S. HRG. 110–171

HEARING ON PENDING HEALTH CARE LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MAY 23, 2007

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HEARING ON PENDING HEALTH CARE LEGISLATION

WEDNESDAY, MAY 23, 2007

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

The Committee met, pursuant to notice, at 9:30 a.m., in Room 562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Obama, Brown, Tester, Sanders, Craig, Burr, and Isakson.

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

Chairman AKAKA. The U.S. Senate Committee on Veterans' Affairs will come to order. Aloha and good morning, everyone. Welcome to the Committee's hearing on pending health legislation.

The Committee has quite a docket of legislation to review, so I will make my opening remarks quite brief so that we can get started. As I said at our last legislative hearing, I am thankful for Members' interest in the needs of veterans and their families and the range of attempts to tackle some of the most pronounced issues. I know that our witnesses had quite an undertaking to do in order to give us views on the various bills we have before us. The Committee has done extensive oversight work and held numerous hearings on these matters. The legislation before us is a culmination of those activities.

Ranking Member Craig and I heard the testimony of witnesses at our March 27 hearing on seamless transition and care for veterans with traumatic brain injuries. We used that testimony to develop bipartisan legislation on TBI, which takes a comprehensive approach to providing the best possible care for veterans with this devastating injury.

I want to mention my legislation to extend the period of eligibility for VA health care for combat service from two to five years. It is my view that doing so will help ensure that returning servicemembers receive the care they need from VA in the five years immediately following separation or deactivation without having to meet strict eligibility rules. The changes my bill would make will contribute to the seamless transition of military personnel from active duty to veteran status.

While the Administration has opposed this legislation in the past, I am delighted that the obvious growth in the diagnosis for mental health conditions has prompted a reconsideration of their

previous position. Two years is often insufficient time for symptoms related to PTSD and other mental illnesses to manifest. In many cases, it takes years for such symptoms to present themselves and many servicemembers do not immediately seek care. Five years would provide a bigger window to address these risks. We face a growing group of recently discharged veterans and this legislation will help smooth their transition to civilian life.

I thank the witnesses from VA and other organizations for coming today to share their views. Because the number of measures before us this morning is unusually large and a number of them have been added to the agenda only recently, witnesses may not have had an opportunity to review them and formulate positions. Therefore, the Committee will hold the record of this hearing open for two weeks so that witnesses can submit supplemental views on any legislative item.

It is important that we have your input well in advance of our markup, which is scheduled for late next month. I look forward with all of you in the days ahead to move the Committee's agenda forward.

[The prepared statement of Senator Akaka follows:]

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

Aloha and good morning. I welcome everyone to the Committee's hearing on pending health legislation. The Committee has quite a docket of legislation to review, so I will make my opening remarks quite brief so that we can get started.

As I said at our last legislative hearing, I am thankful for Members' interest in the needs of veterans and their families and the range of attempts to tackle some of the most pronounced issues. That said, I know that our witnesses had quite a load to carry in order to give us views on the various bills.

The Committee has done much oversight work and held various hearings, and the legislation before us is a culmination of those activities. Ranking Member Craig and I heard the testimony of witnesses at our March 27th hearing on seamless transition and care for veterans with traumatic brain injuries. We used that testimony to develop bipartisan legislation on TBI, which takes a comprehensive approach to providing the best possible care for veterans with this devastating injury.

I want to speak very briefly about some of the items on the agenda.

First, I introduced legislation again this Congress to extend the period of eligibility for VA health care for combat service from two to five years. It is my view that doing so will help ensure that returning servicemembers receive the care they need from VA in the five years immediately following separation or deactivation, without having to meet strict eligibility rules. The changes S. 383 would make will contribute to the "seamless" transition of military personnel from active duty to veteran status.

While the Administration has opposed this legislation in the past, I am delighted that the obvious growth in the diagnoses for mental health conditions has prompted a reconsideration of the previous position. Two years is often insufficient time for symptoms related to PTSD and other mental illnesses to manifest. In many cases, it takes years for such symptoms to present themselves, and many servicemembers do not immediately seek care. Five years would provide a bigger window to address these risks. We face a growing group of recently discharged veterans, and this legislation will help smooth their transition to civilian life.

Second, S. 117, The Lane Evans Veterans Health and Benefits Improvement Act of 2007, introduced by Senator Obama, is a fitting tribute to the former Ranking Member of the House Committee on Veterans' Affairs. The legislation, among other things, would make combat-theater veterans eligible for a VA mental health evaluation within 30 days of the veteran's request. Such a request could be made up to five years after the date of the veteran's discharge or release from active military service.

S. 479, The Joshua Omvig Veterans Suicide Prevention Act, would require the Secretary to develop and implement comprehensive programs to reduce suicide among veterans. The bill is named after Joshua Omvig, a young veteran who com-

mitted suicide after returning from Iraq. On April 25, 2007, the Committee heard testimony from Joshua Omvig's parents about his struggle. It became clear that VA must place greater emphasis on reaching out to returning servicemembers, so as to prevent these types of tragedies from occurring in the future.

S. 1147, the Honor our Commitment to Veterans Act, would repeal the ban on enrollment of middle-income veterans, known as Priority 8 veterans, in the VA health care system. In the Majority's Views and Estimates letter to the Budget Committee, we recommended including funding in VA's Fiscal Year 2008 budget to enable VA to fully open its doors to all veterans who desire VA health care. In doing so, I do not believe that we need to undo what was done in eligibility reform, that is, to allow the VA Secretary to manage a priority system for care within the confines of a limited budget. I do believe that this year, the Congress will appropriate sufficient resources to allow for open access to VA health care while not severely altering the construct of eligibility reform or overburdening the system.

As I mentioned a moment ago, I am quite proud of S. 1233, the Veterans Traumatic Brain Injury Act of 2007. Senator Craig and I worked to develop a bill to address VA shortcomings in rehabilitation treatment, research and clinical care programs for veterans. The Brain Injury Association of America, the American Academy of Neurology, and the American Academy of Physical Medicine and Rehabilitation all support the legislation.

Finally, I also introduced S. 1384, which would make a number of changes to the funding for homeless programs; expand programs to aid in the transition to civilian life for both incarcerated veterans and servicemembers being discharged from the military; and improve domiciliary care for women veterans. All of these changes are yet another step in combating the prevalence of homelessness among those who have served our Nation.

I thank the witnesses from VA and other organizations for coming today to share their views. Because the number of measures before us this morning is unusually large and a number of them have been added to the agenda only recently, witnesses may not have had an opportunity to review them and formulate positions. Therefore, the Committee will hold the record of this hearing open for two weeks so that witnesses can submit supplemental views on any legislative item. It is important that we have your input well in advance of our markup which is scheduled for late next month.

I look forward to working with all of you in the days ahead to move the Committee's agenda forward. Thank you.

I would like to ask for any other remarks. Senator Obama, and then Senator Murray.

STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Senator OBAMA. Thank you, Mr. Chairman, and thank you for holding this hearing. I also want to thank the panelists and especially our friends in the VSO community and expert witnesses for their feedback on legislation under discussion today.

I would like to briefly discuss two important measures that I have introduced in this Committee. The Lane Evans Veterans Health and Benefits Improvement Act, which you mentioned, Mr. Chairman, very graciously, and I appreciate, would enhance mental health care and access for our veterans by enabling them to receive a mental health screening within 30 days of a request and full access to care required as a result of that screening, including hospital care, nursing home care, or family and marital counseling. Veterans would be eligible to request the screening 5 years after discharge and would be eligible for any resulting treatment for 2 years. The bill would also establish one-on-one face-to-face mental health screening for all returning servicemembers and would require that they receive individual electronic records upon discharge.

Now, unfortunately, the VA has expressed opposition to one provision in the bill, a proposed veterans' information tracking system

that would help anticipate the needs of our veterans and lead to more robust policy planning by the VA and Congress. Although VA has regularly struggled—and both you, Mr. Chairman, as well as Senator Murray have been working on this for a long, long time—to adequately anticipate its own budgetary needs and provide information requested by Congress, it argues that current reporting is sufficient and believes this provision is too costly and onerous.

I would argue that whatever costs would be incurred in setting up this tracking system would be more than offset by the better care that we could provide our Nation's veterans. It just strikes me that our planning process continues to break down. In the time that I have been on this Committee, we constantly have to come back with supplementals because we have not anticipated needs. I don't understand why the VA is resistant to instituting the sort of mechanisms that I think every large business and institution around the country puts into place to make sure that their budget is adequate to their needs. So I am going to be interested in finding once again why the VA is not willing to do that.

I am also pleased to have introduced the VA Hospital Quality Report Card Act. Our VA hospital system is considered by many to be the best health care system in the Nation and I think it is a wonderful success story, the progress that the VA has made over the last several decades. This bill does not question the assessment that VA has a high-quality health care system in place. Rather, it is intended to encourage the examination of hospital-specific performance to ensure uniformity and quality across hospitals. The bill would also require hospitals to measure and report quality information for sub-populations that have historically received lower quality care.

The VA's own research studies have identified a number of racial and ethnic differences in health outcomes and patient experiences, some positive and some negative, which support continued data collection and analysis for minority populations. This likely holds true for other patient populations, as well, and I believe that all hospitals should be tasked to conduct this work.

I worked in the Illinois State Senate to pass similar legislation. It succeeded in making my State's hospitals more responsive to the needs of their patients.

Mr. Chairman, I want to thank you again for holding this hearing. I look forward to working with you on passing these measures and thank the panelists for their invaluable feedback. I probably will not be able to stay for all the testimony, but I am hoping to get some of the testimony before I have to go.

Chairman AKAKA. Thank you very much, Senator Obama.

And now, Senator Murray.

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

Senator MURRAY. Thank you very much, Mr. Chairman. I really appreciate your holding this important hearing on ways that we can help improve the health care for our veterans and I think it is really appropriate that we are holding this hearing so close to Memorial Day. It is the day that we honor all of those who have paid the ultimate price for our freedom, and as we remember their

sacrifice, it is an appropriate time to make sure we are keeping our commitment to all of those who served us.

Mr. Chairman, as the needs of our veterans change, we have to update our policies to meet those needs. For example, we just recently learned that there is a significant association between exposure to nerve agents in the First Gulf War and long-term brain damage. That is a great example of how recent research should guide us to improve our care for veterans and I am working with Senator Rockefeller and Senator Bond to do that.

Our veterans do deserve the best care and we are taking steps to provide it. Last week, we passed a budget that provides $3.5 billion more than the President asked for for our veterans' programs, and in fact, Mr. Chairman, working with you, we provided 98 percent of what the Independent Budget requested, and importantly, that budget did away with the Administration's proposed fees and copays for our veterans.

But we do have to do more and it is why we are looking at a variety of bills here today. I am really pleased that there are a number of really great proposals. One of them is legislation that I have introduced that will open the door to VA health care for veterans who were unfairly shut out by this Administration more than 4 years ago. The Bush Administration cut off enrollment of Priority 8 veterans into the VA health care system. Priority 8s are those veterans without service-connected disabilities whose incomes are above a means-tested level that varies throughout the country. But many of those so-called high-income veterans have incomes as low as $26,902.

My legislation is the Honor Our Commitment to Veterans Act of 2007. It would rescind the Administration's January 2003 decision to prevent new enrollment of Priority 8 veterans into the VA health care system and I am very pleased that this legislation is supported by the American Legion, Veterans of Foreign Wars, Vietnam Veterans of America, and the Paralyzed Veterans of America.

Mr. Chairman, according to a recent Congressional Research Service report, the VA estimates that if an enrollment freeze was lifted, approximately 273,000 Priority 8 veterans would have been eligible to receive medical care from the VA in fiscal year 2006, and 242,000 Priority 8 veterans would have been eligible in 2007.

Mr. Chairman, we are nearly 5 years into this war and our veterans are facing lengthy waits just to get to see a primary care physician. They are having trouble accessing critical mental health services and some are waiting up to 2 years for the benefits that they were promised to be processed. These are real problems facing real people and they deserve solutions.

Instead of cutting off enrollment to veterans of modest means 4 years ago, the Bush Administration should have asked Congress for the resources necessary to address its shortcomings and increase access to the VA. It is absolutely unacceptable that veterans in need of care are being prohibited from enrolling in the system that is supposed to serve them. Veterans who have fought hard to secure our freedoms shouldn't have to fight for access to health care at home. They deserve better.

So, Mr. Chairman, I appreciate this opportunity for my bill and the others on the calendar today and I look forward to hearing from our witnesses.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Burr for your remarks.

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

Senator BURR. Mr. Chairman, I thank you. I would only say thank you for holding this hearing. I look forward to the panels of witnesses that we have today and believe that what we are going to learn will help this Committee to move forward with some very important legislation. I thank the Chair.

Chairman AKAKA. Thank you. Thank you very much.

Now Senator Tester for any remarks he may have.

