-Oxley Act and changing Federal Accounting Standards Board (FASB) auditing standards, even the most basic form of nonprofit audit has become an effective means for assessing an organization's financial controls. Additionally, the percentage of NPC funds subject to audits conducted in accordance with OMB Circular A–133, the most rigorous level of applicable auditing standards, will continue to increase as more NPCs assume responsibility for non-VA Federal grants. According to reports submitted to VA in June 2008, nearly 80 percent of prior year NPC expenditures were subject to an A–133 audit and overall, 99.7 percent of NPC expenditures were subject to an audit of one type or another. 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, NAVREF urges the Congress to enact title VI of S. 252 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, this is a timely opportunity to update and clarify the NPCs' enabling legislation. This legislation will accomplish those objectives. Experience working within the current 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 title VI of S. 252 will allow NPCs to better achieve their potential to support VA research and education while ensuring VA and congressional confidence in their management.

NAVREF thanks the Senate Committee on Veterans' Affairs and its staff members for their work on title VI of S. 252. We look forward to working with the Members of the Committee toward enactment of this bill. Please direct any questions you may have to NAVREF Executive Director Barbara West at 301–656–5005 or bwest@navref.org.

PREPARED STATEMENT OF BARBARA COHOON, DEPUTY DIRECTOR, GOVERNMENT RELATIONS, THE NATIONAL MILITARY FAMILY ASSOCIATION

National Military Family Association is the leading nonprofit organization committed to improving the lives of military families. Our 40 years of accomplishments

have made us a trusted resource for families and the Nation's leaders. We have been at the vanguard of promoting an appropriate quality-of-life for active duty, National Guard, Reserve members, retired servicemembers, their families, and survivors from the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration.

Association Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteer Representatives are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive Federal grants or contracts.

Our Web site is: http://www.nmfa.org.

Chairman Akaka and Distinguished Members of this Committee, the National Military Family Association would like to thank you for the opportunity to present written testimony for the record on "Family Caregiver Program Act of 2009." We thank you for this legislation's recognition of the integral role caregivers serve in managing both medical and non-medical care of our wounded, ill, and injured veterans. The proposed legislation ensures access to quality health care and mental health care for our wounded, ill, and injured veterans' caregivers and provides them the opportunity for training, certification, and compensation.

National Military Family Association applauds Chairman Akaka, Senator Burr, and Senator Rockefeller for this legislation. The intent of the legislation is to recognize the important role caregivers play in caring for our veterans. Research has shown the quality-of-life of our wounded, ill, and injured veterans can be directly linked to the level of caregiver involvement. It is because of the caregiver's dedication our veterans get timely quality care and they are also strong advocates who oversee the rehabilitation process.

The legislation addresses the special conditions and behaviors presented by veterans with a wide range of diagnosis. The definition of "severe injury" captures not only physiological conditions and psychological, but the inclusion of "an injury for which a veteran needs supervision or protection based on symptoms or residuals of neurological or other impairment." This provision is key with our Traumatic Brain Injury (TBI) injured veterans and the individuals who care for them.

We especially appreciate the fact this proposal has a more inclusive view for caregivers then other legislation previously introduced. Your legislation includes a provision for medical care, has a provision to expand coverage to other veteran caregivers in the future, and is more than a pilot study for a select few caregivers.

However, there are some areas of the legislation with which we have concerns and believe need further clarification.

Section 2 allows for "emergency" care for caregivers attending a VA facility; however, this is a "may" and not a "shall." A true emergency must be addressed by a hospital when you are physically present on their premises. For example, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 to ensure the public access to emergency treatment regardless of ability to pay. Health care providers have an ethical requirement to "do no harm" and not providing care would cause harm. Hospitals are already allowed to provide emergency services and then bill if the individual has insurance. We understand co-pays and out-of-pocket expenses may be involved, but hospitals have the right to waive those fees. Another concern is what constitutes "emergency" care? Who will decide this, especially as the event is unfolding in real time? The National Defense Authorization Act for Fiscal Year 2008 (NDAA FY08) Section 1672 provides for medical care at Department of Defense (DOD) Military Treatment Facilities (MTFs) or Department of Veterans Affairs (VA) facilities on a space-available basis authorized for certain family members, not otherwise eligible for medical care, caring for a recovering servicemember. According to a briefing by General Elder Granger, Deputy Director and Program Executive Officer for TRICARE Management Activity, on April 13, 2009, DOD has implemented this Section of the NDAA FY08. This law allows for non-emergent care. How has the VA complied with this law in allowing access to care for caregivers?

