S. HRG. 109–376

FIELD HEARING ON THE STATE OF VA CARE IN HAWAII: PART II

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

JANUARY 11, 2006

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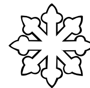

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FIELD HEARING ON THE STATE OF VA CARE IN HAWAII: PART II

WEDNESDAY, JANUARY 11, 2006

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

The Committee met, pursuant to notice, at 10:10 a.m., in the DAV Hall at Keehi Lagoon, Honolulu, Hawaii, Hon. Daniel Akaka presiding.

Present: Senator Akaka.

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

Senator AKAKA. The hearing of the Veterans' Affairs Committee will come to order. Aloha.

AUDIENCE. Aloha.

Senator AKAKA. It's great to be here with you. Normally, we're on a stage, but today we're on the same level. I'm delighted to be here. I want to welcome all of you to the third day of the Senate Committee on Veterans' Affairs field hearings in Hawaii.

It is not often that Senate hearings are held outside Washington. For us, it's really great to have this Committee hearing here in Hawaii. So let's give the Committee a great hand.

[Applause.]

Senator AKAKA. I'd like to thank Pat Weiland and Fred Ballard of the Spark M. Matsunaga VA Ambulatory Care Center as well as the Vietnam Veterans of America for their assistance in coordinating today's hearing. We greatly appreciate all of your hard work.

Today and over this entire week, the Committee will assess VA care in Hawaii. That's the reason most of you are here. Due to its geography, Hawaii is unlike any other State in the Union. As such, VA must tailor its services to reach all of Hawaii's veterans.

I applaud the efforts of every VA employee in Hawaii. These men and women work hard trying to help our veterans. There are many things that VA does well. However, there's always room for improvement. I want to hear about how we can help VA help Hawaii's veterans.

Many brave young servicemen and women are returning from duty in Iraq as we speak. We in Congress work with VA to address our newest veterans' needs, along with our oldest. Services such as readjustment, transition assistance, PTSD-related counseling, are at the forefront of our priorities. We must continue to ensure a smooth transition of service from DOD to VA.

Sadly, some believe that reducing veterans' compensation for PTSD is a good way to save money. I think you remember last year VA planned to conduct a review that would have examined 72,000 claims that were previously awarded compensation over a 5-year period. Compensation should not be viewed as a welfare program. Our veterans have earned their compensation through selfless service to their country. I want to say when I mentioned that review of 72,000 cases that thankfully, VA set aside its plan to conduct the review last year.

Travel for veterans living on Oahu is relatively inexpensive. Traveling from other islands can be costly, and we heard, especially in Maui County, how costly it is for them. It's costly because of inter-island airfare, which can be over $200.

Veterans often have difficulty getting reimbursed—that's another problem—for such expenses. Adding various other travel costs, such as rental cars and lodging expenses, and a veteran may choose to forgo care rather than pay sizable out-of-pocket costs.

We are privileged to have our witnesses with us this morning and to have all of you here present. I must tell you, I'm so delighted to have our National VA officials who are here with us, and you will hear them, and also our regional officials, our State officials here, and all of our veterans organizations here as well as families. We look forward to being informed so that we can help you have better services.

We are happy to have our congressional people here. I should tell you that Senator Inouye is not able to be here this morning, but sends his warmest aloha. Also, Congressman Abercrombie was not able to be here, but he has submitted testimony for this Committee. We have here two of us. With me to testify at this time is our young representative, Representative Ed Case.

[Applause.]

[The prepared statement of Mr. Abercrombie follows:]

PREPARED STATEMENT OF HON. NEIL ABERCROMBIE, U.S. REPRESENTATIVE FROM HAWAII, 1ST DISTRICT

Senator Craig and Senator Akaka, thank you for this opportunity to discuss with you and the other distinguished Members of the Senate Veterans' Affairs Committee my thoughts on both the current status and future of Federal veterans programs in Hawaii.

Before going into specifics, I want to thank all of America's veterans, and especially those in Hawaii, for their service to the Nation. When the Nation called, they answered "send me." We all appreciate the courage and sacrifice of those who leave their friends and families behind and go to fight on our behalf.

Of course, when they get home, the Department of Veterans Affairs is responsible for providing our veterans' assistance and healthcare. As Members of this Senate Committee, you know how important a mission that is. Caring for our veterans is a sacred duty, but it can also be a challenge given the size and diversity of needs within the veteran population.

On that note, I'd like to also publicly thank the men and women of the Department of Veterans Affairs. They work hard every day with limited resources to meet the needs of the Nation's veterans, and I don't think they always get the credit they deserve.

I also want to commend both Senators Craig and Akaka for running the Senate Veterans' Affairs Committee in a bipartisan manner. We could use some of that spirit of working together to help our veterans in the House Veterans' Affairs Committee, but seeing the two of you work so well together reminds me that accommodation and compromise are possible, and in the end, our veterans will get better service as a result.

As you know, Hawaii has more than 100,000 veterans. In many aspects, this large population of veterans shares the same concerns that veterans around the country have about VA operations. These concerns include improving access to VA healthcare, better and more efficient delivery of veterans' benefits, and an overall shortfall in VA funding, particularly for VA healthcare.

I share all of those concerns. Over the past 5 years I have been especially troubled by the tone the Bush Administration has unfortunately taken regarding veterans' benefits and healthcare. The general goal of the Department of Veterans Affairs under its current Washington leadership sometimes seems to be to minimize the amount of money spent on our veterans, and exclude as many veterans as possible from using the VA system created to take care of them.

This general trend has manifested itself in many ways, as you know as Members of this Committee, but let me give a few examples that have troubled me. The first is how the Bush Administration chose to deal with the long waiting times that many veterans are experiencing trying to use or get into the VA healthcare system. Rather than trying to improve or expand services to accommodate the increased demand, the solutions provided to Congress consisted of both shutting out certain veterans and increasing co-payments on veterans already in the system. Of course, both of these proposals have met serious opposition in Congress, but the very fact that they were offered up as solution says a great deal.

A second example is this past year's controversy regarding a multi-billion dollar shortfall in VA healthcare funding. While I'm glad that the Administration finally owned up to the fact that they needed $1 billion more healthcare funding in 2005 and $2 billion more in 2006, it would have been better for our veterans if the Administration had simply been honest in the first place. I just cannot understand why these shortfalls were not identified earlier in the budget process.

I am especially troubled by this trend in under-funding because of what it says for the future. The wars in Iraq and Afghanistan are producing thousands more future veterans every day. Many of these troops are coming back with serious wounds, both physical and mental. If the current VA system cannot provide a consistent level of service to today's veteran population, how is it going to be able to handle the hundreds of thousands of new veterans entering the system over the next decade?

Overall, I would like to see a change in direction from the Bush Administration, one that lets our veterans know that they are not viewed as "wards of the state" who are simply seeking additional entitlement spending, but instead that they are valued and honored for their service.

Will improving veterans care be expensive? Of course it will. However, I think most Americans would be willing to provide the resources if they knew that it would help make sure that our veterans get the care and benefits they deserve and have earned. Unfortunately, over the past 5 years the Bush Administration has not even asked the American people—outside of our military—for any level of sacrifice to fund the wars in Iraq or Afghanistan, let alone the increased burden on our veterans care system caused by these conflicts. I sincerely hope that changes, and soon. We owe our veterans more.

Looking more at local concerns, it is clear that Hawaii faces many issues when it comes to veteran's care, and I'm sure you have heard about these at great length during your series of hearings. The unique characteristics of Hawaii's geography and population distribution make delivering veterans' benefits and care here especially challenging.

Rather than reiterate those same concerns, all of which are very important and need serious attention, I want to focus my testimony today on two groups of veterans with whom I have had the privilege of working with over the past few years, and on whose behalf I support legislation in the House.

The first group of veterans—many of whom live in Hawaii—are known as "Atomic Veterans" because of their participation in nuclear weapons testing and other nuclear weapon activities.

These veterans, while small in number, are paying a large price for doing their duty and not asking questions when ordered to participate in nuclear weapons testing between 1945 and 1965. In short, they did what they were told, and while at the time of these tests the military did not understand all of the health dangers involved, that does not absolve the military, the Congress, or the Nation from providing these veterans with the appropriate care and compensation.

Today, the major barrier faced by veterans seeking care for health problems associated with their participation in these atomic activities is the "dose reconstruction" system. This system, while well-intentioned, is simply not working. The primary reason for that is that it relies upon service records that are either not detailed enough or not in existence to "reconstruct" how much radiation a veteran was ex-

posed to and thus how likely it is that their health problems resulted from this service. This is not just my opinion. Both the Government Accountability Office and the National Academy of Sciences have studied this issue and have concluded that the current dose reconstruction methodology does not work due to a lack of appropriate records.

The result of this dysfunctional system is that very few atomic veterans are able to get access to the VA healthcare system. The National Academy of Sciences 2003 study showed that just 2 percent of veterans who went through the "dose reconstruction" review had their medical conditions validated as "service connected." The other 98 percent of the approximately 2,500 veterans who had applied for service-connected status were told "too bad." While not all claims will have merit, I think this approval rating is disgraceful. It is clear to me that the current approach to evaluating the service of atomic veterans is skewed toward denying them service-related status. This must change. These "Atomic Veterans" are dying every day from diseases caused at least in part by their service in atomic tests and other nuclear weapon-related activities.

To fix this problem I have introduced legislation to eliminate the ineffective dose-reconstruction system. My bill, H.R. 2962—The Atomic Veterans Relief Act, would still require veterans to prove that they participated in an atomic test or served in an atomic occupation area, such as Nagasaki, and that they suffer from a radiogenic disease. That is, a disease related to exposure to ionizing radiation. This legislation would also expand the definition of "radiation risk-activity" to include those veterans who were exposed to ionizing radiation from residual contamination at nuclear test sites, which is now widely understood to be a serious health risk. This legislation now has 40 cosponsors, including Congressman Evans, the senior democrat on the House Veterans' Affairs Committee.

I ask for your support for this much-needed legislation. I think it is a basic issue of fairness that the Department of Veterans Affairs and the Congress must address. I look forward to working with the Committee on this issue in the future, and I will do anything you ask of me to help move this legislation forward.

The second group of veterans whose cause I strongly support is the Filipino veterans of World War II that served alongside U.S. military forces as members of the Commonwealth Army of the Philippines and the Philippine Scouts. As you know, thousands of these veterans who fought under our flag in World War II were denied veterans benefits and healthcare for decades. While I appreciate the progress in 2003 toward getting this group the benefits and care it deserves, I do not believe that those incremental steps are where Congress should stop.

I am a cosponsor of House legislation, The Filipino Veterans Equity Act, which would finally erase all the inequities that this group of brave veterans has endured. This bill has 67 bipartisan cosponsors in the House. The goal of this legislation is full equity for Filipino veterans. They fought shoulder to shoulder with their American comrades in arms, suffered the same hardships, and sacrificed in the same cause. Simple justice demands that we recognize their equal contributions with equal veterans benefits.

As a Member of Congress from Hawaii, I represent a large number of these veterans. Many are now in their seventies or eighties, so time is running out for the United States Government to finally fulfill the promises it made to these veterans during World War II. I look forward to working with your Committee in the future to make this legislation a reality.

I want to again thank you for coming to Hawaii and holding these hearings. I know that you have many demands on your time, as all Members of Congress do, so your willingness to take the time to come and hear from Hawaii's veterans is greatly appreciated.

STATEMENT OF HON. ED CASE, U.S. REPRESENTATIVE FROM HAWAII, 2ND DISTRICT

Mr. CASE. Thank you very much, Senator. I was young a few years ago when I took this job. I'm getting older rapidly.

[Laughter.]

Mr. CASE. Chairman Craig, Ranking Member Akaka, Members of the Senate Veterans' Affairs Committee, guests, especially our veterans that are here with us today, good morning to all of you. I thank the Committee from the bottom of my heart, on behalf of all of Hawaii's people, for joining in addressing this most important of issues for our Hawaii and country: how we fully and honorably dis-

charge our obligation to our Nation's veterans and to those that they leave behind.

I thank our Hawaii's 120,000 and increasing—as a matter of fact, every day that another plane arrives home—increasing number of veterans for your service, and for the honor and privilege, and I do mean that very sincerely, of representing you in your U.S. Congress.

I thank you for the partnership, Senator Akaka, between our congressional delegation and veterans. I think as we look back over the last decades and look at a delegation, as it has changed, it has still been committed every day to the needs of veterans, and we've enjoyed a fantastic relationship with our veterans, a partnership, really. It's been a distinct pleasure to come into that part of my job.

I thank you, Senator, personally for your efforts not only in bringing this Committee here, but, as the representative of the 2nd Congressional District, which I like to define as every part of the State of Hawaii except for that small sliver that lies in downtown Honolulu, for taking the Committee outside of Honolulu. Because of course I think we all know, and we will soon see revealed fully and furthermore today, that differences between the 1st and 2nd districts do exist. I thank you for taking the Committee to the other islands where the needs of the veterans communities are sometimes unique, as this Committee has already seen.

Finally, I think it is vital as we start any one of these hearings, in this and other hearings and meetings and actions, that we pause and remember what we're all about here. We pause to remember the joy that we feel in welcoming home our newest veterans, including members of the 29th Brigade Combat Team. We also pause and remember the great tragedy of the goodbyes that we are saying to our best and brightest that won't be coming home, people like Sergeant Myla Maravillosa.

I don't want to take too much time today because I've seen the panel and it's a fantastic panel. You have excellent and qualified people to inform the Committee. I'm looking forward to hearing them as well. I simply want to offer a couple of perspectives,

I offer these perspectives as a Member engaged in a difficult and crucial national debate over whether we as a country will honor those commitments that I made reference to earlier.

As a Member representing vets individually and collectively who have the same concerns as vets elsewhere, as Senator Akaka has already mentioned, whether it be student loans and other means of advancement; whether it be veterans preferences in small business set-asides for Federal procurement opportunities, which is a major issue right here; whether it be retirement and survivor benefits; or whether it be basic healthcare, which I think we all know and realize is really where the attention needs to be devoted.

I also do it, as I mentioned earlier, as a Member representing a district that is a rural district, a suburban district. In that way, like a lot of other such districts throughout the country, we're particularly unique in terms of the geographic complications.

I do it as a Member that has met personally with so many of your organizations and individual vets, and finally, as a Member like every other Member of Congress, or I hope every other Mem-

ber of Congress, who has a very active casework component of the service that they provide, individual casework services.

I can tell you what I think that we all should know and you know, and that is, when we talk about individual services, the individual connection between our constituents and the Federal Government, veterans issues are at the very top of that list. So that's a unique and very direct and personal way of understanding how our Nation's veterans are being impacted.

In the big picture, let me first say—and I think we need to lay this out because it comes back more and more and repeatedly as a theme—that I completely share the legitimate concerns of veterans nationally, and many Members of Congress over what I think we have to fairly recognize as a lagging commitment by our Federal Government to veterans' needs.

The needs are simply not being kept up with by available resources. Despite the efforts of well-meaning, well-intentioned people, there is an increasing gap between what we need to do and what we are doing. That's a national issue. We've seen it. I've seen it in my budget committee, where we fought major budget battles over the allocation of available resources to veterans.

We have certainly seen it over reports of limitations in terms of outreach and the concerns of extending the net too far out as we look to the needs of veterans today and down the road. We have seen it in shortfalls mid-year in appropriations bills, where we've had to come back on major shortfalls and do emergency appropriations because the projections of need turned out to be dead wrong. We've even seen it in some of the procedural aspects of Congress where, for example, inexplicably, we stopped doing joint hearings with veterans organizations at the outset of this current Congress. I hope that changes.

I don't want to dwell too much on this national debate here because this hearing is really about trying to understand what our particular challenges are here in Hawaii, other than to make this basic observation—and I think this is a truth that we have to keep in mind—and that is that we can provide the most seamless and complete delivery system of veterans benefits throughout Hawaii, solving every single one of the challenges and problems logistically and on paper and otherwise that we are going to hear about today, have already heard about, and will be hearing about.

Are we going to have that system in place? But if we don't have that national commitment, the national resources, we're not going to get the job done. So this does start at the national level. We need to talk about it locally, but it does start nationally.

Now, let's just turn to Hawaii specifically, some specific observations. I hope the witnesses will go into these. I'm sure they will. I want to report to you just on what I've observed in the last 3 years of representing our veterans community.

By the way, the veterans community in Hawaii is split pretty much evenly between 1st and 2nd Congressional districts, 60,000 in each. I don't know who has the lead there, but it doesn't really matter. I think it's fair to say that each and every one of your congressional delegation doesn't distinguish on the basis of districts. I'm sure Congressman Abercrombie and I certainly don't do that.

But I will report on some of the observations that I have. I want to take off, really, on a veterans survey that I just completed. I have for the last 3 years sent out a veterans newsletter to the organizations and to the veterans themselves, trying to reach out first of all, to try to give you a sense of what's happening nationally.

I have that report here. I have a limited ability to distribute it; I can't give it to all the veterans. But the VA does give it to me in terms of who is actually getting benefits today. So I miss the majority of veterans out there that are not actually receiving benefits, but those that are, who are those that we're really trying to take care of, are responding, are getting my report and are responding to my survey.

I think that what is coming back in that survey is relatively reflective of what I have also felt just through casework and talking anecdotally and walking around my district. I think the first thing I need to say, and this is good news, is that in many areas, veterans do feel relatively satisfied with the scope of the services that they are getting.

This is not a picture in which this is a veterans community nor a broader community that believes that the entire system is collapsing around us and there's no care being given to our veterans. I think it's important for us to recognize both individually and institutionally where veterans services are in fact being provided, and the information I have and the feeling that I have is that what we are talking about is a structure that is generally accepted and has generally been committed to improvement, but does have problems, challenges, individual missed opportunities.

So the first thing I want to say is something that Senator Akaka said as well, and that is, we thank our Federal Government. We thank our veterans entities on the Federal level for the commitment that they have. We know from the fact that the people from Washington are here today that they are committed to Hawaii.

I think we have been blessed here in Hawaii by well-meaning and dedicated people in all aspects of the veterans services part of our Government, whether it be Federal, State, or local. So we say thank you to you, first of all, and thank you for a job that is well done in general.

Let's talk about the problem areas. Clearly, the problem areas are isolated in some of the areas that I talked about earlier. I think the number one I would note other than healthcare would be access to Federal procurement, where I certainly have seen a real deficiency. That's not a veterans-driven issue; that's a Federal procurement-driven issue. We simply have to provide those opportunities to our veterans. It's a little bit of a complication on the neighbor islands, but nothing that is significantly different from urban Honolulu.

Healthcare is clearly, as I said earlier, where we need to worry about things. I think there are a couple of areas that are of particular note.

I think access to healthcare throughout Hawaii, and especially on the non-Oahu, non-Honolulu—because this applies to rural Oahu as well—is a little more spotty, obviously, than in downtown Honolulu. That's understandable. You can get to medical facilities a little easier here. You have a greater diversity and range of medical

professionals operating. You don't suffer from some of the problems that go beyond the veterans issue on the neighbor islands, such as the fact that the only ear, nose, and throat specialist in West Hawaii just quit and is leaving. So what does that do to the safety net in West Hawaii? These are problems throughout the islands other than Oahu.

But it's very clear that one of the things that we have to be very vigilant about and work on is just simple availability of medical services to our veterans on the islands other than Oahu.

We have had some concerns in terms of consolidation of veterans services. In some of the islands, the Committee will discover and already knows, the services have in fact been consolidated, so it's kind of a one-stop shop. You can come in there and get services for your benefits, whether they be medical benefits, whether they be clinical benefits, whether they be benefits on economic preferences or otherwise. In other areas, you frankly have to go clear across town or sometimes across island to get them. So I think the concern there is to try to effect consolidation for efficiency of delivery, and also just to service the customer, who is you.

In some of the islands, we do not have adequate centers for veterans to come together, really, to try to focus on the needs of veterans and to provide that camaraderie that is not only part of the veterans community, but is particularly important to recovery from various of the areas in which veterans still suffer. That's been a crucial aspect, I know, for PTSD treatment in a number of our committees throughout Hawaii. So the adequacy of centers is inconsistent.

Veterans cemeteries have been a persistent problem, especially on some of the neighbor islands. Good, solid efforts by Federal, State, and local, county Governments, State government, and Federal Government to provide the full range of the obligation that we have to provide for the final resting place of our veterans and relatives.

But I think the fact of the matter is that although it's relatively available here on Oahu, it is not relatively available, at least that simply, on the neighbor islands. So one of the bills that I have pending in Congress is a proposal to allow for an increase in the burial allowance which is given to the State to assume of the responsibility of the Federal Government in situations in which a cemetery is not available on island.

Now, if you're in the middle of New Jersey, that might not be a problem. But if you're on the island of Hawaii and a veteran, you want to be buried on the island of Hawaii, just to take an example, or Molokai. So if there's not an availability of, or it's too expensive, and you've got to come to another island, well, I think that defeats the basic purpose of what we're trying to accomplish.

I think outreach remains a crucial thing for us all to focus on. There are veterans out there that are not being reached. In general, the veterans that are not being reached are the veterans that most need to be reached. I think that's a truism. I think that we will find, and the Committee will observe and has already observed, that this is true on islands such as Molokai, in which I kind of fear that there is just not enough penetration, if I can put it that way, into the community that needs to be served.

I think this has nothing to do with the efforts and intentions of people that are involved. The veterans councils have done a great job of trying to put together consolidated outreach efforts with Federal, State, and local Government and the veterans groups, and to reach people that need to be reached.

Nonetheless, I think it has not been enough in some areas, and I think we all have to focus on a renewed effort to deliver to veterans, to take to their doors, in some cases, the benefits that the veterans structure does provide and does make available to them.

We can't get caught up in the thinking that because we tried, somehow if they're not utilizing it that's their problem. It's not. It's our problem. We want to reach these veterans. So one of the things that I think we need to do is redouble outreach efforts, especially to the more rural and remote parts of Hawaii.

So where does this all leave us? Well, I just give you a couple of basic points, Senator Akaka, for consideration by the Committee. I think, first of all, I want to reiterate this all starts with a national priority to our veterans and a national commitment to our veterans and we have to focus there because nothing else is going to matter if we don't get that straight.

It is in danger right now, and we are having this debate as we speak, in Washington. It is being fought very hard for the veterans by your national veterans organizations, who are doing a masterful, great job of advocating. But that's not going to be enough. We're all going to have to hang in there.

Again, the challenges of veterans nationally are the same challenges that we have here in Hawaii in a number of areas. Healthcare is number one. Access to Federal Government contracts I would put number two, and then basic outreach. I think that that's important. If I were to say what the three priorities are, those would be them.

We have challenges in Hawaii that affect Hawaii as a rural area, just as they affect any other rural area of our country. Access to medical care. The application of telemedicine, which is an amazing possibility, not possibility, actuality. I certainly encourage our National Government to redouble its areas in the area of telemedicine.

That can eliminate distance problems right away, and all the issues that we have about getting veterans from Lanai to adequate, affordable healthcare on Oahu or Maui. We can do a lot of that just by basic telemedicine. We're doing that in other areas of health provision in the neighbor islands.

We have specific challenges for Hawaii as an island State. It is not as simple as just jumping in your car and driving 200 miles down the road, even though that's a problem for many veterans. It costs a lot of money to get from Lanai nowadays to Tripler or wherever else you might go. We have to accommodate that. We're trying to accommodate that. But I think we've got work to do.

Other concerns are a little more individual. I talked about the cemetery situation. We have particular personnel issues that come up every once in a while in terms of the provision of broader veteran services. This is a hard job to provide. There's some burnout involved, especially in some parts of it. We've got good, solid people that have been doing yeoman's service out there. I think you all

know somebody like that who's in the system right now, who's going above and beyond the call.

But we've got to take care of the personnel that are working in the veterans area on behalf of all of our veterans. I think we've got to pay attention when those situations arise on an isolated basis. Again, I don't think it's something that's pervasive. But I do think it's something that has to be watched over.

So those are some overall observations, so overall conclusions, some overall recommendations, and certainly some overall courses of action that I certainly intend to continue to pursue and which I want to pursue with you.

I thank you again, Senator Akaka, for bringing the Committee here, and I thank all the participants here today. We all need to return to D.C., as you will next week and as I will later in the month, to redouble our efforts on behalf of veterans. We're going into a new Federal budget. We're going to get the new Federal budget in early February, and I fear for what it's going to say about the priorities of veterans. I think we're going to have to fight this fight all over again, so we've all got to be ready to do it.

I certainly am there myself, and look forward to working with each and all of you. Thank you very much.

[Applause.]

[The prepared statement of Mr. Case follows:]

PREPARED STATEMENT OF HON. ED CASE, U.S. REPRESENTATIVE FROM HAWAII, 2ND DISTRICT

I am proud and humbled to represent you and our Hawaii's almost 120,000 fellow veterans in our U.S. Congress.

Fully 14 percent of Hawaii's adult population are veterans, one of the highest percentages in our Nation. Fully 5 percent of all Hawaii citizens 18 to 64 years old are currently serving in our armed forces, the highest percentage in our country. These numbers prove what we all know: that our Hawaii has been, is and will remain deeply committed to contributing to our Nation's defense; and that we must all be especially dedicated to meeting our obligations to not only today's veterans, but tomorrow's as well.

In my 2004 Veterans Report last June, I reported that the prior 108th Congress (2003–2004) was most difficult for our Nation's veterans due to concerted efforts within our Federal Government to reduce benefits earned by current veterans and to underestimate the needs of future veterans. Unfortunately, that trend has continued in the current 109th Congress (2005–2006), where we have seen great resistance to funding especially crucial health needs and to recognizing the special needs of our troops returning from Iraq, Afghanistan and elsewhere.

In this report, I summarize just some of many national veterans issues my Congressional colleagues and I have pursued to fully meet our country's obligations to you and yours. I also summarize some of my efforts in our Hawaii, where I have been especially fortunate to "talk story" with so many veterans throughout our state. As you well know, here at home veterans needs are often different than on the mainland (for example, the difficulty in getting from island to island for healthcare or of maintaining veterans cemeteries on different islands). In addition, I tell you about my congressional office and how we can and want to help you, whether veterans-related or otherwise.

Finally, especially important for me is a quick survey of your views and needs as one of our Hawaii's veterans. This is invaluable to my continued efforts on your behalf, just as my June 2004 veterans survey proved indispensable, and I appreciate your response.

It is my great privilege to serve you and yours in our Congress. I truly look forward to continuing to work with you on not only the needs of our veterans, but our other efforts toward a better Hawaii, country and world.

With aloha.

SELECTED VETERANS ISSUES IN THE 109TH CONGRESS (2005–2006)

1. Veterans Budget

By far the most all-encompassing challenge continuing to face all current and future veterans nationwide is the ongoing effort in Washington, D.C. to limit funding of veterans benefits.

As you know, the U.S. Department of Veterans Affairs (VA) administers promised benefits to eligible veterans, ranging from disability compensation and pensions to hospital and medical care. VA provides these benefits to veterans through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA).

VHA is mainly a direct service provider of primary care, specialized care, and related medical and social support services to veterans through an integrated health care system. Veterans are enrolled in priority groups that determine payments for service and non-service connected medical conditions.

It is veterans healthcare generally and VHA specifically where we have seen both the greatest needs for our veterans and the most concentrated efforts to curtail funding. The current Administration's budget request for fiscal year 2006 (which began on October 1, 2005) would have significantly shortfunded adequate veterans health care in fiscal year 2006 (as was demonstrated when the VHA ran out of money in June and came to Congress for a $1.5 billion supplemental appropriation just to get through fiscal year 2005.)

As a Member of the House Budget Committee, I worked with colleagues on both sides of the aisle to craft a fiscal year 2006 budget that reined in our country's spiraling debt and deficit while adequately funding our Nation's highest priorities, including veterans benefits. When the fiscal year 2006 Budget Resolution, setting the overall framework for the Federal Government's 2006 fiscal year, failed to do this, I voted against it.

This basic debate continued throughout Congress's consideration of H.R. 2528, making actual appropriations for VHA and other military/veterans programs for fiscal year 2006, with many national veterans groups joining us in advocating forcefully for adequate veterans funding. In mid-November, Congress approved a final version of this bill which funds VHA at more than what the Administration requested but less than what is necessary to keep up with true need. Obviously, this effort must continue and is, in my mind, the single most important veterans issue facing us all.

2. Congressional Consideration of Veterans Issue

Perhaps what has happened in Congress on veterans issues is not surprising given that the basic and time-honored legislative process in this area has eroded. Things didn't get off to a good start in the current 109th Congress when the Chair of the U.S. House Committee on Veterans' Affairs was replaced by House leadership because he was viewed as too sympathetic to veterans needs.

More difficult to understand is the recent announcement by the current Committee Chair that the decades-old tradition of conducting annual joint hearings of the House and Senate Veterans' Affairs committees will be discontinued. These hearings have provided an invaluable forum for Congress collectively to review the legislative priorities of veterans and military service organizations like AMVETS, the American Legion, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States, and to dialog directly with these invaluable representatives of America's veterans. I joined many of my colleagues in a letter to the House Speaker decrying this decision and urging that it be reversed; at this writing that has not occurred.

3. New GI Bill of Rights for the 21st Century Act

Clearly, in the big picture, we must not only maintain the basic fabric of our prior undertakings to our veterans, but also adjust and update them to today's and tomorrow's needs. The best overall formulation of where we need to go is contained in H.R. 2131, the proposed New GI Bill of Rights for the 21st Century Act, which was introduced by my colleague, Representative Chet Edwards of Texas. I am an original cosponsor of the measure which, to date, has the support of 171 Members of Congress.

H.R. 2131 seeks a wide-ranging update in our basic deal with our veterans. Among its many provisions, H.R. 2131 would (1) mandate adequate funding for veterans medical care, (2) prohibit until the end of fiscal year 2006 medication co-payments and imposition of a health care system enrollment fee, (3) extend until 2010 Vietnam veterans eligibility for readjustment counseling services, (4) collect and process data from pre- and post-deployment health assessments, and conduct pre-

ventive post-deployment intervention, (5) seek early detection and treatment of post-traumatic stress disorder (PTSD) for returning troops, (6) establish a Department of Defense/Department of Veterans Affairs Council on Post-Deployment Mental Health, (7) increase survivors' dependency and indemnity compensation (DIC), (8) provide certain pay increases and bonuses for active-duty members, (9) expand benefits under both active-duty and reserve Montgomery GI Bill programs, (10) provide employment assistance for homeless veterans, and (11) expand reserve member eligibility under the TRICARE program. This bill would also repeal the DIC offset from the Survivor Benefit Plan surviving spouse annuities.