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

Senator TESTER. Thank you, Mr. Chairman. I, too, want to thank you for holding the hearing. I think there are some very good bills here. I look forward to hearing the Department's opinion on them and the discussion that will revolve around them. I think there are some important issues out there and I think some of these bills deal with those issues, so thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much for your remarks.

Now again, I want to welcome our witnesses from VA, Dr. Gerald M. Cross, the Acting Principal Deputy Under Secretary for Health, who is accompanied by Walter Hall, Assistant General Counsel.

I thank both of you for being here this morning and look forward to your testimony. VA's full statement will appear in the record of this hearing. Dr. Cross, will you please proceed with your testimony.

STATEMENT OF GERALD M. CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER HALL, ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Thank you, sir, and good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here today to present the Administration's views on several bills that would affect programs administered by the Department of Veterans Affairs in the provision of health care to veterans. With me today is Walter Hall, Assistant General Counsel.

Sir, with your permission, I would also like to introduce a guest who happens to be accompanying me this morning, a fighting SeeBee, Michael Christianson—can you stand up, Michael—who is accompanying the VA team this morning. He is on a commission working with us and others looking at their needs. I wanted to thank Michael for his service since he is here with us today, and he actually comes from Washington State.

Senator MURRAY. Very good. Welcome.

Chairman AKAKA. Welcome to the Committee.

Dr. CROSS. He is recently back from Iraq.

Knowing my time is limited, I will highlight bills addressing some of our common interest. I would like to submit, as you said, Mr. Chairman, my written testimony for the record.

First of all, VA supports S. 383, which extends the 2 years to 5 years, the period of eligibility for priority access to VA health care services for combat veterans. This bill would give additional time for separated servicemembers to seek treatment of symptoms that may develop later than 2 years in cases such as PTSD or TBI. We feel that the passage of this bill would eliminate the need for S. 117, Section 101 that provides for mental health services for combat theater veterans after the 2-year eligibility period.

VA understands the intent of S. 479 and acknowledges the need to address suicide prevention comprehensively. Mr. Chairman, a veteran's suicide is a devastating event for family, for friends, and for those who are entrusted with his or her care. VA recognizes the pain that families like that of Joshua Omvig are experiencing and we are fully in sympathy with the aims of the bill that bears Mr. Omvig's name. We feel, however, that the bill is unnecessary because it duplicates many of the efforts that are already underway in the Department.

VA is currently implementing its Mental Health Strategic Plan based on the goals of the President's New Freedom Commission on Mental Health and we are proud of the steps we have already taken and would be happy to brief the Committee on our initiatives as well as to explore additional measures with you that could supplement our efforts, efforts that would honor the memory of Mr. Omvig and pay proper tribute to his family that have done so much to keep this issue in the public's eye.

S. 692 requires the VA to establish a hospital quality report card initiative. VA is already complying with the intent of this bill as it comes into compliance with Executive Order 134–10, requiring Federal agencies to report provider-level data to their beneficiaries. In addition, the Joint Commission on Accreditation for Hospitals makes public information on hospital performance in key areas of care available on their web site where veterans may compare VA hospitals to other accredited hospitals in their communities. Moreover, VA uses over 100 performance measures related to patient care in VA facilities as ongoing components of quality improvement. This information is routinely reported to senior leadership and is a basis for evaluation for facility and network leadership. For these reasons, we do not support S. 692, but we would be pleased to work with the Committee staff to explain how we use performance measures.

On S. 1233, while VA is continuing to review this bill and will submit formal views following this hearing, I would like to emphasize VA shares the passion this Committee has for the impact of TBI on our combat veterans. Mr. Chairman, as you know, VA and DOD are working collaboratively on this diagnosis and on many issues surrounding it, from diagnostic screening tools to rehabilitative transitional care. There is a range for TBI injuries from mild to severe. VA is refining continuously the parts of the program that address all aspects of TBI. VA now has an effective screening tool in place that also has been presented and taught to our clinicians and is also being shared with DOD.

Moreover, VA's comprehensive polytrauma network has individual case managers for veterans with these complex injuries and we are now hiring transitional patient advocates who help families work through the more complex aspects of care. VA continues to be a leader in new approaches for caring for these patients with using their emerging consciousness program. In just 3 years, VA has taken tremendous steps in the TBI polytrauma arena and we plan to continue these advancements within VA and within our partnership with DOD.

I am very proud of the steps we already have taken and will be happy to brief the Committee on any of our programs, and I would be pleased to answer any questions you or any Members of the Committee have, sir. Thank you.

[The prepared statement of Dr. Cross follows:]

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

Good Morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. I am pleased to provide the Department's views on 15 of the 20 bills under consideration by the Committee. I will briefly describe each bill, provide VA's comments on each measure and estimates of costs (to the extent cost information is available), and answer any questions you and the Committee members may have.

Unfortunately, we are unable to comment on the five other bills (i.e., S. 1233, S. 1326, S. 1384, S. 1396, and S. 1441) because we only recently received them and learned they would be on today's agenda. However, we will evaluate those bills and provide our views and estimates for the record.

Mr. Chairman, I will begin by discussing four bills on today's agenda that would address the delivery and types of VA health care services available to veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) and future combat operations.

S. 117—LANE EVANS VETERANS HEALTH AND BENEFITS IMPROVEMENT ACT OF 2007

The first of these is S. 117. We testified regarding certain benefits-related provisions on May 9, 2007. Today I will discuss three sections of that bill that relate to health care benefits: sections 101, 202, and 203.

Section 101 of the bill would make combat-theater veterans eligible for a VA mental health evaluation within 30 days of the veteran's request. The veteran would be able to request and receive such an examination up to 5 years after the date of the veteran's discharge or release from active military service. In addition, such veterans would be eligible for hospital care, medical services, nursing home care, and family and marital counseling for any mental health condition identified during that examination, notwithstanding that the medical evidence is insufficient to conclude that the mental health condition is attributable to the veteran's combat service. Eligibility for medical services needed to treat the veteran's identified mental health condition would continue for 2 years, beginning on the date VA begins to provide such services. The bill would not, however, cover any mental health disability found by the Under Secretary for Health to have resulted from a cause other than the veteran's combat service.

VA supports section 101. However, we note that this bill would be wholly unnecessary should the Congress pass S. 383, which is discussed below.

Section 102 would amend the statutory requirements applicable to the mandated post-deployment examinations conducted by the Department of Defense (DoD). As to this provision, we defer to the views of DoD.

Section 202 would require VA to establish an information system designed to provide an elaborate and comprehensive record of the veterans of the Global War on Terrorism (GWOT) who seek VA benefits and the benefits they receive. Section 203 would mandate that VA submit a quarterly report to Congress on the effects of participation in GWOT on both veterans and the Department. The first of these reports

would be due not later than 90 days after this Act's enactment. Each quarterly report would include aggregated information on VA health, counseling, and related benefits to GWOT veterans, including information on the enrollment status of GWOT veterans; the number of inpatient stays they experienced and the related cost of that care (by both enrollment status and condition); the number of outpatient visits they experienced and the related cost of such services (again by enrollment status and by condition); and the number of visits to Vet Centers and the related cost of providing them readjustment counseling and services.

As we testified on May 9, 2007, this bill's requirements to compile and frequently report to Congress massive amounts of data, much of which are not currently available, in the detail and manner specified, would force VA to divert considerable resources from our primary responsibilities. Health care data on these veterans are currently collected and tracked through the Veterans Tracking Application, which is specific to injured servicemembers who transition to VA care. However, that information is considered only in the aggregate. Therefore, collection and tracking the individual-specific data mandated by the bill would require considerably expanded administrative personnel and resources. But again first and foremost, complying with these sections would require resources that would otherwise be devoted to the medical mission of VA. For this reason, we cannot support sections 202 and 203 of the bill. We remain very mindful of this Committee's oversight responsibilities and would welcome the opportunity to work with staff to identify information that is currently lacking that would be most helpful to the Committee in meeting its responsibilities.

We are, as yet, unable to reliably estimate the costs of compliance [in terms of both manpower and potential for detracting from the primary mission of the Veterans Health Administration], but we believe that they would be substantial.

S. 383—EXTENSION OF TREATMENT AUTHORITY FOR COMBAT-THEATER VETERANS

S. 383 would amend existing law to increase to five the number of years a combat-theater veteran is eligible for free VA health care for illnesses or conditions that might be associated with combat service. The five-year window of eligibility would begin on the date of discharge or separation from active military, naval, or air service. Currently, the law provides these veterans with two years of such eligibility.

VA supports S. 383. When these veterans seek care from VA they are placed in priority Category 6 and make no copayments for covered conditions. When the special treatment authority for combat-theater veterans was originally enacted, it was generally assumed that 2 years was sufficient. However, experience has shown that this is not always the case. In caring for OEF/OIF veterans we have discovered that the onset of symptoms, or adverse health effects, related to Post-Traumatic Stress Disorder (PTSD), and even Traumatic Brain Injury (TBI), are often delayed, or do not manifest clinically, for more than two years after a veteran has left active service. As a result, many OEF and OIF veterans do not seek VA health care benefits until after their two-year window of eligibility has closed. Without eligibility for enrollment in priority Category 6, many, i.e., those with higher incomes and non-service connected conditions, would not be eligible to enroll because they would be in priority Category 8.

In addition, many OEF/OIF veterans are non-career military members who are unfamiliar with veterans benefits and the procedures for obtaining them. For that reason many fail to enroll in a timely fashion. Providing combat-theater veterans with an additional 3 years within which to access VA's health care system would help to ensure that none of them is penalized because of reasons beyond their control or because they have been unable to navigate through VA's claims system in time.

VA estimates the costs associated with enactment of S. 383 to be $14.1 million in fiscal year 2008 and $289 million over a 10-year period. These estimates include both expenditures and lost copayment revenue.

S. 479—JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT

S. 479 would require the Secretary to develop and implement a comprehensive program (comprised of 10 specific elements) for reducing the incidence of suicide among veterans. First, the program would include a national mental health campaign to increase awareness in the veteran community that mental health is essential to overall health and that effective modern treatment can promote recovery from mental illness. Second, it would call for mandatory training on suicide prevention for appropriate employees and contract personnel (including all medical personnel) who interact with veterans. This training would require the provision of in-

formation on the recognition of risk factors for suicide, protocols for responding to crisis situations involving veterans who may be at high risk for suicide, and best practices for suicide prevention. Third, the comprehensive program would include outreach programs and educational programs for veterans and their families, in particular OEF/OIF veterans and their families. The educational programs would serve to help: eliminate or overcome stigmas associated with mental illness; further understanding of veterans' readjustment issues; identify signs and symptoms of mental health problems; and encourage veterans to seek assistance for these types of problems.

Fourth, the program would include a peer counseling program in which veterans are trained as peer-counselors to assist other veterans suffering from mental health issues. (Training of these veterans would have to include specific education on suicide prevention.) The peer-counselors would also be responsible for conducting outreach on mental health matters to veterans and their families. The legislation would require the Secretary to make this peer-program available in addition to other mental health services already offered by VA (including those that would be established by this Act).

Fifth, the Secretary would be directed, as part of the comprehensive program, to encourage all veterans applying for VA benefits to undergo a mental health assessment at a VA medical facility or Vet Center.

Sixth, the program would include the provision of referrals, as appropriate, to veterans who show signs or symptoms of mental health problems.

Seventh, the Secretary would need to designate a suicide prevention counselor at each VA medical facility (other than a Vet Center). These counselors would work with a variety of local non-VA entities to engage in outreach to veterans about available VA mental health services. They would also be responsible for improving the coordination of mental health care furnished to veterans at the local level.

Eighth, VA's program would have to include research on best practices for suicide prevention among veterans. Moreover, the Secretary would need to establish a steering committee to advise on such research. Such committee would be comprised of representatives from the National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC).

Ninth, the Secretary would have to ensure the availability of VA mental health services on a 24-hour basis.

Finally, the Secretary would be authorized to establish a continuously operational, toll-free telephone number that veterans could call for information on, and referrals to, appropriate mental health services.

This legislation would permit the Secretary to include any other activities in the comprehensive program that the Secretary deems appropriate. It would also require the Secretary to submit, not later than 90 days after the date of enactment, a detailed report to Congress on all of the Department's suicide prevention programs and activities. (Any suicide prevention programs VA establishes afterwards would have to be developed in consultation with NIMH, SAMHSA, and CDC.)

We appreciate the purpose of this legislation; however, we do not support this bill. It is unnecessary because it duplicates many efforts already underway by the Department. Indeed, many of the bill's requirements are already being addressed and implemented through VA's current Mental Health Strategic Plan. (As you will recall, this Strategic Plan was designed to both ensure that our Department continues as a leader in the area of mental health and to implement the goals of the President's New Freedom Commission on Mental Health.) We therefore ask that the Committee forbear in its consideration of S. 479. In the meantime, we will be happy to brief the Committee on the myriad initiatives we have right now and explore with you additional measures that could supplement these efforts.