The long extensive list of "family members" is appreciative. Most individuals and government agencies recognize and understand the blood and marriage connection. However, the list left off "significant other" and "fiancée," which we frequently hear are part of the caregiver structure. We see the added provision for the Secretary of the Department of Veterans Affairs to add additional people; however, we find that these additional caregivers are often not recognized by DOD as eligible. The difference between DOD and VA in regards to a caregiver definition and eligibility is important because the choice or self selection of the caregiver begins while the wounded, ill, and injured servicemember is still on active duty. According to the VA,

"'informal' caregivers are people such as a spouse or significant other or partner, family member, neighbor or friend who generously gives their time and energy to provide whatever assistance is needed to the veteran." We would like to make sure the definition of caregiver eligibility is broad enough to capture additional individuals.

The provision regarding the date of enactment is confusing. We understand the intent to start with a certain population, Sept. 11, 2001, and then go back and possibly increase the population to earlier veterans' caregivers, but it is hard to glean that information from the written language. We support the expansion of the program to cover all eligible veteran caregivers.

The provision outlining additional instruction and allowing the caregiver to be certified as a personal care attendant is dependent on the Secretary. It states, the Secretary "may" provide these services. Caregivers are not guaranteed the opportunity to become certified and be eligible for additional instruction and training. Certification will be key in determining the level of care and the scope of practice the caregiver can provide and affecting the amount of compensation they could receive.

The provision on certified personal care attendant versus designates needs further clarification. The legislation provides for a "certified" personal care attendant to receive technical support, counseling, and internet access and allows the "designated" personal care attendant to qualify for mental health services, respite care, medical care, and a stipend. We don't understand why one qualifies for counseling and the other mental health? What would be the difference in services? Adding to the confusion is the fact the designated personal care attendant qualifies for health care, which should cover mental health services. We would appreciate further clarification on the eligibility sequencing. It is hard to determine if there are two levels of eligible caregiver services or if both caregiver categories can be eligible for one or the other. For example, must the caregiver first qualify for one in order to be eligible for the other? If so, then which category must they qualify for first? It would make more sense for there to be a lower level entry first, which would be your "designated" personal care attendant, and they would then be eligible for the higher level, the "certified" personal care attendant, and receive additional services.

What constitutes "protection?" Is it physical protection from physical injury, such as someone who is prone to falls and is in need of bed rails? Or, does it encompass a much broader definition that would include overall safety concerns, such as crossing the street by themselves and navigating their way on public transportation? Our Association would support the adoption of a more expansive definition involving overall safety concerns for the veteran.

National Military Family Association will also take the opportunity to discuss several issues of importance to wounded, ill, and injured servicemembers, veterans, and their families in the following subject areas:

I. Wounded Service Members Have Wounded Families
II. Who Are the Families of Wounded Service Members?
III. Caregivers
IV. Mental Health

WOUNDED SERVICE MEMBERS HAVE WOUNDED FAMILIES

National Military Family Association asserts that behind every wounded servicemember and veteran is a wounded family. Spouses, children, parents, and siblings of servicemembers injured defending our country experience many uncertainties. Fear of the unknown and what lies ahead in future weeks, months, and even years, weighs heavily on their minds.

Transitions can be especially problematic for wounded, ill, and injured servicemembers, veterans, and their families. DOD and the VA health care systems, along with State agency involvement, should alleviate, not heighten these concerns. National Military Family Association believes the government must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded servicemember must also consider the needs of the spouse, children, parents of single servicemembers, siblings, and especially the caregivers.

WHO ARE THE FAMILIES OF WOUNDED SERVICEMEMBERS?

In the past, the VA and the DOD have generally focused their benefit packages for a servicemember's family on his/her spouse and children. Now, however, it is not unusual to see the parents and siblings of a single servicemember presented as part of the servicemember's family unit. In the active duty, National Guard, and Reserve almost 50 percent of the members are single. Having a wounded servicemember is new territory for family units. Whether the servicemember is married or single,

their families will be affected in some way by the injury. As more single servicemembers are wounded, more parents and siblings must take on the role of helping their son, daughter, or sibling through the recovery process. Family members are an integral part of the health care team. Their presence has been shown to improve the servicemember and veteran's quality-of-life and aid in a speedy recovery.

National Military Family Association recently gathered information about issues affecting our wounded servicemembers, veterans, and their families through our Operation Purple® Healing Adventure Camp in August 2008 and a focus group held March 2008 at Camp Lejeune. Families said following the injury, they find themselves having to redefine their roles. They must learn how to parent and become a spouse/lover with an injury. Spouses talked about the stress their new role as caregiver has placed on them and their families. Often overwhelmed, they feel as if they have no place to turn to for help.

CAREGIVERS

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality-of-life of the wounded servicemembers and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DOD and VA health care providers because they tend to the needs of the servicemembers and the veterans on a regular basis. Their daily involvement saves DOD, VA, and State agency health care dollars in the long run.