4. Concurrent Receipt

Until 2004, Federal law required that military retired pay be reduced by the amount of any VA disability compensation received. For many years, some military retirees had sought a change in law to permit receipt of all or some of both, and legislation to allow this has been introduced during the past several Congresses, frequently with cosponsors, including myself, numbering well over half of both the House and the Senate. This is known as "concurrent receipt" because it authorizes the simultaneous receipt of two types of benefits.

The fiscal year 2003 National Defense Authorization Act (NDAA), enacted in 2002, created a benefit known as "combat-related special compensation," or CRSC. CRSC provides, for certain seriously disabled retirees, a cash benefit financially identical to what concurrent receipt would provide them. The fiscal year 2004 NDAA authorized, for the first time, actual concurrent receipt, as well as a greatly expanded CRSC program. The fiscal year 2005 NDAA further liberalized the concurrent receipt rules contained in the fiscal year 2004 NDAA.

While these initiatives, which I supported, addressed some of this longstanding injustice, I asked the House Committee on Government Reform to evaluate the extent to which Hawaii veterans in my Second District are still affected by the non-concurrent receipt penalty. The Committee reported that over 2,100 veterans in our district—and over 4,500 veterans throughout the state—still lose benefits due to the disabled veterans tax.

There have been a number of bills introduced this Congress seeking full concurrent receipt. The one with the greatest support is H.R. 303. This bill would (1) allow immediate concurrent receipt, rather than phasing it in between now and 2014, and (2) repeal the requirement that only military retirees with a 50 percent disability rating can qualify for concurrent receipt, allowing it for any retiree with a service-connected disability.

I am a cosponsor of this bill. Also, because of current leadership's refusal to bring this bill to the floor for a vote, I, along with over 200 of my colleagues, have signed a "discharge petition" which would mandate an up-or-down vote of the full House. As it takes a majority of House Members (218) to successfully force such a vote under this procedure, we have been working closely with national veterans groups toward achieving this goal.

5. Survivor Benefit Plan (SBPI)

Our country's obligation to its veterans extends to your families. However, under previous law, surviving spouses who reach the age of 62 had their retirement benefits reduced from 55 percent of the deceased servicemember's benefit to 35 percent of the deceased servicemember's benefit. This unfair reduction—sometimes referred to as the "widow's tax"—caused a substantial hardship on the surviving spouse.

Prior efforts, in which I joined, to eliminate the penalty were met with resistance. However, last year, sensing growing support, congressional leadership added a provision to the fiscal year 2005 defense authorization bill to phaseout the SBP penalty.

Now, however, the issue, like concurrent receipt, is whether surviving spouses receiving survivor benefits should continue to be penalized by not being entitled to receive the combined total of such benefits and dependent and indemnity compensation (DIC). I and many other colleagues believe this is also unfair, and so have introduced H.R. 808 to eliminate the military families tax.

6. Equity for Filipino Veterans

Our Filipino veterans communities both in Hawaii and throughout our Nation continue to pursue the critical support needed to restore to our Filipino veterans the full benefits unfairly withdrawn by Congress in 1946. During the 108th Congress, we had partial success when Congress passed and the President signed into law H.R. 2297, which I had cosponsored, to increase VA benefits for U.S. Filipino WWII veterans and allow former Philippine Scouts living in the U.S. to be buried in VA cemeteries.

This long overdue effort must be continued until full justice is provided to our now elderly Filipino veterans. To this end, I am a cosponsor of H.R. 302, the Filipino Vet-

erans Equity Act, to deem certain service performed before July 1, 1946, in the organized military forces of the Philippines and the Philippine Scouts, as active military service for purposes of eligibility for U.S. veterans benefits, and to repeal certain provisions discounting such service as qualifying service. We don't have much time left to do the right thing here, and we are working toward doing just that.

7. Federal Budget

There should be no doubt that, in the big picture, the reason for the pervasive resistance in D.C. to full and fair funding of existing requirements and needs, much less long-denied needs and other initiatives necessary to provide basic fairness to our existing and soon-to-be veterans and to encourage enlistment in our armed forces, is largely the rapid deterioration over the last half-decade in our Nation's overall finances. In a nutshell, we have not properly (1) balanced revenues and expenses, resulting in the largest annual deficits and fastest increases in our Nation's total debt (now over $8 trillion, up $2 trillion just since I began representing you here in 2002) in our Nation's history, (2) prioritized spending, and (3) addressed ongoing government inefficiency and waste. Until we correct these all-encompassing deficiencies, too many here will continue, in one form of another, to shortchange our Nation's veterans.

SELECTED HAWAII ACTIVITIES

1. Keeping In Touch

Staying in touch with you and our Hawaii's veterans is essential not only to recognizing your invaluable contributions, but to representing you in Congress and to assisting with Hawaii-specific challenges. I have been fortunate now to join you and speak at many Memorial Day, Veterans Day and other ceremonies throughout our state, in addition to many other events like the groundbreaking for the new Oahu Veterans Center and the annual cleanup at the Kauai Veterans Cemetery. I have also spent time just dropping by veterans centers on Molokai, Maui and Hawaii Island.

My Talk Story community meetings district wide have been especially invaluable to keeping up on veterans issues, not just nationally but locally. I've done 50 in 2005 throughout Hawaii as well as with Hawaii's own 29th Brigade Combat Team in Fort Polk, Louisiana and Balad, Iraq. From these Talk Stories I learned, for example, of a crucial challenge facing Maui's veterans, on which we are working, and of the Lanai veterans' request for a U.S. flag flown over our Capitol, which I was able to provide.

My point here is that we can accomplish more together and I can focus on your needs better if and as we stay in touch. I am always willing to try to work into my schedule a meeting with Hawaii's veterans or attendance at an important event, and encourage you to call on me for such needs and opportunities.

2. Visiting Our Troops

Today's active military forces are tomorrow's veterans. Especially in this extremely difficult time, when we have hundreds of thousands of our own fighting for us overseas, I believe it is crucial for people like me to spend time with our troops where they are, not only to show our support and solidarity, but to understand and address current and future challenges. I've done this through visits throughout our Hawaii and overseas. I've now visited our troops in Iraq in 2003 and 2005, and in Afghanistan in 2004. My discussions and observations during those trips have played a major role in my own thinking on our obligations to our current and future veterans, including our guard and reserve component.

3. Funding

Many of our veterans issues in Hawaii involve funding of local needs, from cemeteries to centers and other facilities to specific programs. My efforts in this area have been to seek financial assistance from our Federal Government through existing programs or annual congressional allocations, and to support funding requests from individual veterans and your organizations and Federal, state and county government veterans representatives. As we move into the Federal Government's 2006 fiscal year, and look already toward the fiscal year 2007 congressional appropriations process which starts up in the remainder of this year and early next year, I especially need to hear from you on specific Hawaii needs so I can assist in the best manner available.

4. Benefits Workshops

Over my last 3 years of representing Hawaii veterans, both individually and collectively, it has become increasingly clear that in too many instances our veterans

are simply not fully aware of their benefit and other rights and entitlements under law. I discussed this challenge most recently with Dr. James Hastings, the new director of the VA's Pacific Health Care System, and will be working with him and your other veterans agencies to sponsor a series of outreach benefits workshops throughout my district. I am aiming to conduct these workshops in the first quarter of 2006, and welcome your input on how best to do so and how my office may otherwise assist in educating our veterans on the basics of our veterans system.

Senator AKAKA. Mahalo. Mahalo nui loa, Representative Case. I thank you very much for what we call in Hawaii mana'o, and it starts about veterans here and across the country. Thank you, Representative Case, so much for taking the time to be with us this morning. Mahalo nui loa. I want to thank him for being here.

I'm pleased also to tell you that we were joined by Chairman Larry Craig for the past 2 days. We're very fortunate to have him because he has other schedules. But he certainly really contributed to the hearings and the success of the hearings that we've already had. But he reluctantly had to go back to his snowy State because he had other responsibilities there.

I want you to know that this is bipartisan effort. We work very closely together and very well together, and look forward to continuing to do that to help our veterans here in Hawaii. I'm also pleased to announce that the VA at the national level and the regional level and the State level on Maui and Kauai did make statements that they'll help our veterans on Molokai and Lanai as well. I think they have unique problems, too.

But this has been very fruitful for all of us. I want to again mention that it made a difference. I want to thank Representative Case. I know he has a busy schedule.

I also want to mention that in the back of the room, uniquely, we have a desk of staff, VA staff as well as our staff in the Senate, who are there to help anyone here who has a concern or needs some help. You can go back there and talk with them.

In case you have a letter, please present it to them. I think you know that letters are very important to us because if we do any inquiry, you know, it's a privacy issue that we have to be careful of, and receiving a letter from you does take care of that for us. I just wanted you to know that they're back there. So please feel free to stand and seek that help.

My purpose in holding these hearings is to find out, as the Ranking Member of the Veterans' Affairs Committee, how we can help VA provide the best care and services to Hawaii's veterans. That's what we're here to do.

So I'd like to call forward our first—our panel here, which is now our second one. William Daves, who's President of Oahu Veterans Council. Mike McCloskey, who's a member of the National Executive Committee of the American Legion, Department of Hawaii. Caz Roswell, service officer, military, awarded the Purple Heart. Lieutenant General (Ret.) Tom Rienzi, Veterans Advisory Council. Gil Hough, member of the Veterans Advisory Council. Colonel (Ret.) Edward Cruickshank, Director, Office of Veterans Services.

We're delighted to have all of you here. I would like to ask you to give your testimony in the order that I introduced you. So the first will be William Daves, and here's your mike.

STATEMENT OF WILLIAM DAVES, PRESIDENT, OAHU VETERANS COUNCIL

Mr. DAVES. Thank you and mahalo.

I want to talk this morning about a program that the VA have. It's called CHAMPVA. CHAMPVA is given out to people on DIC, and there are no doctors. There are two on Oahu, I think.

I happen to know of a widow that's getting DIC with two children. There are no doctors. There are no pediatricians. I can't ask anybody in the VA. They give me the telephone number of the place in Denver, and that's as far as you get. That's all I wanted to talk about this morning.

STATEMENT OF MICHAEL McCLOSKEY, MEMBER, NATIONAL EXECUTIVE COMMITTEE, THE AMERICAN LEGION, DEPARTMENT OF HAWAII

Mr. McCLOSKEY. Good morning. I'd like to thank Congressman Case, Senator Akaka, the VA staffers that are here, and of course all the wonderful veterans and their families that we've got turned out. Mahalo for coming, and aloha. We provided our written testimony from the American Legion's perspective. There are just a couple of things that I'd like to cover.

The American Legion's position on medical care for veterans is mandatory funding. Mandatory funding is needed so that every veteran is adequately taken care of whenever they go to a VA clinic. We are at war, ladies and gentlemen. This is not the time to be arguing over veterans benefits or trying to nickel and dime folks that are shedding their blood and their sweat for this country. We simply need mandatory medical care.

Congressman Case spoke very briefly about the battle that's going to come in Congress over funding for the VA. I know that the VA sitting over here is going to work hard to get as much money as they can to do the best they can for you.

It's not going to be enough. Right now, only about 20 percent of the veterans in this State seek and receive VA medical care. Many of them do not seek care simply because it's so hard to access. As Congressman Case pointed out, geographical separation, cost of travel, lack of specialists, these all contribute. The bottom line is always money. We rely on our congressional delegation, led by Senator Inouye and Senator Akaka, to help us with this issue. It is our major issue.

The American Legion also has some major concerns about the reassessment of PTSD claims. We are very pleased that those claims were not reviewed, the 75,000 cases. We believe that would have been counterproductive not only for the VA, but extremely harmful to those involved in the process.

Lastly, I'd like to talk a little bit about readjustment counseling. We have a great readjustment counseling service led by Steve Molnar here on Oahu. It's not big enough. We need two Vet Centers on this island. Ideally, we would have a Vet Center located somewhere in Kapolei. Population growth on the leeward coast mandates some VA services be placed in that area. I believe that that's something we could do.

The clinics on the outer islands are doing a great job. The Vet Centers on the outer islands are doing a great job. But they need

help. People, some people, do not go to access those services because they don't want to wait in line.

In conclusion, I'd like to say a couple of real good things about the VA. The voc rehab program under Ed Gavigan [ph] is excellent. They're doing a great job. But he needs help, too. The loan guarantee program is also doing an excellent job. They just lost one of the best in the business when Tom Sirocca [ph] retired last year. But I believe the young lady that they've selected to replace Tom is going to do a great job.

We ask that Senator Akaka and Congressman Case fight hard so that we can get the Native Hawaiian program—the Native American loan program, thank you—passed and make it permanent. That would be really a great deal.

I see Jim Carilli sitting out here, and most of you know Jim. He used to be my boss. There were some at the VA that probably thought that the claims process and the workload might improve after I retired a year or so ago. Sadly, it didn't. Jim needs help. He needs more people to do this very complex medical and legal job that he's got. We need to encourage our congressional delegation to give these folks all the help they can get.

Thank you very much, Senator Akaka. I appreciate this opportunity to speak. We hope that you'll carry this back and continue to help our veterans in Hawaii. Mahalo.

[The prepared statement of Mr. McCloskey follows:]

PREPARED STATEMENT OF MICHAEL MCCLOSKEY, MEMBER, NATIONAL EXECUTIVE COMMITTEE, THE AMERICAN LEGION, DEPARTMENT OF HAWAII

Senator Akaka, Thank you for the opportunity to participate in this forum. Our purpose is to bring to your attention various issues and concerns related to the quality and availability of Department of Veterans Affairs health care for veterans who reside in Hawai'i.

As the largest war time veterans organization in the State, we believe we are uniquely qualified to speak on these issues.

1. As National Commander Bock stated in his September 20, 2005 before a joint session of the Congressional Veterans Affairs Committees, there have been recent attempts by some in the 109th Congress to create an artificial distinction among veterans; the so-called "core constituency" of veterans eligible for VA Medical Care. There have been characterizations of deserving versus undeserving. Veterans who Congress granted eligibility for medical care were accused of seeking a "free ride" and causing "real" veterans to wait for care. Honorable military service, whether for a single enlistment, a 30-year career or National Guardsmen and Reservists called to active duty for shorter periods due to war time operations is not comparable to civilian employment. It is not just another job! Now who answer the call to arms are entitled by law to very specific individual legal status and entitlements that must not be denigrated regardless of whether or not their service involved participation in direct combat operations or in support roles. There is no draft or otherwise involuntary military service in the United States. We as a Nation rely upon the willingness of the population at large to serve. Consequently, debate regarding whether or not one group or another is more or less deserving is not only hurtful to the individuals concerned but damages our ability to recruit and retain capable individuals at a time when we most need them. Consider, what would have become of this Country if such debate and controversy had existed in some of the most critical times in our history, e.g., the Revolution, the Civil War, or World War II. It is with this in mind that we support MANDATORY funding of medical care for all honorably discharged veterans. This is the minimum that should be provided to those who raise their right hands and swear to uphold and defend our way of life. Medical care for those who we should not be an annual political ballgame with the only losers those who shed their blood and sweat to insure the continued existence of our Country. It is time to stop balancing the National Budget on the backs of those who defend us.

2. Approximately 110,000 veterans reside in the State of Hawai'i. In recent years, this population has been decreasing due to the demise of aging World War II and Korea Veterans. However, the current war which must be assumed will continue for some years to come will undoubtedly keep this number either stable or increasing. Department of Veterans Affairs data indicates that only about 20 percent of the veteran population receives care from VA medical facilities in Hawai'i. Input from our membership indicates that many more would do so but for the difficulties veterans experience in getting to and from VA those facilities. There are a number of factors that contribute to this problem. One of the most significant is the fact that we are an island State. One cannot drive from Molokai to O'ahu. In recognition of this the Department of Veterans Affairs has established outpatient clinics on the major neighbor islands of Hawai'i, Kaua'i, and Mau'i. new Clinics have generally provided excellent service to those who are able to access them. However, it is our position that too few veterans are We to access that care simply because of limited clinic staffing and limited dollars in the VA budget. Nearly 75 percent of our veteran population resides on the Island of O'ahu. Even on O'ahu which has the largest and most sophisticated VA clinic in the State, most veterans do not seek VA medical care unless they have no other option. Again, limited staffing and limited budget dollars restrict many who need and deserve VA care. Put simply, we need more doctors, more nurses, and more and better equipped facilities. Now, neighbor island patients are often flown to O'ahu for medical care and examinations that cannot be conducted locally due to limited or non-existent facilities. Many debilitated or aged veterans required to make these trips need the assistance of an attendant to travel. The cost of the travel makes this a difficult budget issue for the VA but oftentimes, the lack of local specialists or simply the prohibitive cost of private sector treatment mandates it. Larger, more comprehensive facilities on each major island would eradicate this problem. The argument that many veterans have a wide range of medical care alternatives outside the VA does not negate the Nation's obligation to those who served VA is in effect rationing medical care. This rationing causes many aging veterans to pay high insurance premiums and to make difficult and ultimately unhealthy choices, e.g., do I pay for the medication I need or do I buy food and pay my rent? now who served should not be asked to make sacrifices of this nature.

3. Another problem of increasing concern is the lack of adequate long-term medical services and facilities in the State. The VA's Center for Aging is a 60-bed facility located on the Tripler Army Medical Center. It provides excellent service from a highly trained staff of dedicated medical professionals. However, it is totally inadequate to meet the needs of our aging veteran population. Consequently, it is used to care primarily for patients requiring short-term inpatient care as in surgery recovery. It is not intended for long-term care. To meet the needs of our veterans, similar facilities should be constructed on each of the major neighbor islands. In this same regard, a State Veterans Hospital intended for long-term care is in the works on the Island of Hawai'i at Hilo. This is a great start but again is totally inadequate to meet the needs of the aging veteran population of this State. Our Congressional Delegation is asked to support the development of similar facilities on each of the major neighbor islands.

4. We have a number of concerns regarding the care and treatment of veterans suffering from post traumatic stress disorder (PTSD). The number of veterans filing claims for service connection and treatment for this condition has risen dramatically over the past 10 years. As we are engaged in a global war of unknown duration it is likely that the number of these cases will continue to increase. Consequently, the cost of compensation and treatment is also likely to escalate. This issue and the collateral issue of awarding Individual Unemployability (IU) benefits to many veterans disabled by symptoms of PTSD apparently prompted the Department of Veterans Affairs last year to begin questioning whether some of these claims were appropriate. A review of several thousand cases was conducted, and a review of all such cases granted was announced. As you can imagine, the impact of this announcement on those who suffer from PTSD and rely totally on VA compensation as their only income was enormous. Many patients symptoms were exacerbated because of fear that VA would stop their compensation payments and/or interfere with their ongoing clinical psychiatric care. Many of these veterans had fought for years to obtain the benefits and it was seen as a setback by not only veterans but mental health care professionals as well. Subsequently, the VA announced that the review had been canceled and we applaud that decision. However, we have been recently advised that another move is being made by VA to perhaps restructure the Rating Schedule or to change the criteria for a PTSD diagnosis. Obviously, fewer diagnoses of PTSD or fewer grants of compensation based on PTSD would save lots of money. This appears to be another attempt to balance the budget on the backs of those who served. It is a particularly malignant scheme that presumes that lawyers and bean

counters know more about mental health and the impact of trauma than mental health professionals. The DMSN which provides the basis and requirements for diagnosis of mental illness is predicated on input from the best qualified mental health professionals in the Nation. We oppose any effort to restrict or change the application of criteria currently established by law for the diagnosis of PTSD or the award of compensation benefits based on such diagnosis. We believe that this is particularly unconscionable in light of large numbers of troops returning from the war zone and in need of help for symptoms of PTSD.

5. There are currently five Vet Centers in the State. These facilities provide outreach efforts for readjustment counseling and family counseling for all war time veterans. They have proven to be particularly effective and cost efficient. We currently have two on the Island of Hawai'i (Hilo and Kailua—Kona), one on Kaua'i, one on Mau'i, and one O'ahu. All of these facilities provide excellent and easy to access services to literally hundreds of veterans and their families. However, the Honolulu office is not adequate to meet the needs of our island community. A second facility is needed to meet the increasing need and permit easier access from O'ahu communities outside Honolulu proper particularly the rapidly growing population of the Leeward Coast. We solicit your support in acquiring the necessary funding for additional staffing and a new facility somewhere in the Kapolei area.

6. Until last year, the VA maintained an inpatient facility for treatment of PTSD on the Island of Hawai'i. That facility was closed with the stated intention of moving it to the Island of O'ahu. The new facility has not opened. Put simply, this is an important tool in dealing with our growing PTSD patient population. This facility combined with our VA mental health clinics and Vet Centers has been an extremely effective tool for dealing with what we perceive to be a growing problem. Please insure that adequate funding is provided to make the new inpatient facility a reality.

In closing, Senator Akaka, Members of the Commission, and fellow veterans, we greatly appreciate this opportunity to present testimony regarding VA healthcare in Hawaii. We hope that the information we have presented will be valuable and useful to you in making good decisions for veterans when you return to Washington. As you can see, the VA in Hawai'i has unique problems because of the geographic separation of our islands and distance from the continental United States. Our VA facilities also face the burden of caring for many veterans who reside in Guam, Micronesia, and Samoa. With all this in mind, we hope that your actions will reflect the needs of our veterans and provide us with the tools to meet the challenges of the 21st Century. On behalf of all veterans and especially members of the American Legion Department of Hawai'i, we thank you sincerely for allowing us to participate in this vital endeavor.

STATEMENT OF MASTER CHIEF PETTY OFFICER GIL HOUGH (RET.), U.S. NAVY; MEMBER, VETERANS ADVISORY COUNCIL

Master Chief HOUGH. Senator Akaka, distinguished guests, and fellow disabled veterans, good morning and aloha. My name is Gil Hough. I'm a retired Master Chief Petty Officer in the United States Navy who served 30 years. I am also a member of the Pacific Healthcare Advisory Board of the Department of Veterans Affairs.

First, I'd like to say thank you, VA. The VA to me and my family have been there for everything we've needed. When I first came to Hawaii on my 35th birthday, they gave me a GI loan to buy my first house. They paid for me to get an associate, bachelor's, and master's degree. They gave me veterans preference and disability when I returned, veterans preference in hiring so I could become the Director of the U.S. Department of Labor here for veterans employment and training.

They put me in the hospital as a patient. I received medicine from them in the mail, direct, very promptly. Something I don't want to—well, I will. But my son recently passed away in the VA hospital in Portland, and the VA provided extraordinary care for him. He was too sick to survive. He's also buried at the Willamette National Cemetery in Oregon. So I'm going to say that we are a consumer of the VA in my family.

Is there something wrong with the VA? Well, sure. Somebody as large as the VA, there's always going to be problems. I'm very pleased that General Hastings was appointed to be the new Director because I know with he and General Pollock, they can help us maximize our resources and services to provide even better services for our veterans.

I know right now there's a concept of building a joint hospital in Great Lakes, Illinois, a Navy/VA joint hospital. That would be great. Hawaii is simply one of two States in the Nation that doesn't have a VA hospital. Yes, Senator, we need more money if we don't have a hospital, so we need better services.

I want to say the Center for Aging is a real class organization. Just terrific. I've seen doctors up there cooking hamburgers and hot dogs for their patients. It's just great. I'd like to see some more beds because we have a lot of veterans that are old and need the services, especially on the neighbor islands.

I'm going to just talk about a couple of things. They're not real negatives, but they could be fixed. One of them, Norbert Enos [ph], our past state commander for the VFW, told me that he recently picked up a veteran that came from the neighbor islands to bring up to the VA for an EKG test. Well, I'm sure that we can give an EKG in Maui. I mean, it's not rocket science.

Another case that was shared with me by a member here in this room is a veteran came over from a neighbor island to his appointment. He got tied up with the security processing, was 20 minutes late, and they canceled his appointment. He had to make a new appointment and come back 2 months later. Now, that is just really not right. We've got to figure out something to do to improve that.

A third item that concerns me is the orthopedic care that our veterans get. We have veterans that are very aged, 75, 80 years old, and we want to send them to Palo Alto for a hip replacement or a knee replacement? That's unacceptable. They have a hard time getting back on their own.

We need to figure out here in Hawaii how to get that done. I mean, we can do it. We're a great State. We're the 50th State. We've got the power and the genius to get all these things accomplished.

My fellow veterans, that's all I have to say, but thank you very much.

[Applause.]

[The prepared statement of Mr. Hough follows:]

PREPARED STATEMENT OF MASTER CHIEF PETTY OFFICER GIL HOUGH (RET.), UNITED STATES NAVY; MEMBER, VETERANS ADVISORY COUNCIL

I have the distinct honor of residing in Hawaii since February 3, 1978. I arrived here on that date to serve on the staff of the Commander in Chief, United States Pacific Fleet. I retired from the United States Navy on July 1, 1989 and made Hawaii our family home.

The services provided by the Department of Veterans Affairs in Hawaii are outstanding. I personally have received benefits/services from them to include: home loan guaranty; education benefits; disability payments; preference in Federal hiring; hospitalization, dental treatment; pharmacy services and general health care. My shipmates and I are very proud of them and lucky to have the great services that the VA provides us. However, this is mainly because we live on Oahu!

The consolidation of VA services with the United States Army in Hawaii (Tripler) was an absolute stroke of genius and provides a catalyst for future consolidation of

services which will serve to maximize and leverage Government funding and services.

I retired as the Director, Veterans' Employment and Training Service, United States Department of Labor on March 31, 2004. I had the opportunity to provide services to veterans in the State of Hawaii, Guam, and Asia. During my tenure the only negative areas that were personally encountered are services to our Neighbor Island veterans by all Agencies because services and facilities are limited.

It would be my fondest wish that you and your colleagues do everything in your power to ensure the necessary stream of funding to ensure services to veterans on our Neighbor Islands are increased, services improved, and new facilities created.

I know my fellow veterans on our Neighbor Islands will provide you with their issues regarding services to them.

I wish to thank you for your outstanding contribution(s) to our great State and Nation. Please continue to do everything possible to ensure that our veterans continue to receive that which they so richly deserve.

STATEMENT OF LIEUTENANT GENERAL THOMAS RIENZI (RET.), CHAIRMAN, VETERANS ADVISORY COUNCIL

General RIENZI. Sir, my name is Tom Rienzi. I'm Chairman of the Veterans Council here. I take a little bit different view, having stumbled around here for the last 50 years. I've been Chairman of the Retirement Council, and now the Veterans Council. I think I reasonably have seen and know what goes on and this is what I have to say.

As Chairman of the Hawaii Veterans Council for the Pacific Ocean area, I state that the veterans/military hospital in Tripler, and the CBOCs, the clinics, are the best in the world.

[Applause.]

General RIENZI. It serves more than 120,000 vets, as Congressman Case said, about 60K in his area and 60K in the other congressman's area. It serves these 120,000 in a superior manner. I worked there as a chaplain for 22 years, so a chaplain knows an awful lot of what goes on in a hospital.

Additionally, the VA staff, in my opinion—and I'm just a dumb little Italian from Philadelphia—the VA staff is well-organized, capable, to serve our veterans promptly and effectively. I didn't say efficiently; I said effectively.

[Laughter.]

General RIENZI. I think a thing you should know, with the help of Max Cleland, Senator Max Cleland, who was my first aide, up on that hill now we have a VA hospital and a military hospital in the same place for the old fellows at one end and the young fellows at the other end. That's quite an accomplishment.

Finally, if you would look at what we had 2 years ago in the outer islands, it was next to nothing. Today, except for Molokai, we have a veterans facility, a CBOC, a clinic with a nurse or a PTSD person. The only one we've missed so far is Molokai, and we'll get there.

We're a hell of an organization doing a hell of a job. Are there mistakes being made? Yes. Are there cases in this room here that are awful? Well, I say bring them to me or bring them to Dr. Hastings and we'll solve them.

God bless America, and God bless our veterans.

[Applause.]

[The prepared statement of Lieutenant General Rienzi follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL THOMAS RIENZI (RET.), CHAIRMAN, VETERANS ADVISORY COUNCIL

As the Chairman of the "Hawaii VA Council" for the Pacific Ocean area, I state that the VA/military hospitals on Tripler Hill is the best in the world. It serves our 100,000 veterans in a superior manner. Additionally, the VA staff is well-organized to capably serve our veterans promptly and effectively.

With the help of Secretary Max Cleland, we combined the VA and military hospitals to be like one in caring for our personnel.

STATEMENT OF CAZ ROSS, VETERAN SERVICE OFFICER, THE MILITARY ORDER OF THE PURPLE HEART

Mr. ROSS. Very difficult to follow General Hastings [sic]. I really appreciate your sentiment.

General RIENZI. That's General Rienzi.

[Laughter.]

Mr. ROSS. That's right. Excuse me. Lieutenant General Thomas Patrick Rienzi. Yes, we've talked a lot.

Chairman Akaka, Senator—Representative Case—I've promoted him already—and veterans who are here in attendance as well as members of the VA staff and senatorial staff, my name is Caz Ross and I'm the Veteran Service Officer for the Military Order of the Purple Heart as well as the Veteran Services Coordinator with the Office of Veterans Services. I also work with those members who are really in the Pacific, those people who are in Guam and in American Samoa.

I'd just like to share just a small bit about of the excellent services that we get here on Oahu. We do get the best of medical care, and we have in fact had numerous awards that show that the VA medical care that we get on here in Oahu is in fact fantastic.

Can we do more? Yes, through telemedicine, Oahu will be the center and we'll be able to get more services not only to our neighbor island individuals but also to those individuals in Guam as well as in American Samoa. It's just taking a lot of time, and many of those individuals are extremely frustrated with the amount of time that it's taking.

We also have the same problem in terms of getting more medical care to our neighbor island people. That's what we're advocating for. We've got a very good system. We just need more of that system focused to those individuals in our rural areas, whether it be on Oahu or in our neighbor islands such as Molokai; Lanai, which we have 300 veterans on; Kalaupapa, where we have 5 veterans on. These individuals also need to be able to receive adequate medical services.

A little message in terms of just talking about the services that we get from our benefits section. To date, service is slow due to the number of FTE not meeting the station's needs. I've been asked also to talk about another issue, and that issue is what we call 1151. This refers to individuals who in fact have medical conditions that become a problem because some medical problem occurred while those individuals were in a medical facility; a non-VA medical facility.

As long as these individuals go to VA facilities, it's fantastic. However, in the State of Hawaii, we only have one VA clinic. The vast majority of individuals are sent out, either to Palo Alto or someplace else in California, and receive medical care.

When they receive that medical care under the direction of the Department of Veterans Affairs in a VA facility, they are able to be compensated for any injury that is unintended. For example, if somebody loses an arm or a finger because of something that happened that's not intended to happen but it does, then these individuals are able to claim for a service-connected disability.