Should the Committee proceed to act on this measure, we note our objection to the bill's requirement to train and use veterans as peer counselors for other veterans with mental health issues. The use of adult veterans as peer-counselors in caring for other veterans who suffer from mental health issues is simply not advisable. Data on the efficacy of these types of programs do not reflect favorable results. Although well-intended, we believe such an approach to clinical care lacks scientific support. We strongly believe that VA mental health care services, including counseling, should continue to be provided by our capable, experienced, and appropriately trained cadre of mental health care professionals.

In addition, we do not think the bill's requirement that we encourage every veteran seeking any type of VA benefit to obtain a mental health assessment is justified, and it may cause veterans to believe they have been stigmatized.

S. 882—VETERAN NAVIGATORS TRANSITION ASSISTANCE PROGRAM

Mr. Chairman, the fourth bill on today's agenda that would have particular significance for those returning from deployment in OEF/OIF is S. 882, although it would, in fact, apply to all servicemembers of the Armed Forces who are transitioning from DoD's health care system to VA's.

S. 882 would require the Secretary, in consultation with the Secretary of Defense, to establish and carry out a 5-year pilot grant program to assess the feasibility and advisability of using eligible entities to assist members of the Armed Forces in applying for, and receiving, VA health care benefits and services after completion of military service.

The mandated pilot grant program would focus on eligible entities that provide assistance to members with serious wounds or injuries; members with mental disorders; female members; and members of the National Guard and the Reserves. Eligible entities would include non-VA, non-DoD entities or organizations that possess, or which can acquire, the capacity to provide the described transitional assistance. The entities would provide the assistance through "Veteran Navigators," qualified individuals who would provide assistance to members on an individual basis. The legislation would establish very specific qualifications for, and responsibilities of, Veteran Navigators.

S. 882 would require the Secretary to establish at least one pilot site in the vicinity of a military treatment facility that treats members of the Armed Forces who are seriously wounded or injured in Afghanistan or Iraq, another in the vicinity of a rural VA medical center, and one in the vicinity of an urban VA medical center. To add additional sites, the Secretary would need to consult with the grant application evaluation panel, which would be established by this legislation.

Grants awarded under this pilot program could not exceed 3 years, although a grant could be renewed for 1 year. Eligible entities seeking grants would be required to submit a detailed application to the Secretary, which addresses all of the specified information set forth in the bill. A grant could not be awarded, however, to an eligible entity that is receiving Federal funds for the same activities on the date on which the eligible entity submits an application to VA, unless the Secretary determines that the entity will use the grant authorized under this bill to expand services or provide new services. The bill would permit these grants to be used to recruit, assign, train, and employ Veteran Navigators.

The grant application panel would be comprised of VA employees, DoD employees, and representatives from both Veterans Service Organizations and organizations that provide services to members of the Armed Forces. It would evaluate all grant applications and make recommendations to the Secretary. Finally, S. 882 would create reporting requirements for both the grant recipients and the Department.

The measure would authorize $2 million to be appropriated to carry out the program for fiscal year 2008; $5 million for fiscal year 2009; $8 million for fiscal year 2010, $6.5 million for fiscal year 2011; and $3.5 million for fiscal year 2012. Any amount authorized to be appropriated would remain available for obligation through the end of fiscal year 2012.

Mr. Chairman, VA does not support S. 882 because it is unnecessary and duplicative of ongoing outreach services and seamless transition efforts currently underway by VA and DoD. It would also duplicate responsibilities of Veterans Service Organizations and State veterans' offices and agencies.

S. 815—VETERANS HEALTH CARE EMPOWERMENT ACT OF 2007

Mr. Chairman, we next address S. 815, a bill that would significantly change the nature of the VA health care system. S. 815 would authorize veterans with a service-connected disability to obtain their health care at VA-expense from any provider eligible to receive payment under Medicare or TRICARE. This authority would cease after September 30, 2009.

VA strongly opposes enactment of S. 815. We fully concur in the views of several of the major VSOs, who recently wrote to the Chairman of the Senate Committee on Veterans Affairs in opposition to S. 815. (We will provide this letter to the Committee for the record.) At bottom, S. 815 could lead to the undoing of the VA healthcare system—a world-class health care system—as we know it today. For this fundamental reason, we must oppose this bill.

We also have other concerns. The proposal would fragment the care of our veterans. VA would no longer have a complete record of all the care a covered veteran has received. This could lead to VA duplicating care already provided in the private sector or providing care that conflicts with what the veteran is receiving in the private sector. As you are aware, some in the private sector rely on paper records while the VA uses a comprehensive electronic health record. Electronic records promote

patient safety. We are concerned that the bill, if enacted, could jeopardize continuity of care for our patients. Last, unlike the private sector, VA screens all returning combat-theater veterans for TBI, PTSD, depression, and substance abuse.

S. 1146—RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2007

We now turn to S. 1146, which is intended to improve VA's ability to meet the health care needs of rural veterans. Section 2 of this bill would amend VA's beneficiary travel program by making VA pay or reimburse eligible veterans at the same per diem rates and mileage rates that apply to Federal employees using privately owned vehicles for official travel. This section would also repeal existing deductible requirements that apply to the receipt of VA beneficiary travel benefits.

Section 3 would require the Secretary, through the Director of the Office of Rural Health, to establish up to five Rural Health Research, Education, and Clinical Centers of Excellence ("Centers"). The bill sets forth detailed requirements that would govern the Secretary's designation and placement of such Centers. It also would limit designation of Centers to those facilities found by a peer review panel to meet the highest competitive standards of scientific and clinical merit and also found by the Secretary to have met the requirements specified in the legislation.

Section 4 would require the Secretary to establish a grant program for State Veterans' Service Agencies and Veterans Service Organizations for purposes of providing veterans living in remote rural areas with innovative means of travel to VA medical centers (and to assist them with their other medical care needs). A grant awarded under this section could not exceed $50,000. Grant recipients would not be required to provide matching funds as a condition for receiving a grant. This section would require the Secretary to prescribe regulations to implement this program and also authorize to be appropriated $3 million for each of FYs 2008 through 2012 to carry out this program.

Section 5 would require the Secretary, through the Director of the Office of Rural Health, to carry out demonstration projects to examine alternatives for expanding care to veterans in rural areas. In so doing, the Secretary would be required to establish partnerships with the Department of Health and Human Services (HHS) to coordinate care for veterans in rural areas at both critical access hospitals and community health centers. VA would also be obliged to coordinate with HHS' Indian Health Service to expand care for Native American veterans.

The bill would institute annual reporting requirements, the first of which would have to include the results of the statutorily mandated assessment of VA's fee-basis program on the delivery of care to veterans residing in rural areas, along with the results of VA's extensive outreach program to OEF/OIF veterans living in rural veterans.

Mr. Chairman, in accordance with Congress' mandate in the "Veterans Benefits, Health Care, and Information Technology Act of 2006," VA recently established the Office of Rural Health (ORH) within the Veterans Health Administration. Part of that office's charge is to determine how we can best continue to expand access to care for rural veterans.

Indeed, VA has already done much to remove barriers to access to care for enrolled veterans residing in rural areas and is continuing a robust rural health program. Currently, over 92 percent of enrolled veterans reside within one hour of a VA facility, and 98.5 percent of all enrollees are within 90 minutes. Still, we continue our efforts to try to ensure that all enrolled veterans living in rural areas have adequate and timely access to VA care. We expect the data for this year to be even better.

Community-Based Outpatient Clinics (CBOCs) have been the anchor for VA's efforts to expand access to veterans in rural areas. CBOCs are complemented by contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area. In addition, there are a number of rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans, and several additional outpatient clinics are positioned to provide care for veterans in surrounding rural communities. VA's authority to contract for care under 38 U.S.C. § 1703 provides a local VA Medical Center director with another avenue through which to meet the needs of many rural veterans.

These efforts have borne fruit. Rural veterans tell us that they are satisfied with the services and high-quality care we are providing to them. This is substantiated by their reporting even higher satisfaction with VA services than their urban counterparts. Moreover, performance measure data indicate that as a result of our intensive efforts to expand services for rural veterans, veterans have access to services much nearer to home. In 1996, VA users of mental health services lived an average

of 24 miles from the nearest VA clinic; as of 2006, they now live only 13.8 miles away. In addition, quality of care in the rural environment matches that of urban care on 40 standard measures.

Mr. Chairman, VA shares the Committee's concern for ensuring that rural veterans have adequate access to needed health care and services. However, for the aforementioned reasons, we do not support S. 1146 and we recommend that no legislative action be taken in this area until VA has had sufficient time to complete and review the internal assessments currently underway by ORH and other Department components. We will of course share ORH's findings and recommendations with the Committee. On the changes proposed for beneficiary travel, we note that similar provisions are found in S. 994. We therefore address these changes in our comments on S. 994, below.

S. 1147—TERMINATION OF THE ADMINISTRATIVE FREEZE ON ENROLLMENT OF VETERANS IN CATEGORY 8

Mr. Chairman, S. 1147 would require VA to enroll all eligible veterans in Category 8. As you and the Subcommittee are well aware, VA suspended the enrollment of new veterans in the lowest statutory enrollment priority (priority category 8—veterans with higher incomes and no compensable service-connected disabilities) in January of 2003. This action was taken to protect the quality and improve the timeliness of care provided to veterans in higher enrollment-priority categories.

VA strongly opposes enactment of S. 1147. In 1996, Congress enacted Eligibility Reform legislation that allowed VA to provide comprehensive care to veterans in the most appropriate treatment setting. Additionally, in order to protect the traditional mission of VA (to cover the health care needs of service-disabled and lower-income veterans), that law originally defined seven priority levels (PL) of veterans—PL 7 veterans (higher income and not service-disabled) were the lowest priority. The law mandated that beginning in fiscal year 1999, VA use its enrollment decision to ensure that care to higher-priority veterans was not jeopardized by the infusion of lower priority veterans into the system for the first time. In FYs 1999 through 2002, the VA Secretary determined in each year that all veterans were able to enroll. Prior to 1999, PL 7 veterans' care was not funded in budgets, but they could use the system on a space available basis. Consequently, they were only about 2 percent of the annual users. In fiscal year 2001, 25 percent of enrollees and 21 percent of users were PL 7 veterans (using 9 percent of the resources). In 2001 PL 7 veterans were split into two parts—those making *above* the geographic-specific HUD threshold for means-tested benefits were moved to a new PL 8 category. More than half of the 830,000 new enrollees in fiscal year 2002 were in Priority Group 8 and VA was not able to provide service-connected and lower income enrolled veterans with timely access to health care services because of the unprecedented growth in the numbers of the newly eligible category of users. When the appropriation was finally enacted for fiscal year 2003, VA's Secretary made the decision that the Department would not enroll any new PL 8 veterans—but those currently in the system would retain their right to care. Every appropriation since 2003 has supported this enrollment decision.

S. 1147 would essentially render meaningless the prioritized enrollment system, leaving VA unable to manage enrollment in a manner that ensures quality and access to veterans in higher priorities. VA would have to add capacity and funding to absorb the additional workload that this bill would entail, and so the quality and timeliness of VA health care to all veterans, including service disabled and lower income veterans, would unavoidably suffer until this capacity is added.

We note VA has authority to enroll combat-theater veterans returning from OEF/OIF in VA's health care system and so they are eligible to receive any needed medical care or services.

S. 994—DISABLED VETERANS FAIRNESS ACT

Like S. 1146, S. 994 would amend VA's beneficiary travel benefits program by repealing the statutory deductible-requirements and requiring the Secretary to reimburse all beneficiary travel benefits and allowances at the same rates that apply to Federal employees. Beneficiary travel benefits would be paid out of amounts appropriated or otherwise made available to VA specifically for this purpose. S. 994 would provide that these changes apply to travel expenses incurred after the 90-day period beginning on the date of enactment.

Although S. 994 would appear to prevent payment of beneficiary travel allowances and payments from funds appropriated to VA for direct patient care, we believe the cost of S. 994 would be utterly prohibitive. The cost of this bill would be significantly increased without the buffering effect of deductibles. As you know,

deductibles play an important cost-sharing function and help contain costs by discouraging needless travel. Increased funding in the amount this bill would require could be put to better use on the provision of direct patient care to our veterans, particularly on our aging veterans and new cohorts of OEF/OIF veterans. We are unique among health care providers in that we already provide beneficiary travel benefits to eligible veterans.

S. 692—VA HOSPITAL QUALITY REPORT CARD ACT OF 2007

Mr. Chairman, S. 692 would require VA to establish a Hospital Quality Report Card Initiative to, among other things, help inform patients and consumers about the quality of care in VA hospitals. Not later than 18 months after the date of enactment, the Department would be mandated to establish a hospital Quality Report Card Initiative. Under the Initiative, the Secretary would be required to publish, at least bi-annually, reports on the quality of VA's hospitals that include quality-measures data that allow for an assessment of health care effectiveness, safety, timeliness, efficiency, patient-centeredness; and equity.