Caregivers of the severely wounded, ill, and injured services members who are now veterans have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. This will require the VA to train them through a standardized, certified program, and appropriately compensate them for the care they provide. National Military Family Association is pleased with the "Family Caregiver Program Act of 2009" legislation that will provide for the training, certification, and compensation for injured servicemembers or veterans. This legislation places VA in an active role in recognizing caregivers' important contributions and enabling them to become better caregivers to their loved ones. It is a "win win" for everyone involved.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. These pilot programs are important, but there is a strong need for 24-hour in-home respite care, 24-hour supervision, emotional support for caregivers living in rural areas, and coping skills to manage both the veteran's and caregiver's stress. These pilot programs, if found successful, should be implemented by the VA as soon as possible and fully funded by Congress. However, one program not addressed is the need for adequate child care. Veterans can be single parents or the caregiver may have non-school aged children of their own. Each needs the availability of child care in order to attend their medical appointments, especially mental health appointments. Our Association encourages the VA to create a drop-in child care for medical appointments on their premises or partner with other organizations to provide this valuable service.

RELOCATION ALLOWANCE

Active Duty servicemembers and their spouses qualify through the DOD for military orders to move their household goods (known as a Permanent Change of Station (PCS)) when they leave the military service. Medically retired servicemembers are given a final PCS move. Medically retired married servicemembers are allowed to move their family; however, medically retired single servicemembers only qualify for moving their own personal goods.

National Military Family Association is requesting the ability for medically retired single servicemembers to be allowed the opportunity to have their caregiver's household goods moved as a part of the medical retired single servicemember's PCS move. This should be allowed for the qualified caregiver of the wounded servicemember and the caregiver's family (if warranted), such as a sibling who is married with children or mom and dad. This would allow for the entire caregiver's family to move, not just the caregiver. The reason for the move is to allow the medically retired single servicemember the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single servicemember to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired servicemember. Instead of trying to create the services in the area, a better solution may be to allow

the medically retired servicemember, their caregiver, and the caregiver's family to relocate to an area where services already exist, such as a VA Polytrauma Center.

The decision on where to relocate for optimum care should be made with the Federal Recovery Coordinator (case manager), the servicemember's physician, the servicemember, and the caregiver. All aspects of care for the medically retired servicemember and their caregiver shall be considered. These include a holistic examination of the medically retired servicemember, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired servicemember and his/her caregiver.

The consideration for a temporary partial shipment of caregiver's household goods may also be allowed, if deemed necessary by the case management team.

MENTAL HEALTH

Families' needs for a full spectrum of mental health services—from preventative care and stress reduction techniques, to individual or family counseling, to medical mental health services—will continue to grow. It is important to note if DOD has not been effective in the prevention and treatment of mental health issues, the residual will spill over into the VA health care system. The need for mental health services will remain high for some time even after military operations scale down and servicemembers and their families transition to veteran status. The VA must be ready. They must partner with DOD and State agencies in order to address mental health issues early on in the process and provide transitional mental health programs. They must maintain robust rehabilitation and reintegration programs for veterans and their families that will require VA's attention over the long-term. National Military Family Association recommends Congress require Vet Centers and the VA to develop a holistic approach to veteran care by including their families in providing mental health counseling and other programs.

National Military Family Association is especially concerned with the scarcity of services available to the families as they leave the military following the end of their activation or enlistment. They may be eligible for a variety of health programs, such as TRICARE Reserve Select, TRICARE, or VA. Many will choose to locate in rural areas where there may be no mental health providers available. We ask you to address the distance issues families face in linking with mental health resources and obtaining appropriate care. Many isolated veterans and their families do not have the benefit of the safety net of services and programs provided by MTFs, VA facilities, Community-Based Outpatient Centers, and Vet Centers. Our Association recommends the use of alternative treatment methods, such as telemental health. Another solution is modifying licensing requirements in order to remove geographical practice barriers preventing mental health providers from participating in telemental health services outside of a VA facility.

The VA must educate their health care and mental health professionals, along with veterans' families of the effects of mild Traumatic Brain Injury (TBI) in order to help accurately diagnose and treat the veteran's condition. Veterans' families are on the "sharp end of the spear" and are more likely to pick up on changes contributed to either condition and relay this information to VA providers. Our Association recommends spouses and parents of returning servicemembers and veterans need programs providing education on identifying mental health, substance abuse, suicide, and Traumatic Brain Injury.

VA mental and health care providers must be able to deal with polytrauma—Post Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. National Military Family Association appreciates Congress establishing the National Center of Excellence and the Defense Center of Excellence. It is very important for DOD and VA to partner in researching TBI and PTSD. We believe the VA needs to educate their civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD. As the VA incorporates Project Hero, they must educate civilian network mental health providers about our military culture.