However, for those individuals who go to Straub, St. Francis, or Tripler Medical Center, they are not able to get the same type of benefit. They are not protected. We need to ensure that the Legislature, meaning the Congress, changes 1,151, especially Section 38 U.S.C. 1701(3), which states that only those facilities under the direct control of the Department of Veterans Affairs are eligible to receive this type of protection. We need to include all veterans in Hawaii who go to non-VA medical facilities and who are not able to travel to the mainland, and make them comparable to the services that they will get at any other VA facility.

Another thing that I would like to touch upon is that Hawaii is an island State. Everyone here noticed that. But when we have consolidation of services in terms of benefits, sometimes we lose out.

Right now, we have a consolidation where we in Hawaii have to call to either Muskogee, Oklahoma or to St. Louis or to Minneapolis-St. Paul for certain types of benefits. People in Hawaii only have a 2-hour window to get in a 1–800 telephone call, and it doesn't happen. It's just very difficult in terms of accessing these services because the services have been consolidated to a mainland facility.

Part of the solution, of course, is money. We've talked about this. We need to have an adequate number of raters here in the State of Hawaii so that we can handle ratings for those individuals. We don't have to send off so many of our claims to the mainland to be worked.

I want to thank the VA for the services that they do provide. I want to thank the healthcare staff particularly because you've come a long way from where we first started. VA Benefits Staff are struggling, but I know that your people are working really hard to make this one of the better units in the United States.

Again, thank you so much for allowing me to testify.

[Applause.]

STATEMENT OF COLONEL EDWARD CRUICKSHANK (RET.), DIRECTOR, OFFICE OF VETERANS SERVICES

Colonel CRUICKSHANK. Senator Akaka, Members of the Senate Committee on Veterans' Affairs, my name is Ed Cruickshank. I'm the Director of Veterans Services for the State of Hawaii. Based on everything you heard so far, I'm going to change my testimony because I just don't want to repeat myself.

But before I get started, I'd like to recognize the Wessel [ph] family back there in the room. They lost their son fighting in Iraq. Will the Wessels please stand up? Let's give them a hand.

[Applause.]

Colonel CRUICKSHANK. Thank you.

Before I discuss some of the challenges that we all face here—and it's primarily because we're an island State—as Senator Akaka

said, getting the services to our outer islands to provide services for veterans is a real problem. Getting the services here, we're very lucky. But we need to find ways to get services out to the other islands.

But before I mention the challenges, I want to let all of you know, as everyone else has said so far, the VA healthcare has been excellent. The way the VA staffs treat their veterans—they treat their veterans with dignity and respect, and they do everything they possibly can to show the veterans they really do care. To you, General Hastings, I'd like to say your group and General Pollock do a wonderful job. With our returning 2,900 soldiers coming back this week, let me tell you, we're going to be counting on you to provide that service to them.

On the island of Oahu, we have 70 percent of the veterans here. Two concerns that they have—well, not for those that are here but for those that are located on the other islands—is what they get assigned to mainland VA medical centers for surgical services. For neighbor island veterans, this can be very traumatic. They're saying, please let us fly out if at all possible from the neighboring islands. Especially since our veterans are quite elderly, many times it's a lot easier for them to do that.

The other part that they keep mentioning a lot to me continually is on specialty care. I know when I spoke to General Hastings on this telemedicine, what is happening and what his goals are in the future, being just recently appointed, he's mentioned that we've got to get this telemedicine to the other islands so that we can take care of our veterans. I hope on his behalf, that really will be an integral part and something that happens very, very quickly.

I'd like to just—we're a little bit separate from what we said here, and that is I think all of us have to continually address the issues of veterans and what care they're getting. For all of you here, you know exactly what we're talking about. But to you, Senator Akaka, it always comes down to a matter of money. If we can get the money or if VA can get the money, they can do their job. There's only so much they can do based on the amount of money that they have. That becomes the issue.

So for all of you here, thank you very much for supporting the veterans. That completes my testimony, Senator Akaka.

[The prepared statement of Colonel Cruickshank follows:]

PREPARED STATEMENT OF COLONEL EDWARD CRUICKSHANK (RET.), DIRECTOR, OFFICE OF VETERANS SERVICES

Chairman Craig, Senator Akaka and Members of the Senate Committee on Veterans' Affairs, I am Edward Cruickshank, Director of the Office of Veterans Services, this office serves as the single office within the State Government responsible for the welfare of Veterans and their family members. We act as a liaison between the Governor and veterans groups and organizations and serve as an intermediary between the Department of Veterans Affairs and Hawaii's veterans. Based upon veteran's population estimates as of September 30, 2004, data from the Office of the Actuary, Department of Veterans Affairs, there are 107,310 veterans in Hawaii. The majority or 72 percent live on Oahu, 13 percent reside on the island of Hawaii, 10 percent live on one of the three islands which comprise Maui County, and approximately 5 percent live on Kauai. We are an island state located in the middle of the Pacific Ocean and Hawaii presents unique challenges for the Department of Veterans Affairs.

Before I discuss some of these challenges, I want to share with you comments that my staff and I hear about VA health care very frequently. These comments speak

to the excellence of VA care, how VA's staff treat our veterans with dignity and respect, and that the services rendered by the dedicated health care professionals is superior to the care they received on the mainland (that is the continental United States). These comments are shared with us by local veterans as well as by veterans who visit Hawaii and have a need to interact with Spark M. Matsunaga Medical staff. When you speak of an organization that supports our troops, the VA exemplifies that phrase by supporting our troops at home, when they return and after conclusion of their military service. I am delighted with the services that VA offers to Hawaii's veterans, to include the health care, benefits, and services provided at the National Memorial Cemetery of the Pacific; locally known as the Punchbowl Cemetery.

As mentioned earlier Hawaii presents challenges to the VA. We are an island state with one large population center on Oahu and 30 percent of veterans living on the neighbor islands. Presently many of our veterans are referred for surgical services to mainland VA medical centers. For neighbor island veterans this can be very traumatic. They are booked on flights, sent to a city on the mainland, find the VA facility, operated on and sent back to Hawaii. We ask that: those who reside on neighbor islands that have direct flights to the mainland be offered, at a minimum, return flights that do not require a stop in Honolulu but fly directly to their island of residence. Individuals who are recovering from surgery are further inconvenienced by a delay in route because they were not booked on a direct flight. This delay increases the time these individuals endure pain and discomfort. Direct booking is available, we ask the VA to make this option a standard.

Another issue that affects Hawaii and Alaska involves changes that were made to 38 U.S.C. 1151, Benefits for persons disabled by treatment of vocational rehabilitation. With the change the only facilities covered by the law are those over which the Secretary of Veterans Affairs has direct jurisdiction or Government Facilities contracted by the Secretary. Tripler Army Medical Center and other medical facilities in Hawaii, such as Straub, Queens and St Francis do not qualify. This means that in the unlikely event that a veteran is disabled or their death is caused by hospital care, medical or surgical treatment, or examination in any medical facility that VA refers the veteran to in Hawaii, he or she will not be covered under 38 U.S.C. 1151. The definition as listed in 38 U.S.C. 1701 (3), of who is covered by the law should be changed so that veterans in Hawaii are afforded the same protection as veterans who receive VA medical care in VA facilities on the mainland. Hawaii's veterans must have the same right of redress as veterans treated at mainland VA facilities. They too must be able to apply for and be granted compensation for injuries and not forced to pursue legal action against the facility. Only a modification of the law can address this issue. We ask the Committee to consider including VA referrals to medical facilities that provide surgical and medical treatment in Hawaii and Alaska under 38 U.S.C. 1701(3).

Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu. Presently neighbor island veterans wait long periods to be scheduled for specialty medical care. With the use of Tel-a-medicine, this problem is being addressed, never the less, implementation has been slow. Veterans have been known to wait several months before they see a specialist. We can and must do better in supporting these veterans. Additionally, VA should consider contracting dental care on the neighbor islands. With rising airline fairs, contract dentist may save veterans time and the VA much needed dollars that can be reallocated to other needed medical services, such as orthopedic or mental health services.

As you are aware, Hawaii will be receiving thousands of its returning National Guardsmen and Reservist. As Director of the Office of Veterans Services and a Vietnam combat veteran I want these returning military members to be able to access medical and benefit services in a timely manner. We ask that VA Health and Benefits Administration be adequately staffed to provide medical care and benefit services to all veterans who make Hawaii their home. I know this involves dollars, however, as an organization that supports our veterans, we must acquire funds to complete the job. We must take care of our veterans. We must continue to support our troops, our veterans, and our citizens—after all they are our most Patriotic Americans.

I thank the Committee for this opportunity to speak on this matter and I will respond to any questions that you may have.

Senator AKAKA. Thank you. Thank you very much for your testimony. We just heard from our VSOs, and I have some questions for you.

This first question is to the whole group. I'm very concerned about VA's inquiry to post-traumatic stress disorder claims, and I mentioned that. I personally saw the level of aggravation that this review caused our veterans, and I heard from you, many of you from Hawaii.

I ask all the members, and we'll go down the line again, members of the panel, whether you're familiar with the PTSD review that was recently called off by the Department of Veterans Affairs, and for you to tell me about the impact the review had on you and any fellow members that you may be in contact with.

Let's begin with William Daves.

Mr. DAVES. I'm also a service officer for the Fleet Reserve Association, and I help veterans with their claims. It would have had a deep impact on all of us service officers because it put the claims process back a ways.

Right now I think most of the claims are done within 200 days or less. If they had to review all of those cases, it would have put the claims that are now going into the mill back. We don't need that, sir.

Mr. MCCLOSKEY. Thank you, Senator. I'm a little bit more of a unique bird here than most of you. I actually did the job of doing claims at the VA for many years. My boss will sit up here and tell you how bad or how good I was.

But I can tell you that if I was sitting in my old job as a decision review officer and I was faced with these reviews, it would be a nightmare. It would be an absolute nightmare because I know that almost every one of these cases we would lose subsequently in court. It would be all done for naught. The VA generally does a very good job rating cases. If they're given the facts, they're going to rate the case properly in most cases.

My big problem with this, though, really, is the impact that it had on every veteran who suffers from PTSD in this country. When that word went out, I got literally hundreds of phone calls in my capacity as an American Legion service officer. I had people coming to my office: What are they doing to me? I won't be able to feed my family. I won't be able to do this. I won't be able to make my mortgage payments.

I left concerned. But then I got real concerned when mental health care professionals that work for the VA, and I won't name them, started calling me saying, Hey, what's going on? Do you know anything about this? Because my patients are coming in really freaked out.

Then, slowly, people started coming in to me saying, You know, if this happens, what do I do? It tripled my workload for about 3 months. I'm sure that it created nightmares for many of the folks over here at the VA also.

To me, especially during a time of war, Senator Akaka, it is absolutely unconscionable that we would try to do something like this. I'm a Vietnam veteran. My father was a World War II veteran. I have a son who's a combat infantryman in the 100th Battalion. He's coming home this week. If they treated me like that, I can imagine how I would feel, or some member of my family.

We appreciate whatever pressure you put on the VA. I know it wasn't the folks sitting here that were trying to do it. It was some

bean-counter in Washington that was trying to save some money. It's sad, and it hurt, and we can't let it happen again. Thank you very much.

[Applause.]

Master Chief HOUGH. I concur with my good friend there, Mike McCloskey. These are traumatized war veterans. These people, men and women who served our country, did their very best for us. We rated them and adjudicated their claim. The VA Inspector General did not find any fraud. So if there's any fault, it lies with the system itself.

Perhaps the internal controls of the VA in the rating of compensation needs to be strengthened at the national level. But it's certainly not the fault of our veteran. Our veteran got the rating, and to take somebody away from somebody, as Mike said, would cause not only an emotional breakdown, but human tragedy. We just don't want to see that.

There's another thing that I'm little concerned with, Senator, is that there's a study the VA has a big panel going on now for a year studying compensation. One of the recommendations was to give a lump sum payment to those veterans with a lesser degree of disability, such as 10 to 30 percent.

This too is unconscionable because as we know, as we grow older we're going to have problems. This is essentially saying, hey, here's a wad of money, and don't come back and bother us.

I know that the veterans organizations are adamantly opposed to this, and I hope that you could do your best for us to make sure that our veterans are treated with the dignity and respect they deserve for their efforts. Thank you.

[Applause.]

Colonel CRUICKSHANK. I'm just going to simply say I'm glad that issue is not being readdressed again. I go along with Mike that it's been done. Let's just move on.

Mr. ROSS. I have two perspectives on that. The first one is that really it's not over. The Institute of Medicine, as we know, has been contracted by the Department of Veterans Affairs—not the people sitting here, their bosses—to go ahead and look at the vet condition of post-traumatic stress disorder and determine whether or not that particular definition that is medically looked at right now as the standard—because it's in the Diagnostic and Statistical Manual No. IV–R—and determine whether or not they should have a new definition for our veterans so that we can in fact not grant so many of these benefits.

Now, we're talking money here. This is the problem. We're talking money. We don't talk money when I ask you—because many of us were—asked to go off to fight in a war. We were picked up and they said, now, of course, it's very different because you get a chance to volunteer. But I'm holding up where I wasn't asked. It was a question of saying, when are you going to go fight or join the military? Because it's coming up and your draft number is coming up and you need to go in sooner or later.

Now the question is that since we never talk about, when we start these wars, how much it's going to cost, we do start talking about what is it costing us now that we've started it.

Well, it's going to cost us some damages. We've got people who come back with broken arms, shot arms, damages not only to their physical self but also to their bodies. Why is it that because someone who has a mangled hand that is so evident for everybody to see should be treated so much differently from an individual who has a mangled brain and because it's not so noticeable?

I have another question for people who are considering this. We have individuals in the military who have come from all walks of life. Some of them have been choirboys. Some of them have served in the church. Then we sent them off to war. They've seen the horrors of war, and then they come home and they have post-traumatic stress disorder.

What kind of country would we have if we could send our people off and have them see the horrors of war and come back and have no problems? Wouldn't we be a little bit more concerned with those kinds of individuals because of what they have done and seen, and now are able to just walk off and have no feelings or emotions about what they saw?

I say that we are in fact extremely lucky to have a country that's concerned about those individuals that we ask to do our bidding, and that we need to in fact continue what the VA says: Care for him or her who has borne the battle. Thank you very much.

[Applause.]

General RIENZI. Tom Rienzi again. I served in eight wars in 37 years in the Army, and no shell-shock. It's been around, and we're going to have a lot more of it. I don't think, Senator Akaka, that what we all talked about, and Secretary Nicholson talked about and before him—I don't think we—I have not seen any strategic plan or major plan that's going to care for these many, many, many, many people that will have the head problems.

I think we can all know here that because of these shell-shocked—and that's a better term for me—coming back, we're going to have a lot of problems. So we need the money. But the VA should be prepared for an awful lot of head problems.

May I suggest that somehow, in your strategic plans, you think it through better than just this group here because I don't think you have. Not that you're indifferent to it or not that—but it's going to be one hell of a big problem for these shell-shocked folks that are coming back. I hope we can put it in your strategic plans how to care for this head problem, which is a big one.

Thank you very much, Senator Akaka. Thank you.

[Applause.]

Senator AKAKA. Thank you very much, General. I want to thank this panel for their mana'o and their responses. I want to say at this point that the VA did withdraw the review that we're all talking about, and it has made such a big difference. But I wanted to know how our folks felt about that, and you've heard them do that.

My next question to all of you again, in order, is what are some of the unique problems that veterans face in Hawaii? There are so many different ways.

I want to thank the panel for mentioning how well they feel the VA is doing. They are, you know, trying their best to do it whatever limits they have. But they are serving our veterans.

I'd like to hear from you about what unique problems veterans face in Hawaii. Second part—where do you see room for improvement, for improvement in services for veterans? So I don't want you to tell me only your problems, but also to tell me how we can fix it. We look forward to that.

Mr. DAVES. I think the VA needs to have more people, more raters, more DROs, more veterans in positions that understand what veterans go through in battle and et cetera. That's exactly what we need, is more people.

Mr. MCCLOSKEY. Thank you, Senator Akaka. To mention a unique problem, we have a couple. Our geographical separation, of course, from the mainland and the separation of our islands and how our veteran population is spread out are rather unique.

I think somebody mentioned a guy in Utah may have to drive 200 miles. But most folks can get that 200 miles. Even if you're pretty old, you can usually get your kids or somebody to drive you. You can't drive to Molokai from here. You just can't do that. It's a real problem. Money will help.

Another unique problem we have here, I believe, and I think most of the VA folks that work here will agree, it's very difficult for us to access specialists. Specialist care for veterans themselves, specialists to do specialist exams that are required for certain cases that are before the Board and the DROs. It boils down again, I think, to money and time.

When we ask these doctors to do this, especially for an exam for a claim, typically that doctor has to spend a couple of hours reviewing a case, then do an examination, provide a report to the VA—in a timely basis, by the way, I might add—but the VA doesn't pay them very much for this. I'm trying to—off the top of my head, $150, I think we used to pay the specialist for an exam. That may have gone up some. That is one of our big problems, I think, here.

If we had a better way of handling specialists—maybe it's getting our own specialists here to do these things. I remember we had big cardiovascular problems, cardiovascular examination problems, ophthalmologists. Some of these may have been helped in the last year or resolved in the last year or so because I know we've added some specialties in the clinic. But I'm certain that it's still a problem.

Bill Daves brought up the issue of CHAMPVA. I don't think again we really understood what he was talking about. CHAMPVA is a program that the VA has that's intended for indigent people who are DIC recipients. These are men or women who are receiving dependency indemnity compensation benefits. They have no other access to healthcare through any other source.

So the CHAMPVA provides them a system kind of similar to TRICARE to get their medical care. Here in Hawaii, we have, that I know of, two doctors and no pediatricians. There are a number of people here in Hawaii who are eligible for this program.

If they're eligible for CHAMPVA, they cannot get QUEST. So it really locks those people out. I know it's not a large population. We're only talking about maybe a dozen people, 20 people, on Oahu. But for those 10 or 20 people, this is a major problem because they can't get medical care for their children and they can't get medical care for themselves on a timely basis. I think, again,

this is a matter of how much are we willing to pay these doctors to get involved with the CHAMPVA program.

That's all I have, Senator. Again, thank you very much.

Master Chief HOUGH. Senator Akaka, it's my feeling that Hawaii and Alaska are being penalized because we don't have a full-scale Department of Veterans Affairs hospital here. I saw the workings of a VA hospital when my son was in Oregon, and they are teamed with the Oregon Health Sciences University, and it's amazing to see the resources available and the teamwork.

I know we're teamed with the Army. But again, if we team up a lot with the Army, then that means that probably retirees and soldiers are going to be penalized because there's not room for everything.

We simply need a steady stream of funding to come up with innovative new ways to provide the healthcare that our veterans need here in the State. If you look at this State and compare it to like Wyoming or Vermont, they have a full-scale VA hospital. But we don't, and Alaska doesn't.

I think that if anybody was to make an analysis of the money spent in Hawaii on VA projects as opposed to some of these other States, you will see that we're not getting our fair share. Thank you very much.

Colonel CRUICKSHANK. You know, we're going around the panel but we all feel the same way. For me, again, it's the geographical distance, the specialty care. I know for my office, to get off the track a little bit, my office has been inundated with veterans because VA can't take care of the workload.

Because of that, I'm going to the Legislature this year to request for another counselor for my office to better service our veterans. When our troops return, and they'll be coming back this week, it's not going to be a matter of overtime to service them. What we're going to do is to ensure that our troops are serviced properly.

Our additional counselor will be flying to the neighbor islands whenever the counselor on that island is out of the office on sick or vacation leave.

When the 100th Battalion returns and gets ready to fly back to American Samoa, Guam and Saipan, we are going to make sure we fully service them before they leave for their homes.

Mr. ROSS. Thank you very much, Senator Akaka. Unique problems. One of the unique problems that we have in Hawaii is that we have cultural differences. We kind of talk in America about cultural differences. Since I'm the only guy up here who looks different, I can talk about this.

[Laughter.]

Mr. ROSS. Everybody in America is not the same. That means when we start sitting around and talking to the psychologist about things like post-traumatic stress disorder, that's really good for those individuals that grew up in a culture that allows you to talk about mental health problems.

In Hawaii, we have many cultures that do not talk about mental health problems. What happens? Those individuals are short-shifted because someone says, "Well, how do you feel about that?" The therapists looks at them straight in their eyes and the person kind of puts their head down because that's culturally correct in their

culture. Of course, someone else misinterprets it, and the guy says, "I'm all right."

They're not all right, and they're telling you that by their body language, which shows that they're not all right. But we have a talk culture. So those individuals who receive mental health care do in fact have an extra barrier because of the cultural differences that exist.

Another thing, is the access. When we have individuals who are located on a neighbor island, in rural areas, who cannot receive the same quality of care, we do have access problems. We need to address that, and I'm happy that the VA is spending a lot of money on telemed and other kinds of things to address that.

We also need, you know, additional staffing to make sure that those individuals who are rating the cases that come through our VA facilities here are culturally sensitive to what they're rating. When we send cases off to other places and they read and they see what the person is saying, or, even worse, when they look at the transcript and they can't read the transcript because the guy's speaking pidgin, we really do have an issue.

We need to make sure that we do have people in Hawaii—because we all grew up speaking pidgin—who can understand some of the differences that we have and be willing to address those differences through appropriate care. Thank you.

[Applause.]

General RIENZI. I'll just take up the specific, and I hope you write a note, Senator Akaka. Two years ago, there weren't any clinics at all on the outer islands for veterans. Through a big fight—or not fight, lots of hard work—we now have CBOCs, clinics, except Molokai. Probably some of the biggest PTSD problems are on Molokai.

I would hope you'd write a note there: Molokai CBOC clinic within—by 1907. I mean, some of the worst problems are there. The rules sort of keep us from getting there, and they have to go Lanai or Maui or come over here. We should get a storefront and a nurse, and we have one doctor there that we've been able to hire that does it out of his office. But Molokai needs some specific help. I hope you write down: Molokai CBOC. Thank you very much.

[Applause.]

Senator AKAKA. Thank you. I want to thank all of you for your input. That was my final question. I have other questions for this panel, but I'm going to submit the questions for the record to all of you.

I want to thank you for your testimonies here. You have highlighted, as we wanted, some key issues that we will look at with VA. I especially appreciate the insight provided regarding the need to address culture because culture in Hawaii in particular is very, very important. This is why I'm so happy that we're paying attention to culture in Hawaii in trying to help our veterans here.

General Rienzi, we're working on a satellite clinic for Molokai and Lanai. Thank you very much.

[Applause.]

Senator AKAKA. We are working on that, and we hear you, all of you. I thank you again so much. I thank you for your testimony today. Thank you.

I'd like to call up the next panel. Diana M. Rubens, Director, Western Area Office, Veterans Benefits Administration. She will be accompanied by James Carilli, Acting Director of the Honolulu regional office. Stephen Molnar, M.S.W., Team Leader, Honolulu Vet Center.

Fred Gusman, M.S.W., Chief Operating Officer, Pacific Islands Division, National Center for PTSD. Alfred Wylie, Public Relations Coordinator, Vietnam Veterans of America. T. Samuel Shomaker, M.D., J.D., Interim Dean, John A. Burns School of Medicine, University of Hawaii at Manoa. Dr. Shomaker will be accompanied by Haku Kahoano, a 4th-year medical student at the John A. Burns School of Medicine, University of Hawaii.

I look forward to your testimony on some of these issues that are pressing for all of us. So I'd like to begin this panel with Diana Rubens.

STATEMENT OF DIANA M. RUBENS, DIRECTOR, WESTERN AREA OFFICE, VETERANS BENEFITS ADMINISTRATION; ACCOMPANIED BY JAMES CARILLI, ACTING DIRECTOR, HONOLULU REGIONAL OFFICE

Ms. RUBENS. Thank you, Senator Akaka. I appreciate the participation of all the veterans and the service organizations today, and the opportunity to appear here on behalf of the Veterans Benefits Administration to provide you some information on the response to the needs of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. I am accompanied today by Mr. Jim Carilli, the Acting Director of the Honolulu regional office.

Veterans returning from Iraq and Afghanistan are eligible for an array of benefits offered through VBA. These include disability compensation and related benefits; educational and training benefits; vocational rehabilitation and employment benefits and services; home loan guarantees; life insurance; burial benefits; and the dependents and survivor benefits.

The VA Honolulu regional office serves an estimated veteran population of more than 107,000 veterans in the State of Hawaii. Of the 21,842 veterans, surviving spouses, and surviving children who receive VA benefits each month, 16,754 are service-disabled veterans. In addition, the regional office effectively participates in numerous outreach activities to inform and assist returning servicemembers who are soon to be released from active duty.

For those separating servicemembers, the Honolulu regional office Veterans Service Center has a designated Military Services coordinator who performed many of the outreach functions to those returning servicemembers.

The service coordinator conducts regular briefings covering the full range of VA benefits as part of the military Transition Assistance Program at various military installations in Hawaii. A Veterans Service Representative is also outbased in Guam to provide those same TAP briefings there.

Each month there are 4 TAP briefings at Schofield, 3 at Pearl Harbor, 2 to 3 at the Marine Base in Hawaii, and once a month at Hickam, Anderson Air Force Base in Guam, and the Guam Naval Station. There's also a briefing every 3 months at the Coast Guard facility at Sand Island, Hawaii.

In addition, the military service coordinator conducts briefings for members of the Army or Navy being discharged for medical disabilities. This briefings, which are part of the Physical Evaluation Board orientations, are conducted three or four times each month at Pearl Harbor Naval Regional Medical Center and at the Tripler Army Medical Center.

During the past fiscal year, in 2005, the Honolulu regional office conducted 219 separate briefings, reaching over 4,500 active duty servicemembers and spouses in Hawaii and Guam. A total of 623 servicemembers were interviewed following these briefings for personnel information. Activity was especially heavy during this past January through June of 2005, when a large contingent of the 25th Infantry Division returned from deployment. Already in fiscal year 2006, the Honolulu regional office has conducted 48 military briefings for over 1,200 servicemembers and conducted 98 post-briefing interviews with active duty servicemembers.

For our National Guard and Reserve members, the regional office here provides the veteran benefits briefings to those as part of the Army Deployment Cycle Support program to reorient servicemembers returning from Iraq and Afghanistan. All attendees receive a copy of our pamphlet, "A Summary of VA Benefits," as well as a VA Health Care and Benefit Information for Veterans wallet card.

Briefings are scheduled on demand based on the dates of return of the various units. The Honolulu regional office anticipates conducting numerous briefings in January and February of this year when an estimated 2,100 servicemembers are expected to return to Hawaii.

In addition, Veteran Service Center staff provide individual case management for our seriously disabled OIF/OEF veterans. The Honolulu regional office receives periodic referrals from Tripler social workers about the seriously disabled OIF/OEF servicemembers and assists with the appropriate applications. Acting Director Carilli personally meets with all the OIF/OEF soldiers who visit the regional office to assure them that VA will provide them the best possible service. Each month, the Honolulu regional office follows up by calling each servicemember to ensure that their claims are being processed expeditiously.

Additionally, the regional office gets immediate information about returning disabled soldiers who are likely to be eligible for compensation or other benefits, and the veteran service staff either visit these servicemembers at the Deployment Health Center or during medical hold or medical board briefings.

Our Vocational Rehabilitation and Employment Division at the regional office works closely with the Tripler Army Medical Center inpatients, National Guard members, and Reservists to make sure the patients receive information about the vocational rehabilitation and employment program. When appropriate, they also refer patients to the Honolulu regional office for assistance with their disability claims.

The Tripler Army Medical Center has created a special Deployment Health Center to assist returning Reservists and Guard members. It is staffed by professional treatment providers and caregivers, as well as a VA Employment specialist from the Hono-

lulu regional office. The VA Employment specialist sees 3 or 4 servicemembers a week at the Deployment Health Center and makes referrals accordingly. Some recuperating soldiers have been referred to the local Disabled Veteran Outreach Program for employment briefings as part of the Department of Labor ReaLifelines Program.

The VR&E program provides ongoing monthly briefings at Disabled Transition Assistance Program sessions at Pearl Harbor Naval Base and Schofield Army Barracks.

The VA's liaison to the Department of Labor's Disabled Veteran Outreach Program, who is co-located in the regional office VR&E Division, regularly meets with all medical hold servicemembers and special services liaisons to provide job-finding assistance.

The Schofield Barracks Army Base established a Soldier and Family Assistance Center to provide one-stop service for returning servicemembers and their families. Our VR&E personnel, along with VA Mental Health Clinic personnel, participate in this program.

Our home loan guarantees activities here in Hawaii. With the increasing activation of those Reservists and National Guard, these servicemembers are becoming eligible for VA home loans faster and in greater numbers than they would have had they not been activated. Instead of the time-in-service requirements of 6 years as a member of the Reserves or National Guard, these active duty personnel and veterans become eligible for benefits under the Loan Guaranty and Native American Direct Loan programs after having 90 days or more of active wartime service. As a result, VBA anticipates there will be an increase in eligible veterans applying for VA loan guaranty benefits through both the Loan Guaranty Program and the Native American Direct Loan Program.

Further, as a result of Public Law 108–454, veterans will be eligible for VA guaranteed loans equal to the Freddie Mac conforming loan limit. As of January 1, 2006, that rate increased to $625,500 for the high cost areas such as Hawaii and Guam. We anticipate that this will make VA guaranteed home loans much more attractive to the veterans here.

Moreover, assuming that pending legislation is passed making the Native American Direct Loan Program permanent, the very important housing benefit will be continued for many returning minority veterans in Hawaii and the Pacific U.S. Territories.

Ranking Member Akaka, I hope this testimony has given you and the Members of the Committee a better understanding of the benefits, services, and outreach that VA is providing to veterans of the OIF/OEF conflicts. I assure you that the Honolulu regional office is ready and eager to serve the men and women coming home to Hawaii and the Pacific.

This concludes my testimony. Mr. Carilli and I will be pleased to answer any questions you might have.

[The prepared statement of Ms. Rubens follows:]

PREPARED STATEMENT OF DIANA M. RUBENS, DIRECTOR, WESTERN AREA OFFICE, VETERANS BENEFITS ADMINISTRATION

Senator Akaka, I appreciate this opportunity to testify today on the Veterans Benefits Administration's (VBA) response to the needs of veterans returning from Oper-

ation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). I am accompanied today by James Carilli, Acting Director of the Honolulu Regional Office.

Veterans returning from Iraq and Afghanistan are eligible for a full array of benefits offered through VBA. These include:

- Disability Compensation and Related Benefits;
- Education and Training Benefits;
- Vocational Rehabilitation and Employment Benefits and Services;
- Home Loan Guaranties;
- Life Insurance;
- Burial Benefits; and
- Dependents' and Survivors' Benefits.