In collecting and reporting this data, the Secretary would have to include very extensive and detailed information (i.e., staffing levels of nurses and other health care professionals; rates of nosocomial infections; volume of various procedures performed, hospital sanctions and other violations; quality of care for specified patient populations; the availability of emergency rooms, intensive care units, maternity care, and specialty services; the quality of care in various hospital settings, including inpatient, outpatient, emergency, maternity, and intensive care unit settings; ongoing patient safety initiatives; and, other measures determined appropriate by the Secretary). However, VA would be allowed to make statistical adjustments to the data to account for differences relating to characteristics of the reporting hospital (e.g., size, geography, and teaching status) and patient characteristics (e.g., health status, severity of illness, and socioeconomic status). In the event VA makes such adjustments, there would be a concomitant obligation to establish procedures for making that data available to the public.

The bill would permit the Secretary to verify reported data to ensure accuracy and validity. It would also require the Secretary to disclose the entire methodology (for the reporting of the data) to all relevant organizations and VA hospitals that are the subject of any information prior to making such information available to the public.

Each report submitted under the Initiative would have to be available in electronic format, presented in an understandable manner to various populations, and presented in a manner that allows, as appropriate, for a comparison of VA's hospital quality with local hospitals or regional hospitals. The Department would also need to establish procedures to make these reports available to the public, upon request, in a non-electronic format (such as through a toll-free telephone number).

In addition, S. 692 would require the Secretary to identify and acknowledge the analytic methodologies and limitations on the data sources used to develop and disseminate the comparative data and to identify the appropriate and inappropriate uses of such data. The bill would further mandate that, at least an annual basis, the Secretary compare quality measures data submitted by each VA hospital with data submitted in the prior year or years by the same hospital to identify and report actions that would lead to false or artificial improvements in the hospital's quality measurements.

This measure would further require the Secretary to develop and implement effective safeguards to: protect against the unauthorized use or disclosure of VA hospital data reported under this measure; protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective VA hospital data; and ensure that identifiable patient data is not released to the public. In addition, the Secretary would need to evaluate and periodically report to Congress on the effectiveness of this Initiative and its effectiveness in meeting the purposes of this Act. And such reports would have to be made available to the public. Finally, this legislation would direct the Secretary to use the results of the evaluations to increase the usefulness of this Initiative.

S. 692 would authorize to be appropriated to carry out this section such sums as may be necessary for each of FYs 2008 through 2016.

Mr. Chairman, we do not support S. 692 because it is overly prescriptive and largely duplicative of existing activities. As such, we believe this legislation is unnecessary. Relevant information on VA hospital quality is already available to the public through several mechanisms, including our compliance with Executive Order 13410 that requires transparency of quality measures in Federal health care programs. (Because of our efforts in meeting the Executive Order, we are way ahead

of the private sector in making our health care system and outcomes data transparent; there exist no bases for comparison with the private sector.)

Information on the quality of VA hospital care is also available from the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). JCAHO provides standardized comparative data in a form that has been tested for consumer understandability and usefulness.

We believe the design of such a program, such as this, is best left to industry experts, including VA. We further believe that highly technical health care matters such as this are not well-suited to detailed statutory mandates. For example, the proposed measures set forth in the bill are less reliable, robust, and helpful than those currently used by VA. Further, they are indicators of process, not of patient outcomes. We would be pleased to meet with the Committee to discuss how we comply with Executive Order 13410, identify the sources of information currently available on the quality of VA hospitals, and demonstrate how such information may be accessed.

S. 610—CLARIFICATION OF EFFECTIVE DATE OF SECTION 132 OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PROGRAMS ENHANCEMENT ACT (RELATING TO COMPUTATION OF RETIREMENT ANNUITY FOR CERTAIN HEALTH-CARE PERSONNEL)

Mr. Chairman, another bill under consideration by the Committee is S. 610, which would retroactively change retirement benefits to certain VA health-care personnel. VA defers to the Office of Personnel Management on this issue and notes that it is contrary to Administration policy to make such changes retroactively.

S. 874—SERVICES TO PREVENT VETERANS HOMELESSNESS ACT OF 2007

Mr. Chairman, I will next discuss S. 874, which is a measure intended to prevent low income veterans transitioning to, or residing in, permanent housing from falling back into their former homeless condition. Subject to the availability of appropriations provided for the bill's purpose, S. 874 would require the Secretary to provide financial assistance in the form of per diem payments to eligible entities to provide and coordinate the provision of supportive services for very low-income veteran-families occupying permanent housing or transitioning from homelessness to permanent housing.

S. 874 would establish the amount of per diem payment as the amount of the daily cost of care estimated by the eligible entity. Yet, in no case could that amount exceed the per diem rate that VA pays to State homes for domiciliary care. The bill would permit the Secretary to adjust the per diem rate by excluding from the entity's cost-estimate any costs it incurs in furnishing services to homeless veterans for which the entity already receives funding from another source (both public and private). It would further require that such financial assistance be equitably distributed across geographic regions, including rural communities and tribal lands.

To receive such financial assistance, eligible entities would have to submit an application including all of the detailed information specified in the bill. It would also require the Secretary to consult with the Secretaries of Housing and Urban Development and Health and Human Services when selecting the recipients. S. 874 would also require the Secretary to provide training and technical assistance to participating entities on the planning, development, and provision of supportive services. Such assistance could be provided either directly, or through grants or contracts with appropriate public or nonprofit private entities.

S. 874 would define "supportive services" to include, among other things, outreach services, health care services, transportation, educational services, assistance in obtaining income support, legal assistance, fiduciary and representative services, and child care services.

As to funding, the proposed law would make available out of the amounts appropriated for medical care $15 million for fiscal year 2008, $20 million for fiscal year 2009, and $25 million for fiscal year 2010. Of these amounts, not more than $750,000 in any fiscal year could be used to provide technical assistance.

Finally, this bill would require the Secretary to conduct a study of the effectiveness of this program in meeting the needs of very low-income veteran-families. As part of the study, the Secretary would have to compare the results of this program with other VA programs dedicated to the delivery of housing and services to veterans.

VA opposes S. 874 as currently configured. We understand there is a high demand for supportive services for these vulnerable low-income veterans and their families who are at risk of becoming homeless. However, it is inappropriate to provide such assistance in the form of per diem payments. We recommend that the bill be modified so that financial assistance is furnished in the form of grants, similar to all

other Federal programs that provide financial assistance to entities providing supportive services to homeless persons.

We also note other concerns with this legislation. First, the list of supportive services should not include health care services because this would be duplicative of those already furnished to homeless veterans through VA and/or Medicaid. Second, the term "habilitation and rehabilitation services" is not defined, and supportive services provided under VA and other Federal programs for homeless persons typically include referrals to legal services, not actual legal services. Third, the application requirements are inadequate as they fail to require the applicants to demonstrate the need for the services they propose to provide. Fourth, because of the administrative costs involved, it would be more efficient to disburse the very small amount of funding available for technical assistance directly and apart from the grant program. Fifth, the definition of "private nonprofit organization" should not include for-profit partnerships, as it presently does. Finally, the definition of veteran-family differs from that used in the McKinney-Vento Homeless Assistance Act (42 U.S.C. § 11302).

S. 472—MAJOR MEDICAL FACILITY PROJECT FOR DENVER, COLORADO

Mr. Chairman, the last four bills on today's agenda relate to construction and real property matters. The first of these is S. 472, which would authorize the Secretary to carry out a major medical facility project for a replacement facility for the Denver Veterans Affairs Medical Center in an amount not to exceed $523,000,000. It would also authorize the Secretary to obligate and expend any unobligated amount in the "Construction, Major Projects" account to purchase a site for, and for the construction of, that replacement facility.

VA supports S. 472. Authorization in the amount of $98,000,000 was provided for this project in P.L.109–461; however, additional authorization in the amount of $548,000,000 is required to complete the project, bringing it to the total of $646,000,000, which is consistent with the President's budget submission request.

S. 1026—RENAMING OF VA MEDICAL CENTER IN AUGUSTA, GEORGIA

The second of these bills is S. 1026, which would designate the Department of Veterans Affairs Medical Center in Augusta, Georgia as the "Charlie Norwood Department of Veterans Affairs Medical Center." Captain Norwood helped develop the military's Dental Corps while serving in Vietnam. After his military service, he continued to provide needed dental care to military personnel and dependents through his private practice. Later, as a distinguished Congressman, he was key in advancing the military's health and dental programs.

The Department defers to Congress in the naming of Federal property.

S. 1043—USE OF LANDS AT VA WEST LOS ANGELES MEDICAL CENTER

S. 1043 would require the Secretary to submit a report on the master plan relating to the use of Department lands at West Los Angeles mandated by Public Law 105–369. Such report would have to include the master plan, if it exists; a current assessment of the master plan; any Departmental proposal for a veterans' park on such lands; any VA proposal to use a portion of these lands as dedicated green space; and, an assessment of any such proposal. In addition to establishing new reporting requirements for the master plan, S. 1043 would require that the master plan be completed before the adoption of the plan under the Capital Asset Realignment for Enhanced Services (CARES) initiative.

VA shares the Committee's desire to have a short term and long term strategy to address how we are to manage our capital assets and operational needs for the care of more than 78,000 enrolled veterans in the Los Angeles area. However, VA opposes S. 1043. As you are aware, since the enactment of Public Law 105–368, VA has embarked upon the CARES Business Plan Studies generally, and specifically the CARES Business Plan Study (Study) of the West Los Angeles campus. In the Study, options will be identified for use of any underutilized capital assets, as well as modernizing the campus to provide care to veterans now and in the future at the safest state-of-the-art facilities possible. VA's contractor has completed the initial steps in preparing planning options for public input through Local Advisory Panel (LAP) public meeting sessions. The third LAP session is presently expected to be held this summer and will be well advertised. The LAP sessions allow for input from those on the reviewing panel, veterans, as well as the community at large. All LAP and community input will be considered when formulating final recommendations for the Secretary, as well as during the Secretary's decisionmaking process. The development of the master plan for the West Los Angeles campus must be done in conjunction with this CARES study to ensure that operational needs are

met into the future. Indeed, the CARES study, with some refinement, is designed to meet the requirement for a master plan as set forth in the Public Law. We will continue to keep the Committees informed as the process continues.

S. 1392—MAJOR MEDICAL FACILITY PROJECT PITTSBURGH, PENNSYLVANIA

S. 1392 would authorize an increased amount, $248,000,000 instead of $189,205,000, for the consolidation of the Department's medical facilities in Pittsburgh, Pennsylvania (at University Drive and H. John Heinz III divisions). VA supports S. 1392, as the bill's increased amount is consistent with the President's budget submission request.

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

[Note: The following is a copy of the letter sent by major VSOs to Senator Larry Craig regarding their views on S. 815.]

MARCH 22, 2007.

Hon. Larry Craig,
Ranking Member, Comminee of Veterans' Affairs,
U.S. Senate, Hart Senate Office Building,
Washington, DC.

DEAR SENATOR CRAIG: While we appreciate your concern about the need for veterans' improved access to care in the Department of Veterans Affairs (VA), your bill, S. 815, to provide health care benefits to veterans with service-connected disabilities at virtually any private medical facility, raises a number of concerns among our organizations. We want to bring these concerns to your attention in hope that you might reconsider the merits of your proposal.

As a general principle, we believe service-disabled veterans should have the highest priority access to VA health care services, and that those services should be of the highest quality. Service-connected veterans generally have that level of access and quality in VA today, but no doubt you will recall that early in the current Administration then-Secretary Principi directed all VA field facilities to ensure that service-connected veterans not be placed on waiting lists or refused cure. In fact VA's current policy statement on this issue clearly affirms this priority, as follows:

> "VA is committed to providing priority care for non-emergent outpatient medical services and inpatient hospital care for any veteran seeking treatment of his or her service connected disability. It is VA's policy to provide priority access to outpatient medical care and elective inpatient hospital care for any veteran who requires non-emergent care for a service connected disability . . . For veterans who are 50 percent service connected or higher, VA's policy is to provide priority access to medical services and inpatient care, regardless if treatment is needed for their service connected disability."

With this policy in mind, it is difficult to comprehend your rationale for establishing a precedent for the highest priority veterans in the VA health care system to leave that system and seek services elsewhere. Over the past year we have read as you did all the accolades given to VA health care by independent observers, newsweeklies and other publications. While we believe VA represents the best available care, oversight is needed to provide an additional guarantee that VA-provided services are of the highest quality for all veterans who use VA, but especially for those with service-incurred disabilities.

While your bill may be well intentioned, it raises a series of potential unintended consequences, including a rekindled debate on so-called "Medicare subvention," a policy proposal that Congress and the Administration have been unable to resolve in ten years, and diminution of established quality, safety and continuity of VA care. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the needs of combat wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, poly-trauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans from those programs. The VA's medical and prosthetic research program, designed to study and hopefully cure the ills of disease and injury consequent to military service, would lose focus and purpose were service-connected veterans no longer present in VA health care. Additionally, Title 38, United States Code, section 1706(b)1 requires VA to maintain the capacity of these specialized medical pro-

grams, and not let their capacity fall below that which existed at the time when Public Law 104–262 was enacted.