INFORMATION TECHNOLOGY (IT) INTEROPERABILITY

The DOD, VA, and State agencies, along with civilian providers, need to work together, creating a seamless transfer of medical record information regarding health care services received by our servicemembers, veterans, National Guard and Reserve members, retirees and their families and survivors. Interoperability, especially between DOD and VA, is crucial. A recent visit to the Naval Branch Medical Clinic Key West found servicemembers and their families utilizing a VA provider. This clinic is a joint facility. There are systems in place for sharing of data between the

two agencies' electronic health servers, yet staff at the clinic were unable to access this option. Medical records were being hand carried and manually entered into the receiving health care server. As we move toward more joint facility operations, medical record information must be easily accessed and transferred between agency servers. This is especially important for our wounded, ill, and injured servicemembers who frequently transfer between the two agencies' health care systems and, eventually, from active duty status to veteran status. We encourage Congress to adequately fund VA and DOD IT interoperability.

SENIOR OVERSIGHT COMMITTEE

Our Association is appreciative of the provision in the NDAA FY09 continuing the DOD/VA Senior Oversight Committee (SOC) for an additional year. We understand a permanent structure is in the process of being established and manned. We urge Congress to put a mechanism in place to continue to monitor DOD and VA's partnership initiatives for our wounded, ill, and injured servicemembers and their families, while this organization is being created.

National Military Family Association proposes the top agenda items that would benefit veterans, wounded servicemembers, their families, and survivors are:

- Coordination and collaboration of health care and behavioral health care services between the VA, DOD, and State and governmental agencies in sharing of resources;
- Provision of sufficient, timely, and accurate funding for VA benefits and services;
- Train, certify, compensate, and provide benefits to include health care for the caregivers of our severely wounded servicemembers and veterans;
- Increased respite care for severely wounded veterans and their caregivers;
- Increased access to behavioral health services for survivors, caregivers of wounded servicemembers and veterans, and their families;
- Increased outreach to veterans, their families, and the communities they live in about available benefits and services, including education on the signs and symptoms of behavioral health conditions and available resources;
- Continue to quickly and efficiently address the needs of our wounded servicemembers, veterans, and their families regarding transition, IT sharing, and joint facility operations; and
- Inclusion of senior DOD and VA leaders, along with respective VSOs and MSOs regarding the discussion of a National health care agenda by Congress because of its potential impact on both health care systems and the veteran, servicemember, and their families.

National Military Family Association would like to thank you again for the opportunity to present testimony for the record on the "Family Caregiver Program Act of 2009" for veterans and their caregivers. Military families support the Nation's military missions. The least their country can do is make sure servicemembers, veterans, and their families have consistent access to high quality health care in DOD and VA. Wounded servicemembers and veterans have wounded families. The caregiver must be supported by the VA by providing training, certification, and compensation for the care of their loved one. The system should provide coordination of care and DOD and VA to work together to create a seamless transition. We ask this Committee to assist in meeting that responsibility.

We look forward to working with you to improve the quality-of-life for veterans and their families.

PREPARED STATEMENT OF THE NURSES ORGANIZATION OF VETERANS AFFAIRS

Mr. Chairman, Ranking Member Burr and other Members of the Committee: The Nurses Organization of Veterans Affairs (NOVA) is the professional organization of the approximately 40,000 registered nurses employed by the Department Affairs. NOVA is committed to providing high quality care to our Nation's veterans.

S. 362

NOVA appreciates the opportunity to provide input into S. 362, legislation that would allow VA health care professionals to bargain over the issue of Clinical Competency, Clinical Conduct, Title 38 Compensation and Peer Review. NOVA is opposed to this legislation.

Summary:

This bill would remove from the existing Title 38 collective bargaining statute the provisions that bar bargaining and grievances over issues relating to direct patient care, clinical competence, peer review, or Title 38 compensation. It would also repeal the statutory provision that authorizes the VA Secretary to determine whether a particular union proposal or grievance is subject to one of those subject matter exclusions.

While proponents of the bill assert that it will "restore" collective bargaining rights for VA doctors, nurses, and other medical professionals, those employees have never had the right to bargain over the subjects excluded by the current statute. If this bill were to pass, VA would be required to bargain over patient care issues, clinical competence issues, peer review processes, and the discretionary aspects of Title 38 compensation (e.g. nurse locality pay and physicians' market pay and performance pay) to an extent that is unprecedented and would represent an unwarranted intrusion into the way that VHA manages its clinical practices and adjusts pay for physicians and nurses. Quality of care delivered to patients should not be subject to negotiation.

Background:

1. The existing statute.

An existing provision of the Title 38 personnel statute, 38 U.S.C. § 7422, was enacted in 1991 to authorize VA physicians, nurses, and other Title 38 medical professionals to engage in collective bargaining. Prior to 1991, VA physicians and nurses were not authorized to engage in collective bargaining because they were not covered by the Title 5 statute that authorizes bargaining for most Federal employees.

a. What the existing statute says:

Subsection (a) of section 7422 generally authorizes Title 38 medical professionals to engage in bargaining under the Title 5 collective bargaining rules that apply to other Federal employees.