The VA Honolulu Regional Office serves an estimated veteran population of more than 107,000 veterans in the State of Hawaii. Of the 21,842 veterans, surviving spouses, and surviving children who receive VA benefits each month, 16,754 are service-disabled veterans. In addition, the Regional Office effectively participates in numerous outreach activities to inform and assist returning servicemembers who are soon to be released from active duty.

SEPARATING SERVICEMEMBERS

The Honolulu RO's Veterans Service Center has a designated Military Services Coordinator (MSC) who performs many of the outreach functions provided to returning servicemembers. The Military Services Coordinator conducts regular briefings covering the full range of VA benefits as part of the military Transition Assistance Program (TAP) at various military installations in Hawaii. A Veterans Service Representative is also outbased in Guam to provide TAP briefings there. Each month there are four TAP briefings at Schofield Barracks; three at Pearl Harbor Naval Base; two or three at Marine Base Hawaii; and one a month at Hickam Air Force Base in Hawaii, Anderson Air Force Base in Guam, and Guam Naval Station. There is also a briefing every 3 months at the Coast Guard facility at Sand Island, Hawaii. In addition, the military service coordinator conducts briefings for members of the Army or Navy being discharged for medical disabilities. These briefings, which are part of the Physical Evaluation Board orientations, are conducted three or four times each month at Pearl Harbor Naval Regional Medical Center and Tripler Army Medical Center.

During fiscal year 2005, the Honolulu Regional Office conducted 219 separate briefings reaching over 4,500 active duty members and spouses, in Hawaii and Guam. A total of 623 servicemembers were interviewed following these briefings. Activity was especially heavy during January through June 2005, when a large contingent of the 25th Infantry Division returned from deployment. Already in fiscal year 2006, the Honolulu Regional Office conducted 32 military briefings for 845 servicemembers and conducted 98 post-briefing interviews with active duty servicemembers.

MEMBERS OF THE NATIONAL GUARD AND RESERVES

Honolulu's Veterans Service Center staff provide VA benefit briefings to National Guard members and Reservists, as part of the Army Deployment Cycle Support program to reorient servicemembers returning from Iraq and Afghanistan. All attendees receive a copy of the VA pamphlet, A Summary of VA Benefits, as well as the VA Health Care and Benefit Information for Veterans Wallet Card. Briefings are scheduled on demand based upon the dates of return of the various units. The Honolulu Regional Office anticipates conducting numerous briefings in January and February 2006 when an estimated 2,100 servicemembers are expected to return to Hawaii.

In addition, Veteran Service Center staff provides individual case management for seriously disabled OEF/OIF veterans. The Honolulu Regional Office receives periodic referrals from Tripler Army Medical Center social workers about seriously disabled OEF/OIF servicemembers. The Military Services Coordinator provides a comprehensive briefing on VA benefits and assists with appropriate applications. Acting Director Carilli personally meets with all OEF/OIF soldiers who visit the Regional Office to assure them that VA will provide them the best possible service. Each month, the Honolulu Regional Office follows up by calling each servicemember to ensure them that their claims are being processed expeditiously.

In addition, the Regional Office gets immediate information about returning disabled soldiers who are likely to be eligible for VA compensation or other benefits. Veteran Service Center staff either visit these servicemembers at the Deployment Health Center or during "Medical Hold" or "Medical Board" briefings.

VOCATIONAL REHABILITATION & EMPLOYMENT ACTIVITIES

The Vocational Rehabilitation and Employment (VR&E) Division at the Honolulu Regional Office is working closely with Tripler Medical Army Center inpatients, National Guard members, and Reservists to make sure patients receive information about the Vocational Rehabilitation and Employment Program. When appropriate, they also refer patients to the Honolulu Regional Office for assistance with their disability claims.

The Tripler Army Medical Center has created a special Deployment Health Center to assist returning Reservists and National Guard members. It is staffed by professional treatment providers and caregivers, as well as a VA Employment Specialist from the Honolulu Regional Office. The VA Employment Specialist sees three or four servicemembers a week at the Deployment Health Center and makes referrals accordingly. Some recuperating soldiers have been referred to the local Disabled Veteran Outreach Program (DVOP) for employment briefings as part of the Department of Labor's Recovery & Employment Assistance Lifelines (ReaLifelines) Program.

The VR&E Division provides ongoing monthly briefings at Disabled Transition Assistance Program (DTAP) sessions at Pearl Harbor Naval Base and Schofield Army Barracks.

VA's liaison to the Department of Labor's Disabled Veteran Outreach Program, who is co-located in the Regional Office VR&E Division, regularly meets with all "Medical Hold" servicemembers and special services liaisons to provide job finding assistance.

The Schofield Barracks Army Base established a Solider and Family Assistance Center to provide one-stop service for returning servicemembers and their families. VR&E personnel, along with VA Mental Health clinic personnel, participate in this program.

HOME LOAN GUARANTY ACTIVITIES

With the increasing activation of Reservists and National Guard, these servicemembers are becoming eligible for VA home loan benefits faster and in greater numbers than they would have had they not been activated. Instead of the time-in-service requirement of 6 years as a member of the Reserves or National Guard, these active duty personnel and veterans become eligible for benefits under the Loan Guaranty and Native American Veteran Direct Loan Programs after having 90 days or more of active wartime service. As a result, VBA anticipates that there will be an increase in eligible veterans applying for VA loan guaranty benefits through both the Loan Guaranty Program and Native American Direct Loan Program.

Further, as a result of P.L. 108–454, veterans will be eligible for VA guaranteed loans equal to the Freddie Mac conforming loan limit. As of January 1, 2006, that rate increased to $625,500 for high cost areas such as Hawaii and Guam. VA anticipates that this will make VA guaranteed home loans much more attractive to veterans.

Ranking Member Akaka, I hope this testimony has given you and the Members of the Committee a better understanding of the benefits, services, and outreach that VA is providing to veterans of the OEF/OIF conflicts. I assure you that the Honolulu Regional Office is ready and eager to serve the men and women coming home to Hawaii and the Pacific. This concludes my testimony. Mr. Carilli and I will be pleased to answer any questions you might have.

Senator AKAKA. Thank you very much.

Stephen Molnar.

STATEMENT OF STEPHEN T. MOLNAR, M.S.W., TEAM LEADER, HONOLULU VET CENTER

Mr. MOLNAR. Aloha, Senator Akaka, fellow veterans, families. It is an honor to have this opportunity today to testify at these important congressional hearings on "The State of VA Care in Hawaii." I still vividly recall when I had testified before you at the Senate Veterans' Affairs Committee hearings in Washington, DC back in 1993 to address the concerns about VA mental health programs.

As a result of those hearings, much changed in Hawaii. Public Law 104–262 was passed in 1996, thereby expanding eligibility for

Vet Centers and authorizing the extension of readjustment counseling to all combat veterans and their families. This landmark legislation made it possible for combat veterans and their families to receive free counseling in convenient locations at 207 Vet Centers nationwide.

More importantly, though, it helped to eliminate the stigma that is often associated with seeking help for mental health care. This law was a critical step toward the development of seamless and comprehensive care for our returning war veterans and their families.

At Vet Centers, veterans receive counseling for war-related issues, including post-traumatic stress disorder, in a comfortable community-based setting that is confidential, private, and, as I've said, without stigma or embarrassment. The law authorized the Vet Centers to provide family therapy as a core component of readjustment counseling.

As provided at Vet Centers, family counseling is available as necessary in connection with any psychological, social, or other military-related readjustment problem, whether service-connected or not. As a special authority in the law, veterans eligibility for readjustment counseling is determined solely by military service in a combat theater and does not require the veteran to go through any enrollment procedure.

Additionally, providing family services at Vet Centers is not time-limited but rather is available as necessary for the veteran's readjustment throughout the life of the veteran. The veteran's family members are included in the counseling process as necessary to address the whole range of family adjustment issues stemming from the military experience and post-military readjustment.

Early intervention by way of outreach and preventive family counseling services help returning veterans stabilize their post-military family and work lives, thereby reducing the risk of subsequently developing more chronic forms of PTSD and associated family problems.

As you know, Senator, I am one of the original hire in the Vet Center program. For over 25 years, I have had the honor and unique privilege of serving Hawaii's combat veterans and their families in the sometimes difficult readjustment process. The Honolulu Vet Center has served over 10,000 veterans and their families since opening in 1980. Our clients range in ages from 19 to 90, and reflect that diversity that distinguishes Hawaii from any other place in the world.

In addition to readjustment counseling for combat-related issues, the Vet Center provides assessment and counseling for PTSD, sexual trauma, family counseling, and employment. We provide services and referral to homeless veterans and do extensive outreach, education, and networking to ensure that veterans have access to comprehensive care and assistance within their community.

In 2003, the Secretary directed that Vet Centers be the focal point for delivery of bereavement counseling to families who lost a servicemember while on active duty. To date, we have provided 11 families with bereavement counseling and support. As you can imagine, these have been amongst our most difficult cases. The

pain of these families often runs deep. However, I know that our efforts have made a difference.

With the anticipated return of soldiers from Iraq and Afghanistan and the recent hiring of our OIF/OEF outreach worker, we expect our proportion of OIF/OEF clients to rise accordingly.

I would like at this point just to introduce our OIF/OEF counselor, Matthew Handelsford [ph]. He's in the back there.

[Applause.]

Mr. MOLNAR. He served in Iraq and he also served in Kosovo. We brought him on in November, and we're happy that he is back to outreaching and working with our returning soldiers.

While all clients are offered individual counseling at the Vet Center, we also provide group counseling. Group counseling is important. It's extremely effective therapeutically as well as it's an efficient way to deliver services. At present, we offer 10 different groups. Many of our groups are held in the evenings to better accommodate our veterans and their families.

As you know, Senator, Vet Centers are community-based counseling centers with a small core staff of only three or four employees. At the Honolulu Vet Center, we have four full-time staff: myself, the team leader; two counselors; and an office manager. In addition, we have a part-time sexual trauma social worker.

As I mentioned, in November we hired our recently returned Iraqi veteran to serve as our outreach specialist. His role will be to be the bridge, the conduct, for our returned OIF/OEF veterans and their access not only to Vet Centers but the VA and other community resources. In addition, we have augmented our Vet Center with a comprehensive employment program courtesy of the State of Hawaii Department of Labor Disabled Veteran Outreach Program. We have a full-time DVOP onsite. He provides veterans with immediate access to a full range of computerized job listings and placement services that are geared to the needs of our veterans.

I am deeply proud of our dedicated and committed staff, Senator. Through their efforts in serving Hawaii's veterans, our Vet Center has received both local and national recognition, and two of our counselors have been awarded the VA Secretary's prestigious "Hands and Heart" award for what they have done with veterans. I have no doubt that the staff will continue to provide the same level of dedication and commitment to ensuring that our returning OIF and OEF veterans receive the best possible care and support.

As you know, the 1996 legislation which I referred to expanded eligibility from a single group of war veterans to now all war zone veterans. This has resulted in a significant increase in eligible veterans without increased staffing. However, I'm glad to say recently VHA authorized 100 additional outreach specialists like Matthew, themselves veterans of OIF/OEF, to enhance the Vet Center program's ability to extend timely services to this new era of war veterans.

The dedication and can do attitude of the Vet Center staff will continue to ensure that combat veterans of all wars receive complete and comprehensive care and services. Similarly, the recent addition of bereavement services required a deep commitment of the staff to ensure that families were provided with immediate and

sensitive assistance as well as a full range of comprehensive services and care, which the staff undertook willingly.

The additional number of veterans who we anticipate may reside in Hawaii after discharge from OIF/OEF service will add to the Vet Center's demand. As a result, the role of the Vet Center will likely continue to be significant in providing for their readjustment needs.

In closing, I would like to again thank you, Senator, for this opportunity to be able to address those issues facing Hawaii's veterans, particularly those who have served in combat, as well as those still deployed in combat. Your willingness to identify the problems facing our veterans and their families, and your commitment to finding appropriate solutions, is deeply appreciated by all here.

Senator Akaka, this concludes my statement. I'll be glad to answer any questions that you may have. Thank you.

[The prepared statement of Mr. Molnar follows:]

PREPARED STATEMENT OF STEPHEN T. MOLNAR, M.S.W., TEAM LEADER, HONOLULU VET CENTER

Aloha Senator Akaka and other Members of Congress. It is an honor to have this opportunity today to testify at these important congressional hearings on "The State of VA Care in Hawaii." I still vividly recall when I had testified before you at the Senate Veterans' Affairs Committee hearings in Washington, DC in 1993 to address concerns about "VA Mental Health Programs." As a result of those hearings, Public Law 104–262 was passed in 1996, thereby expanding eligibility for Vet Centers and authorizing the extension of readjustment counseling to all combat veterans and their families. This landmark legislation made it possible for combat veterans, and their families, to receive free counseling in convenient locations at 207 Vet Centers nationwide. More importantly though, it helped to eliminate the stigma often associated with mental health care. Public Law 104–262 was a critical step toward the development of seamless and comprehensive care for our returned war veterans.

At Vet Centers, veterans receive counseling for war-related issues, including Post-traumatic Stress Disorder (PTSD), in a comfortable community-based setting that is confidential, private, and without stigma or embarrassment. The law authorized the Vet Centers to provide family therapy as a core component of readjustment counseling. As provided at Vet Centers, family counseling is available as necessary in connection with any psychological, social, or other military-related readjustment problem, whether service-connected or not. As a special authority in the law, veterans eligibility for readjustment counseling is determined by military service in a combat theater and does not require the veteran to go through the enrollment procedure. Additionally, providing family services at Vet Centers is not time limited, but rather available as necessary for the veteran's readjustment throughout the life of the veteran. Veterans' family members are included in the counseling process as necessary to address the whole range of family adjustment issues stemming from the veteran's military experience and post-military readjustment. Early intervention via outreach and preventive family counseling services help returning veterans stabilize their post-military family and work lives, thereby reducing the risk of subsequently developing more chronic forms of PTSD and associated family problems.

As you know Senator, I am one of the original hires in the Vet Center program. For over 25 years, I have had the opportunity and unique privilege of serving Hawaii's combat veterans, and their families, in the sometime difficult readjustment process. The Honolulu Vet Center has served over 10,000 veterans and their families since opening in 1980. Our clients range in ages from 19 to 90 and reflect the diversity that distinguishes Hawaii from any other place in the world. For example, 47 percent of our caseload is composed of Asian Pacific Islander veterans and a full two-thirds of our caseload lists their ethnicity as "other than Caucasian."

In addition to readjustment counseling for combat-related issues, the Honolulu Vet Center provides assessment and counseling for PTSD, sexual trauma, family counseling and employment. The Vet Center provides services and referral to homeless veterans and does extensive outreach, education and networking to ensure that veterans have access to comprehensive care and assistance within their community. In 2003, the Secretary directed that Vet Centers be the focal point for delivery of bereavement counseling to families who lost a servicemember while on active duty.

To date, we have provided 11 families with bereavement counseling and support. As you can imagine, these have been amongst our most difficult cases. The pain of these families runs deep. However, I know that our efforts have made a difference.

Our most recent annual workload data reflects that we have served 628 unique veterans, recorded 5,500 visits and opened 250 new cases. At present, the approximate breakdown of new clients who have served in a combat theater are 40 percent for Vietnam, 30 percent for WWII, 15 percent for OIF/OEF and 15 percent for Other Combat Ops. With the anticipated return of soldiers from Iraq and Afghanistan, and the recent hiring of our OIF/OEF outreach worker, we expect our proportion of OIF/OEF clients to rise accordingly.

While all clients are offered individual counseling, we also provide group counseling. Group counseling is an extremely effective therapeutic modality as well as an efficient one. At present, the Honolulu Vet Center offers 10 different groups. These include groups focusing on combat, sexual trauma, bereavement, family members, life skills, meditation, and POWs. Many of these groups are held in the evenings to better accommodate our veterans and their families.

As you know Senator, Vet Centers are community-based counseling centers with a small core staff of 3 or 4 employees. At the Honolulu Vet Center, we have four full-time staff: a team leader, two counselors (a social worker and psychologist) and an office manager. In addition, we have a part-time sexual trauma social worker. In November we hired a recently returned Iraqi veteran to serve as our outreach worker. His role is to be the bridge for our returned OIF/OEF veterans and their access to Vet Centers, the VA and other community resources. In addition, we have augmented our Vet Center with a comprehensive employment program through the State of Hawaii Department of Labor Disabled Veteran Outreach Program (DVOP). A full-time DVOP counselor out stationed onsite provides veterans with immediate access to a full-range of computerized job listings and placement services geared to the needs of veterans.

I am deeply proud of our dedicated and committed staff, Senator. Through their efforts in serving Hawaii's veterans, the Honolulu Vet Center has received both local and national recognition. Two of our counselors have been awarded the VA Secretary's prestigious "Hands and Heart Award" that is presented annually to an employee involved in direct patient care who does the most to exercise professional expertise, to provide emotional support, help and guidance to patients. I have no doubt that the staff will continue to provide the same level of dedication and commitment to ensuring that our returning OIF/OEF veterans receive the best possible care and support.

As you know, the 1996 legislation (Public Law 104–262) expanded eligibility from a single group of war veterans (Vietnam) to all war zone veterans. This resulted in a significant increase in eligible veterans without increasing staffing, and, recently, VHA authorized 100 additional outreach specialists, themselves veterans of OEF/OIF, to enhance the Vet Center program's ability to extend timely services to this new era of war veterans. The dedication and can do attitude of the Vet Center staff ensured that combat veterans of all wars received complete and comprehensive care and services. Similarly, the recent addition of bereavement services required a deep commitment of the staff to ensure that families were provided with immediate and sensitive assistance as well as a full-range of comprehensive services and care which the staff undertook willingly in a professional and compassionate manner. As already noted, with the increased success of our OIF/OEF outreach worker, we anticipate added demands will be placed upon our current counseling staff.

The additional number of veterans who we anticipate may reside in Hawaii after discharge from their OIF/OEF service will add to the Vet Center's demand. As a result, the role of the Vet Center will likely continue to be significant in providing for their readjustment needs.

In closing, I would like to thank you for this opportunity, Senator Akaka, to be able to address those issues facing Hawaii's veterans; particularly those who have served in combat, as well as those still deployed in combat areas. Your willingness to identify the problems facing our veterans, and your commitment to finding appropriate solutions is deeply appreciated.

Senator Akaka, this concludes my statement. I will be glad to answer any questions that you or other Members of the Committee may have.

Senator AKAKA. Thank you very much.

Mr. Gusman.

STATEMENT OF FRED GUSMAN, M.S.W., CHIEF OPERATING OFFICER, PACIFIC ISLANDS DIVISION, NATIONAL CENTER FOR PTSD

Mr. GUSMAN. Thank you, Senator Akaka.

Mr. Chairman, Senator Akaka, distinguished Members of the Senate Veterans' Affairs Committee, thank you for providing me the opportunity to come before you today to share with you insights and lessons learned from three decades of working with veterans and active duty personnel from all areas, and more recently those serving in OIF and OEF.

I am the Chief Operating Officer of the VA's National Center for PTSD, Pacific Islands Division, Hawaii, and the Director of the National Center for PTSD's Education Division in Palo Alto, California. It has been my privilege as a clinician, a clinical program developer, and a veteran to be part of the VA's primary effort to understand and treat combat-related stress and other medical and psychological co-morbidities affecting the men and women who have bravely served in our country's military. I have submitted my written testimony for the record.

I would like to now highlight some of the lessons learned from providing treatment to veterans who suffer from combat-related stress, and share with you some examples of how education can play an integral part in supporting the VA's mission to provide the best quality care to our Nation's veterans.

The VA is very familiar treating combat veterans from prior wars. As a result, the VA has been instrumental in developing a variety of therapies, assessment measures, treatment models, educational tools, and research related to combat-related stress and PTSD.

However, our servicemembers fighting in the wars in Iraq and Afghanistan present other unique factors that we need to incorporate into our current knowledge base. For example, their age range is 18 to 60 years. Women are a sizable segment of the force. Many more servicemembers are married with children.

In addition, a majority of the men and women in today's military have grown up in an age of great technological advances. This data would suggest that the current fighting force may be very different demographically from previous combat cohorts. As such, it may be necessary to deliver existing treatments using innovative formats that are easily accessible for both VA and DOD healthcare providers as well as the new warrior veterans and their families.

An example of such innovation is the VA's National Center for PTSD's Iraq War Clinicians Guide. Originally developed for VA providers, the guide was later revised by the National Center and the Army in order to make this information more relevant and user-friendly to military providers. In order to maximize accessibility, the guide was then distributed via CD–ROM and the internet.

The Marine Corps is also currently working with the National Center for PTSD to tailor a guide for the Navy and the Marine Corps personnel. This is another example of using technology that has been recent in application of tele-mental health care for the treatment of combat stress and PTSD by VA providers located in Honolulu and to neighboring islands.

The VA's National Center for PTSD's mission continued not only to develop a state-of-the-art in clinical treatments, but also to employ innovative platforms to widely disseminate and deliver their care. I think that for the VA in particular, providers education is a critical tool that can be employed to help bridge the gap between servicemembers in need and providers who can assess and address these needs.

In order to best serve our new warriors, we must further develop and provide ongoing state-of-the-art training and continuing education to VA personnel. This is a critical call because approximately 40 percent of the VA providers are nearly retirement age in this decade. This translates into current personnel who need to be updated with training specific to this new cohort and, perhaps even more importantly, new hires that will new to the VA, new to veterans, and certainly new to the provisions of services to our men and women of today's military.

It is possible that the future educational clinical treatment materials can be made available via files easily downloadable onto handheld devices such as iPods or MP3 players as a technology familiar to many of the new warriors. An example would be an Iraq veteran who receives an audio file on stress management to listen to on his MP3 player as part of the veteran's ongoing self-care program.

This type of innovative approach would make education materials available 24 hours a day, 7 days a week, to augment the existing therapies and be made widely accessible to treatment providers, veterans, soldiers, and their families.

In summary, I believe that the VA and the VA's National Center for PTSD have provided outstanding clinical care for veterans from previous wars as well from current conflicts in Iraq and Afghanistan. We look forward to continuing to collaborate with the Department of Defense as well as other Federal, State, and local community agencies to care for our veterans.

A fine example of this type of collaboration is the conference, Senator Akaka, that you have so willingly cosponsored last year and this year. The conference title, "Stress, Violence and Trauma: Providing Resiliency in Hawaii 2006." This is an example of collaboration between the VA, the State, and the community at large, and your office, and other supporters. It's a great example of how we can bridge the gap for our many returnees.

Senator Akaka, that concludes the remarks that I have today. Thank you.

[Applause.]

[The prepared statement of Mr. Gusman follows:]

PREPARED STATEMENT OF FRED GUSMAN, M.S.W., CHIEF OPERATING OFFICER, PACIFIC ISLANDS DIVISION, NATIONAL CENTER FOR PTSD

Thank you, Mr. Chairman and Members of the Committee. I wish to applaud the efforts by Members of the Congress and the Department of Veterans Affairs (VA) to address the healthcare needs of those service Members currently engaged in combat operations. Moreover, recent legislation to support additional mental health care programs throughout VA demonstrates leadership's support for quality care for the men and women who bravely serve in the United States military.

Thank you for the opportunity to appear before you today to discuss the role of the Department of Veterans Affairs and the National Center for Post-traumatic Stress Disorder (NCPTSD) in meeting the mental health care needs of veterans and

servicemembers returning from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). VA has performed a tremendous service to our country's soldiers and veterans through outreach programs designed to provide unprecedented access to care for those who have served.

My testimony today will focus on a number of topics, including (1) comparisons between veterans from previous combat and peacekeeping missions and the current cohort of OIF/OEF veterans; (2) lessons learned from working with veterans from these previous combat and peacekeeping missions; (3) an overview of collaborative educational and clinical initiatives between NCPTSD and DoD to support OIF/OEF servicemembers, veterans and their families; and efforts to provide education and training to the mental health community located on the Hawaiian Islands concerning stress, violence and traumatic stress. (4) anticipation of educational and clinical training needs to augment VA/DOD seamless transition process.

I. COMPARISONS BETWEEN VIETNAM VETERANS AND OIF/OEF VETERANS

During the last 30 plus years, VA and the National Center for PTSD have performed an outstanding service to this country's veterans by developing the best possible assessment and treatment protocols for combat related Post-traumatic Stress Disorder (PTSD). VA has provided outstanding and quality healthcare to thousands of veterans who bravely served their country in overseas wars for their emotional and psychological difficulties. As a result of this long standing commitment, accurate assessment tools and evidenced-based guidelines are now readily available for VA and DoD providers. As we move forward in this tradition to provide quality healthcare to our Nation's servicemembers and veterans, we need to recognize the importance to update and refine VA's models of care in order to best serve the next generation of American Veterans.

Most of what we know about the effects of traumatic stress, we learned from veterans from previous wars and peacekeeping missions (e.g., Vietnam, Somalia). We now face both a great challenge and opportunity as we translate our knowledge and clinical expertise, learned over the past 30 years, into evidenced based treatment for this current cohort of OIF/OEF veterans. We must appreciate both the differences and similarities between the previous generations of warriors with those serving in today's military.

PAST PERSPECTIVES: THE VETERANS OF THE VIETNAM WAR

Veterans of the Vietnam era cohort were a relatively homogeneous group: largely young males between the ages of 18–22 years old, single, drafted-active duty, and therefore in the relatively early stages of life development, and education, work, and career goals. Typically, they served a single 12–13 month deployment in country. Unlike those veterans of prior wars, those who returned from Vietnam faced a divided, and at times, hostile public. Unlike the experience of veterans of prior wars, few large scale homecoming ceremonies were offered to show support. In fact, veterans were often publicly scorned and society's negative stereotyping/stigmatizing often foretold a difficult and problematic readjustment/reintegration into society.

At first, a small percentage of Vietnam veterans accessed VA care. This may have been due, in part, to the lack of knowledge about the effects of combat stress on psychological adjustment following military service. Also, these veterans returned to a hostile and divided U.S. public who cast blame on the veterans as well as the government for the war. At that time, veterans may have avoided VA due to a fear of being labeled "crazy" or "mentally imbalanced."

CURRENT PERSPECTIVES: VETERANS/RETURNEES OF THE OPERATION IRAQI FREEDOM/OPERATION ENDURING FREEDOM (OIF/OEF)

Veterans and returnees of OIF/OEF and the Global War on Terror (GWOT) often return to supportive communities who express appreciation for their sacrifices—despite political divisions in our country about the meaning and purpose of these wars. The age range of these combatants is 18–60 years. Many servicemembers are married with children. Most of the Reserve and National Guard have jobs and careers at home. Currently, women constitute a significant segment of the combined forces approximately 10 percent, many of whom serve in leadership roles. Unlike those who served in previous combat theaters, those deployed in OIF/OEF are likely to have experienced deployments lasting longer than 12–13 months and significant numbers may have experienced repeated deployments.

In terms of assessment, diagnosis, and treatment, the field of PTSD is no longer in its infancy. We now have a body of knowledge that is replete with a variety of theories, assessment measures, treatment models, practical interventions, educational tools, and research findings in physiological, medical, psychological, and be-

havioral domains. Studies suggest that the great majority of current returnees, like those veterans of prior wars, experience the normal range of post-deployment adjustment reactions. Similarly, a smaller percentage develops PTSD as a result of their combat experiences. A recent study (Hoge, et al., 2004) in a sample of Army and Marines (n = 3,671) who served in Iraq and Afghanistan, indicates that post-deployment, approximately 12 percent met criteria for PTSD. Pre-deployment assessment found the rates for PTSD were very similar to those of the general population: 5 percent and 3–4 percent respectively. Collectively, 17 percent met criteria for PTSD, Depression, or Generalized Anxiety Disorder (GAD). Of those whose responses were positive for a mental disorder, 38–45 percent were actually interested in receiving help and 23–40 percent actually received help.

II. LESSONS LEARNED FROM RESEARCH AND TREATMENT OF PREVIOUS VETERANS

Important lessons from clinical research and treatment interventions to thousands of veterans in the past 30 years provide us with a solid foundation of treatment experience that should enable us to respond appropriately and effectively to the needs of veterans and servicemembers from OIF/OEF. Through our work with active duty, National Guard and military reserve units, we have learned to integrate such experience with recent scientific and clinical advances in the field. The following are lessons learned to be considered for OIF/OEF servicemembers and veterans:

1. Greater implementation of early intervention strategies for servicemembers recently exposed to highly stressful events provides an opportunity to apply primary prevention to offset the psychological trauma of combat operations. The importance of early intervention strategies, such as psycho-education to servicemembers, veterans, and families, can not be over-emphasized. Early intervention may provide the best opportunity to prevent more chronic forms of PTSD in the months and years following combat operations.

2. Associated with early intervention strategies is the concept of "stage of transition." We now recognize that many individuals who experience traumatic stress go through a normal transitional period which may be marked by mild clinical features (e.g., insomnia, sadness). However, it is important to recognize that this phase is an absolutely normal response to loss or stress. We encourage providers not to immediately label these responses with psychiatric labels. In addition, we recommend to providers to watch for potential "red flags" such as substance abuse, anger, concentration deficits, which may be signs that the individual requires additional professional interventions.

3. Further, we have been promoting a population-based approach to screening for combat stress within the military and VA. Both agencies are now routinely using the NCPTSD Primary Care PTSD Screen. This screen is a brief, four-item tool that can accurately and efficiently identify individuals who warrant further assessment for possible PTSD. In addition, NCPTSD has produced many gold-standard assessment instruments, such as the Clinicians Administered PTSD Scale (CAPS).

4. We have learned that in addition to addressing issues of traumatic stress, that it is important to address resilience and growth. Instead of a narrow focus on PTSD symptoms and related difficulties, we have promoted resilience, or "psychological armor" to both active duty and veterans from OIF/OEF. This approach has the effect of increasing positive, active coping and maintaining one's life goals and plans both during and after military experience.

5. Veterans and servicemembers do not always seek out behavioral health care, even when they suffer from combat stress/PTSD or other psychiatric conditions. For example, many veterans will seek mental healthcare from their primary care providers. In response, we now provide greater education to primary care providers about the effects of combat stress on the physical and psychological status of their patients. Further, we now provide more onsite mental health staff in primary care settings in order to address these psychological issues, such as combat stress/PTSD, within the medical setting and during the primary care appointment.

6. Veterans from each combat era develop a unique lexicon, or language to describe their own unique combat experiences. In addition to appreciating the unique aspects of their war zone experiences, it is also important that clinicians learn the lexicon that veterans speak to describe these experiences. By having a shared language, clinicians can deliver treatment interventions that more accurately capture the veterans experience.