We are also concerned about the financial implications of S. 815. Previously you have expressed your concern over the increasing costs for veterans' health care. Yet, your proposal would seem to move VA in this very direction—toward higher costs. The escalating costs of health care in the private sector are well documented. To its credit VA has done an excellent job of holding down costs by effectively managing its in-house health programs and services for veterans. While as a consequence of enactment of your bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in the private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

An additional possible consequence of your bill, if enacted, would be to most likely shift care for service-connected veterans from discretionary to mandatory spending. While we are devoted to proposals that Congress move VA health accounts into the mandatory funding arena, we question whether this would be your intent as well. The undersigned organizations could not support a bill that would move VA from a primary provider of health care to an insurer, even if funding for that function were made mandatory.

We believe that mixing complex chronically-ill service-disabled veterans with other veterans in VA care creates a needed critical mass and properly balanced case mix. A diverse case mix with the variety of acute and chronic clinical patients that motivates excellence in the academic health center environments cements solid relations beteeen those tertiary VA facilities and their health professions schools—another guarantor of quality of care.

We know, as the former Chairman, you would not want to bear witness to deterioration in quality of care or in availability of services in the VA for service-disabled veterans as a result of your bill. Therefore, we question the wisdom of S. 815 and ask that you consider withdrawing this ill-advised legislation.

Sincerely,

KIMO HOLLINGSWORTH,
National Legistative Director,
AMVETS (American Veterans).

DENNIS CULLINAN,
Legistative Director,
Veterans of Foreign Wars
of the United States.

JOSEPH A. VIOLANTE,
National Legistative Director,
Disabled American Veterans.

THOMAS ZAMPIERI,
Director of Governmental Relations,
Blinded Veterans Association.

HERB ROSENBLEETH,
National Executive Director,
Jewish War Veterans of the USA.

HERSHEL GOBER,
National Executive Director,
Military Order of the Purple Heart
of the USA, Inc.

CARL BLAKE,
Legistative Director,
Paralyzed Veterans of America.

RICHARD F. WEIDMAN,
Director of Government Relations,
Vietnam Veterans of America, Inc.

cc: Chairman Daniel Akaka, Commitee on Veterans' Affairs.

RESPONSE TO ADDITIONAL INFORMATION REQUESTED
BY COMMITTEE MEMBERS DURING THE HEARING

Question 1. Regarding the President's New Freedom Commission on Mental Health, please provide a list of recommendations and the status for each one on whether or not it has been implemented.

Response: Please see the attached document providing a list, description, and status of the requirements of the President's New Freedom Commission on Mental Health and VHA's Mental Health Strategic Plan.

Here is a glossary for acronyms used.

AASC = Action Agenda Steering Committee
ADA = Americans with Disabilities Act
CARES = Capital Asset Realignment for Enhanced Services
CBOC = Community Based Outpatient Clinic
CME = Continuing Medical Education
CMO = Chief Medical Officer
CPG = Clinical Practice Guidelines
CPRS = Computerized Patient Record System
CWT = Compensated Work Therapy
CWT/TR = Compensated Work Therapy/Transitional Residence
DOD = Department of Defense
DOL = Department of Labor
DOM = Domiciliary Unit
ECF = Executive Career Field
EES = Employee Education System
ELDA = Enrollment-Level Decision Analysis
EPRP = External Peer Review Program
FE = Family Education
FPE = Family Psycho-Education
FPE/FE = Family Psycho-Education/Family Education
G&PD = Grant and Per Diem
GEC = Geriatrics and Extended Care
HACU = Hispanic Association of Colleges and Universities
HBCU = Historically Black Colleges and Universities
HCS = Health Care System
HEDIS = Health Plan Employer Data and Information Set
HHS = Department of Health and Human Services
HPDM = High Performance Development Model
HR = Human Resources
HRSA = Health Resources and Services Administration
HSR&D = Health Services Research and Development
HUD = Department of Housing and Urban Development
IDMC = Informatics and Data Management Committee
IHS = Indian Health Service
IOM = Institute of Medicine
IT = Information Technology
LT = Long Term
MAP = Medical Advisory Panel
MD = Medical Doctor
MEB = Mental Evaluation Board
MHICM = Mental Health Intensive Case Management Program
MHSHG = Mental Health Strategic Healthcare Group
MHSP = Mental Health Strategic Plan
MHSPWG = Mental Health Strategic Planning Workgroup
MICA = Mental Illness and Chemical Abuse
MIRECC = Mental Illness Research, Education, and Clinical Center
MOU = Memorandum of Understanding
MST = Military Sexual Trauma
MTF = Military Treatment Facility
NAMI = National Alliance on Mental Illness
NCPTSD = National Center for Post Traumatic Stress Disorder
NEPEC = Northeast Program Evaluation Center
NIMH = National Institute of Mental Health
OAA = Office of Academic Affiliations
OAT = Opiate Agonist Treatment
OCC = Office of Care Coordination
OEF = Operation Enduring Freedom (Afghanistan)

OIF = Operation Iraqi Freedom
OQP = Office of Quality and Performance
ORD = Office of Research and Development
PCS = Patient Care Services
PDHRA = Post-Deployment Health Reassessment
PEB = Physical Evaluation Board
PRRTP = Psycho-social Residential Rehabilitation Treatment Program
PSR = Psycho-social Rehabilitation
PTSD = Post Traumatic Stress Disorder
QMO = Quality Management Officer
QUERI = Quality Enhancement Research Initiative
RCS = Readjustment Counseling Service (Vet Centers)
RFP = Request for Proposals
SA = Substance Abuse
SAMHSA = Substance Abuse and Mental Health Services Administration
SARRTP = Substance Abuse Residential Rehabilitation Treatment Program
SHG = Strategic Healthcare Group
SMI = Serious Mental Illness
SMITREC = Serious Mental Illness Treatment, Research, and Evaluation Center
STRAF = Special Therapeutics Rehabilitation Activities Fund
TIDES = Translating Initiative for Depression into Effective Solutions
USB = Under Secretary for Benefits
USH = Under Secretary for Health
VACO = Veterans Affairs Central Office
VAMC = VA Medical Center
VAPAHCS = VA Palo Alto Health Care System
VARO = VA Regional Office
VASH = VA Supported Housing
VBA = Veterans Benefits Administration
VCT = Veterans Construction Team
VHA = Veterans Health Administration
VISN = Veterans Integrated Service Network
WMHC = Women's Mental Health Coordinator
WRAMC = Walter Reed Army Medical Center

[The Comprehensive VHA Mental Health Strategic Plan follows:]

The Comprehensive VHA Mental Health Strategic Plan

Update February 2007

Aligned with the Recommendations of the Action Agenda (AA)

NOTES: 1) Progess toward implementation is indicated through color coding in column C and comments in column D: Ongoing =*Initiated in FY 2004-2006 Near Term= FY 2007 Future= FY 2008 and Beyond* 2) Initial projections for timetables for implementation are indicated thorugh underlined and italicized test in column C 3) the Mental Health Strategic Healthcare Group (MHSHG) has been renamed the Office of Mental Health Services (OMHS)

President's New Freedom Commission Goal 1: Americans understand that mental health is essential to overall health.

Commission Recommendation 1.1 . Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

Create a VA National Mental Health Campaign to increase awareness in veteran community that mental health is essential to overall health and that very effective modern treatments can promote recovery in mental illness. Request that Secretary Principi serve as the champion for this campaign and declare 2004 Veterans Mental Health Year. A. Initiate a campaign targeted at Iraqi Freedom and Enduring Freedom veterans and their families. B. Develop monthly messages on VA's Intranet home page focused on the theme that mental health is essential to overall health. The message would change monthly. C. Develop destigmatizing messages on VA's Internet home page for veterans, their families and the general public focused on the themes that mental health is essential to overall health and on the availability of effective new treatments. The monthly message would be developed with the help of VA Mental Health Consumer/Advocate Councils to be culturally competent and acceptable to veterans and their families D. Secretary Principi and other senior officials would include this theme in public addresses, speeches, and VSO convention addresses.

AA Rec. #	Mental Health Strategies	Initiatives	
1.1.1 A, B, C, D Initiatives 1-4	Promote mental health awareness in collaboration with VA Office of Communications, EES, NAMI, SMI Committee Consumer Liaison Council, etc.	***Immediate Program Office MHSHG:*** Identify a spokesperson to represent VA in this effort. This will be a cross-cutting campaign with emphasis on special groups, e.g., PTSD, women, older groups, returning service personnel. This will be accomplished by outreach to veterans & families; use of public service announcements, train VA staff in these approaches to new vets/ families. Mental Health Strategic Healthcare Group (MHSHG) will coordinate Mental Health Awareness Day, with educational activities mandated at each VAMC and kickoff of Veterans Mental Health Year in 2005	**Ongoing**
		Near Term Program Office MHSHG . MHSHG will create a Mental Health Workgroup to identify existing resources and develop a communications plan, based on the Action Agenda recommendation 1.1.1 A, B, C, D, to inform the veteran community, including families, Veterans Support Organizations, VHA staff, Veterans Benefits Administration staff, and veterans themselves as well as the public of the importance of mental health care.	**Ongoing**
	Promote effective outreach and reintegration of soon to be or recently deactivated military personnel.	***Near Term Program Office MHSHG:*** 1. Provide "State of the Art" outreach, screening and referral to military personnel transitioning from active or reserve status to civilian status. 2. Readjustment Counseling Service (RCS)/MHSHG to extend seamless care model to mental health service for combat veterans 3 RCS/MHSHG to develop and coordinate VHA outreach to National Guard, Reserve, and soon to be or recently discharged military personnel and to the families of these groups. 4. RCS/MHSHG to develop models of care to address mental health needs of recently discharged combat veterans.	**Ongoing**
	Promote destigmatization through partnering with VBA, Department of Labor, state and local programs to provide career development services.	***Near Term Program Office MHSHG:*** Design and establish Career Development Centers in VHA Medical Centers and Community-based Outpatient Clinics (CBOCs), for recently deactivated military personnel based on partnerships between Psychology Services in Mental Health, VBA, and DoL	**Ongoing**

Promote a Mental Health Awareness Day, for instance in May, which is Mental Health Month.

AA Rec. #	Mental Health Strategies	Initiatives	
1.1.2	Institute an annual Mental Health Awareness Day.	***Near Term Program Office MHSHG:*** Mental Health Awareness Day annually and partner with other national organizations to reach broader audience.	**Ongoing**

Identify Mental Health an Employee Education Services (EES) focus area in 2005. All health care workers should understand that mental health is essential to overall health; reduce stigma by their interactions with veterans and their families; and understand the major suicide risk factors and the principles of suicide prevention. A. Use the Mental Illness Research, Educational and Clinical Centers (MIRECC) and National Center for PTSD (NCPTSD) Education Groups for VA staff education for Best Practices. B. A satellite broadcast program similar to the "Face Behind the File" series can be launched in which veterans; perhaps some with national stature address their mental health and physical problems and their interconnection. The profiles will illustrate veterans overcoming disability and demonstrating recovery and individual success. C. Develop a Mental Health Speakers Bureau for Continuing Medical Education (CME) credits and patient education.

AA Rec. #	Mental Health Strategies	Initiatives	
1.1.3 A, B, C Initiatives 1-2	Educate all VHA healthcare providers that mental health is essential to overall health and that integrating mental health care with medical health care promotes recovery in both aspects of health.	***Near Term Program Office MHSHG:*** MHSHG will assign a staff person to work with EES in the development of education programs which will include issues related to all special emphasis groups, i.e., PTSD, women veterans, older adults, etc. These programs will emphasize the interrelationships between mental health and physical health and the recovery model of care.	**Ongoing**
		Immediate Program Office MHSHG: Task MIRECCs and NCPTSD with development of a joint education plan by 12/31/2005. This plan will include the three tenets of recovery; consumer self determination, empowering relationships and veteran consumer participation in the development and delivery of mental health care services.	**Ongoing**

Endorse the National Strategy for Suicide Prevention (2001) and the Institute of Medicine's report, "Reducing Suicide: A National Imperative" (2003). Implement their recommendations. A. Develop a Suicide Prevention Program for VA patients, families, staff and the community. B. Develop electronic suicide prevention database using institutional surveillance mechanisms that support population-based screening.