Subsection (b) of section 7422 excludes from Title 38 medical professionals' bargaining rights (and from any grievance procedure provided under a collective bargaining agreement) three specific subjects:

- professional conduct or competence (which subsection (c) of the statute defines to mean clinical competence or direct patient care);
- peer review (the process by which Professional Standards Boards and other peer review entities review medical professionals' clinical skills); and
- the establishment, determination, and adjustment of Title 38 employee compensation (which in general means that VA doctors and nurses, like other Federal employees, can't bargain over their pay, but for slightly different reasons).

Subsection (d) of section 7422 authorizes the VA Secretary to determine whether a particular bargaining proposal or union grievance is subject to one of the exclusions set forth in 38 U.S.C. § 7422(b). The VA Secretary has delegated that authority to the Under Secretary for Health.

Subsection (e) of section 7422 says that only the U.S. Court of Appeals for the District of Columbia Circuit can hear certain types of cases relating to collective bargaining for Title 38 medical professionals.

b. The legislative history of the existing statute:

The current version of 38 U.S.C. § 7422 was sponsored by Senator Alan Cranston (D-CA), the then-Chairman of the Senate Veterans' Affairs Committee. Senator Cranston and his colleagues worked for several years, over several sessions of Congress, to craft a compromise bill that would extend collective bargaining rights to VA doctors and nurses under terms that were acceptable to all stakeholders, including labor unions, physicians' and nurses' professional associations, Veterans' Service Organizations, and the Department. Senator Cranston's remarks to the Senate when he introduced the new law indicate that the statute was intended to strike a balance between inherently conflicting interests, i.e., between the interests of VA physicians and nurses to engage in collective bargaining, and of the Department and its veteran patients to ensure patient care is not compromised by the collective bargaining process.

2. Proposed bill.

S. 362 proposes 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." If enacted, this bill would:

• Repeal the collective bargaining exclusions for professional conduct or competence, peer review, and employee compensation that are currently set forth in 38 U.S.C. § 7422(b);
• Repeal the provisions of 38 U.S.C. § 7422(c) and (d) that define the 7422(b) exclusions and authorize the Secretary to determine whether a particular union proposal or grievance is excluded; and
• Modify certain provisions of 38 U.S.C. §§ 7462 and 7463 relating to Title 38 medical professionals' adverse action appeal rights.

The effect of S. 362 would be to require VA to bargain over issues of clinical competence, patient care, peer review, and employee compensation that are currently excluded from bargaining. Moreover, the bill would allow arbitrators, through rulings on grievances filed through the negotiated grievance procedure, to substitute their own judgment for the judgment of VA managers and clinicians on these issues. Examples of issues that are currently excluded from union bargaining and grievances, but would be subject to bargaining and the negotiated grievance procedure under the Filner legislation, include the following:

• Mandatory TB testing for employees
• Professional Standard's Board restricting a provider's clinical privileges due to competency issues.
• Work schedules for physicians and nurses, including alternative or compressed work schedules;
• The amount of market pay recommended for a particular physician by a Physician Compensation Panel or approved for that physician by a VAMC Director;
• The adjustment of locality pay for nurses at a particular VAMC or within a particular work unit;
• The selection of a particular RN or physician for a specialized work assignment for clinical competence reasons;
• A Professional Standards Board's assessment of a provider's clinical competence;
• A Physical Standards Board's assessment of a provider's mental or physical fitness for duty; and
• The decision of a VAMC Director to require staff psychiatrists to rotate weekend call duty, rather than relying on the Medical Officer of the Day to assess patients' emergent mental health needs.

Consider that without the Title 38 collective bargaining exclusions, the Department would be unable to respond expeditiously to changes in veterans' health care needs. For example, as the need for expanded mental health services for returning OEF/OIF veterans became clear, the Department was able to quickly set up a dedicated Suicide Prevention hotline and to assign qualified medical professionals to staff the hotline on a 24/7 basis. In the first 60 days of the Suicide Prevention hotline's existence, hundreds of veterans in critical need of mental health counseling called the hotline and received the care they needed. Absent the Title 38 collective bargaining exclusion for issues of direct patient care, the Department would have been required to bargain over the procedures by which employees would be assigned to the hotline before it could be implemented, resulting in unacceptable delays and potentially many lost lives.

Finally, the Unions would have you think that the existing statute weakens the VA's ability to recruit and retain an adequate work force. To the contrary, one of the draws for the VA in being able to recruit high quality clinical staff is the high level of "clinical competence" of its existing workforce. Allowing the Unions status to address competency issues will only erode the high level of clinical competence that exists. The VA's current branding for recruitment is "The Best Care/The Best Careers." Nurses are drawn to the VA because of the quality of care VA nurses provide to the Veterans. VA Nurses are proud of their reputation of providing the best care.