7. Polytrauma and blast related injuries are complex medical conditions that require focused, coordinated and comprehensive medical interventions. These conditions may consist of trauma to the head, eyes, ears, and spinal cord, as well as multiple injuries to internal organs, musculoskeletal and connective tissue systems. Closely related to the physical injuries are potential mental health conditions, such

as posttraumatic stress disorder (PTSD), major depression, and anxiety disorders, which may interact with the physical injury to decrease overall health status and adherence to medical regimens. Such complex medical injuries require coordination with mental health to treat the psychological wounds associated with these physical injuries.

III. OVERVIEW OF COLLABORATIVE EDUCATIONAL AND CLINICAL RESEARCH INITIATIVES BETWEEN NCPTSD AND DOD

The National Center for PTSD is a consortium composed of the following seven divisions: Executive, Women's Health Sciences, Behavioral Science, Clinical Neurosciences, Evaluation, Education, and Pacific Islands. Our world renowned website is *www.ncptsd.va.gov.* I would like to highlight some of the National Center's recent educational and clinical research initiatives. For clarity of discussion, I have divided these into two main groups: (i) those that are primarily the purview of personnel of the NCPTSD Education, VA Palo Alto Healthcare System and the Pacific Islands Divisions (VAPIHCS), and (ii) those related to the entire NCPTSD consortium.

NCPTSD EDUCATION AND THE PACIFIC ISLANDS DIVISIONS

NCPTSD personnel have been engaged in multiple collaborative educational and clinical research activities with the Department of Defense.

In January 2005, the Navy Bureau of Medicine (BUMED) asked NCPTSD/ VAPAHCS staff to coordinate a leadership summit of Navy, Marine and VA leadership in Southern California. The summit was attended by military and VA mental health, medicine, and chaplains, and line officers from Marine Corp Headquarters, BUMED, Camp Pendleton, Camp Lejuene, San Diego Naval Hospital, National Center for PTSD, and VA Central Office. The focus of the meeting was coordination between services, across hospital settings, and transition to VA treatment facilities. In May 2005, the NCPTSD organized a 2-day combat stress clinical training program for Navy and Marine mental health and primary care military staff located throughout the western states (i.e., Camp Pendleton, Naval Hospital San Diego, Miramar Air Station, Twenty-nine Palms).

In June 2005, based on trainings provided to staff at Camp Pendleton, Marine Corp Headquarters requested that NCPTSD/VAPAHCS staff provide clinical training related to identification and interventions for combat related stress to all Marine Corp Community Services (MCCS) staff at major Marine Corp bases in the U.S.

NCPTSD/VAPAHCS has created an internet web-based clinical training curriculum entitled PTSD 101. The goal is to provide enhanced training for all VA and DoD field clinicians who provide services to veterans, reservists, and active duty returnees with PTSD, adjustment disorders, or other combat stress reactions. This web-based curriculum of over 20 courses provides practitioners with a convenient, practical, and user-friendly means to access a range of continuing education materials that focus on the diagnosis, assessment, and treatment for PTSD and other combat stress reactions. This new web-based curriculum will allow practitioners to access training materials 24-hours a day/7 days a week, from any computer terminal.

Since the Congressional mandate for VA/NCPTSD includes developing and providing education and trainings about cultural issues affecting the Pacific Islands, I sought out partnerships with leadership from community mental health agencies and DoD. Further, VA/NCPTSD reached out to partner with local, state, and private agencies to provide educational and clinical trainings about combat stress/PTSD.

One outcome of partnering with the larger communities on the islands has been the establishment of what will become an annual conference entitled "Stress, Violence, and Trauma: Promoting Hawaii's Resilience." This conference is organized by a planning committee comprised of a consortium of multiple Federal, state and local governmental and non-profit agencies. Also, after Senator Akaka's staff learned about the conference, they expressed enthusiastic support and joined the planning efforts. Our first conference was held in April 2005 and was attended by a very receptive audience of over 250 people. Our next conference is being held January 11 and 12, 2006 at the Hale Koa Hotel. (A description of the conference, at which the Under Secretary for Veterans Health Administration, Dr. Jonathan Perlin, will be presenting, is located at our website at (*http://stressconference.com/*). This educational event has increased the visibility for the Pacific Island Division. This collaboration has already had many positive outcomes as we have provided important clinical trainings for both Army and Marines in Hawaii who have been deployed and redeployed from Iraq and Afghanistan. We want to take the opportunity to thank Senator Akaka and his staff for their support to make this annual conference a success.

Staff from NCPTSD's Pacific Island Division (VAPIHCS) collaborates closely with the Army personnel stationed at Schofield Barracks' Soldier Assistance Center and the Family Assistance Center. NCPTSD staff consult the Directors of the Solider Assistance Center and the Director of the Family Assistance Center who oversee the collection of needs assessment/clinical intake data for soldiers who screen positive for combat-related stress. In 2004, we provided a series of monthly trainings to DoD mental health providers at the Soldier Assistance Center on treatment for OIF/OEF returnees suffering from combat stress. Since that time, we have continued to provide ongoing trainings for newly hired therapists and residents on evidenced based treatment guidelines for the treatment of PTSD, assessment of combat stress-related disorders, early intervention for combat stress, intervention for sexual assault, and alcohol abuse treatment. Additionally, NCPTSD staff members co-lead group educational interventions with military personnel at the Soldier Assistance Center for returnees and their spouses.

In February 2005, members of the NCPTSD Educational and Clinical Laboratory (VAPAHCS) and Pacific Island Divisions (VAPIHCS) provided a 5-day conference at Tripler Army Medical Center and Schofield Barracks titled "War-Zone Related Issues for Active Duty Personnel: Pre-, Post-, and Redeployment." Audience members were over 100 Tri-service mental health professionals, including Family Service Workers, Social Workers, Psychiatrists, Psychologists, Chaplains, and Primary Care Providers. Members of the NCPTSD/VAPIHCS and U.S. Army, Schofield Barracks also developed a "Building Resilience Coping Skills Group," with a manual and workbook that address post-deployment stressors uniquely reported by OIF/OEF returnees. Tri-service military providers were trained in implementing the group intervention, and several groups have been successfully conducted at Schofield Barracks and at Pearl Harbor.

Personnel from the NCPTSD (VAPAHCS/VAPIHCS) were requested to provide a series of outreach and educational trainings to the 3,000 deploying members of the Hawaii's 29th Infantry Brigade (National Guard) and their families in March 2005. We conducted lectures addressing the impact of deployment stress upon families, and provided educational materials, created by the NCPTSD, that were specifically geared to their needs. The National Guard has requested that VA/NCPTSD provide follow-up educational trainings to families prior to their spouses return and again upon the servicemember's return in March 2006.

Similarly, the Marine Corps requested ongoing educational trainings to spouses of the 800 returning Marines at Kaneohe Marine Base. Members of the VA/NCPTSD are also conducting presentations that address deployment and post-deployment stress on families and provide accompanying VA/NCPTSD educational materials specifically geared to families.

VA/DOD EDUCATION AND THE NCPTSD CONSORTIUM

Due to the successful collaboration to create an Army version of the Iraq War Clinician's Guide, a Marine Corps version is also currently being created. The Marine Corps version is a collaboration between USMC/VAPAHCS/VAPIHCS and will provide the most current relevant clinical information about combat stress and PTSD for both military and VA personnel.

Returning from the War Zone: A Guide for Military Personnel: This pamphlet was created to assist active duty, National Guard, military reserve, and veteran military servicemembers to positively cope with adjustment during their transition back to civilian life. Returning from the War Zone: A Guide for Families of Military Personnel: This pamphlet was created to help military families understand and assist their loved ones following a homecoming.

IV. RECOMMENDATIONS FOR EDUCATIONAL AND CLINICAL TRAINING NEEDS TO AUGMENT VA/DOD HEALTHCARE

In the months and years ahead, VA nationwide and VA/NCPTSD will continue to serve as a tremendous resource for servicemembers and veterans. VA's task is to continually refine and improve the processes of care in order to apply evidenced-based treatment models for those servicemembers injured or psychologically affected during combat operations. Further, the collective goal of the VA and DoD healthcare is to support and facilitate the seamless transition and reintegration of the veteran into his or her family, work, and community settings. VA/NCPTSD is well positioned to support this mission.

Here are four suggested recommendations for continued enhancements to quality care within VA system:

Implementation of Innovative Treatment Delivery Systems

Compared to the Vietnam era veterans, the current cohort of veterans display a wider diversity in age, racial, cultural, and educational backgrounds. They tend to be more comfortable using advanced technology. Many in the current generation of warriors have grown up with instant access technology, such as the internet, digital imagery and communication and other electronically advanced public and military technologies. These servicemembers and veterans may be more comfortable with technology than any other previous generation of warriors and veterans. Thus developing innovative treatment delivery systems employing technology based systems (internet-based, virtual reality) may provide a relevant platform that suits these individuals' preferences for treatment. VA/NCPTSD's Pacific Islands Division continues to promote PTSD telemental health as a way of providing specialty PTSD services to veterans residing in remote locations. In addition, NCPTSD provides ongoing education and supervision to national programs interested in developing PTSD telemental health for current veterans and returning OIF/OEF veterans.

Continued Education and Clinical Training for VA Providers

Many treatment providers in VA have tremendous expertise working with older generations of veterans. According to VA estimates, 40 percent of these providers will be nearing retirement age in the next 5 years. We can expect a new influx of younger treatment providers to enter VA's workforce during this time as well. These younger treatment providers will not share the first hand knowledge of lessons learned from the work over the past 30 years.

For these reasons, education and clinical training have become the primary foundation to support the mission and goals of VA and DoD health care. In order to best serve the unique health care needs of the OIF/OEF veterans, a wide educational net must be cast to clinical service providers, including mental health and primary care providers. In addition, veterans will seek out health care from spiritual leaders or others in the community. Education and clinical training will play an integral role in determining whether a veteran's combat stress reactions resolve early, or develop into a more chronic form of PTSD.

In summary, continued education and training are important foundations as VA continues to provide quality care to veterans from OIF/OEF, as well as previous wars. Further, it is imperative that the VA continues to develop innovative strategies to disseminate education not only to the veterans who come to VA but also the veterans who will access other community based healthcare. VA's NCPTSD is uniquely positioned, as VA's leader in the field of combat-related stress, to support VA to meet this objective. The VA/NCPTSD is staffed with highly talented clinicians, researchers, and educators who are devoted to development and dissemination of empirically based treatment protocols, assessment instruments, and guidelines for addressing combat stress and PTSD.

Senator AKAKA. Thank you very much. I just want to say we'll include your full testimony in the record.

Mr. Wylie.

STATEMENT OF ALFRED WYLIE, PUBLIC RELATIONS, COORDINATOR, VIETNAM VETERANS OF AMERICA

Mr. WYLIE. Senator, thanks. I've been asked to speak about my experience with veterans with PTSD and my own experience with PTSD.

First, I wish to clarify that PTSD is essentially an emotional wound that is just as crippling as physical wounds, especially in personal and social relationships. In fact, there is neurological damage from the traumatizing events of war.

This damage is exemplified by the veteran who hits the ground when he hears a car backfire 30 years after the stressor occurred. What happens to those of us who are emotionally wounded is that certain stimuli will trigger a flashback that is in essence a short circuit or a hardwired response that will be with the veteran until death.

This hardwiring of our neural circuits will never be resolved. It is with us for the rest of our life. We can be improved in our emo-

tional reaction to these specific triggering stimuli. The reduction of our emotional reactions is a long-term process called psychotherapy.

The issue of psychotherapy is a double one. First, there is the emotionally wounded veteran, and then there are those who develop secondary PTSD, which is primarily the children of the veteran. This issue of secondary PTSD can be resolved if the veteran is treated prior to the conception of the children.

This issue of veterans can be resolved by the VA developing procedures to identify those veterans with PTSD at the time of discharge and then integrating them into a mandatory therapy program immediately upon separation. This would save the Government an enormous amount of money in costs of future treatment and care.

The Government needs to truly understand that intensive psychotherapy programs such as the VA intensive program in Hilo, Hawaii and its follow-up procedures are effective for the older veteran and would be doubly effective for the newly released veterans with PTSD.

Again, I must emphasize that this neurological hardwiring from the chronic death threats will never go away. But with psychotherapy that focuses on processing the repressed death threat emotions, the veteran's experiences will diminish in time.

Going through the shakes of fear and letting out the tears of grief are necessary for the healing process. Unfortunately, the veteran with PTSD is usually unconscious of his emotional wounds since the environment that caused them required that he or she numb out to such feelings. This numbing-out process to emotional feelings is a natural process that occurs in humans and non-human primates as well as numerous mammals exposed to high levels of stress.

So here we have veterans fresh from the high stress zone who can be treated of for his emotional wounds in a immediate manner, or they can be released into society where they will become a liability for many years. Most veterans don't become conscious of the actual cause of their disability until they are older, when they can no longer produce enough epinephrine, which is also known as adrenalin, to suppress the emotions.

Depending on the individual veteran, this occurs around 45 to 65 years of age. This, by no means, means that the veteran is symptom-free, but just that he will start having reality level flashbacks when he can no longer produce enough adrenalin to suppress conscious memory of traumatic events and lifestyle.

The second issue concerning veterans is the secondary PTSD they cause their children. Being a parent who has caused emotional wounding to my own children from my own PTSD, I speak with authority on the subject as well as speaking for other veteran fathers. Please get us into therapy before we have our children.

Of course, there is the moral issue of the Government's responsibility to its emotionally wounded veterans. However, after 65 years of life, I conclude that the real moral issue is money. Therefore, from this point of view, it is much more cost-effective for the Government to provide emotional therapy soon after separation from service, thus avoiding the cost to the social system of years of vet-

erans who are emotionally wounded and the subsequent burden to the social welfare system involving their families.

Secondarily, getting the young emotionally wounded veteran into emotional therapy will prevent a generational cost inasmuch as the emotionally wounded veteran produces emotionally wounded children.

In conclusion, the Government in the long run will save money if veterans with PTSD are identified and entered into emotional third-party programs upon separation from service. Another benefit of entering young veterans into therapy soon after separation is stopping the secondary PTSD that develops in children of PTSD parents, which in turn becomes an economic drain to society.

[The prepared statement of Mr. Wylie follows:]

PREPARED STATEMENT OF ALFRED WYLIE, PUBLIC RELATIONS COORDINATOR, VIETNAM VETERANS OF AMERICA

I have been asked to speak to you about my experience with veterans who have PTSD.

First I wish to clarify that PTSD is in essence emotional wounds that are just as crippling as physical wounds, especially in personal and social relationships. In fact there is neurological damage from the traumatizing events of war. This damage is exemplified by the veteran who hits the ground when he hears a car backfire 30 years after the stressor occurred. What happens to those of us who are emotionally wounded is that certain stimuli will trigger a flash back that is in essence a short circuit or a hardwired response that will be with the veteran unto death. This hard wiring of our neural circuits will never be resolved. It is with those of us who have PTSD for life. What can be improved is our emotional reaction to these specific triggering stimuli. The reduction of our emotional reactions is a long term process called psychotherapy.

The issue of psychotherapy is a double one. First, there is the emotionally wounded veteran and then there are those who develop secondary PTSD which is primarily the children of the veteran.

The issue of secondary PTSD can be resolved if the veteran him/herself is treated prior to the conception of the children.

The issue of the veteran can be resolved by the VA developing procedures to identify those veterans with PTSD at the time of discharge and then integrating them into a mandatory therapy program immediately upon separation. This would save the government an enormous amount of money in costs of future treatments and care.

The government needs to truly understand that intensive psychotherapy programs such as the VA intensive program in Hilo, Hawaii and its follow up procedures are effective for the older veterans and would be double effective for newly released veterans with PTSD.

Again, I must emphasis that the neurological hardwiring from the chronic death threats will never go away. But with psychotherapy that focuses on processing the repressed death threats the emotions the veteran experiences will diminish in time. Going through the shakes of fear and letting out the tears of grief are necessary for the healing process. Unfortunately, the veteran with PTSD is usually unconscious of his emotional wounds since the environment that caused them required that he/she numb out to such feelings. This numbing out process to emotional feeling is a natural process that occurs in human and non human primates as well as numerous mammals exposed to high levels of stress.

So here we have a veteran fresh from the high stress zone who can be taken care for his emotional wounds (PTSD) in an immediate manner or he can be released into society where he will become a liability for many years. Most veterans don't become conscious of the actual cause of their disability until they are older when they can no longer produce enough ephiphrine (adreline) to suppress the emotions. Depending on the individual veteran this occurs around 45–65 years old. This by no means, means that the veteran is symptom free but just that he will start having reality level flash backs when he can no longer produce enough adreline to suppress conscious memory of traumatic events and lifestyle.

The second issue concerning veterans is the secondary PTSD they cause their children. Being a parent who has caused emotional wounding to my own children from my own emotional wounds (PTSD) I speak with authority on the subject as well as

speaking for other veteran fathers. Please get us into therapy before we have our children.

Of course there is the moral issue of the government's responsibility to its emotionally wounded veterans. However, after 65 years of life I conclude that the real moral issue is money. Therefore, from this point it is much more cost effective for government to provide emotional therapy soon after separation from service thus avoiding the cost to the social system of years of veterans who are emotionally wounded and the subsequent burden to the social welfare system. Secondarily, getting the young emotionally wounded veteran into emotional therapy will prevent generational cost in as much as the emotionally wounded veteran produces emotionally wounded children.

In conclusion the government in the long run will save money if veterans with PTSD are identified and entered into emotional therapy programs upon separation from service. Another benefit of entering young veterans into therapy soon after separation is stopping the secondary PTSD that develops in children of PTSD parents, which in turn become an economic drain on the economy.

Senator AKAKA. Thank you. Thank you very much, Mr. Wylie.

Dr. Shomaker.

STATEMENT OF T. SAMUEL SHOMAKER, M.D., J.D., INTERIM DEAN, JOHN A. BURNS SCHOOL OF MEDICINE, UNIVERSITY OF HAWAII AT MANOA

Dr. SHOMAKER. Good morning, everyone. I want to thank Senators Craig and Akaka and the Committee staff for holding these important and historic hearings here in Hawaii. I particularly want to thank Senator Akaka for his longstanding support of the School of Medicine. We're proud to count several members of his immediate family amongst our graduates, including a son, a grandson, and a nephew, I believe.

I also want to take a moment, as an ordinary citizen, to thank all the veterans in the audience for the service that you render us. I am deeply grateful, and I think we all owe you a debt of gratitude. Thank you very much for all you've done for our country.

[Applause.]

Dr. SHOMAKER. I'm joined today by Haku Kahoano, who's a 4th-year medical student. You'll hear from him in just a second.

The John A. Burns School of Medicine is the only medical school in the State. We provide a culturally appropriate medical education program for the State's citizens. Our partnership with the VA dates back over many years. We share a common mission of clinical care, medical education, and biomedical research.

We're very, very excited with the appointment of Dr. Hastings, who's a former Chair of the Department of Internal Medicine at our school, as the VA Director here. We feel that that will open up all sorts of new partnership opportunities for us.

Our partnership in medical education is already very strong. Twenty-six members of the VA medical staff have faculty appointments at the John A. Burns School of Medicine, and they teach our students and residents at the Spark Matsunaga Center, which is an active teaching site for the John A. Burns School of Medicine.

The VA also funds 16 residency training slots in residency programs in specialties like geriatrics, internal medicine, and psychiatry. We also have a very strong and burgeoning partnership in biomedical research in areas like dementia, movement disorders, kidney disease, and telemedicine. So we're excited about developing that partnership further. We're very supportive of the VA's commitment to funding education and research programs.

I'm joined today by Haku Kahoano, who's a perfect example of the partnership that we have at the VA. He is both a future physician and a future veteran. He's a member of the United States Army. He's just been accepted to do his residency at Tripler, and recently completed a clinical rotation at the VA. So I'd like Haku to say a few words today.

[The prepared statement of Mr. Shomaker follows:]

PREPARED STATEMENT OF T. SAMUEL SHOMAKER, M.D., J.D., INTERIM DEAN, JOHN A. BURNS SCHOOL OF MEDICINE, UNIVERSITY OF HAWAII AT MANOA

Chairman Craig, Senator Akaka, and Members of the Committee on Veterans' Affairs, thank you for this opportunity to testify on the relationship between the VA and the University of Hawaii's John A. Burns School of Medicine. I am Sam Shomaker, currently serving as interim Dean, and I am accompanied by a 4th-year medical student, Haku Kahoano.

I am pleased to report that our Medical School enjoys a very strong relationship with the VA in Hawaii—one that is mutually beneficial to our state's veterans and medical education programs. Residents in Hawaii enjoy the longest average life span of any state in the Nation. For that reason, our Medical School has developed especially strong programs in geriatric medicine.

The Hawaii VA hosts medical residents in internal medicine, transitional, psychiatry and geriatric psychiatry programs. At any given time, there are about 16 medical residents and fellows serving in VA facilities here.

Areas of active collaboration between our Medical School and VA include dementia, movement disorders, aging, kidney disease, epidemiology, and telemedicine. More than two dozen members of the VA staff hold appointments as faculty of the John A. Burns School of Medicine.

As Hawaii's only medical school, we bear a special responsibility to prepare students to meet the health needs of our residents—among them our aging military veterans. At this time I would like to introduce one of our students who is both a future physician and a future veteran—Lt. Haku Kahoano is a member of the U.S. Army and a 4th-year medical student.

STATEMENT OF HAKU KAHOANO, 4TH-YEAR MEDICAL STUDENT, JOHN A. BURNS SCHOOL OF MEDICINE, UNIVERSITY OF HAWAII

Mr. KAHOANO. Thank you, Dean Shomaker. Aloha, Senator Akaka, Committee Members, and veterans.

I'm a lifelong resident of Hawaii and will graduate from the John A. Burns School of Medicine this May. You've heard Dean Shomaker describe the many ways the VA helps our medical school fulfill its mission in creating fully functioning residents and primary care physicians.

I might also add that as the baby boomers enter their senior years, they can be expected to once again redefine the needs of society, redefine the needs of the VA. The need to create a cadre of physicians who will be able to address issues like polypharmacy, loss of cognitive and physical function, dementia, delirium, assisted living, long-term care, palliative management, has never been greater.

In addition to its nationally recognized geriatric fellowship, John A. Burns School of Medicine now requires all 4th-year students to undergo a monthlong geriatric elective. JABSOM offers this program in partnership with the VA and provides tutelage of attending physicians with expertise in geriatrics. Students gain invaluable firsthand exposure to the care of geriatric ex-military members, both in the long-term care and outpatient arenas.

I am one of the fortunate members of the class of 2006 to benefit from this program, and I come before you to day to attest to the

truly valuable lessons learned from my geriatric experience at the VA. My 4th-year geriatric elective ambulatory block was conducted at the VA's Spark M. Matsunaga Clinic located on the grounds of Tripler Army Medical Center.

It is said that the saving grace of medicine is repetition. If that is true, then continuity should be seen as an integral part of any sound medical education. During my internal medicine rotations at Tripler, I had the distinct privilege of servicing veterans that I would later see during my outpatient geriatric experience. I can honestly say that it is difficult to forget a given pathology or a mix of pathologies when you see them in the same patient over and over again.

Case in point: I recall the 87-year-old Mr. H, who was admitted to Tripler's inpatient medicine wards for management of his ural sepsis and concomitant aspiration pneumonia. He was a pleasantly demented gentleman who had suffered a stroke 2 years prior that left him with significant left-sided weakness and an inability to take food orally.

During his inpatient stay, I learned a great deal about the management of ural sepsis and aspiration pneumonia, all of which came in very handy when, 3 weeks later, I saw the same gentleman again, this time in the outpatient setting. Already familiar with the patient's history and the pertinent issues, I was able to quickly generate a management plan for Mr. H's new onset shortness of breath and cough.

I was also able to get social work involved to help set up some respite time for the patient's care provider. Both the patient and his caregiver also seemed to appreciate dealing with a familiar face, a face who had already put in the time to learn their story and earn their trust.

Continuity of care in the clinical arena is a win-win situation for everyone involved. Through its alliance with the VA, the Tripler Army Medical Center, and the various private healthcare institutions in the State of Hawaii, the John A. Burns School of Medicine works hard to provide for its students experiences rich with this kind of continuity.

In closing, gentlemen, every VA patient who is cared for here in the State of Hawaii is yet another patient whom JABSOM students can interact with, service, and learn from. Every patient that is sent away to another State for healthcare becomes another lost opportunity for our physicians-to-be.

Senator Akaka, Committee Members, veterans, good people. I thank you for giving me the opportunity to discuss the tremendous relationship enjoyed by the VA and the John A. Burns School of Medicine. Aloha kakahiaka.

[Applause.]

[The prepared statement of Mr. Kahoano follows:]

PREPARED TESTIMONY BY HAKU KAHOANO, 4TH-YEAR STUDENT, JOHN A. BURNS SCHOOL OF MEDICINE

Chairman Craig, Senator Akaka and other Committee Members, my name is Haku Kahoano and I am a lifelong resident of Hawaii as well as a graduate of the University of Hawaii. I had the privilege of playing on the UH football team from 1987 to 1991 and received an MBA in 1996.

I am on track to graduate from the John A. Burns School of Medicine (JABSOM) next year, and I have accepted a residency in internal medicine at the Tripler Army Medical Center.

You've heard Dean Shomaker describe the many ways the VA helps our Medical School fulfill its mission to create fully functional residents and primary care physicians.

Allow me to add that there is a national health care crisis on the horizon; The reality of the baby-boomers turning 80 and the need to create physicians who are "geriatric" savvy. As the baby-boomers enter this demographic they can be expected to once again redefine the needs of society. The need to create a cadre of physicians who will be able to address issues like (polypharmacy, loss of cognitive and physical function, dementia, delirium, assisted living, long term care, palliative management, etc.) has never been greater.

In addition to its nationally recognized geriatric fellowship, JABSOM now requires all 4th-year students to undergo a month-long geriatric elective. JABSOM offers this program in partnership with the VA, and provides tutelage of attending physicians with expertise in geriatrics. Students gain invaluable first-hand exposure to the care of geriatric ex-military members both in the long term care and outpatient arenas.

I am one of the fortunate members of the Class of 2006 to benefit from this program, and I come before you today to attest, to the truly valuable lessons learned from my geriatric experience at the VA.

My 4th-year geriatric elective ambulatory block (outpatient clinic) was conducted at the VA's Spark Matsunaga Clinic located on the grounds of Tripler Army Medical Center. Senators, thank you for giving me the opportunity to discuss the tremendous relationship enjoyed by the VA and Hawaii's medical school, from a medical student's perspective.

Senator AKAKA. Mahalo nui loa. Mahalo, Haku Kahoano, and Dr. Shomaker.

Dr. Shomaker, I know you have another event to attend, too, so I plan to ask you a question first. I want you to feel free to depart after you've answered the question.

Dr. SHOMAKER. Thank you, sir. I appreciate it.

Senator AKAKA. Dr. Shomaker, I noted in your testimony that you have collaborated with VA on telemedicine issues. What advances do you think that VA can make in the area of telemedicine in Hawaii?

Dr. SHOMAKER. I think it's a wonderful adjunct to providing onsite care. There obviously are going to be situations in which it's not possible to have a specialist such as a cardiologist present at every VA clinic on neighbor islands.

However, providing access to those services via telemedicine is a viable alternative to stationing specialists in neighbor island clinics on a regular basis. So I think it's a tremendous adjunct to the care that serves the role of extending the capabilities of the VA, and it's something that is probably well worth the investment.

Senator AKAKA. Thank you for your testimony. I want you to know that our Washington level VA folks here, led by Dr. Perlin, have been looking forward to the future and the use of high tech to get services to veterans. This certainly fits in that future.

So I want to thank you and Haku Kahoano for being here and for adding to this, and would wish you well.

Dr. SHOMAKER. Thank you, Senator.

[Applause.]

Senator AKAKA. I have questions for the rest of the panel. I would like for each of you to comment on this.

The spiraling costs of post-traumatic stress disorder have intensified a debate in Washington, adding fears of my fellow veterans.

I believe that this debate is unfounded, as the cost of post-traumatic stress disorder should be viewed as a cost of war.

Some have suggested that a veteran's PTSD compensation should be reduced if the veteran's decision is deemed to be improved. Some have also said that this move would be politically courageous.

My question to each of you, first, on this side, and we'll move to my right: Do you believe this to be a wise move?

Ms. RUBENS. Well, the Veterans Benefits Administration is in place to enact and administer the laws that have been passed by Congress. The issue of cost savings is not one that we, quite honestly, trouble ourselves with because we feel as though the laws that are on the books are the ones that we are here to implement, and we can only make the assumption that you put the laws in place in Congress and you will find money to ensure that our veterans are being paid the benefits to which they are entitled.

Mr. MOLNAR. Thank you, Senator. I will try to answer that question from a clinical point of view.

When the decision was made to look at the 72,000 cases, I can tell you that, as others who have testified in the panel before, there was a great deal of concern about what it meant for the veteran we were serving.

A couple of examples. One is, many of our World War II veterans never came forward after the war. They didn't deal with their issues of trauma. There are some good reasons for that. We didn't even recognize PTSD officially in the psychiatric diagnosis until 1980. We didn't have the kind of mental health care that we have today. For many cultural reasons, people did not want to be identified as a mental health provider.

Nevertheless, after many years, some of them applied for compensation. Most of our World War II veterans are in their later years, the autumn of their life. Their concern is taking care of their families. This was an added stress, an added aggravation. They asked me, what do you think is going to happen? Do you think I might lose my PTSD, my compensation? What will happen to my wife? Those kinds of questions certainly came up.

Clinically, was there an impact on that discussion? Yes.

Mr. GUSMAN. Thank you, Senator Akaka. I think I would add that I'd like to also speak to that from a clinical perspective, that our understanding of now what we term combat-related stress and post-traumatic stress disorder are really different from 30 years ago. There's so much more information.

I believe it's really important, without any intent to do harm, to look at how we do our assessments and how we make determinations on what's best for our veterans. I think that there was a lot of concern by many, many veterans. I got calls from veterans that I had seen, you know, 20 years ago asking me what did this really mean.

I believe that we have to find a happy medium somewhere, that we have to work with where science is taking us today. We have to look at what the impact is, and in some ways I personally—this is not the VA's policy—is that sometimes we institutionalize people unintentionally. We create situations that allow for a dependency that in many instances is not healthy.

I can personally tell you there are many veterans that come to me that say, I want to be in treatment but I don't want to have this label. I don't want to be compensated that way. I want a job. I want a place to live. I want to be able to raise my family in a healthy way.