AA Rec. #	Mental Health Strategies	Initiatives	
1.1.4 A, B	Reduce suicide among veterans.	***Future Program Office MHSHG:*** Promote evidence based strategies for suicide assessment and prevention, including emphasis on special emphasis groups. MHSHG will work with HSR&D, NEPEC, and SMITREC to develop and test an electronic suicide prevention database. Develop a national systematic program for suicide prevention. MHSHG develops a plan to educate all staff that interact with veterans, including clerks and telephone operators, about responding to crisis situations involving at-risk veterans. This would include suicide protocols for intake, telephone operators, and other first contact personnel.	**Ongoing**

Develop and promote support programs that: A. reinforce help seeking from marital and family counselors, etc B. establish crisis-support, and C. support programs for development of more adaptive coping skills and resilience.

AA Rec. #	Mental Health Strategies	Initiatives	
1.1.5 A, B, C Initiatives 1-11	Promote coping skills, resiliency and community support.	***Near Term Program Office EES:*** 1. Educate and train DoD mental health care providers about VHA and VBA programs and eligibility requirements equivalent to a TAP for staff, 2. Develop and disseminate educational material on VHA and VBA programs and eligibility requirements for mental health patients and families; 3. Outreach to active duty, especially those with life altering injuries, and recently deactivated military personnel and their families to make them aware of VHA and VBA programs and eligibility requirements for persons with mental health problems.	**Ongoing**

		Future Program Office MHSHG: In its National Mental Health Campaign, MHSHG will promote veterans' seeking help from multiple sources and points of entry (e.g., marital and family counselors, legal counselors, financial counselors, mental health specialists, clergy and other appropriate community leaders), and promote to all VHA and VBA staff a biopsychosocial/ spiritual orientation to health care that includes cultural competency with relation to unique veterans, racial, ethnic, sexual orientation, and gender sensitivities.	**Future = FY 2008 and Beyond**
		Future Program Office MHSHG and VISNs: Medical Centers establish contacts through the Chaplain Service with faith-based organizations and community resources to assist with culturally competent suicide prevention and other mental health issues at local and national levels.	**Future = FY 2008 and Beyond**
		Near Term Program Office MHSHG: MHSHG develops a plan for 24 hour mental health care availability throughout VHA.	**Near Term = FY 2007**
		Near Term Program Office MHSHG: MHSHG directs the VISNs to develop plans, including peer support programs, to assist veterans in coping with common problems.	**Future = FY 2008 and Beyond**
		Near Term Program Office MHSHG: Peer Support: FY-05: Issue national Information Letter to promote paid Peer-led services programming, (directly or through contract with community providers) as an adjunct to traditional mental health services at all facilities serving veterans with serious mental illness. FY-06: Issue national directive with detailed procedural guidance. Peer Support: FY-06: Explore expansion of Vet Centers to include veterans with SMI.	**Near Term = FY 2007 - Deferred related to focus on OIF/OEF**
	Ease Transition of victims of Military Sexual Trauma (MST) from active duty into the VA health care system.	***Near Term Program Office MHSHG and DoD Liaison:*** Initiate universal MST screening at MTFs and all components of national guard and reserves for separating service members (self-administered with counselors available).	**Ongoing through outreach and liaison with DoD**
		Near Term Program Office MHSHG and EES: TAP literature will include material on MST.	**Future = FY 2008 and Beyond**
		Near Term Program Office MHSHG and OQP: Establish EPRP MST screening supporting indicator: 90% of all veterans will be screened for MST; 80 % of all veterans screening positive will be referred for counseling within 30 days of screening.	**Near Term = FY 2007**
		Near Term Program Office MHSHG: VISN 4/5 MIRECC to expand work to focus on female veteran transition issues including MST.	**Ongoing - Reassigned to NCPTSD**
	Provide seamless transition of women veterans from outpatient care to more acute levels of mental health care and vice versa.	***Immediate VISN:*** The outpatient and Inpatient Mental health providers will serve as team members for both treatment modalities for female veterans.	**Near Term = FY 2007**

Commission Recommendation 1.2. Address mental health with the same urgency as physical health

Develop a modular VA-adapted mental health collaborative care model dissemination package as the basis for national rollout, in collaboration with the mental health Quality Enhancement Research Initiative (QUERI) Mental Health, VA Central Office and Veterans Integrated Service Networks (VISN) leaders.

AA Rec. #	Mental Health Strategies	Initiatives	
1.2.6 Initiatives 1-5	Develop a collaborative care model for mental health disorders that elevates mental health care to the same level of urgency/intervention as medical health care.	***Immediate Program Office MHSHG/ORD:*** MHSHG will collaborate with Mental Health QUERI to develop infrastructure needed for national rollout, including an organizational structure in which the Mental Health QUERI Depression Working group connects to MHSHG. Primary and Ambulatory Care SHG, OQP, National Clinical Practice Guidelines Council and the Performance Measures Workgroup, as well as to the TIDES Leadership Group. The development will include a VA integrated care model.	**Ongoing**
		Future Program Office OQP: Align performance measures to promote evidence-based collaborative care for depression.	**Ongoing**

		Near Term Program Office MHSHG: Work with OQP to rapidly update depression guidelines to include evidence-based collaborative care for depression.	**Ongoing**
		Near Term Program Office MHSHG: Develop a VA integrated care model similar to the Four Quadrant Clinical Integration Model for dissemination to VA medical centers. This will be done in collaboration with the Quality Enhancement Research Initiative (QUERI) program and VISN leadership.	**Ongoing**
	Assure that medical co-morbidities are identified and addressed in the mental health care population at the same rate as medical issues in the primary care population.	***Near Term Program Office Chief of Patient Care Services (PCS):*** Develop a tool and process for assessing physical co-morbidities in mental health patients. Collect and monitor data at a national level on medical co-morbidities in the mental health population using existing electronic databases; Promote and support epidemiological research in the area of medical co- morbidities in the mental health population; Collect and monitor data at a national level regarding access to medical care for the mental health population using existing electronic databases.	**Ongoing**

Identify good working models of Mental Health/ Primary Care/ Geriatric integration (including a module on differentiating normal and abnormal aspects of aging) in terms of service delivery and workload/supervision arrangements. Promote research activities on mental health/primary care integration best practices.

AA Rec. #	Mental Health Strategies	Initiatives	
1.2.7 Initiatives 1-13	**Develop an accurate mental health projection model for the full continuum of mental health care.**	***Immediate Program Office MHSHG and SMI Committee:*** **Continue the MH CARES Advisory Work Group to further develop the projection model with special emphasis on domiciliaries and geropsychiatry.**	**Ongoing**
		Immediate SMI Committee in conjunction with the Chief Consultant for Mental Health: **A projection model has been developed by a combined subgroup (SMI committee and GEC). Validation of this model as an accurate projection tool will occur from now through the end of FY07. This will be monitored by the continuing subgroup which will become a subgroup of the AASC. This projection model will be further evaluated in relation to its utility in conjunction with the algorithm to guide clinical decisions for long term psychiatric and nursing home care described in 1.2.8. Expand to cover all MH.**	**Near Term = FY 2007**
	Develop innovative programs of integrated care involving some combination of primary care, geriatrics, and mental health.	***Near Term Program Office MHSHG:*** The MHSHG will continue to work closely with geriatrics and primary care to develop clinical models of care and guidelines that better integrate mental and physical health.	**Near Term = FY 2007**
	Educate VHA providers on the normal and abnormal aspects of aging.	***Near Term Program Office MHSHG and EES:*** Develop a module on differentiating normal and abnormal aspects of aging. Address principles of information processing and memory processes for older adults, based on normal age-related changes. Provide information on sensory needs (e.g., use of large font). Differentiate normal cognitive changes with aging from changes indicating dementia or other cognitive functional problems. Cover evidence on demographics of aging and mental health, challenging common distortions (e.g., that depression is normative for older adults). Discuss evidence that older adults benefit at least as much from psychotherapy and psychotropic medication as do younger adults. Discuss adaptations of psychotherapy that enhance its effectiveness with older adults. In accord with recovery principles, articulate respect for the older veteran's choices for mental health resources.	**Future = FY 2008 and Beyond - Deferred to focus on OIF/OEF**

	Integrate primary medical care with homeless services.	***Near Term Program Office MHSHG:*** Expand two existing pilots (VA Conn HCS & West LA) to other facilities. Incorporate primary care into the women's homeless demonstration program.	**Near Term = FY 2007**
	Identify outreach to homeless recently discharged military servicepersons.	***Near Term Program Office MHSHG:*** Add an indicator to the intake form to assess outreach . A draft document has already been sent to the field for evaluation of feasibility and other comments.	**Ongoing**
	Ensure that mental health examinations are a part of all physical examinations in VHA.	***Immediate VISN and VA/DoD Liaison:*** Every returning service man/woman will meet with a mental health professional as part of the post-deployment and separation medical examinations and be provided with a brief pamphlet that reviews the information provided during the session. He/she will be encouraged to share this pamphlet with his/her family. Those found to have significant readjustment problems in the course of the examination would be triaged to care as appropriate. Those who decline intervention at time of screening, or who are not presently symptomatic, but deemed at risk for future readjustment problems based on the exam, will have their medical record flagged for repeat screening at future medical appointments.	**Ongoing**
	Eliminate gender disparities and provide accessible mental health services to women veterans.	***Future Program Office MHSHG and Chief Consultant for Women's Health:*** Charge a women's mental health committee to identify and design evidence based optimal women's' mental health practice models.	**Ongoing**
		Future Program Office ORD: Expand women's HSR&D research agenda to evaluate women's' mental health programs effectiveness and patient outcomes.	**Assigned to WMHC**
		Immediate Program Office MHSHG and SMI Committee: Appoint a women's health representative to the SMI Committee.	**Ongoing**
	Women veterans will have access to mental health services in a milieu that promotes comfort and security.	***Immediate Program Office MHSHG and Chief Consultant for Women's Heath:*** Women Veterans Program Manager will participate in the MH EOC planning process for both inpatient and residential programs.	**Ongoing**
	Expand dental services for homeless veterans.	***Near Term NEPEC:*** NEPEC and Dental Service will jointly develop a means of monitoring services delivered.	**Ongoing**
	Realign Domiciliary Program.	***Near Term Program Office Chief Officer PCS:*** **The domiciliary programs that primarily treat substance abuse and PTSD patients should be placed under MH in VACO and the field. A subgroup of the AASC will be formed to explore details of how this can be accomplished while maintaining domiciliary-type services for frail elderly veterans and for enhancing services for special populations such as women veterans. Subgroup to include representatives of MH, GEC and the Women's Strategic Planning Task Force, as well as others selected by the Exec Comm of the AASC. Subgroup to be formed and begin to explore implementation plans by 10/1/04.**	**Ongoing**

Eliminate variability in access to mental health, substance abuse, long term psychiatric care and homeless services by 2008. A. Complete expansion of specialty mental health services in all Community Based Outpatient Clinics (CBOCs). B. Use tele-mental health approaches for smaller sites including access to specialized services such as PTSD and substance abuse counseling. C. Implement the Veterans' Millennium Health Care Act requirements for long-term psychiatric care. D. Produce VHA mental health strategic plan and VISN-level tactical plans to ensure uniform implementation.

AA Rec. #	Mental Health Strategies	Initiatives	
1.2.8 A, B, C, D Initiatives 1-40	Provide a full continuum of compassionate care to veterans with mental illness.	***Immediate Program Office OQP:*** **Implement Performance Measure for FY 05: 85% of CBOCs serving more than 1,500 veterans will provide on-site, contract, or tele-mental health services at or above 10% of all clinic visits by FY'05. Increase to 15% of all clinic visits by FY 07. (Data is being reexamined by 10N in order to use the latest information.)**	**Ongoing - Increase to 15% deferred for prioritizing vs extending to smaller facilities**
		Immediate VISNs: **All Networks that are below the 85% standard at COB 3rd Qtr FY'04 must submit an Action Plan to the Action Agenda Steering Committee Task Force for review and recommended approval, and the Task Force will monitor progress. Appendix B of the Secretary's Mental Health Task Force contains a list of over 200 CBOCs that are below the standards as of 6/30/04.**	**Ongoing**
		Immediate VISNs: **Establish a Point of Contact for Mental Health in CBOCs and notify VACO MHSHG who that individual is.**	**Ongoing**
		Near Term Program Office MHSHG and VISNs: **All CBOCs should provide access to mental health services, either on site or by contract with offsite being the option of last resort. In remote locations telemental health may be used. The level care of care and the competencies of the staff available at the CBOCs must be equvalent to the care at the parent medical center and not at the expense of the parent facility (VHA Directive 2001-060). This workgroup recommends an integrated model of 1.0 FTE bahavioral health clinician per 1,500 primary care patients. Clinicians who operate at a distance from VAMCs in CBOCs manage a broader and more complex range of mental health disorders and require an adjusted case load size. Develop a national performance measure that addresses the mental health staff/patient ratios in CBOCs. All VISNs should develop a plan of how to deliver mental health services in CBOCs to patients with primary substance use disorder diagnoses.**	**Ongoing**
		Near Term Program Office OQP: **Develop national performance measure that addresses MH staff/patient ratios in CBOCs.**	**Future = FY 2008 and Beyond - Deferred to consider telemental**
		Near Term Program Office MHSHG: Update CBOC application directive and form to include requirement to specifically detail MH services and staffing to be provided at all new CBOCs. Ask for a focused evaluation from the Mental Health representative on each CBOC application currently under review and secure additional information as needed.	**Ongoing**
		Near Term VISNs: All medical centers and CBOCs will develop service agreements between primary care and mental health on bipolar disorder, schizophrenia, PTSD, SA defining treatment and referral guidelines.	**Near Term = FY 2007**
	Reduce geographic variation and include access to specialized MH and SA service delivery to homeless veterans.	***Near Term VISNs:*** Expand homeless programs to bring all VISNs up to the current national average for provision of mental health services to homeless veterans.	**Ongoing**
		Near Term Program Office OQP and NEPEC: Consistent with the recommendation that variation in service availability will be reduced, the homelessness subgroup of MHSPWG developed a model for meeting the needs of homeless vets which suggests that $11.6 M of new annual funding over the next 5 years will bring all VISNs up to the current national average of 38.4 veterans served by homeless staff in homeless programs per 1000 veterans at risk for homelessness. $33 M could bring all VISNs up to the current 85th percentile or 49.7 for 1000 at risk. It could cost $86 M to bring all VISNs up to the level of the top VISNs (73.4/1000) in FY 03. NEPEC, in collaboration with Performance Measures Work Group, will develop a performance measure.	**Ongoing**