The Secretary has not abused his discretionary authority in using 38 U.S.C. 7422 to exclude issues relating to direct patient care, clinical competence, peer review, or Title 38 compensation. Of the issues that were decided by the Secretary in 2008, approximately 41 percent were held to be partially or fully negotiable.

As is noted above, the current Title 38 statute was a carefully crafted compromise bill that empowers VA doctors and nurses to engage in collective bargaining while protecting from compromise VA clinicians' patient care determinations and related peer review and compensation adjustment processes. S. 362 would upset that careful balance in a way that is unwarranted, unprecedented, and unwise at a time where responding quickly to the needs of our Veterans is imperative.

In conclusion, repeal of Title 38 Collective Bargaining exclusions would cripple VA's patient care mission by:

- Delaying critical changes in health care delivery and substituting the decisions of labor negotiators/arbitrators for clinician's professional judgment;
- Allowing the unions to decide whether or not it is appropriate if patient care needs dictate than an RN stay beyond their scheduled tour;
- Substituting staff preferences for tours of duty in lieu of patient care needs;
- Delay the detail of staff from one area of need to another until negotiations are completed; and
- All other issues pertaining to the clinical needs of our Veterans.

NOVA understands that provisions in S. 362 have been adopted by the Department of Defense (DOD); however we feel strongly that this policy cannot adequately be compared to the VA health care system. The unions have used the argument that Collective Bargaining within Walter Reed on issues of Clinical Competency, Clinical Conduct, Title 38 Compensation and Peer Review has not compromised patient care and should, therefore, also be adopted by VA. This is not a true comparison. DOD employs considerably fewer bargaining unit MDs and nurses than the VA does. DOD has approximately 500 bargaining unit physicians and 4,600 bargaining unit nurses while VA has 10,000 bargaining unit physicians and 50,000 bargaining unit nurses. If absolutely necessary, NOVA would agree to the reestablishment of Mandatory Labor/Management Councils at each VA Facility and alternative legislative language as proposed by VA. NOVA is dedicated to the safe, quality care of America's heroes and thanks the Committee for considering NOVA's position on S. 362.

PREPARED STATEMENT OF DAVID J. HOLWAY, NATIONAL PRESIDENT, NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES, SEIU/NAGE LOCAL 5000

On behalf of the National Association of Government Employees (SEIU/NAGE), and the more than 100,000 workers we represent, including 20,000 at the Department of Veterans Affairs (VA), I would like to thank you for the opportunity to submit written testimony regarding pending health care legislation.

SEIU/NAGE strongly supports S. 362. This bill would restore a meaningful scope of bargaining for Title 38 health care providers at the VA, a critical necessity to boost morale and strengthen recruitment and retention at the agency. Giving health care providers a meaningful voice in their workplace will lead to better care for the American veteran.

In 1991, Congress amended Title 38 to provide VA medical professionals with collective bargaining rights, which include the rights to use the negotiated grievance procedure and arbitration. Under Sec. 7422 of Title 38 ("7422"), covered employees can negotiate, file grievances and arbitrate disputes over working conditions, except for matters concerning or arising out of professional conduct or competence, peer review, or compensation. Increasingly, VA management is interpreting these exceptions very broadly, and refusing to bargain over virtually every significant workplace issue impacting medical professionals. The broad interpretation 7422 is leading to significant dissatisfaction among rank-and-file VA health care providers.

We have heard from our local members across the country, who have urged our union to make passage of S. 362 our top legislative priority for legislation impacting the VA workforce in the 111th Congress. Their concern is that too many highly qualified, outstanding health care professionals have left the VA for other employment because they were unsuccessful in getting someone of authority at the agency to listen to or address legitimate concerns because the issue fell under the ever-growing umbrella of 7422.

The agency has increasingly been unwilling to address those issues that are most important to Title 38 employees, including time schedules, shift rotations, evaluations, fair and equal opportunity to be considered for a different position within the facility, and fair treatment among colleagues. Rather than suffer under a system where they have no mechanism to provide input or air grievances, disenfranchised VA employees simply move on to other employment. It has gone on too long, and it has to stop.

VA medical professionals have extremely limited collective bargaining rights in the first place, and the broad interpretation of 7422 is narrowing the scope of bargaining to the point that it is practically meaningless. As a result, RNs, doctors, and other impacted employees at the VA are experiencing increased job stress, low morale and burnout. This in turn exacerbates the VA's well-documented recruitment and retention problems. Chronic short-staffing has been shown to adversely impact quality of care, patient safety, and workplace safety, leading to costly stopgap measures such as the overuse of contract nurses and doctors.