So I think that, yes, we need to look at things. But I think we need to clear this with the veterans, and we don't do this with the intent to do harm, but to look at where science today is taking us.

Senator AKAKA. Mr. Gusman, let me ask you a question here. Is there a time frame for PTSD symptoms to appear? How long does it take for this disorder to reveal itself?

Mr. GUSMAN. Well, I'd like to say, as my colleague to the right had mentioned, that there really isn't a timeline. You try to narrow that down scientifically, and we really haven't been able to because what we've seen is that for some people, they can come home and manage the stress levels. They reintegrate to the community well. But then it might be many years later, if they're having a loss in the family, that many of the old memories can trigger. Then some of the issues for that will come roaring in and overwhelm him.

I think that what we do know is that we not have tools to help people. I think the issue really is about how we deliver those tools. How do we make them more accessible and user-friendly?

I think some of the things that we're starting to do, and including here in Hawaii, is working with the community at large because we know many of these veterans do not go to the VA, as they don't in most of the country. I believe it's a little above 7 percent of veterans who go to the VA on a national level.

So it's important that we share our knowledge with the community providers because they interface with the majority of veterans more frequently. I think that knowledge is the key here. Veterans who understand, as I've had the benefit of working with many Marines who are active duty, and what I find is that when they have knowledge about what they're feeling and experiencing and understand that this is normal, that they do much better.

Senator AKAKA. Thank you, Mr. Gusman.

I want to finish the panel with Mr. Wylie's answer on that question that I asked the panel.

Mr. WYLIE. Well, I believe the question was, should compensation be lowered for the veteran if he gets better. I think for us older veterans, there is nothing that can be done for us. We're getting too old. We had years and years of adding on pain due to the PTSD. Consequently we have to spend years working on emotional healings, whereas the young veteran only has to heal with the military trauma once they come out of service. They should be able to achieve a better adjustment. However, if the Government doesn't accept that responsibility, I don't see much progress to be made beyond that.

Senator AKAKA. Thank you very much.

Mr. Molnar and Mr. Gusman, we have seen in the past that substance abuse can become a secondary condition to another service-connected condition such as PTSD. How do you feel we can prevent our veterans from becoming users of illegal substances?

Mr. MOLNAR. Well, I think it's also both illegal and legal substances when you talk about substance abuse. I can speak to that

question, Senator, both from a professional perspective and also from a personal one. My father was a World War II Marine, fought on Saipan and Tinian, was wounded there, and struggled most of his life with PTSD. He often went down to the VFW Hall and drank with his buddies, and developed an alcohol problem over the years.

I think that quite often, since time immemorial, people seek to numb their pain, whether it be physical or whether it be emotional. That's not unusual. Our doctors prescribe medication when we have pain.

Many people, though, who are suffering from post-traumatic stress symptoms often will not present to the mental health clinic. They have fear, whether it be cultural, they have fear job-wise, that they do not want to be labeled or stigmatized with a mental health issue.

So they can fall between the cracks. That's why, as a number of folks have mentioned, outreach is important. Networking is important. Liaison is important. When our OIF/OEF person goes out there, Matthew, I want him to do one thing, to tell veterans, remember our phone number, 973–VETS. Call us. Perhaps if we can't help you, we can put you in touch with someone who can.

Because the important thing is that people have a readjustment period where they can begin to talk about these issues that they will carry the rest of their lives. The friend they lost, the day they lost that friend, the mistake that was made, the error, these things will live with them for the rest of their lives.

If we can assist them in that readjustment process, we hopefully can minimize issues of substance abuse.

Senator AKAKA. Thank you.

Mr. Gusman.

Mr. GUSMAN. Thank you, Senator. Substance abuse is becoming more of a problem, as I understand from my——

Senator AKAKA. Excuse me. Would you please pull up the mike?

Mr. GUSMAN. Yes. As I said, Senator Akaka, as I understand from my DOD colleagues and working with them, that substance abuse is becoming more of a problem in the sense that our young men and women use this as a way of avoiding having some of the recall, some of the flashbacks, as we call them, some of the uncomfortableness.

I think that DOD and the VA is making every effort, and we need to continue to do so to do some early intervention in this regard. We didn't understand that 30 years ago, and many—by the time Vietnam veterans came to the VA, many then had chronic substance abuse problems. Then there was a constant debate within the VA: Do we treat the substance abuse or do we treat the so-called PTSD?

I think we're not going to go down that road this time, thank God, and what we understand is that PTSD does not discriminate. It doesn't matter what ethnic group you are, your education or background; that if you're exposed to enough events, you're going to have some issues to deal with.

It's only natural that if you're away from home, whether it's 7 months or multiple tours of being redeployed, that there is going

to be some difficulty in transitioning back. You might possibly see people using substances of different sorts.

As Dr. [sic] Molnar just said, it's not only alcohol or dugs, but there are other kinds of problems—eating disorders, compulsive behavior, spending. I could tell you that when the first cadre of Marines came back to Camp Pendleton, the Harley dealers heard that these Marines needed to buy Harleys, and they just lined up everywhere you can go from San Diego up to Camp Pendleton to sell these Harleys. What was that about? Well, this is about the rush that many of these Marines felt more akin to.

So there are many different ways that people so-called self-medicate. I think it's important for us in the VA and for the community healthcare providers that we look for those flags, that we don't only look for traditional drugs and alcohol but other kinds of behaviors that are addictive.

Senator AKAKA. Mr. Gusman, in your opinion, how can VA better help the families of veterans with PTSD cope with the situation and take care of our veterans?

Mr. GUSMAN. One of the ways actually is happening today, Senator, which I mentioned earlier that I'm very happy and thankful that you're a supporter of, and that's the community conference that's happening at Hale Koa dealing with resiliency and stress and bonds in the community.

These kinds of partnerships with the VA and other State and county agencies and nonprofits is essential. I think right now one of the things the VA has been doing, and again I'm proud to say that we have been part of this, including the Pacific Islands Division in Hawaii, is to develop materials that are easily accessible to families so that they can get the kind of education that they need to understand what their family members are dealing with.

That's the key, I think, you know. When people understand what to do, the mystery is taken away and things become sort of at least somewhat acceptable. Then the veteran, the returnee, doesn't also feel like maybe they're going crazy or something when in fact they're not. They're having normal reactions to some very terrifying experiences.

I think that the VA is on the right track right now working with families and Vet Centers, doing a lot of that. Groups like the National Center's PTSD section are working hand-in-hand with employee education in the VA to develop all kinds of materials, is the way to go.

More outreach, sir. That's what we have to do.

Senator AKAKA. Thank you very much, Mr. Gusman.

I want to thank this panel very much for your testimonies, and I'll dismiss you at this time.

Folks, we have another panel. This is the panel that are at the head of our VA. I would like to call them forward at this time.

Dr. Perlin, who's Under Secretary of Health, Department of Veterans Affairs; Robert Wiebe, who is the VA Network Director, VISN 21, Sierra Pacific Network; James Hastings, Doctor, and Director of VA Pacific Islands Health Care System; Steven MacBride, Chief of Staff, VA Pacific Islands Health Care System; and Major General Gale S. Pollock, Commander, Tripler Army Medical Center.

General Pollock and Dr. Perlin, I appreciate your patience. I ask for the witness order to be adjusted today so that I could hear from you in response to all that has been shared. I greatly value your input and response, and I look forward to your testimony.

I know, hearing from you already, that you're making huge efforts to try to deal with the concerns of Hawaii's veterans. I want you to know that I'm so grateful to you. Let me step back and say I'm grateful to Chairman Larry Craig of this Committee who did come out and did add so much to the hearings here. He, too, as we work together so well, will be looking forward to dealing with these issues.

So let me ask Dr. Perlin to proceed with your testimony.

STATEMENT OF HON. JONATHAN B. PERLIN, M.D., PH.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT WIEBE, M.D., VA NETWORK DIRECTOR, VISN 21, SIERRA PACIFIC NETWORK; JAMES HASTINGS, M.D., DIRECTOR, VA PACIFIC ISLANDS HEALTH CARE SYSTEM; AND STEVEN A. MACBRIDE, M.D., CHIEF OF STAFF, VA PACIFIC ISLANDS HEALTH CARE SYSTEM

Dr. PERLIN. Aloha kakahiaka, Senator.

Senator AKAKA. Aloha.

Dr. PERLIN. Mahalo nui loa for the opportunity to appear before you today to discuss VA care.

Senator AKAKA. I want to say, Dr. Perlin, in the short time that he's been here, see how eloquent he is in Hawaiian? Thank you so much.

[Applause.]

Dr. PERLIN. Mahalo nui loa.

Senator AKAKA. You're getting better.

[Laughter.]

Dr. PERLIN. Senator, it's really a delight to be here with you. Thank you, Senator Akaka, for your incredible leadership, your passion, your advocacy for veterans, and your support of VA and Department of Defense, the men and women who support and serve America in uniform.

I'm pleased to be able to discuss with you VA care, especially care related to post-traumatic stress disorder. I have found care throughout all of the islands of Hawaii, and the access to that care. In fact, I've had the opportunity these last couple of days to move around the islands—we've had some hearings—and to see that care firsthand.

We've had some good discussions in those hearings. We've identified some of the issues that we're working on to make improvements to our, in fact, already very robust services for veterans in the State. Especially, the area of the greatest improvement is extending greater access to veterans on the neighbor islands, especially reaching out even more strongly to Lanai and Molokai.

Improving access will take a number of shapes and forms. But let me assure you that the care is already very, very robust. For example, I'm proud of how [inaudible] CBOCs, such as those on Kauai and Molokai. The CBOCs are an element with one to two physicians, primary care physicians, one nurse practitioner, one

psychiatrist, and generally a psychologist, with a panel about 1,000 to 1,500 patients. This compares favorably to services on the mainland, where one primary care provider has a panel of 1,200 patients themselves.

I realize that there are unique logistical issues. But these are the ways that we want to make sure that we transcend some of those logistical issues and continue to improve care.

A number of issues have been identified this morning, and we look forward to sharing with you what emerged from some of the discussions, the hearings yesterday on Maui and the previous day on Kauai. Through hiring additional care providers, particularly in specialties that were identified as being in short supply—orthopedics and ophthalmology, for example.

Through better scheduling of traveling doctors and nurses and psychologists to the neighbor islands to make sure that those specialty services are available more regularly and more timely. Through the use of advance technologies such as those Senator Akaka has championed in terms of telehealth and extending the care, and something I've had an opportunity to discuss during the questions in even more detail, some of the additional advances in telehealth supporting tele-mental health and all of the mental health services.

In fact, which General Hastings later showed, the improvements in scheduling of services so when the veteran does travel from one of the neighbor islands, that the clinics, that services that are needed, are scheduled on the same day.

But in fact my best observation is that it's not just about the quality of care, which is excellent, nor about the access to service, but about the compassion with which that care is delivered.

The thing that I learned in listening to the clinics that we visited together and the Vet Centers, that it's not just about patients. It's about community. It's about family. That is absolutely remarkable and as good as if not better than I've seen anywhere else in this country. I commend the men of VA Pacific Islands Health Care System, who give not only of their technical skills but in their hearts in serving individuals who are not just their patients but their family.

Here on Oahu we operate one of the Department's finest and most innovative facilities. The Spark M. Matsunaga VA Medical Center is located, as I think you all know, on the campus of the Tripler Army Medical Center. Care here on the islands is provided through our VA Pacific Islands Health Care System, which is part of our Sierra Pacific Health Care Network, one of our 21 Veterans Integrated Service Networks. Dr. Robert Wiebe is the Director of that very, very large network.

We're joined also today by Dr. James Hastings, who is the new Director of the VA Pacific Islands Health Care System and also a card-carrying cardiologist who goes around still, despite his administrative duties, to the other islands providing cardiac care.

The compassion and the sense of community and family is never better exemplified than anyone other than our Chief of Staff of that facility, Dr. Steven MacBride, who has, in his words and action, shown the absolute love and commitment he feels for the veterans that we serve.

The Medical Center provides primary care services in its ambulatory care center. This includes mental health, specialty services, radiology, optometry, all in a state-of-the-art facility that was dedicated in May 2000. It houses also the Center for Aging, which is a 60-bed facility that provides outstanding convalescent and end-of-life care, rehabilitation services, geriatric, and geripsychiatric assessments for veterans, all with the goal, if possible, of improving veterans' functions so they can return to their homes and their families.

I have to tell you that I would be remiss if I didn't acknowledge Senator Akaka's leadership in securing $83 million for the ambulatory care center and for the Center for Aging. This clearly is a demonstration of that support and leadership and compassion in caring for veterans.

VA's partnership here with Tripler Army Medical Center is one of the largest and most important of all the VA and DOD partnerships. I appreciate the great leadership and partnership that Major General Gale Pollock, Commander at Tripler Army Medical Center, provides. We're pleased also, as I mentioned, to welcome the former commander of Tripler Army Medical Center as director. I know that these two individuals can form an unprecedented level of effectiveness in their partnership in serving both servicemembers and their dependents as well as our veterans.

We heard also from Dr. Shomaker, who is the Dean of the John A. Burns School of Medicine. That relationship is not only so important, but was so well demonstrated by the presence of the medical student who will carry the torch on even beyond our times caring for the citizens and veterans and servicemembers here in Hawaii.

That partnership provides a number of services, including emergency room care and acute medical/surgical inpatient care, outpatient specialty care, and ancillary services, and we greatly appreciate the leadership that Tripler Army Medical Center provides in allowing VA to use those services to provide the state-of-the-art care for veterans.

That care extends. VA and DOD have secured $1.25 billion in funding for projects related to such things as computer-aided design and manufacturing and prosthetic devices, and for the construction of a chronic dialysis center, something that will help the servicemembers and veterans, and for the development of a chronic pain management program.

We also work together on a single separation health examination for active duty personnel who will be leaving military service so they don't have to go through two examinations with the same information required.

One more piece of good news, particularly for the residents on Oahu, on that relates to the topic of today's hearing, and that's that we're relocating our Post-Traumatic Stress Residential Rehabilitation Program from Hilo to here. It's a program that provides intensive residential rehabilitation for veterans suffering from PTSD.

The PTSD residential rehab problem was established about 10 years ago to meet the needs of veterans with chronic post-traumatic stress disorder who would benefit from a specialized residen-

tial program. Over the years, approximately 830 veterans, mostly Vietnam era, have been treated at the center, and many of these patients, nearly 75 percent, were not in fact from the Big Island but from right here in Oahu.

Now, clearly the discussion indicates, and we fully expect, that there will be veterans of the Global War on Terror with PTSD or combat stress reactions. We hope to provide them—plan to provide them—with the very best of services at the center in the next few years.

Most of these veterans reside in Oahu, and the best treatment for them is outpatient care that integrates their formal treatment with the service and support to their families and community. Consequently, we're moving that program to Honolulu over the next few months.

PTSD, as we've heard, is a major concern for our Department because of the activities and exposures inherent to military service. We've found that up to one-third of the veterans treated in the VA Pacific Islands Health Care System who are provided service for mental health issues also carry a diagnosis of PTSD.

Besides the Residential Rehabilitation Program, we will provide a broad spectrum of mental health services on the island for veterans with PTSD and all mental health disorders, especially outpatient PTSDs that are now provided in Oahu by a traumatic stress recovery program, which is interdisciplinary.

It includes a team of psychiatrists, psychologists, social workers, nurses. Readjustment counseling staff from the Vet Centers, as you've heard, are also so important. That work, that close relationship, extends not just on this island but over all of the islands.

Each of our five community-based outpatient clinics in Hawaii are staffed by full-time psychiatrists, and our post-traumatic stress recovery program helps to provide care for those veterans who require a fair level of service.

In fiscal year 2005, the VA treated 2,006 island veterans with PTSD, and we expect that there will be additional veterans to care for in the year to come. But we'll meet those needs of all island veterans in this important area.

Senator Akaka, with your help and the help and leadership provided by Chairman Craig, who's equally passionate in terms of supporting the VA and veterans, and the support of all Members of Congress, we feel the VA is providing an unprecedented level of care in health services to all veterans residing on Oahu and throughout all of Hawaii. Thank you very, very much for that, and thank you for the opportunity to testify today.

[Applause.]

[The prepared statement of Mr. Perlin follows:]

PREPARED STATEMENT OF HON. JONATHAN B. PERLIN, M.D., PH.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Senator Akaka, mahalo nui loa for the opportunity to appear before you today to discuss the state of VA care in Hawaii. It is a privilege to be here on Oahu—The Gathering Place—to speak and answer questions about issues important to veterans residing in Hawaii.

First, I would like to express my appreciation and respect for how much you have done, along with your colleague, Senator Inouye, for the veterans residing in Hawaii and other islands in the Pacific region. As I will highlight later, your vision, guidance and assistance have directly led to an unprecedented level of health care serv-

ices for veterans, construction of state-of-the-art facilities in Honolulu and remarkable improvements in access to health care services for veterans residing on neighbor islands.

Also, I would like to commend Chairman Craig for his outstanding leadership and advocacy on behalf of our Nation's veterans. During his tenure as Chairman of this Committee, he has clearly demonstrated his commitment to veterans by acting decisively to ensure the needs of veterans are met. In addition, I appreciate his interest in and support of the Department of Veterans Affairs (VA).

Today, I will briefly review the VA Sierra Pacific Network that includes Hawaii and the Pacific region; provide an overview of the VA Pacific Islands Health Care System (VAPIHCS) and the VA facilities here in Oahu; and highlight issues of particular interest to veterans residing in Hawaii, including post-traumatic stress disorder (PTSD), VA-Department of Defense (DoD) joint venture in Honolulu and access to specialty services.

VA SIERRA PACIFIC NETWORK (VISN 21)

The VA Sierra Pacific Network (Veterans Integrated Service Network [VISN] 21) is one of 21 integrated health care networks in the Veterans Health Administration (VHA). The VA Sierra Pacific Network provides services to veterans residing in Hawaii and the Pacific Basin (including the Philippines, Guam, American Samoa and Commonwealth of the Northern Marianas Islands), northern Nevada and central/northern California. There are an estimated 1.25 million veterans living within the boundaries of the VA Sierra Pacific Network.

The VA Sierra Pacific Network includes six major health care systems based in Honolulu, HI; Palo Alto, CA; San Francisco, CA; Sacramento, CA; Fresno, CA and Reno, NV. Dr. Robert Wiebe serves as director and oversees clinical and administrative operations throughout the Network. In fiscal year 2005 (fiscal year 2005), the Network provided services to 227,000 veterans. There were about 2.8 million clinic stops and 24,000 inpatient admissions. The cumulative full-time employment equivalents (FTEE) level was 8,200 and the operating budget was about $1.3 billion, which is an increase of $378 million since 2001.

The VA Sierra Pacific Network is remarkable in several ways. In fiscal year 2005, the Network was the only VISN in VHA to meet the performance targets for all six Clinical Interventions that directly address adherence to evidence-based clinical practice. The Network hosts 11 (out of 65) VHA Centers of Excellence—the most in VHA. The VA Sierra Pacific Network also has the highest funded research programs in VHA. Finally, VISN 21 operates one of four Polytrauma units that are dedicated to addressing the clinical needs of the most severely wounded Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans.

VA PACIFIC ISLANDS HEALTH CARE SYSTEM (VAPIHCS)

As noted above, VAPIHCS is one of six major health care systems in VISN 21. VAPIHCS is unique in several important aspects: its vast catchment area covering 2.6 million square-miles (including Hawaii, Guam, American Samoa and Commonwealth of the Northern Marianas); island topography and the challenges to access it creates; richness of the culture of Pacific Islanders; and the ethnic diversity of patients and staff. In fiscal year 2005, there were an estimated 113,000 veterans living in Hawaii (9 percent of Network total).

VAPIHCS provides care in six locations: Ambulatory Care Center (ACC) and Center for Aging (CFA) on the campus of the Tripler Army Medical Center (AMC) in Honolulu; and community-based outpatient clinics (CBOCs) in Lihue (Kauai), Kahului (Maui), Kailua-Kona (Hawaii), Hilo (Hawaii) and Agana (Guam). VAPIHCS also sends clinicians and support staff from these locations to provide services on Lanai, Molokai and American Samoa. The inpatient post-traumatic stress disorder (PTSD) unit formerly in Hilo is in the process of relocating to Honolulu at the Tripler AMC. In addition to VAPIHCS, VHA operates five Readjustment Counseling Centers (Vet Centers) in Honolulu, Lihue, Wailuku, Kailua-Kona and Hilo that provide counseling, psychosocial support and outreach.

Dr. James Hastings was recently appointed Director, VAPIHCS. Dr. Hastings has impressive credentials, including tenure as Chair, Department of Medicine, John A. Burns School of Medicine, University of Hawaii, and Commanding General at Walter Reed AMC and Tripler AMC. I am excited about the possibilities that his tenure as Director at VAPIHCS brings.

In fiscal year 2005, VAPIHCS provided services to 18,300 veterans in Hawaii (8 percent of Network total). There were 194,000 clinic stops in Hawaii during fiscal year 2005 (7 percent of Network total), an increase of 36 percent since fiscal year 2000. The cumulative FTEE for the health care system was 478 employees. The

budget for VAPIHCS (including General Purpose, Specific Purpose and Medical Care Cost Funds [MCCF]) has increased from $53 million in fiscal year 1999 to $102 million in fiscal year 2005 (about 8 percent of Network total). In addition, VISN 21 provided over $20 million in supplemental funds to VAPIHCS over the past two fiscal years to ensure VAPIHCS met its financial obligations.

VAPIHCS provides or contracts for a comprehensive array of health care services. VAPIHCS directly provides primary care, including preventive services and health screenings, and mental health services at all locations. Selected specialty services are also currently provided at the Honolulu campus and to a lesser extent, at CBOCs. VAPIHCS recently hired specialists in gero-psychiatry, gastroenterology, ophthalmology and radiology. VAPIHCS is actively recruiting additional specialists in cardiology, orthopedic surgery and urology. Inpatient long-term care is available at the Center for Aging. Inpatient mental health services are provided by VA staff on a 20-bed ward within Tripler AMC and at the PTSD Residential Rehabilitation Program (PRRP) that was formerly in Hilo (now relocating to Honolulu). VAPIHCS contracts for care with DoD (at Tripler AMC and Guam Naval Hospital) and community facilities for inpatient medical-surgical care.

The current constellation of VA facilities and services represents a remarkable transformation over the past several years. Previously, the VAPIHCS (formerly known as the VA Medical and Regional Office Center [VAMROC] Honolulu) operated primary care and mental health clinics based in the Prince Kuhio Federal Building in downtown Honolulu and CBOCs on the neighbor islands that were staffed primarily with nurse practitioners. Senator Akaka and his colleagues in Congress approved $83 million in Major Construction funds to build a state-of-the-art ambulatory care center and nursing home care unit on the Tripler AMC campus and these facilities were activated in 2000 and 1997, respectively. VISN 21 allocated nearly $17 million from fiscal year 1998 to fiscal year 2000 to activate these projects. VISN 21 also provided dedicated funds (e.g., $2 million in fiscal year 2001) to enhance care on the neighbor islands by expanding/renovating clinic space and adding additional staff to ensure there are primary care physicians and psychiatrists at all CBOCs.

OAHU FACILITIES

VA operates the Spark M. Matsunaga VA Medical Center in Oahu, located on the campus of Tripler AMC at 459 Patterson Road, Honolulu, HI, 96815. The medical center primarily consists of the Ambulatory Care Center (ACC) and Center for Aging (CFA). Congress appropriated $25.1 million Major Construction funds during fiscal years 1993–1994 to build the CFA; $14.9 million in fiscal year 1995 to construct the parking garage; and $43.0 million in fiscal years 1994/1995/1997 to build the ACC and renovate the E Wing of Tripler AMC for VA administrative use. Veterans Benefits Administration (VBA) is co-located with VHA on this campus. The Honolulu Vet Center is located nearby at 1680 Kapiolani Boulevard.

The VA facilities in Oahu serve an estimated island veteran population in fiscal year 2005 of 80,118. In fiscal year 2005, 25,222 veterans were enrolled for care and 12,739 veterans received care ("users") in Oahu. The market penetrations for enrollees and "users" are 31 percent and 16 percent, respectively and compare favorably with rates within VISN 21 and VHA.

The current authorized full-time employment equivalents (FTEE) level in Oahu is 425. With this staff, VAPIHCS provides a wide range of outpatient services, including primary care, several medical subspecialties (e.g., cardiology, gastroenterology, nephrology, pulmonary and women's health), mental health and dental care. In addition, VAPIHCS provides diagnostic services such as laboratory, echocardiography and radiology. As noted earlier, VA staffs a 20-bed inpatient mental health unit within Tripler AMC and a 60-bed nursing home care unit (i.e., CFA). If veterans need services not available at the ACC or CFA, VAPIHCS arranges and pays for care at Tripler AMC, local community or VA facilities in California.

In fiscal year 2005, VA facilities in Oahu recorded about 156,000 clinic stops, representing a 35 percent increase from fiscal year 2000 (i.e., 116,000 stops). The clinic has short waiting times for new patients with few veterans waiting more than 30 days for their first primary care appointment. In fiscal year 2005, the combined average daily census (ADC) was 19 in the mental health ward and PRRP (52 percent occupancy rate) and 56 at the CFA (94 percent occupancy rate). VAPIHCS spent about $14.0 million for care at Tripler AMC and another $9.2 million for non-VA care in the community for residents in Oahu.

SPECIAL ISSUES

Post-traumatic stress disorder (PTSD). PTSD is a psychiatric disorder that can occur after the experience of a life-threatening event. This is a major concern for VA because of the activities and exposures inherent to military service. PTSD has been observed in veterans from all conflicts, including Vietnam and Gulf theaters.

VA has very active PTSD programs nationally. In fiscal year 2005, a significant portion of the $2.4 billion spent on mental health programs was used to treat veterans with PTSD. In fiscal year 2006, more than $40 million will be earmarked to establish new PTSD and Returning Veterans Outreach Education and Care (RVOEC) programs. VA is also enhancing staffing levels at many Vet Centers.

There is a high prevalence of PTSD in veterans served by VAPIHCS (e.g., up to one-third of veterans treated in VAPIHCS mental health clinics carry the diagnosis of PTSD). Consequently, VAPIHCS provides a broad spectrum of mental health services for veterans with PTSD at the main facilities here in Honolulu (i.e., ACC and inpatient mental health ward in Tripler AMC), neighbor island CBOCs and the PTSD Residential Rehabilitation Program (PRRP) now in transition. Specialty outpatient PTSD services are provided in Oahu by the Traumatic Stress Recovery Program (TSRP), which is an interdisciplinary team of psychiatry, psychology, social work, nursing and readjustment counseling staff. The TSRP team also collaborates with the Honolulu Vet Center.

On the neighbor islands, outpatient PTSD services are provided by full-time psychiatrists located at all CBOCs. The PRRP has also been available to veterans with chronic PTSD who need a higher level of care. In fiscal year 2005, VAPIHCS treated 2,006 veterans with PTSD throughout the system and provided PTSD care during 8,401 clinic stops. This represents increases of 39 percent and 16 percent, respectively, compared to fiscal year 2002.

In addition to VAPIHCS, the VHA National Center for PTSD in Honolulu is an important resource for veterans. Mr. Fred Gusman, operations officer at the National Center for PTSD, Pacific Islands Division, is also testifying today and will highlight the activities of the Center, including its collaboration with DoD.

Although VAPIHCS is currently very active in PTSD treatment, we expect additional patients from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) will present to our facilities for evaluation of possible mental disorders. VA estimates up to 15,000 residents of Hawaii have been deployed to Afghanistan and Iraq as active duty personnel, Reservists or Hawaii National Guard personnel. Major General Lee, Adjutant General, State of Hawaii, Department of Defense (DoD), reports there are 2,200 Reservists and National Guard serving in Iraq and Afghanistan.

VAPIHCS estimates that 10–20 percent of OIF/OEF veterans may present to its facilities for evaluation of possible PTSD or other adjustment disorders. In fiscal year 2005, VAPIHCS evaluated 393 OIF/OEF veterans and 30 of these patients were diagnosed with PTSD. For planning purposes, VAPIHCS projects an increased demand from OIF/OEF veterans presenting for care at its mental health clinics in the next several years.

VAPIHCS will meet the needs of our newest veterans. Currently, VAPIHCS has 9.0 psychiatry FTEE. This equates to 43 mental health physicians per 100,000 unique patients, which is higher than the national VHA average (i.e., 35 FTEE per 100,000). VAPIHCS will use these and other staff to assist those veterans who have either acute PTSD, also known as Acute Stress Disorder (ASD), and chronic PTSD. The goals are outreach, early identification, standardized assessment, individualized treatment plans and emphasis on recovery.

To accomplish these goals, VAPIHCS will make several changes in its care delivery model, including the relocation of the PRRP unit from Hilo to Honolulu. The new outpatient program will be built on the successful foundation of the Hilo program. A Vietnam veteran who returned from combat with serious physical and emotional wounds, graduated from the PRRP last year. “I had lost 10 years of my life to drugs and chaotic living,” he said. “Healing takes a long time, but I carry note cards as reminders of the most important lessons I learned from VA. I’m clean and sober and my wife and I have love and happiness.” The veteran summarized his experience by saying, “I will be eternally indebted to the VA for turning my life around.”

VAPIHCS is also developing new programs (e.g., VAPIHCS submitted several proposals related to the $100 million set aside in fiscal year 2006 by VHA for new mental health initiatives) and hiring additional staff as needed (e.g., Hilo CBOC). In these endeavors, VA will continue to closely collaborate with our DoD partners, including Tripler AMC.

VA-DoD Joint ventures. VAPIHCS participates in one of the largest and most complex VA-DoD partnerships. The partnership with Tripler AMC accelerated when VA began to move clinical and administrative functions from the Prince Kuhio Federal Building to the Tripler AMC campus in 1997. The co-location of VAPIHCS and Tripler AMC allows functional integration and opportunities to provide high quality care to Federal beneficiaries residing in Hawaii and the Pacific region. VAPIHCS relies on Tripler AMC for emergency room care, acute medical-surgical inpatient care (including intensive care unit), outpatient specialty care and ancillary services. VAPIHCS also partners with Tripler AMC for nutritional services (e.g., inpatient meals at Tripler AMC and CFA), housekeeping, security and medical maintenance. In fiscal year 2005, VAPIHCS purchased about $14 million of services for veterans at Tripler AMC.