Provide a full continuum of care to homeless veterans with mental illness.	***Immediate Program Office OQP and MHSHG:*** **Implement Performance Measure for FY'05: 75% of homeless veterans will receive at least one mental health or substance abuse visit and one primary care visit within six months of initial outreach (The denominator against which the 75% measure is calculated will be all veterans for whom a Form X is completed).**	**Ongoing**
	Immediate Program Office OQP and MHSHG: **Implement Performance Measure for FY'05: 75% of veterans with SMI who meet clinical criteria for MHICM program will be enrolled and provided services.** **The denominator for this measurement is the population based need estimate developed by the SMI subcommittee of the MHSPWG. All VISNs will submit a plan (by 9/30/04) for providing care to meet this measure.**	**Ongoing**
	Immediate Program Office MHSHG & VISNs: VHA Directive 2000-034 specifies the evidence based operational performance criteria for MHICM in VHA and defines the target population. This directive to be renewed and facilities held accountable for adhering to all performance criteria.	**Ongoing**
	Immediate Program Office OQP and NEPEC: **Require that all homeless veterans who meet clinical eligibility criteria for MHICM programs be offered assignment to a MHICM team and enrollment in the MHICM program. All MHICM teams will adhere to established clinical standards and caseloads.**	**Ongoing**
Restore VHA's ability to consistently deliver state of the art care for veterans with SA disorders.	***Immediate Program Office MHSHG and VISNs:*** **Mandate that VAMCs restore specialized SA treatment programs. All networks will be ranked on their percentage of substance abuse treatment capacity, which is defined as follows: The numerator is the number of substance abuse patients treated in FY03 as defined in the capacity report, and the denominator is the number of enrolled veterans in the network. The lowest quartile of networks (i.e., the bottom 5) on this measure will be required to bring their networks up to the national average on this measure on the rapid schedule laid out by the Secretary.**	**Ongoing**
	Near Term Program Office MHSHG and VISNs: Develop a National Plan to meet SA capacity requirements. Capacity distributed by VISNs to meet all dimensions of access: geographic distribution, affordability, availability, acceptability, and accommodation. The plan uses VHA's clinical practice guidelines for substance abuse treatment as primary guide in reestablishing services and show how VISNs resources will be reallocated to accomplish the plan objectives.	**Ongoing - Plan developed in FY2005, and RFPs in FY2005/06 based on the plan. Plan to be reevaluated and updated in FY 2007/08.**
	Future Program Office MHSHG and EES, Chief Consultant: Ensure that primary care at all VA facilities has physicians trained, accredited and privileged in primary care provision of buprenorphine and Naltrexone or technology to connect to services at a larger medical center. Recommend that Pharmacy and Therapeutics Committees approve these agents for the facility's formulary. Ensure that all VA facilities have the resources to provide 5 days of inpatient/residential detoxification services either on-site, at a nearby VA facility, or at a contracted facility. All facilities will have a specialized substance abuse provider to ensure linkage between the inpatient and outpatient follow-up treatment programs.	**Ongoing - Funding provided and training implemented**
	Immediate Program Office OQP: Implement HEDIS for benchmarked performance measures for substance abuse in FY 06.	**Ongoing**

	Establish case management programs for homeless veterans with mental illness and/or substance abuse.	*Near Term Program Office MHSHG:* Implement a special needs grant program for homeless chronically ill veterans coupled with Critical Time Intervention (CTI) services at partnering VAMCs. Current available funding in the Homeless Provider Grant and Per Diem Program can support five collaborative projects. Based on the outcome of the pilots, a plan for national implementation will be developed. Homeless veterans with complex medical problems, serious mental illnesses and/or substance use disorders will be assigned to a targeted case management program.	Ongoing
		Near Term NEPEC: Eligible veterans who receive services in grant and per diem programs will have the number of visits (529 stop codes) consistent with their need, but no less than one HCHV visit per month, to assure facilitated access to VA mental health and medical services. Telemental health can be used to provide these services in remote locations. NEPEC to track data and report to MHSHG.	Ongoing
		Immediate Program Office OQP and MHSHG: Establish a performance measure requiring that homeless veterans suffering from SMI and/or SA who receive residential services receive at least one MH or SA treatment visit during residential care and one follow-up visit during discharge from residential care.	Ongoing
	Develop a full range of supportive services for veterans in collaboration with community partners.	*Near Term Program Office MHSHG:* Provide incentives to improve homeless veterans access to VA Treatment services and enhance collaboration between VA medical centers and Grant and Per Diem funded transitional housing programs.	Ongoing
		Near Term Program Office MHSHG: Establish financial incentives for providing necessary VHA mental health services to homeless veteran in Grant and Per Diem programs. A report of options will be sent to the Secretary from the VHA National Leadership Board Finance Committee.	Ongoing - Same as previous entry
		Immediate Program Office OQP, MHSHG and VISNs: Enhance supported CWT and employment activities within VA by: 1. Establish a performance measure/monitor for assessment of occupational dysfunction, and referral to transitional and supported employment models authorized by 38 USC 1718. Such a measure/monitor will establish reasonable expectations for access to transitional and supported employment separately for veterans with homelessness and for those with psychosis. 2. Provide approx $6,000,000 in FY'04 for staffing resources to implement supported employments at 107 existing vocational programs authorized by 38 USC 1718. Provide approx $4,000,000 in FY'05 for staffing resources to operate and sustain work restoration services authorized under 38 USC 1718 for the provision of both transitional and supported employment models at facilities without existing CWT programs. These resources should be provided through recurring Specific Purpose funding with new permanent positions established.	Ongoing
		Near Term Program Office MHSHG: Finalize a policy directive that places a priority on making underutilized space on VAMC campuses available to nonprofit community-based organizations that wish to develop residential programs for homeless veterans. Enhance partnerships with community partners to provide transitional housing.	Ongoing

		Immediate VISNs: **Mandate that all VISNs address the transition needs of incarcerated veterans and develop a plan that will be implemented in FY 2005.**	**Near Term = FY 2007 - Plan was deferred to FY 2007 and now being implemented**
		Future VISNs: Each VISNs will submit a specific plan for pre-release assessments of veterans in federal & state correctional facilities to determine degree and type of need and methods of providing services. The assessments to include mental health, medical and social service needs.	**Future= FY 2008 and Beyond**
	Meet the needs of SMI veterans for Community Residential Care.	***Immediate VISNs:*** 1. Meet levels as projected by the MHSPWG for FY07. Market level plans developed for any market with a gap that exceeds 1,000 CRC stops in FY07. For meeting these gaps, a plan must be submitted by 10/1/04 to the AASC. 2. Increase staffing to meet the required minimum one case management visit per month; 3. Emphasize individualized, recovery-oriented placements versus placements that have an institutionalized atmosphere and very little rehabilitation services.	**Deferred until later time - other residential care programs became higher emphasis areas**
	Each Medical Center will have a Mental Health Clinic with adequate staffing to meet the mental health needs of veterans.	***Immediate VISNs:*** Each VISN will develop a planning initiative to address service gaps in outpatient mental health care identified by the MHSP model. Analysis and Network plan to address issues (with at least a 30% gap closure by COB FY07) must be submitted to MHSHG and AASC by 10/04. Markets with positive gaps over 16,000 (actual CARES) stops in FY07 MHSP model need to be addressed. This is the same market level gap used in the original CARES model. Each VA facility that currently does not have one will have a PTSD clinical team or PTSD specialists or a plan to secure these services. The role of these clinicians is to serve the facility MHC and CBOC based OPC services and also to provide consultative or clinical support to acute inpatient units for patients with PTSD.	**Ongoing**
		Near Term Program Office MHSHG and VISNs: Expand PTSD outpatient services in VISNs with gaps as identified in the PTSD subgroup report. Twelve VISNs, 3, 4, 5, 8, 9, 10, 11, 12, 15, 19, 22 and 23 are identified as having PTSD care gaps in the P.L. 108-170 solicitation and will be considered the first priority for new PCT development. In addition, other VISNs especially those with significant Global War on Terrorism troop returnees (2, 6, 16, 17 and 21) will also received priority in expanding new PCTs.	**Ongoing**
	Medical Centers will have adequate beds and staffing to meet the needs of the local veteran populations for acute inpatient psychiatric services.	***Immediate VISNs:*** Each VISN which has a market(s) with a MHSP projected service gap in inpatient mental health both for FY'02 and for FY'07 that exceeds 7,300 bed days of care at the market level must submit a plan to close that gap by FY'07 with phased in increments of a minimum of 10% per year. Those markets that exceed a 7,300 BDOC gap either for FY'02 or for FY'07 will assess and report if a plan is needed. Reports should be submitted to the AASC no later than 10/1/04.	**Near Term = FY 2007 - Deferred to FY 2007 and now being implemented**

Expand clinical monitoring systems to include Work Restoration services.	***Future Program Office MHSHG:*** Explore development of a Work Restoration Information Management System (WRIMS) for use in each VAMC and CBOC (using the CMIS of VISNs 1 as a model), to ensure that each veteran is offered the choice in participating in work restoration services; Increase Work Restoration services until all veterans in VAMCs and CBOCs have equal access to work skills training and development, implement the Evidence-Based practice of Supported Employment into all Work Restoration programs; Add work restoration to Illness Mgt Training of unemployed patients who are participating in programs transferring from LT custodial care to rehabilitation in the community; Add work restoration training to MHICMs and other community support teams	**Ongoing**
Meet the needs of SMI veterans for residential rehabilitation services.	***Immediate VISNs:*** General psychiatry PRRTP (residential care) services increase at the VISN level by FY'07 based on the MHSP Model projection. VISNs that have a gap of 15 or more PRRTP beds should develop a plan to reduce the gap by at least 30% by FY07, phased in annually with a minimum of 10% improvement each year. The plan to be developed by 10/1/04 and reviewed by the Action Agenda Steering Committee.	**Ongoing**
Meet the needs of veterans with substance abuse for residential rehabilitation services.	***Immediate VISNs:*** SARRTP (residential care) services increase at the market level by FY'07 based on the MHSP Model projection. Market areas that have a gap of 15 or more SARRTP beds, after taking into account bed section 86, DOM/SA, develop a plan to reduce the gap by at least 30% by FY07. The plan to be developed by 10/1/04 and reviewed by the Action Agenda Steering Committee.	**Ongoing**
Meet the needs of veterans with PTSD for residential rehabilitation services.	***Immediate VISNs:*** 1. PRRP (residential care) services to be increased at the VISN level by FY07 based on the MHSP Model projection. VISN areas that have a gap of 5,475 or more PRRP beds (taking into account Dom PTSD program beds as equivalents) will develop a plan to correct the gap. The plan to be developed by 10/1/04 and reviewed by the Action Agenda Steering Committee. Preliminary analyses indicates that VISNs 4, 6, 9, 16 and 22 would develop plans.	**Ongoing**
Allocate additional resources for enhanced outpatient treatment of all Mental Illness Chemical Abuse (MICA) patients. These treatments must consist of appropriate integration of substance abuse and mental health treatment services.	***Near Term VISNs:*** Proposed that VHA adopt the standards outlined in the integrated treatment of patients contained in the MICA Task Force report (January 2004) at each facility with a substantial population of individuals who meet the definitions for MICA.	**Ongoing - Standards adopted in SA operating plan, FY 2005; Resources allocated in FY 2005/06/07**