I want to share a good example of the kind of management abuse that occurs at the VA when management has the unfettered discretion to attain a 7422 ruling, and therefore, take a seemingly bargainable issue off the table. We witnessed a case where a staff RN position was posted for nurse on an acute medical/surgical unit. Four RNs applied for the position, one of which had far more experience and competence by any reasonable measure than the other three. This was meaningful because the local collective bargaining agreement provided that when two or more equally competent nurses request to fill an open position, preference will be given to the most senior competent nurse. When the more senior competent nurse was passed up for the position in favor of a nurse with substantially less experience, the union filed a grievance on behalf of the more senior nurse. In the first step of the grievance, which involved the unit manager, no settlement could be reached. In the second step of the grievance, which involved the acting nurse executive, the unit manager's decision to hire the less experienced nurse was upheld. In the third step of the grievance, which involved the medical center director, our nurse's case was heard, but management chose to use their allotted time to respond after hearing our case. But management never ended up responding. Instead, at this late stage of the grievance process, the director notified the union that the grievance was a 7422 issue and was therefore not grievable. The union reminded the director that he did not have the authority to make that decision. The director then made a request for a 7422 ruling from the Under Secretary who did, in fact, render the grievance as a 7422 issue and therefore not grievable. This was extremely demoralizing to this nurse, who had spend years caring for the American veteran and rightfully deserved the position that was applied for.

We see cases like this, and worse, every day at the VA. Our health care providers know that there is no use in even questioning management's decisions when they can always fall back on 7422 as a way to trump the efforts of the union to give Title 38 VA workers a fair shake. It is especially egregious that management can claim 7422 very late in the grievance process. Our local union representatives report management threatening to seek a 7422 decision over practically any issue they do not want to bargain over, and the disturbing thing about that is, in most cases, those managers will be granted their 7422 claim if it is requested.

Additionally, we have seen cases where RNs have been denied union representation during fact-finding for a potential disciplinary action; the agency claimed this was a competence issue. We have been prevented from bargaining over nurse-patient ratios, which has resulted in geriatric nurses having as many as 30 patients in their care because of poor staffing. We have seen nurses sent on mandatory temporary reassignments that required them to take a shuttle bus from one facility to another that was approximately 60 miles away. We have seen management spontaneously cancel annual leave requests that were granted months in advance, because of chronic understaffing. This causes nurses to scrap vacation plans that may have been several months in the making.

Health care providers at the VA are very frustrated with the kind of management style that has been demonstrated in many VA facilities in recent years, and they end up leaving because they do not have to take it. Most nurses and other health care providers can find equal or even higher paying jobs in private sector medical facilities in the same city or town where they are currently living; places where they can have a meaningful voice in their workplace. This is a major reason why maintaining staffing has been such a major concern at the VA. VA workers are not willing to tolerate being disrespected by the agency when they can go down the street to a private facility, where they can probably make more money while getting treated with dignity.

Passing S. 362 would help to address many of these concerns. This bill would restore a meaningful scope of bargaining for Title 38 VA professionals by eliminating the "7422 exceptions" (conduct, competence, compensation, and peer review) under the law.

Eliminating these exceptions will provide health care providers with the same rights as other VA providers, including psychologists, LPNs, and pharmacists, as well as other Federal employees. Title 5 health care providers at the VA have full collective bargaining rights. Even nurses and doctors at Army Medical Centers such as Walter Reed, who perform the same exact function as nurses and doctors at the VA, have full collective bargaining rights. Most private sector health care providers have a meaningful voice in their workplace as well. Nowhere have we seen cases where collective bargaining has had a negative impact on patient care. There is no reason for Title 38 VA workers to have these critical rights taken away.

Restoring meaningful bargaining rights will greatly increase morale at the VA. It will also serve to address recruitment and retention issues at the VA, which are

critical at this time, given the veterans returning home from conflicts abroad. All this will lead to better care for our Nation's veterans.

SEIU/NAGE greatly appreciates the Committee's decision to hold a hearing on pending health-related legislation. I thank the Committee for the opportunity to provide testimony.

PREPARED STATEMENT BY LUANNE LONG, RN, PRESIDENT, HAWAI'I NURSES ASSOCIATION, UNITED AMERICAN NURSES, AFL–CIO

I would like to thank Chairman Akaka, Ranking Republican Member, and Members of the Committee for the opportunity to provide testimony for the hearing on S. 362, legislation that will restore collective bargaining rights to registered nurses working in the Department of Veterans Affairs. My name is Luanne Long and I have been a registered nurse for over 21 years. I'm also the President of the Hawai'i Nurses Association and an 18 year Army veteran.

I'm testifying today as a member of the United American Nurses AFL–CIO, a union representing registered nurses—6,000 of whom are VA nurses. I will give my testimony from the perspective of a nurse labor leader, as well as a veteran who has used the VA health care system.