VAPIHCS and Tripler AMC also collaborate in several other important endeavors. The joint venture in Honolulu has successfully competed for several Joint Incentive Fund (JIF) projects. JIF was established by Congress in the National Defense Authorization Act (NDAA) in fiscal year 2003 to encourage ongoing collaboration. The VA-DoD joint venture in Honolulu has secured $4 million in funding for projects related to computer-aided design and manufacturing of prosthetic devices; chronic dialysis center; and chronic pain management program. The venture was also selected as one of eight formal VA-DoD Joint Venture Demonstration Sites and will review budget and financial management systems. We are also collaborating on a single separation health examination for active duty personnel who will be leaving military service.

VA appreciates the leadership of Major General (MG) Gale Pollock and the responsiveness her staff to VA concerns. The joint venture has made great strides in both clinical and administrative areas. Admittedly, some systemic barriers still exist, such as conflicting mission priorities, lack of computer interoperability, ambiguities regarding dual-eligible beneficiaries and differences in financial systems. Some of these barriers can be overcome at the local level, but many will require a solution at the national level. In any case, I am confident that our new Director, Dr. Hastings, and MG Pollock will continue the growth and accomplishments of this very important joint venture.

Specialty services. VAPIHCS does not operate its own acute medical-surgical inpatient unit and has a limited number of specialists on staff. Historically, VAPIHCS has relied on its DoD partners and community facilities to provide these and specialty outpatient services to veterans. Over the past several years, VAPIHCS has significantly increased its recruitment of specialists to improve the access and continuity of care for veterans. Since fiscal year 2004, VAPIHCS has hired physicians in gero-psychiatry, gastroenterology, ophthalmology and radiology. VAPIHCS is actively recruiting additional specialists in cardiology, orthopedic surgery and urology. VAPIHCS has also hired hospitalists to provide care for veterans admitted to Tripler AMC.

Although these specialists will be based in Oahu, most will travel regularly to CBOCs on neighbor islands and will be able to conduct telehealth clinics. The topography of the Pacific region makes telehealth one of VA's most valuable programs—not only for our older veterans from World War II, but also for our newest veterans from Iraq and Afghanistan. For example, a veteran came to VAPIHCS after surviving severe injuries from a rocket grenade attack in June 2004 that left him as a triple amputee (both legs and one arm). The veteran lives in Pohnpei, Federated States of Micronesia (FSM). After his return home to FSM, VA staff in Hawaii followed him weekly with telehealth visits to monitor his progress.

CONCLUSION

In summary, with your support and the support of other Members of Congress, VA is providing an unprecedented level of health care services to veterans residing in Hawaii and the Pacific Region. VA now has state-of-the-art facilities and enhanced services in Honolulu, as well as robust staffing on the neighbor islands and has expanded or renovated clinics in many locations. VA is bringing more specialists on board and preparing for the newest generation of veterans—those who bravely served in southwest Asia.

VAPIHCS still faces several challenges, in part due to the topography of its catchment area. VAPIHCS will meet these challenges by utilizing telehealth technologies, sharing specialists, developing new delivery models and opening new clinics as demographics suggest and resources allow. I am proud of the improvements in VA services in Hawaii, but recognize that our job is not done.

Again, Senator Akaka, mahalo nui loa for the opportunity to testify at this hearing. I would be delighted to address any questions you may have for me or other members of the panel.

Senator AKAKA. Thank you very much, Dr. Perlin. I want to thank Dr. Perlin, who is Under Secretary for Health for VA. I want to tell you that whenever we have high level hearings and we have the Secretary of VA at the hearing, usually Dr. Perlin is there with him. So we are hearing from a person who is really at a high level in VA across the country.

At this moment, this is a personal break. I'm going to ask for about a minute or so, and I'll be right back. I'm going to call a recess. I've had the permission from the General. So we'll just recess for a couple of minutes. Thank you. I'll be back. Please don't leave. We aren't done. We are going to hear from the General about Tripler and the partnership that's really working out. So we'll see you in a few minutes.

[Recess.]

Senator AKAKA. The hearing will come to order.

I'd like to call from testimony of Major General Gale Pollock. She's the Commander of Tripler Army Medical Center.

STATEMENT OF MAJOR GENERAL GALE S. POLLOCK, COMMANDER, TRIPLER ARMY MEDICAL CENTER

General POLLOCK. Senator Akaka, aloha and mahalo for the opportunity to share information about the collaborative relationship and initiatives under the auspices of Department of Defense and the Department of Veterans Affairs joint ventures here in Hawaii.

I've submitted my written testimony for the record.

Senator AKAKA. It will be included in the record.

General POLLOCK. Thank you, sir.

As the commanding general at Tripler Army Medical Center, I represent the largest military medical treatment facility in the entire Pacific basin. Tripler's area of responsibility spans more than 52 percent of the earth's surface and provides medical support to nearly 400,000 beneficiaries, including active duty members of all branches, their eligible families, military retirees and their families, veterans, and many Pacific island residents.

In 1991, what leaders initially conceived as a small veterans hospital adjacent to our medical center is now a vast $20 million sharing agreement spanning inpatient and outpatient services and nonmedical support such as security, meals, and housekeeping. This collaboration has increased patient care at both Tripler and for the VA.

On a daily basis, VA patients represent a large part of our workload. For example, during the last month, my average hospital census was 131 patients. Approximately 30 percent of those patients were veterans. An average 3 of the 12 daily admissions from my emergency room are veterans. The VA-operated psychiatric ward averages 9 patients each day.

Over the years, we've hired additional clinical staff to accommodate the growing VA workload, forming a reliance on the input reimbursement from the VA. While other medical treatment facilities may have excess capacity and can accommodate additional work-

load without a need to hire, that is not the situation at Tripler. The additional workload requires that we add staff.

While reimbursement is essential to a successful DOD/VA partnership, it is not the primary motivation. Veteran access to specialized care in Oahu and their satisfaction is improved due to our joint venture. Another dimension of caring for the veteran is that the illnesses and surgeries associated with aging are very relevant to keeping our active duty military personnel trained and ready for our battlefield mission.

We stay competent by caring for acutely ill patients. At Tripler, we have a robust graduate medical education program spanning 10 different medical specialties and training 220 residents per year. Our anesthesia nursing graduate program, recognized as the number two program in the Nation, also depends upon these complex patients. All of our patients, graduate health education programs, and our staff benefit from serving the veteran population.

One major recent initiative was already mentioned, and that's our joint separation process and examination. The separation physical performed while the servicemember is still on active duty is convenient for the military member. It eliminates duplicative physical exams, and ideally completes the disability determination prior to discharge from the active duty. This process is very much appreciate by the beneficiaries, and is cost-effective for both DOD and the VA.

Recently, we developed several joint initiative fund proposals, and three of them were approved and funded, computer-aided design and manufacturing for orthotics and prosthetics, a chronic dialysis center, and a pain management project. All three of these initiatives will improve access to care for our joint beneficiaries and decrease their waiting time.

We continue to explore opportunities and initiatives that allow the services and VA to share staffing, ensuring that we are both effective fiduciary stewards of the Government's resources. In the past month, we've signed two new sharing agreements.

The first agreement relocates the post-traumatic stress disorder program from Hilo to Tripler. This facility currently provides residential PTSD services to veterans. Once relocated to Tripler, the program will also treat military active duty members.

The second agreement is in support of a clinical investigation study titled, "Women's Deployment Stress and Health: A Pilot Study." The principal investigators are the providers from Tripler and the VA. We have also undertaken a joint approach in planning our response to a pandemic avian flu.

In terms of DOD/VA joint venture development, we are clearly ahead of most other locations in that we are already one of the most functionally integrated joint ventures. Instead of two freestanding medical centers, we have one emergency room, one inpatient medical, surgical, and psychiatric service, and essentially one major specialty outpatient service. We have integrated our clinical services for psychiatric on-call support, hospitalists, nephrology, and psychology services.

There are still opportunities for continued development of our joint venture. There's top DOD leadership support to make Tripler a model joint venture site. The two key determinants for additional

progress are expansion of our patient care services and elimination of redundant overhead.

As with most merger activities, there are barriers that impede unfettered, efficient coordination. I believe, though, that most of our joint venture barriers are systemic in nature. In order to perpetuate sharing between VA and DOD entities, national initiatives applicable to all types of sharing must continue.

Information systems require evaluation for applicability for sharing, and solutions for any systemic issues must be identified and shared expeditiously. We must address and resolve all barriers to achieve our ultimate goal—high quality care for our beneficiaries in a seamless healthcare system. The men and women currently serving in America's military and those who have already completed their service to our Nation deserve no less.

Senator, thank you for the opportunity to appear before you today and for your support of the military and veterans. I look forward to your questions.

[Applause.]

[The prepared statement of Major General Pollock follows:]

PREPARED STATEMENT OF MAJOR GENERAL S. POLLOCK, COMMANDER, TRIPLER ARMY MEDICAL CENTER

Mr. Chairman and distinguished Members of the Committee, thank you for the opportunity to share information about the collaborative relationship and initiatives under the auspices of the Department of Defense (DoD)—Department of Veterans Affairs (VA) Joint Venture in Hawaii. As Commanding General, Tripler Army Medical Center (TAMC), I represent the largest military medical treatment facility in the entire Pacific Basin. TAMC's area of responsibility spans more than 52 percent of the entire Earth's surface and provides medical support to nearly 400,000 beneficiaries, including active duty servicemembers of all branches of service; their eligible families; military retirees and their families; veterans; and many Pacific Island nation residents.

In 1991, Under Secretary of the Army and the Deputy Secretary of Veterans Affairs approved the basic concept of a Joint Venture for Hawaii. What was initially conceived as a small veteran's hospital adjunct to the medical center, now is a vast twenty million dollar sharing agreement spanning inpatient and outpatient services and non-medical support, such as security, meals and housekeeping. Beginning in 1997, the VA began to relocate administrative and health care services to the TAMC campus. Construction and renovation to portions of the medical center infrastructure have resulted in both new and relocated veteran services on the Tripler campus. By 1997, both the parking structure and the Center for Aging were completed. In 2000, the renovation of the E-Wing of TAMC and the Ambulatory Care Clinic were completed and operational. The relocation resulted in increased workload for both TAMC and the VA Pacific Islands Healthcare System (VAPIHCS).

A collaborative of this magnitude requires diligent planning and oversight. Both the VA and TAMC have dedicated staff to ensure the exploration and development of collaborative efforts. On a daily basis, VA patients represent a large part of our workload. For example, during the last month my hospital census was 131 patients. Approximately 30 percent of those patients are veterans. Additionally, an average three of 12 daily admissions from the emergency room are veterans. The VA operated psychiatric ward averages nine psychiatric patients a day.

Over the years, additional clinical staff has been hired to accommodate the growing VA workload, forming a reliance on the inpatient reimbursement from the VA. While there are Medical Treatment Facilities (MTFs) with excess capacity that can accommodate some workload within their minimum staffing requirements without adding significantly to their costs, that is not the situation at Tripler.

While reimbursement is essential to a successful DOD/VA partnership, it is not the primary motivation. For the military, caring for veterans represents a continuation of the services we provided when they were active duty. In fact, when I talk to audiences regarding the relationship between the active duty and the veteran populations I say the active duty are "veterans in training". Our ultimate status will be as veterans. Another dimension of caring for the veteran is that the illnesses and

surgeries associated with aging are very relevant to keeping active duty medical personnel trained and ready for our battlefield mission. We need to stay competent caring for acutely ill patients. At Tripler we have a robust graduate medical education program spanning 10 different medical specialties and training 220 physicians per year. Our graduate medical education occurs in Orthopedics, Radiology, Urology, Medicine, Obstetrics & Gynecology, Psychiatry, ENT, Pediatrics, Family Practice and General Surgery. We have found that these programs benefit from caring for the veterans population.

Our current DoD/VA sharing agreements cover a wide variety of patient care services including inpatient care, outpatient specialty services and ancillary support. We also partner for facility support for housekeeping, security and medical maintenance. I am particularly proud that the medical center's Nutrition Care Division prepares all the meals and nourishments for the 50-bed VA Center for Aging facility. We continuously receive positive feedback on our meals from the VA beneficiaries residing there.

One major initiative is the Cooperative Separation Process/Examination Memorandum of Understanding (MOU) of June 2005, designed to create a coordinated effort between DoD and the VA on Oahu for a single separation physical exam through the VA with specialized services primarily performed through the MTFs. The separation physical, performed while the servicemember is on active duty, is not only convenient to the military member, it eliminates duplicative physical exams for servicemembers who leave the military and file disability claims with the VA. Thus it is cost effective to both the VA and the DoD.

This year, there have been approximately 90 claims filed with 44 physicals completed. Currently, we are working through some minor disconnects with the VA on the process of returning the physical paperwork to the proper points of contact as well as the process of informing the member of the benefit eligibility and how to receive it. TAMC, along with the other MTFs on Oahu are working with the VA to refine the process and ensure the physical return of the paperwork allowing the active duty servicemember to separate from the military in a timely manner.

Recently several new initiatives have been undertaken under the Joint Incentive Program and the Joint Demonstration Project. Development of several Joint Incentive Fund proposals totaling $4 million have been completed and funded including computer-aided design/computer-aided manufacturing for orthotics and prosthetics, a chronic dialysis center for veterans and a joint pain management improvement project. All three of these initiatives will improve access to care to our joint beneficiaries and decrease wait times. The Hawaii Collaborative was also selected as one of eight sites to serve as a demonstration project. Our Collaborative proposes to meet the need of establishing a structure and process to jointly assess, execute, and evaluate improvements in the following: Health Care Forecasting and Demand; Referral Management and Fee Authorization; Joint Charge Master Based Billing development; and Knowledge and Document Management. The collaborative expects to garner benefits from these demonstration studies including improved planning and programming for resource sharing (e.g. facility construction, joint staffing, joint purchase of services in the community, etc); improved budget forecasting; improved monitoring of access, workload, and budget execution for the Collaborative; improved access to documents for information exchange within the Collaborative; improved continuity of patient care; and improved fiscal resource management.

We have also undertaken a joint approach in planning for pandemic flu response. We continue to explore opportunities and initiatives that allow the Services and VA to share staffing representing effective fiduciary stewards of our government resources. In the past month, we've signed two new sharing agreements. The first agreement relocates the Post Traumatic Stress Disorders (PTSD) Residential Rehabilitation Program (PRRP) from Hilo to TAMC. This facility currently provides residential PTSD services to veterans with chronic PTSD. However, once relocated to TAMC, the PRRP will be able to treat active duty members too. The current PRRP program admits patients as a cohort group, and provides a 7-week program of integrated treatment, including but not limited to PTSD symptom management, communication skills, anger management, relaxation training, behavior therapy, trauma focus therapy, adjustment counseling, substance abuse and relapse prevention treatment, and general health education. The second agreement is in support of a Clinical Investigation study titled "Women's Deployment Stress and Health: A Pilot Study". The principal investigators include providers from both TAMC and VAPIHCS. The primary objective of the study is to explore the relationship between deployment stress and women's health in a population of women returning to Oahu from deployment to Iraq or Afghanistan. We have also undertaken a joint approach in planning for pandemic flu response. We continue to explore opportunities and ini-

tiatives that allow the Services and VA to share staffing, and remain effective fiduciary stewards of our government resources.

As with most merger type activities, there are barriers that impede unfettered, efficient coordination. I believe, however, most of our Joint Venture barriers are systemic in nature.

Despite the barriers we confront, we continue to work together diligently to devise local solutions. The Pacific Telehealth & Technology Hui is an agency that represents a partnership between TAMC and the VA. The DoD/VA Interoperability Project is a healthcare systems interchange initiative focused in three distinct areas—Pharmacy Bi-Directional Data Interchange, Common Data View (Janus) and Laboratory Interoperability. The Pharmacy Bi-Directional Data Interchange allows providers on both the DoD and VA sides to order and receive prescriptions from either information system. The common data view presents patient data (demographics, lab, pharmacy, etc) to be viewed on a common screen. Finally, the laboratory interoperability allows lab orders and results to be communicated between both systems. The common goal of these initiatives is to improve patient care by developing interfaces to allow the electronic sharing of pertinent patient information between the VA, DoD and other clinical data providers.

In terms of DoD VA/joint venture development, our future is now. We are ahead of most localities in that we are already one of the most functionally integrated joint ventures. Instead of two freestanding medical centers, we have only one emergency room; one inpatient medical, surgical, and psychiatric service; and essentially one major specialty outpatient service. We have integrated clinical services for psychiatric on-call support, hospitalist support, nephrology support and psychology services. However, this functional integration is just the beginning.

While we are ahead of most of the other joint venture sites in the Nation in developing our sharing agreements and establishing policies and procedures, there are still opportunities for continued development of our Joint Venture. The two key determinants when developing opportunities for improved coordination are expansion of our patient care services to care for more patients and elimination of redundant overhead. We have worked diligently to develop initiatives for VA Chronic Dialysis, shared pain management resources and expanded orthotic/prosthetic support to veteran patients through the Joint Incentive Fund. However, additional opportunities for improved coordination and cooperation are numerous.

There is local VA and DoD top management support to make Tripler a model joint venture site. In this respect, countless hours have been invested by both activities to improve our joint venture. In order to perpetuate sharing between VA and DoD entities, national initiatives applicable to all types of sharing should continue to be developed.

Information systems are evaluated for applicability to sharing, and solutions to systemic issues should be identified and resolved expeditiously. We must address and resolve the barriers to achieve our ultimate goal—high quality care for our respective beneficiaries in a seamless healthcare system.

Senator AKAKA. Thank you. Thank you very much, General Pollock, for your testimony. I really appreciate what you're doing there for our active duty servicemembers as well as our veterans. I want to tell you that with Tripler, we have a great model of services there for our active duty servicemembers as well as our veteran members, the situation there on the hill.

I have some questions for this panel. Dr. Perlin, I want to commend your efforts to expand the delivery of mental health services in fiscal year 2006. I note the excellent way in which you are distributing $100 million for mental health services, allowing the networks to develop their own creative proposals.

I wish to call your attention to Hawaii's proposal to meet the needs of all veterans residing on remote Pacific islands as well. The cornerstone of one enhancement is the use of telemedicine capabilities to address existing gaps. Another proposed enhancement would improve PTSD and substance abuse treatment as well as staffing levels at Hilo on Hawaii, on Maui, and Oahu.

With a relatively minimal investment in equipment and staff, we believe we will see tremendous improvements in outreach and out-

comes with each of these enhancements. I hope you find their proposals meritorious.

Moving on to a related issue, it is my understanding that the relocation of the Hilo PRRP has yet to be completed. Dr. Perlin, has a suitable location been found on the Tripler campus for these much needed services yet? Where are we with regards to the relocation and restoration of the service?

Dr. PERLIN. Thank you, Senator Akaka. If I may address the two questions first, the telemedicine and the $100 million for mental health care, first let me thank Chairman Craig and you for your leadership in making $100 million available to make sure that mental health needs are not only met, but met in the best possible way.

Part of that, I think you'll find, will help services here in Hawaii in some very unique ways. My goal when these $100 million were distributed were to make sure that those dollars got to the very front lines of care. I think in Hawaii, the ability to use telemedicine for tele-mental health is a unique opportunity to reach veterans across all the neighbor islands.

What I'd like to do is have Dr. Robert Wiebe, who directs our VA Pacific—I'm sorry, the Sierra Pacific Health Care Network, VISN 21, describe the proposal that, under his leadership, his excellent leadership, aimed for. I think you'll find the answer to how those funds are coming right here to Hawaii to be very, very satisfactory.

Dr. Wiebe.

Dr. WIEBE. Thank you, Dr. Perlin and Senator Akaka. Thanks to the generous acts of you and your colleagues in Congress as well as the outstanding leadership of Dr. Perlin, VA did indeed make $100 million available this year to support the implementation of the VA Strategic Health Plan for Mental Health.

Facilities across the country were given the opportunity to apply for funds and submit proposals that would describe how those funds would be used to directly benefit veterans. The VA Pacific Islands Health Care System submitted four such proposals that received strong support from the network office as well as the program office in VA headquarters, and ultimately, the approval of Dr. Perlin.

All four proposals submitted by the Pacific Islands Health Care System are being funded, so there will be more than $1 million coming directly to Pacific Islands Health Care System this year to support improvements in mental health.

They will come in four areas: Substance abuse; tele-mental health; enhancement of mental health services on two neighbor island clinics; and also funds for direct support of OIF/OEF care, and specifically the creation of an intensive outpatient program so that we can serve the veterans returning from Iraq and Afghanistan with the full range of adjustment disorders, including PTSD.

As you noted in your question, Senator Akaka, indeed this will be a great benefit to the veterans in Hawaii, and I look forward to the implementation of those programs later this year. Thank you.

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

[Applause.]

Senator AKAKA. We've heard from the Director and the Regional Director of the VA.

Dr. PERLIN. If I may address your second question, you asked about finding a suitable location for the PTSD Residential Rehabilitation Program. I'll ask our new director of the Matsunaga Medical Center, Dr. James Hastings, to address that, along with Dr. MacBride, the Chief of Staff.

Senator AKAKA. Dr. Hastings.

Dr. Hastings. Thank you very much, Dr. Perlin.

Senator Akaka, I have come into this system and become aware of this changing philosophy of how we are going to address the problem of PTSD for our new generation of veterans, and this is embodied in the move that we're currently undertaking.

As of, I think, 2 weeks ago, we were able to take possession of space in Tripler, which is currently being formatted so that we can continue the treatment of our PTSD patients, but on this island instead of in Hilo.

So we have the space. We have moved some of the employees over. We are currently in the process of acquiring a few more employees. We hope that in the near future, we'll be able to begin to open our new class.

Senator AKAKA. Thank you very much.

Dr. MacBride.

Dr. MACBRIDE. Thank you, Senator Akaka.

I would just like to add that because I was there before Dr. Hastings joined us, I remember vividly the day that the VA asked General Pollock and her staff for help in relocating the PRRP, and General Pollock graciously made this a very high priority for her staff to help us locate space within Tripler. That has, as testified by Dr. Hastings, become a reality. We're very grateful again for that partnership with Tripler.

Senator Akaka, thank you so much for supporting the formation of the PRRP initially for us 10 years ago. Now, we take the next step forward and move into the 5C–1 unit at Tripler—and by the way, I learned on the way over here from our ACOS for Mental Health, Dr. David Bernstein, that the furniture has now been installed and that we have three staff that are busy putting things in place. As General Hastings mentioned, we are recruiting new staff.

But that vision to begin for Hawaii a post-traumatic stress residential rehabilitation program was yours, Sir. Again, we thank you for that leadership.

Senator AKAKA. Thank you very much. You've just heard from Dr. Hastings, who's the Director, and also the Chief of Staff, Dr. MacBride, their testimony. I want to thank you folks for being here. You've heard what they're trying to do here, and it's really great for Hawaii.

I have a question for General Pollock. In your written statement, you mention systemic barriers to joint ventures. Could you elaborate and provide examples of these barriers?

General POLLOCK. Thank you for that question, sir, because it really relates to the needs of the patients. It's very, very confusing for the patients when they're dual eligible. They're not clear about what their benefit really is and which of us it's best to go to receive that benefit. Then as we coordinate it, just that additional coordi-

nation can be frustrating for the patients as we work that. That would be one example, that dual eligibility.

The other that I would talk about is we really need a standard methodology throughout DOD and VA for billing and reimbursement because I would much rather that we spend our staff money on people who can assist the patients and do patient education and patient support than have them doing stubby pencil pushing pieces of paper back and forth in order to accomplish that billing mission. They would be two examples.

Sir, if you would indulge me for just 1 second, you asked the question about the status of the residential treatment facility. We've signed together a document that has gone down to the installation management activity, Colonel Howard, who's down at Schofield Barracks.

He's promised us that we will have expedited review and evaluation. So we'll know exactly where on the campus we'll be able to break ground for that new building.

Senator AKAKA. That's great news. Thank you so much for that.

General Pollock, talking about paperwork and all of that, how do you handle dual-eligible beneficiaries?

General POLLOCK. We spend a significant amount of time trying to educate them. Both sides of the building, whether they go in to the VA for advice or if they come to us for advice, there's a significant amount of time, just because the benefits are different. So it's very complex.

We both have staff that are dedicated to resolving those issues, to coordinating that care, to make sure that we're able to go as quickly as possible. But one of the other concerns that I have as one of the healthcare providers is that when they can go from one organization to the other, we have concerns about, well, who's really managing their care? Who's their primary care manager? How can we ensure that everything is in line so they're getting the best care possible?

So that would be one I would really like see us resolve.

Senator AKAKA. Thank you for your response.

Dr. Hastings, from your vantage point as the former commander and now a director at VA Hawaii, where do you see the most opportunities for increased sharing here in Hawaii?

Dr. HASTINGS. Senator, I think I want to start off by answering that and thanking you and your Committee for all the efforts that you have put forward over the years in helping us. I've had the opportunity for 30 years to look at how the veterans are taken care of at Tripler, and I am absolutely astounded at the improved care, quantity of care, in a very high performance organization that I see.

I have to agree with General Pollock in one of the comments that she made, that the sharing that is going on today between these two organizations, these two very high quality healthcare organizations, is as good as it gets anywhere in our country.

I've heard a lot of the problems of sharing across the country, and you have heard some of the examples here. But I can tell you from firsthand experience, we're sharing in many, many other ways and are running a seamless system in spite of a number of frustrations.

Now, that's not to say that, you know, we're finished. We have, I think, a lot of opportunities to develop over the next few years. One of the ones that I would mention has been addressed today, and that's specialty care.

A number of years ago, the Veterans Administration in Hawaii was not terribly involved with specialty care. The philosophy has changed enormously, and we are now getting much more involved in specialty care.

At the same time, Tripler, which has been a tertiary care institution with significant specialty care for many years, is under significant stress because of the war that we're in. I see a significant opportunity for us to augment the specialty care that Tripler is providing at this time. I think that's one example.

As was mentioned earlier, the VA has already put in motion hiring some sub-specialists who will improve care to our veterans on the outer islands, but at the same time will do it right here on the Tripler campus.

I think another example that I would bring out is the same-day surgery. An opportunity that we have—when I talk to the surgeons at Tripler, they're maxed out in their operating room. They are stretched as far as they can stretch them. I'm sure you've heard problems from our veterans of having to go out into the community to get procedures done that we would like to have been done at Tripler.

I think a win-win situation for both the Veterans' Administration and for the Department of Defense is to come up with some solutions that would increase the availability of same-day surgery and, indeed, endoscopy for our veterans. So I think this is another area where we clearly can make some very significant headway.

Another area that has struck me as I have been with the VA in the past couple of years, and that is we have very well developed community-based clinics on the other islands. That has been addressed today. These clinics deliver a very high quality of care.

I'm sure that there are members of the active duty and dependents who have needs for healthcare and exist on our outer islands. The density is not high enough to make it possible for General Pollock to provide care. This is an area where we can share, we can develop sharing, where we can help out Tripler just because we are distributed in a different kind of way.

These are all areas that I think are areas where working together, we can come up with much better access and quality and quantity healthcare for both our veterans and our active duty personnel and their dependents.

Senator AKAKA. Thank you, Dr. Hastings.

Before I end the hearing, I want to recognize a special person in the audience, Claire Wiebe. Is Claire here? Just stand. Claire is in the third grade, up front here, and she is attending her first Senate hearing.

[Applause.]

Senator AKAKA. I'm sure you are proud of your dad. You can see how hard he works here.

I also want to recognize the Committee, the Committee staff, who have worked hard over months and during the days that we're here at these hearings. They have worked to put these hearings to-

gether, and it's a tremendous job because I see it being done. I want to thank Pat Driscoll, Rob Mann, and Kim Lipsky, who were primarily responsible for today's hearing.

I also want to thank—and again, I want to say I have much aloha for Chairman Larry Craig and for what he has been to this Committee and what he has done. And it's tremendous.

And of course, I'm saying that so I can say mahalo to his staff, too, who are here. I want you to know Lupe Wissel and Billy Cahill are here from Chairman Craig's staff. They've been here working with us and are here today.

I also thank Tom Harvey, who's executive assistant to Secretary Nicholson, for joining us here in Hawaii.

I also want to recognize Michelle Moreno, Ted Pusey, Dahlia Melendrez, Alex Sardegna, Donalyn Dela Cruz, and Jim Yoshimura on my staff who are here. I want to thank them for all they've done.

Of course, before I forget, Noe Kalipi. We have two staff directors. Lupe is Senator Craig's staff director, and Noe is my staff director.

[Applause.]

Senator AKAKA. Finally, I want to thank our veterans in Hawaii. I thank God for you for our great country and for all of our boys and girls who are in service right now in Iraq and Afghanistan and in other places, who are serving to keep our country free and with liberty. That's a great effort, and they sacrifice themselves for it.

We're grateful. This is why Larry Craig and I are trying our best to help out. VA is also doing it. We all are here, trying to help give the best service to our veterans when they come off of active duty. But we have ideas, and you'll hear about it in the future, and we'll let you know about that. But this Committee will continue to strive to do all of these things.

I want to thank the veterans in Hawaii for all you and your families have done to make our State and our Nation so great. Mahalo nui loa, and aloha.

[Applause.]

Senator AKAKA. This hearing is adjourned.

[Whereupon, at 1:03 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Travis Combs

Mahalo, Senator Akaka for bringing the Senate Committee on Veterans' Affairs hearings to our DAV Hall recently. I found the historic event very interesting and the ecumenical spirit alive and well amongst the various veterans groups.

I look forward to your re-election and thank you and your staff for all your support and hard work.

Prepared Statement of Charles H. Turner

I have had claims filed with the VA for nearly 15 years for injuries suffered from mustard gas during my service in World War II. My first claim was denied on the basis of lack of evidence. I could not provide such evidence because the Army conducted a secret operation on me and my fellow servicemen while we were on maneuvers in Mississippi. We were sprayed with phosgene to test the efficiency of new gas masks that were supposedly impervious to any gas the enemy had.

These new gas masks also were used in field operations while we were engaged in qualifying tests for the Expert Infantryman's Badge that involved chemical warfare tactics. I qualified and was awarded the Badge and a pay boost of $5 a month. I still have that treasured Badge. But the Army refuses to admit that I earned it! It has stonewalled my application for correction of my Honorable Discharge since 1991 when I also filed a VA claim. The VA apparently could not proceed without verification of the award and thus I have been frustrated.

I now feel that I should come forward and disclose something I have never revealed before: While I was engaged in preparations for overseas duty in Mississippi in 1944 I was detached from my unit—Company I, 376th Infantry—and assigned to a special unit that was preparing our 201 Files for shipment. My MOS was as a BARman but because I could type I was assigned to the Company Clerk, Cpl. D. Nelson Russ.

While working at headquarters, I noticed something strange. Information about the Expert Infantryman's Badge was being deleted. Furthermore, no General Orders had been cut, as was normal procedure. I questioned the company clerk and he told me not to worry about it.