There exists a health care crisis in our country regarding the shortage of registered nurses. A 2002 report by the Health Resources and Services Administration states that, by 2020 hospitals will be short 808,416 RNs. In a 2002 survey by the United American Nurses, three out of every ten nurses said it was unlikely they would be a hospital staff nurse in 5 years. The VA health care system has by no means been immune to the shortage.

As nurses leave the VA system, new nurses are not joining the VA at comparable rates, and patient load is increasing. In its own report, "A Call to Action," the VA states that it must replace up to 5.3 percent of its RN workforce per year to keep up with RNs retiring. By all accounts, that is not happening. In its web site documentation of system-wide capacities, VA statistics show that between 1996 and 2002 the number of full-time-equivalent RNs went down by 8.4 percent. During that same time period, the number of "unique patients" treated at the VA went up by 55 percent.

Congress amended Title 38 to provide medical professionals who work at VA facilities with collective bargaining rights, which include the rights to use the negotiated grievance procedure and arbitration. Under 38 U.S.C., section 7422, covered employees can negotiate, file grievances and arbitrate disputes over working conditions except "any matter or question concerning or arising out of:"

- professional conduct or competence (defined as direct patient care or clinical competence;
- peer review; or
- the establishment, determination, or adjustment of employee compensation.

Increasingly, VA management has interpreted these exceptions very broadly, and has refused to bargain over significant workplace issues affecting medical professionals. Recent court decisions are upholding the VA's broad reading of Section 7422, even when management raises it after completion of the arbitration process.

Congress recognized the benefits of collective bargaining rights in the VA and the merit of nurses' input into workplace and quality of care issues. As a result, Congress passed a law in 1991 to strengthen collective bargaining rights for nurses working at the VA. The VA has also acknowledged the critical role that nurses have in improving quality of care. According to the VA Office of Nursing, "VA nurses have been widely recognized for their instrumental work in initiating, developing, implementing, and monitoring the practices and policies that made VHA one of the world's foremost authorities in patient safety and quality outcomes evidenced by performance measures—an exceptional achievement by any assessment." (DVA Web site, April 30, 2007) An excellent example of this can be seen in the development of VA's health information technology system. Nurses and other health care providers worked with VA management on the design and implementation of VA's health IT system. The VA's health IT system is now well-recognized as one of the most effective and efficient systems in the world, a shining example for other health care systems.

Unfortunately, VA nurses are experiencing an ever-shrinking role in workplace issues, quality assurance, and patient safety. Too often, the Human Resources staff is making health care decisions instead of nurses. The VA's current 7422 policy goes directly against good medicine and Congressional intent. Congress needs to amend section 7422 of Title 38 to ensure that the VA complies with Congressional intent

and that registered nurses are able to care for veterans with dignity, respect and the basic bargaining rights they were intended to have.

As an RN, I am proud to be a member and leader of the Hawai'i Nurses Association—the union representing nurses where I work. Because I have the protections of my union behind me, I am able to forcefully and effectively advocate for my patients every day, using the tools afforded me by my union, such as a grievance and arbitration procedure, to improve working conditions for nurses and quality for patients. Congress intended that VA nurses likewise have the benefits of union representation in all matters except those dealing with compensation, direct patient care, and clinical competence, but VA management has stepped in to change Congress' intent, depriving VA nurses of the full benefits of union representation to which they are entitled.

As a veteran whose sizable extended family uses the VA health care system, I fully support legislation that would restore the collective bargaining right of registered nurses. I am concerned about the nurse shortage in the VA health care system. This shortage has been exacerbated by the VA's recent effort to restrict RNs' collective bargaining rights through the use of section 7422 of Title 38. Nurses are becoming frustrated by the fact they have less rights than the LPNs and Certified Nursing Assistants that work in same units, just because these health care providers work under Title 5. As a result, registered nurses are leaving the VA to work at private sector hospitals right down the street, where they have full collective bargaining rights.

As a veteran, I'm also concerned that VA RNs are not fully protected by their collective bargaining rights. RNs should be able to use the grievance process to challenge management when well established policies are being broken. For example, if a nurse is asked to complete assignments that regularly violate the VA's safe patient handling policy, the RN should be able to file a grievance. This would make it safer the nurse as well as veteran patients. Unfortunately, VA's use of section 7422 unfairly prohibits the grievance of most any issue.

To address the problems with section 7422 of Title 38, Senate Rockefeller has introduced S. 362, a bill that would improve collective bargaining rights of registered nurses in the Department of Veterans Affairs. Congress needs to pass S. 362 to increase RN recruitment and retention, as well as protect RN's and veteran patients they take care of. The UAN and HNA strongly urge Members of the Committee to support and work for the passage of this important legislation.

Thank you again for opportunity to provide testimony regarding this important issue.