But I did worry about it . . . so much that I secretly began making a list of everyone in my company—name, rank, serial number and hometown address. I still have that list. I never got a chance to complete it.

I was summarily dismissed from my special assignment and sent back to do BAR training.

I have irrefutable evidence that I received the Expert Infantryman's Badge. I submit with this letter an enlarged photo of me while I was in Company Formation at Camp McCain, Miss., shortly before we went overseas. One can plainly see that I am wearing the Expert Infantryman's Badge. I can make the full photo (it shows 200 men) available if necessary. Would anyone dare wear such a badge in formation unless he earned it? The Army, in attempt to cover up the abuses in our training, has done a terrible thing. Most of those 200 men in the picture are long dead. Even Corporal Russ, our Company Clerk, no longer is among the living. Even if I finally win my case, it will be a hollow victory.

But I am determined that the truth shall come out. I want the Army to end the charade once and for all. I would hope that in a sense of decency it would finally correct my Honorable Discharge to show that I received the Expert Infantryman's Badge as well as the other awards omitted from the document because I took the word of a clerk at the Mustering Out facility at Ft. Dix, N.J., that "No one wants to hire a killer!"

I have submitted medical evidence to support my latest claim with the VA and am awaiting a decision.

Meantime, I hope I can survive to see this matter to a final conclusion. At age 82, fighting cancer and heart trouble, the Diagnosis is not good.

[From the Memphis Commercial Appeal, July 9, 1944]

CAMP McCAIN UNITS TO RECEIVE HONORS

EXPERT INFANTRY REGIMENT AWARDS PLANNED TODAY—PUBLIC WILL ATTEND

CAMP MCCAIN, MISS.—The three infantry regiments of the 94th Division will receive the highest award of the Army Ground Forces—that of Expert Infantry Regiment—in elaborate ceremonies at the division parade grounds Monday morning.

The event will mark the first award of the Expert Infantry Regiment streamer to any regiment in the Army, which at present count is more than 8,000,000 troops. The honor of being the first regiment to qualify for the streamer goes to the 376th Regiment, commanded by Col. Harold H. McClune, who has progressed from a private in World War I to his present position.

376TH REGIMENT WINS

Three days after the 376th became the first in the Army to deserve the streamer, the 302nd Regiment, commanded by Col. Earl A. Johnson, and the 301st, led by Col. Roy N. Hagerty, qualified. The last two outfits, however, are still shy of the record set by the 376th, which has every company in the regiment qualified for the Expert Infantry company streamer.

This latest recognition is a continuation of a long string of honors which have come to the 94th Division, commanded by Maj. Gen. Harry J. Malony.

Among the distinguished general officers who will be present for the ceremonies are Maj. Gen. John P. Lucas, who led the Army corps which initiated the Anzio beachhead south of Rome and now is commander of the Fourth Army, and Maj. Gen. Frank M. Milburn, commander of the XXI Corps, of which the 94th is a part. Also ranking officers from the Army Ground Forces headquarters in Washington are expected to be on hand.

MEANS PAY BOOST

The Expert Infantry awards, created by the War Department to partially give the Doughboys credit for the unsung work they do in winning wars, require a high degree of efficiency from the soldier in every phase of training—from military discipline to bayonet skill to chemical warfare.

A company, battalion or regiment must qualify 65 percent of its personnel to be eligible for the award. As further recognition of the work of the Doughboy, Congress recently passed a bill granting pay raises of $5 per month to holders of the Expert Infantry Badge, which means practically an en masse pay raise for the 94th foot troops.

In the parade Monday Brig. Gen. Louis, division artillery commander, will serve as commander of troops, forming the division for review by Generals Lucas, Milburn and Malony. The public is invited to attend at 10 a.m.

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26 JUN 1991

DEPARTMENT OF
VETERANS AFFAIRS

NEWS RELEASE

VA PROPOSES NEW POLICY FOR MUSTARD GAS CLAIMS

Barry Raff, Director of the VA Medical & Regional Office Center (VAMROC), Honolulu, announced that World War II veterans exposed to mustard gas testing during military service and who suffer from certain long-term effects will become eligible for disability compensation under new rules being proposed by the Department of Veterans Affairs (VA).

"Because of the confidential nature of some mustard gas testing during World War II, we are giving the benefit of the doubt to those veterans who were involved in these tests. This decision also is based on VA's determination that certain diseases may result from exposure to mustard gas," said Raff.

Criteria normally used in evaluating claims for VA disability compensation require documentation that the illness or condition occurred during military service, which usually consists of treatment noted in the individual's military medical record. Because of the confidentiality of some of the testing, the possible lack of military medical records associated with these tests and the lack of long-term followup of veterans by the military branches involved, these criteria will not be applied to the mustard gas claims.

-more-

PREPARED STATEMENT OF DR. STANLEY LUKE, HELPING HANDS HAWAII

We are writing to you regarding the VA services in the State of Hawaii. The focus of the below issues is on gaps and barriers to care for the local veterans. Please allow us to review these problems from the perspective of a mental health provider in the community.

1. On Oahu, veterans have much difficulty obtaining an appointment at the VA. Our understanding is that the NCQA standard for a Routine appointment is 5 working days. The VA system clearly does not meet this community standard for Access to care.

2. There has been a strained relationship between our agency and the Mental Health department at the VAMROC. Specifically, we had a VA client, S.A., who was denied services at the mental health clinic by Drs. Bernstein and Batzer. In my letters to Senators Inouye and Akaka, I filed a formal complaint regarding the quality of care problems associated with the denial of services for this 100 percent Service Connected veteran, who is now deceased.

3. Regarding PTSD treatment, as a psychologist, I have worked twice for the PRRPHilo program, which was closed in December 2005. I understand that there is a plan to build an expensive inpatient PTSD facility at TAMC. I would recommend that a comprehensive study be conducted to determine if this is an efficient and effective manner to provide PTSD services to veterans in Hawaii. In general, I believe that an intensive outpatient PTSD program and supported housing program would be an alternative to inpatient treatment. Such a treatment program would be possible for All locations, including the neighbor islands.

4. On Oahu, the C and P process has often been a burden and even a traumatic process for the local veterans. They have had to wait for their disability evaluations and have been disrespected by some of the mental health professionals who have conducted the PTSD evaluations. Specifically, I had a veteran express rage and resentment after being told that he was a "faker," who was exaggerating his PTSD symptoms.

5. There has been no on call coverage for mental health services. Veterans are simply told to go to the Tripler ER after business hours. Psychiatrists are not providing 24-hour coverage for their patients.

6. We understand that mental health professionals have no office space now at the psychiatric unit at Tripler's 3B2. This has affected morale and wasted time for the mental health staff assigned to treat inpatients.

7. We also have observed that the staff at the benefits department have been burdened by large caseloads. This has affected morale and effectiveness in this department. We have noticed burn out and conflicts between staff members as well.

8. Dr. Bernstein, who is chief of mental health services, has not been able to answer our questions regarding denial of services for veterans. He has even produced a rather flawed policy and procedure regarding veterans who are on a Conditional Release from the Hawaii State Hospital. In short, we have been told that the State of Hawaii's Adult Mental Health Division, not the VA, is responsible for the mental health needs of the veterans, even if he/she is 100 percent Service Connected for a disability. I am not clear why Dr. Bernstein has not addressed this issue regarding dual eligibility for services.

9. We have not been impressed with the utilization of the telemedicine resources. On Oahu, there are rural areas such as the Leeward side and North Shore which could benefit from telemedicine. There are many homeless veterans in these areas of Oahu, and they could benefit from outreach services as well.

10. There has been a lack of resources in the VA's mental health system. For example, there has been no hiring of clinical psychologists when replacements are needed. Positions have either been frozen or eliminated. No psychologists have been hired to work in Primary Care settings. Only a Maui psychologist has been hired for this kind of integration of mental health with Primary Care.

11. There has been no replacement hired for the chief psychologist position after Dr. Rodney Torigoe retired many years ago. This has weakened the Psychology Service.

12. In the past, cultural issues have been given both emphasis and money to improve VA services. Cultural competence is considered to be essential in any health care system, but the local VA has decreased its resources for this area. Many of the veterans are Native Hawaiians, and it concerns us that the VA has allowed an erosion in the trainings and education on cultural competence.

13. The National Center for PTSD (Pac Center) has located its offices in downtown Honolulu. It has been on Bishop Street for many years, and veterans have had to go to this location for services and also research projects. We recommend an audit of this office location to determine if this is efficient and effective. We wonder if the

National Center office should be located at TAMC rather than in an expensive location in downtown.

14. The VA services have been affected by poor leadership and management. In Honolulu, the VA upper management have been insensitive to mental health services, usually using money and resources for other areas. In addition, there has been poor morale for staff members at VAMROC. There has even been infighting between staff at the VA.

15. The Vet Centers have been extremely busy. They are providing mental health services with a small staff model. Therefore, we recommend that the Vet Centers hire additional staff to improve their capacity for services.

16. Finally, we have been concerned about the lack of outreach services to veterans on Oahu. Generally the mental health services have been office or facility based, rather than community based. Essentially, veterans have avoided going to the VA because mental health outreach services have not attempted to engage them. They also perceive the services to be poor in quality. Thus, other health systems in Oahu have had to provide mental health services for veterans. For example, they have opted out and gone to private sector providers or even state-funded programs to receive their care.

Prepared Statement of Malcolm M. Giblin

Thank you for taking the time to update the veterans on the state of VA care in Hawaii.

The status of coordination health care resource between the Department of Veterans Affairs (DVA) and the Department of Defense (Tripler Army Medical Center) (TAMC) delivery of adequate medical care is grossly inadequate.

I want to express the fact that the DVA lack a strong commitment to support the activities and deliberation of health care. Collaboration between the VA and DOD has to be improved in order to provide adequate services to our veterans. For example, the DVA prefers to send veterans to Palo Alto, California for surgery when the same services are available at Tripler Army Medical Center. We desperately need to improve coordination between the two departments in order to achieve enhanced and much needed benefits for our deserving veteran population.

It is important to note that the VA and DOD leadership in Hawaii has not worked jointly for several years to address improvement or expansion of health care to our veterans.

I recently had a conversation with an Orthopedic Surgeon at Tripler Army Medical Center. He informed me that the DVA prefers to fly a patient to Palo Alto for surgical procedures. The surgery is performed and then the patient is flown back to Hawaii. The primary doctor is in Palo Alto and the patient is in Hawaii. The same procedure could have been performed at TAMC with the doctor located here in Hawaii, instead of the mainland. Follow-up treatment can be performed locally. Additionally, the DVA prefers to farm the veteran out to local doctors for specialty care vs. using TAMC.

A new Orthopedic Surgeon will be assigned to DVA at TAMC in the near future. What is the value of a surgeon who will not have operation room privileges at Tripler? Between the two, we need to explore collaboration to improve delivery of care at patient level. The VA Leadership needs to explore the potential of sharing with TAMC. As a matter of fact, health care officials need to declare that health care is local. Therefore making facility-level between coordination the VA efforts extremely important, in order to improve health care delivery to our beneficiary collaboration and Tripler.

In addition, under TRICARE, the nature of interagency sharing health care has shifted from direct sharing of Federal Complicated partners to VA, primarily functioning in a subcontractor role and making sharing even more complex and complicated.

In conclusion, I believe that in order to improve "The State of Health Care in Hawaii", the VA and TAMC need to work at all levels to expand and improve our sharing relationship. In addition to those specifically issues discussed, we need to continue to ensure that both our departments work together as effectively as possible.

PREPARED STATEMENT OF HENRY KAUHI

Subject: Assistance With the Following Pertinent Veteran Benefits and Health Related Issues:

(1) Priority: Direct Hawaiian Home Lands to allow my 71-year-old mom to reinstate her lease of 40-plus years, so that the Regional VA Office can assist me in completing my VA Home Mortgage Loan to a Veteran who currently is collecting 100 percent Social Security Benefits and at least 50 percent total VA Disability Benefits which has been in appeals for over 6 years and demands closure;

(2) To Assist me and future Veterans Who are still in the Appeals Stage by either expediting or having a process that is more easy to understand and easier for the Veteran to follow as currently it seems that we are locked in many red tape issues or/and catch 22 issues;

(3) Currently I received a diagnosis and half treatment for the following conditions:

(a) Thyroid Cancer Glands surgery performed late August 2005 by Dr. Francis, Tripler Medical Personnel and have yet to perform the follow up Iodine Treatment to ensure total removal of all cancerous cells;

(b) Received confirmation by Dr. Bahrenberg of same facility that I have Multiple My Loma, another Cancerous Diagnosis in late Sept. 2005 which has resulted in current treatment making my body weak, and susceptible to current Pneumonia Conditions and also in dealing with my current service connected injuries which are pain to the middle lower back and also PTSD, which Social Security has recognized, however VA has yet to acknowledge that is connected regardless of currently being treated by my Prim Nakatsu and also Dr. Wong from Psychiatry at the Clinic at Tripler.

(4) I have maxed out the Voc. Rehab Program (to include Completing Independent Living);

(5) My current health requirement is an assistant immediately, as my mom is currently helping but have health limitations of her own, and I have been bed ridden for over 2 weeks!

(6) In addition, I could use a way to get around, like a bed that can assist me to stand and also one of those carts that can transport me to and from shopping as I have been unable to work since 1997.

PREPARED STATEMENT OF WILMA HOLI, PRESIDENT, PAPA OLA LOKAHI

Good morning Chairman Craig and Members of the U.S. Senate Committee on Veterans' Affairs and a special Aloha to Senator Akaka, Ranking Member. Papa Ola Lokahi (POL) wishes to express its deep gratitude to Senator Akaka for bringing the Committee to Hawai'i to review "The State of VA Care in Hawai'i." My name is Wilma Holi, president of Papa Ola Lokahi.

Papa Ola Lokahi is the Native Hawaiian Health Board that was established in 1988 to plan and implement programs, coordinate projects and programs, define policy, and educate about and advocate for the improved health and wellbeing of Native Hawaiians. This was done in conjunction with the U.S. Congress establishing its policy "to raise the health status of Native Hawaiians to the highest possible level and to provide existing Native Hawaiian health care programs with all the resources necessary to effectuate this policy (P.L. 100–579/P.L. 102–396).

Native Hawaiians have served in the military services of the United States almost from the very beginning of the Nation. Young Prince George Kaumuali'i enlisted in the U.S. Navy and fought in the War of 1812 in the Mediterranean. In following conflicts including the American Civil War, the Spanish-American War, World Wars I and II, Korea, Vietnam, Iraq, and now Afghanistan and again Iraq, Native Hawaiians have continued to serve and serve with distinction. As a side note, a number of Native Hawaiians have also served historically in the military services of other countries including England and Canada.

Current U.S. Census data indicate that there are about 30,000 Native Hawaiian and Pacific Islander veterans in the United States. A large proportion of this number is resident in Hawaii; thus, the great importance of the local VA offices.

In 1997, when the VA released the results of the Hawaii's late Senator Spark Matsunaga-initiated study on the impacts of exposure to war zones on Native Hawaiian and Asian veterans, it became clear that along with American Indians and Alaska Natives, Native Hawaiians have borne a higher burden of battle-related stress and trauma. More than one in two Native Hawaiian veterans experienced war-related trauma in Vietnam. The report goes on . . . Upon returning home after one or more tours in Vietnam many Native Hawaiian veterans struggle with ex-

tremely severe problems that neither they nor their families, friends, or communities know how to understand or cope with: depression, shame, guilt, isolation and emotional emptiness, alienation, unable to relax, addiction. One in three Native Hawaiians have full or partial PTSD currently . . . More than one in two Native Hawaiians have had full or partial PTSD sometime since Vietnam.

With conflicts in the 1990s in Iraq and now ongoing conflicts in Iraq and Afghanistan, and with Reserve and National Guard units being heavily utilized along with regular military and the particularly brutal nature of the current warfare, these PTSD episodes will only greatly increase. An additional factor in these conflicts is the full participation of women now integrated with formally almost all male forces.

Native Hawaiians have been actively engaged with the Hawai'i Office of the VA (Veterans Affairs) for more than 10 years.

In 1993, the Office of Hawaiian Affairs under Babette Galang and working with Native Hawaiian kupuna (elders) developed for VA staff statewide a cultural sensitivity program entitled "Project Ho'olauna". POL became involved with health and wellness issues surrounding Native Hawaiian veterans shortly thereafter. It actively participated with the Department of Veterans Affairs and Director Barry Raff in the holding of its landmark Symposium on Healing Alternatives in October 1995, "An Interdisciplinary Orientation to Healing from Native Hawaiian, Native American, and Asian Perspectives."

Later, in March 1998, with Director David Burge and Thomas Kaulukukui, POL hosted a special section in its Native Hawaiian Health Summit on the health and wellness issues and concerns of Native Hawaiian veterans. Later, in 1999, both Director Burge and Mr. Kaulukukui were part of a POL team that visited the Navajo Nation to discuss with its veteran leadership how it was dealing with PTSD and other health issues surrounding Navajo veterans.

Also, in 1999 Federal legislation established the Hawai'i Federal Healthcare Partnership which brought together Hawaii's federally designated health entities—the Native Hawaiian Health Care Systems and Papa Ola Lokahi and the community health centers and the Hawai'i Primary Care Association—with the VA and TAMC (Tripler Army Medical Center) to focus on collaborative efforts around Native Hawaiian health. This partnership has developed into an increasingly effective mechanism to address Native Hawaiian health concerns including those of Hawaii's veterans.

In 2001, POL initiated with the VA a symposium for VA personnel and for others working with Native Hawaiian veterans. Noted psychologist Dr. Kekuni Minton presented a number of sessions on cultural trauma and its impacts. Also in 2003 and 2004, POL provided Native Hawaiian cultural competency sessions for VA and TAMC professional staff. These sessions clearly indicated the importance sensitivity to culture is in treating Native peoples.

Most recently in 2005, POL launched an effort with Dr. Bud Cook of Ka Maluhia Learning Center to begin to develop a program for Native Hawaiians, their families, and others which would look at building on the strengths of the Hawaiian culture to help mitigate veteran health and wellness issues. Work is just beginning on this initiative but it hopefully will enhance the work of the VA as well as bring together those entities working in the Hawaiian community in health such as the Native Hawaiian Health Care Systems to better address the on-going needs of our returning Native Hawaiian veterans-men and women-from the Afghanistan and Iraq theatres.

Despite these efforts, there is so much more to be accomplished as the needs of many Native Hawaiian veterans remain unaddressed. Reports of Hawaiian veterans living in caves and in rural forested areas continue to be heard. Health care access for them and their families is non-existent. Somehow we need to find ways of reaching out to these 'lost warriors.' This remains our challenge for the future.

Finally, before making the following recommendations, POL would like to acknowledge the appointment of Dr. Hastings as the new VA Director. POL looks forward to continuing to work with him and his staff. POL makes the following recommendations for your Committee's consideration:

1. Good health is integral to wellness and in the Hawaiian context, it incorporates mind, body, and spirit. POL strongly recommends that VA programs need to be mindful of and support cultural approaches which enhance wellness as well as address physical health needs;

2. Native organizations have an important role to play in the healing process for Native peoples. POL recommends that the VA work closely with and collaborate with such groups as the now being chartered National American Indian Veterans, Inc.; the Native Hawaiian Health Care Systems; the Hawai'i Federal Healthcare Partnership and others to include sharing resources and expertise to better address the health and wellness issues of Native Hawaiian veterans and others;

3. Culture serves as the foundation for healing for Native peoples. POL strongly recommends that the VA incorporate cultural competency sessions for its professional staff working with Native Hawaiian veterans;

4. The concept of 'place' has great significance in Native Hawaiian culture as it does in American Indian and Alaska Native cultures. POL recommends that the VA study this concept as a means to enhancing its ability to provide services to Native Hawaiians; and

5. Finally, on-going research into the needs and concerns of current Native Hawaiian veterans returning from war zones is crucial to saving lives. POL strongly recommends that the VA increase its research capacity to investigate what the health and wellness issues are for returning Native Hawaiian men and women veterans from today's war zones. It is hoped that many of these studies could be undertaken by Native Hawaiian health researchers themselves.

Thank you for giving POL an opportunity to provide testimony on this important issue.

PREPARED STATEMENT OF WILLIAM C. S. PARK, RETIRED MASTER SERGEANT

Mr. Chairman and Members of the U.S. Senate Committee on Veterans' Affairs:

I offer all honor and respect to the Great Spirit who brings us together today, to the spirits of this sacred land, the sky above, the earth below, the streams which run to the sea and the sea itself. I pay all honor and respect to our ancestors who watch over us, to the kupuna who have passed, to the kupuna who yet live to guide us with their wisdom; and to the chiefs, dignitaries, Senators, and other leaders present, to the Department of Veterans Affairs, its Chair, to all veterans and to all others present.

I thank you for taking the time to be here today and providing us the opportunity to discuss with you our concerns regarding veterans care here in Hawaii.

I am a disabled veteran employed with a non-profit organization that works with adult mental health clients and the homeless, many of which are disabled veterans. Through my position, I am not only a witness to the care disabled veterans receive (or don't receive), I am also faced with the challenge of helping them to find ways to overcome all the obstacles that are placed before them.

Through the teachings of our elders and Papa Auwae, we were taught that Hawaiian tradition and culture believed that warriors returning from battle needed to be "re-born". Special rituals were performed to help the warriors through this process. In today's society, we also must address and meet our warrior's needs.

Although it appears that this Committee is addressing many issues that directly affect veterans care, it doesn't seem as if the long-standing, underlying issues are getting the attention they should. I would like to stress that as a veteran receiving care at the VA and working with veterans, my complaint does not lie with staff. I have nothing but great respect and gratitude for the doctors and staff at the VA. They are committed and dedicated to the veterans and their care. They are also overworked, intimidated by management, and disillusioned with leadership at all levels. It is a ripple affect and it starts at the top with poor leadership, low staff morale, distrust of management by staff, no open door policies, no adequate resolution of complaints, misuse of VA funds, but most important, a severe lack of care for veterans.

Here locally, the VA has what it terms a "hands off" policy. This means that when a veteran is incarcerated or becomes a patient at one of the State's facilities, the VA considers him/her a "ward of the State", and thereby relinquishes all contact, communication and care of the veteran. (Enclosed is a Facility Policy Memorandum No. 136–01–030.) Although this policy does provide for a possible collaboration of a veteran's care once deemed to be a ward of the State or other government agencies, the local VA does not participate in such agreements for the care and well-being of the veteran. Working with these types of clients, living in the State of Hawaii, and given the lack of care provided by the VA, it seems only logical that at some point in time, a veteran will likely require the services of the State.

It has been my experience that when this happens there is absolutely no communication between the doctors and/or staff at the VA, the detention facilities, or the hospitals. I personally know of veterans who have for one reason or another (whether it be difficulty in getting appointments with VA doctors, lack of transportation, lack of understanding, misinterpretation of procedures, among a few) have failed to take their medications and in an attempt to seek help, ended up being referred to a State Agency. It is a well known fact among the veterans requiring mental health care, that the VA has NO case management services for its veterans. NONE. When a veteran is in a mental health crisis and calls the VA for help, they are told to

call the State Access line. I ask you, when you are in a health crisis, do you want to talk with a stranger who knows absolutely nothing of you or your circumstances, and who has no access to your files and records to refer to if you are unable to communicate your needs to them? And the story gets even better, because the veteran is the pawn, the State's hands are tied, and the VA has an uncooperative and uncommunicative spirit.

What is a veteran's alternative then? He/she seeks services on a fee basis which is approved by the VA. Unfortunately, more often than not, the vendor fails to get paid by the VA and the veteran receives the bill. Unable to pay the bill, it ends up with a collection agency. Now the veteran faces an additional challenge, when all he/she wanted and deserved was to get the care they are entitled to, a small compensation for the great sacrifice they have made in service of our country.

I implore you, each of you on this Committee, to listen well to all that is being said, not only today, but at all of your meetings with the public.

Go beyond what leadership and management are telling you.

Listen carefully to staff who care and are brave enough to speak regarding their needs and concerns, and please, please pay heed to what the veterans themselves are telling you.

He 'onipa'a ka 'oia'i'o. Truth is not changeable.

I firmly believe that the brave warriors of this country deserve the best health care services its government has to offer.

In closing, I once again thank you for holding these meetings and giving us the opportunity to voice our concerns. My thanks to you who cared enough to be here today, to those who were instrumental in arranging these meetings, and to you, the Committee, for seeking to ensure better care for veterans.

My heartfelt thanks to each and every veteran throughout this Nation, who have served our country so well. May the Great Spirit that watches over all, bless and keep each of us.

DEPARTMENT OF VA REGULATION—DEPARTMENT OF VETERANS AFFAIRS MEDICAL & REGIONAL OFFICE CENTER, HONOLULU, HI 96819, FACILITY POLICY MEMORANDUM, NO. 136–01–030, SEPTEMBER 30, 2001

EXCLUSION FROM TREATMENT OF VETERANS WHO ARE ALSO WARDS OF THE STATE OF HAWAII OR OTHER GOVERNMENT AGENCY

1. Purpose

To establish policy and procedures that expressly exclude hospital and outpatient care for a veteran who is a patient or inmate in an institution of another government agency.

2. Policy

(a) In October 1999, VA promulgated regulations, establishing the enrollment system and a medical benefits package describing the services VA furnishes to veterans enrolled in the VA health care system. In developing the benefits package, VHA decided to change its long standing policy and expressly exclude from the benefits package, by regulation, hospital and outpatient care for a veteran who is a patient or inmate in. an institution of another government agency if that agency has a duty to give the care or service.

(b) Under the Eight Amendment, a State or local government has a duty to provide adequate medical care and services to those whom it has incarcerated. To be adequate, the care must be reasonably designed to meet the routine and emergency health care needs of prisoners, including medical treatment for physical ills, dental care and mental health care. The medical care also must be at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards. That standard arguably applies to virtually all care that VA might furnish to a veteran.

(c) Emergency services will be provided to stabilize any veteran brought in. However, inpatient treatment will be considered only on a case-by-case basis.

3. Definitions

(a) 38 U.S.C., 1710(g). In 1986, Congress amended 38 U.S.C., 1710 (formerly 610) providing that VA "shall" furnish certain veterans with hospital care. To ensure that State and local officials did not use the new statute to argue that VA must provide care for incarcerated veterans, Congress added language providing that the statute does not require VA to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government. Subsection (g) does not prohibit VA from caring for incarcerated

veterans, thus from 1986 until late 1999, VA did provide such care. Rather, subsection (g) provides VA with legal authority for refusing to furnish such care to incarcerated veterans if it so chooses. VA did just that when it chose to exclude care for incarcerated veterans in the regulations establishing the benefits package, as discussed above.

(b) *Sharing Agreement:* The policy on providing care to incarcerated veterans does not prohibit VA facilities from entering into sharing agreements with prison or other state officials to furnish care to incarcerated veterans.

(c) *Ward of the State:* Any person who is forensically committed to an institution or is under conditional release. Patients on parole or probation are not considered wards of the state.

(d) *Conditional release:* A person who is forensically committed by the State of Hawaii Courts, but who is allowed community treatment based on their meeting a specific set of conditions approved by the court. These patients are considered active patients in Hawaii State Hospital (HSH) or other institution and are still a "ward of the State". A violation of any condition is considered grounds for revocation of the release.

(e) *Voluntary vs. Involuntary:* Voluntary assumes treatment that is with explicit permission of the patient, involuntary assumes legal involvement. There are involuntary admissions, which are based on medical opinion of danger to self or other while awaiting court ruling.

4. Procedure

(a) All patients meeting the ward of the state criteria are excluded from obtaining VA hospital or outpatient care.

(b) The VA reserves the right to enter or not enter into sharing agreements with other government agencies for the provision of care to veterans who are wards of the state.

(c) All patients on probation or parole are expected to have signed release of information agreements with the Hawaii State agency (either parole or probation officer, or HSH) and the VA, to afford free communication between the treating clinicians and the State officials.

(d) Treatment, other than emergency care, will not be provided when it is required as a result of a breach in conditions of release. Subject to signed releases of information, the VA will notify the proper State officials, such as parole officers or HSH staff, to assume their responsibility in care of the patient.

(e) Voluntary treatment as an inpatient or outpatient may be provided within VA or TAMC facilities for decompensation due to the veteran's medical or psychiatric illness. VA will not be responsible for care in other facilities.

(f) Involuntary inpatient or outpatient treatment will not be provided unless part of sharing agreement or if patient arrives at VA facility in need of emergent care. If a decision is made not to provide inpatient or outpatient care or treatment to a ward of the State, the appropriate State officials will be notified to act on the legal conditions.

5. Responsibilities

Compliance with this policy is the responsibility of all VA clinical staff. The ACOS of Mental Health Service, the Chief of the inpatient service, Fee Service, or attending physician is responsible for contacting the appropriate authorities.

6. Reference

(a) Title 38 U.S. Code Section 1710(g)

7. Rescission

Facility Policy Memorandum No. 116–99–001, dated July 30, 1999.

8. Attachments

None.

9. Review Dates

September 30, 2002 and September 30, 2003.

10. Re-issue Date

September 30, 2004.

11. Follow-up Responsibility

Chief, Health Administration Service, H. David Burge, Director.

PREPARED STATEMENT OF RANDALL TSUNEYOSHI

1. Health Care is excellent when you get it.
2. It took 18 months to get an Agent Orange review.
3. Takes 6 months to get an appointment.
4. Why does VA send out letter requesting proof that a veteran served in RUN, when the DD 214 clearly states they were there.
5. VA staff is overworked and under budgeted.
6. VA benefits should be tied in with the annual Defense Budget. A quarter of the budget should be for Vet care.
7. It takes 1 Combat Tour (we months) to develop PTSD. VA care should be funded of the level of 24 hours x 365 days = minimum time required for mental health care.
8. On Agent Orange diseases: Why does VA not used EPA Standards on Chemical affects. Agent Orange problems take years to affect the veteran. A CIB or Purple Heart is not the only justification for disability.

PREPARED STATEMENT OF LORI AND PAUL WESSEL

The support, therapy and guidance that they continue to provide for us (and our sons) have been excellent and very helpful throughout this awfully painful time in our lives. Bereavement Counseling provided by those who are knowledgeable about the military as well as being trained as counselors makes a difference. Sitting in the waiting area has also allowed me to witness first hand what they (the center, facilities and staff) provide to the veterans who walk in for information, support, advise and the work info center is a great asset and well utilized. We've seen vets come in for a bite of respite.

As non-military, without access to the VA benefits or really, information, this center has proven to be a life saver for us in dealing with the loss of our son.