	Expand Opiate Agonist Treatment (OAT) in urban centers with high prevalence of heroin use and large CARES-projected gaps in VA methadone treatment.	***Near Term VISNs:*** Open OAT clinics at Phoenix, AZ; Denver, CO; Tampa, FL; Orlando, FL; Salt Lake City, UT.	**Ongoing - OAT programs are being expanded through use of buprenorphine**
	Ensure effective utilization of the continuum of long term inpatient mental health care.	***Immediate VISN and Program Office MHSHG:*** 1. Authorize a joint review and refinement by Mental Health, Geriatrics and Extended Care, and the SMI Committee, of the 1996 VHA Program Guide 1103.22 "Integrated Psychogeriatric Patient Care;" by 2/2005. 2. Promulgate throughout VA the algorithm for functional decisions on level of nursing and mental health care for older veterans needed (presented in full report of the Older Adult subgroup) over the next year (and then ongoing), as a recommendation by the Secretary for decision-making in each VISN. This will be done in conjunction with ongoing efforts in Geriatrics and Extended Care to develop a broad new, compassionate model of nursing home care for Veterans 3. All nursing home care facilities will have staff educated in and competent to care for patients with both functional and behaviorial health problems. In some circumstances, specialized units such as dementia units, or psychogeriatric units may be necessary to meet local needs.	**Future = FY 2008 and Beyond - Deferred to allow focus on OIF/OEF**
	Ensure adequate day treatment facilities for SMI veterans.	***Near Term VISNs:*** VISNs without Day Treatment (or equivalent) capacity should add it at the most appropriate facility, based on size and access considerations.	**Ongoing**
		Near Term VISNs: Facilities serving over 1,000 veterans in the psychosis registry without a Day Treatment (or equivalent) facility should add one with appropriate staffing and education. Peer Specialists should be used whenever feasible.	**Future = FY 2008 and beyond - Was deferred to focus on OIF/OEF and integrated care**
		Near Term VISNs: Existing Day Treatment programs with waiting lists will provide resources to eliminate them.	**Future = FY 2008 and beyond - Was deferred to focus on OIF/OEF and integrated care**

President's New Freedom Commission Goal 2: Mental health care is consumer and family driven.

Commission Recommendation 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Develop a performance measure based on percentage of Seriously Mentally Ill (SMI) patients whose family members have been contacted to participate in developing an individualized plan of care. A. Create data capture mechanism for family contacts that include implementation of a clinic stop code for family work and a family education / counseling field on encounter forms.

AA Rec. #	Mental Health Strategies	Initiatives	
2.1.9 A Initiatives 1-5	Ensure that every mental health patient has an individualized treatment plan that includes family involvement in treatment plan and process.	*Immediate VISNs/DSS:* Operationalize Family Education clinic stop code and encounter form procedure code in FY-05; implement (VISN 10 pilot) Family Involvement Performance Measure nationwide in FY-05.	**Near Term = FY 2007**
		Immediate Program Office MHSHG: The FPE/FE Task Force of MH QUERI outlined the following in FY-05: Develop policy directive on Family Involvement/Education to include issues of confidentiality and expectation that the care plan for all patients with schizophrenia establish at least one family contact or document the reason for its absence.	**Near Term = FY 2007**
	Expand seamless transition efforts to fully cover veterans with mental health diagnoses.	*Near Term VA/DoD Liaison:* 1. Assign Transition case managers to focus on mental health programs, based on case load to WRAMC, Brooke etc. where the bulk of the mental health MEBs and PEBs are conducted; 2. Develop case management program for all DoD "complex care" patients coming into VHA health care system; 3. Include VHA social worker/case manager and patient family in transition planning for DoD personnel with mental health problems who will be transitioning to VHA health care system, with a special focus on pain management; 4. Improve transition planning, referral/placement and information exchange for patients with mental illness coming into VHA health care system; 5. Improve outcomes for patients eligible for VA services and /or benefits thru use of recovery approach to provision of services.	**Ongoing - Case managers assigned at identified sites and programs expanding**
		Immediate Program Office MHSHG and VISNs: 1. Assign Transition Social Workers to focus on mental health including; 2. Survey all MTFs to determine the need for social workers focused on mental health programs; 3. Ensure that Points of Contact at VISN and local treatment systems have appropriate knowledge about mental health programs and capabilities; 4. Have transition social workers follow-up on referrals at three and six months to ensure effective program placement; Identify VACO point (s) of contact for problem resolution.	**Ongoing**
	Mental health assessments are an integral part of all exams of separating military service personnel.	*Near Term Program Office MHSHG and VA/DoD Liaison:* 1. Every military man and woman meet individually with a mental health professional as part of the post-deployment and separation exams. 2. An MOU needs to be developed with DoD to spell out authority, responsibility, accountability, and funding for the necessary clinical capacity to be assured.	**Ongoing - PDHRA outreach from Vet Centers**

Commission Recommendation 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

Involve veteran consumers and families in educating staff/veterans/family members on recovery.

AA Rec. #	Mental Health Strategies	Initiatives	
2.2.10 Initiatives 1-2	Seek stakeholder input into mental health programming related to recovery.	*Near Term Program Office MHSHG:* For VHA staff educational efforts, MHSHG will ensure that stakeholders are included in planning educational programs related to recovery.	**Ongoing**
		Near Term Program Office MHSHG and VA/DoD Liaison: Assess barriers and explore implementation of Vocational Rehab and education for DoD patients with mental health problems while they await their MEBs or PEBs.	**Deferred for development of processes with DoD**

Implement administrative incentives that facilitate work with veteran's families.

AA Rec. #	Mental Health Strategies	Initiatives	
2.2.11 / 2.2.12 Initiatives 1-3	Reduce barriers to working with families.	***Future Program Office OQP and MHSHG:*** Implement (VISN 10 pilot) Family Involvement Performance Measure, including developing stop codes and other incentives for tracking workload. MHSHG and Mental Health QUERI will review results of VISN 10 performance measure pilot prior to advocating for national performance measure.	**Future Program = FY 2008 and beyond**
		Near Term Program Office EES and MHSHG: Implement Family Education in every Network through partnership with NAMI (Family to Family Program).	**Near Term = FY 2007**
		Near Term Program Office MHSHG: Offer Family-to-Family Education in partnership with NAMI in every Network. Partner every facility, outpatient clinic and CBOC with corresponding county NAMI Affiliate, or other comparable Family Education program where FFEP is not offered and/or there is an already existing Family Education program; FY-06: Implement FPE in pilot Networks; Implement FPE/FE utilizing technology in pilot Networks; Work: Insure Family Education addresses issues regarding Work Restoration.	**Near Term = FY 2007**

Educate staff. A. Begin process of educating staff with a satellite broadcast introducing the current evidence base for the recovery based model of treatment. B. Develop programs for staff use on family psycho-education. C. Educate staff on clinical benefits and effective approaches to working with families, including issues of older couples and intergenerational families.

AA Rec. #	Mental Health Strategies	Initiatives	
2.2.13 A, B, C Initiatives 1-3	Educate staff on the evidence based recovery model of treatment.	***Near Term Program Office EES and MHSHG:*** MHSHG will work with EES to develop an educational program, including a satellite broadcast, for staff regarding the recovery model of treatment including issues of older veterans, female veterans and other special emphasis groups.	**Ongoing**
		Future Program Office EES and MHSHG: Family: Train staff on QUERI FPE via EES Broadcast and develop FPE Tool Kit; Disseminate FPE Task Force Tool Kit (planned) which will include working with diverse families to include older couples and intergenerational families.	**Future Program = FY 2008 and Beyond**
		Future Program Office EES and VISN: Develop programs for staff use on family psycho-education at the VA Palo Alto MIRECC and NCPTSD (VAPAHCS is the educational site for the National Centers for PTSD).	**Responsibility reassigned/shared - Ongoing at Palo Alto and VA Los Angeles**

Include veteran consumers and family members in facility mental health councils.

AA Rec. #	Mental Health Strategies	Initiatives	
2.2.14 Initiatives 1-3	Establish facility mental health council that include consumer membership.	***Immediate VISNs and Program Office MHSHG:*** All facility Mental Health Services will report to MHSHG about membership composition of the facility mental health council.	**Ongoing**
		Immediate VISNs and Program Office MHSHG: All facility mental health councils will have at least one veteran consumer and one family member as standing members of the facility mental health council.	**Near term = FY 2007**
		Immediate Program Office MHSHG and VISNs: To provide guidance to the field, VACO to develop and issue a Directive promoting the establishment of consumer/advocate liaison councils at both VISN and facility levels by 2nd Qtr FY'05. Such a Directive to include language about the communication chain to maximize the effectiveness of the council.	**Directive in draft form - Near term = FY 2007**

Commission Recommendation 2.3 Align relevant Federal programs to improve access and accountability for mental health services.

Develop Peer Support Program as an adjunct to mental health services. A. Explore models of peer support certification (e.g. those developed by Georgia). B. Determine whether a directive on Peer Support is advisable.

AA Rec. #	Mental Health Strategies	Initiatives	
2.3.15 A, B Initiatives 1-5	Partner with other federal agencies to develop peer support programs.	***Near Term Program Office MHSHG and VISNs:*** **Peer:** FY-05: Pilot State Peer Specialist Certification projects (such as Georgia/South Carolina, Hawaii, etc); **Peer Support:** FY-05: Issue national Information Letter to promote paid Peer-led services programming, (directly or through contract with community providers) as an adjunct to traditional mental health services at all facilities serving veterans with serious mental illness. FY-06: Issue national directive with detailed procedural guidance.	**Ongoing**
		Near Term Program Office MHSHG and Health Policy Coordination: Establish partnership with SAMHSA and continue participation in federal partners workgroup at VACO level. Establish nationwide method for reimbursing peer support . Add Work Restoration to Peer Counseling and Vets Helping Vets programs. Oversight of this effort to be conducted by the AASC.	**Ongoing - However, national models for reimbursing peer support already in development**
		Future Program Office MHSHG: Develop a partnership between the MHSHG and RCS to develop model systems for consumer and family driven services with VHA and to create a National Program of Excellence in Peer Counseling Services within VHA.	**Ongoing**
		Near Term Program Office MHSHG: VISN 1 MIRECC will develop a "How To" manual on developing a Peer Support program.	**Ongoing**
	Transition planning and referral/placement for OEF and OIF returnees	***Immediate Program Office MHSHG and VA/DoD Liaison:*** Explore early transfer of patients with mental health problems to the VA treatment system and the use of VA health care providers to conduct MEBs and PEBs.	**Deferred pending further discussion with DoD**

Initiate a national Recovery and Rehabilitation Task Force to develop a "How To" manual on developing a Peer Support Program.

AA Rec. #	Mental Health Strategies	Initiatives	
2.3.16	Provide support for the development of a Peer Support Program.	***Near Term Program Office MHSHG:*** VISN 1 MIRECC will facilitate the following efforts: 1. Family Support/education - Implement family education program in each VISN; educate staff; appoint family POC within each facility. 2. Veteran Advisory Councils/peer support. 3. Change VHA culture to recovery oriented service delivery. Reference AA Recommendation 5.3.61.	**Ongoing**

Develop task oriented veteran-consumer councils in each facility. A. Insure consumer council has communication mechanism to facility leadership.

AA Rec. #	Mental Health Strategies	Initiatives
2.3.17 A	combined with 2.3.14	

Develop paid positions for veterans) within the facility/network to work with Mental Health leadership in developing Peer to Peer Programs.

AA Rec. #	Mental Health Strategies	Initiatives	
2.3.18 Initiatives 1-3	Utilize veterans in the provision of mental health care. Reference AA Recommendation 5.3.61.	***Near Term HR and Program Office MHSHG:*** Hire or identify existing staff as a permanent veteran mental health consumer in the MHSHG and in each Network to work with Mental Health leadership in developing Peer Programming and to represent the consumer perspective in other mental health planning/management initiatives and to serve as peer/MH para professional.	**Ongoing**
		Near Term Program Office MHSHG and VISNs: FY-06: Pilot Certified Peer Specialists in selected VISNs (suggest VISNs 7 and 20); Pilot Peer Bridgers in selected VISNs (suggest VISNs 2 and 3); Modify current State Certified Peer Specialists training to tailor for VHA implementation nationwide.	**Ongoing**
		Near Term Program Office MHSHG and OQP: **FY-07**: Issue national directive on Peer programs; Establish Network performance monitor to require a formal Peer Support Program at each facility serving greater than 2,500 veterans with SMI; **FY-06**: Establish a clinic stop code for Peer-Led Groups, and a Peer Provider category on encounter forms.	**Future Program = FY 2008 and Beyond - Deferred for focus on OIF/OEF**

Hire veterans as Peer / Mental Health Para Professionals.

AA Rec. #	Mental Health Strategies	Initiatives	
2.3.19	See 2.3.18 and 5.3.61.	***Near Term VISN and Program Office OQP:*** FY 06. Establish network performance monitor to require a formal paid peer support program at each facility serving greater than 2,500 veterans with SMI. FY 07. Expand that monitor to include facilities with more than 1,200 veterans with SMI.	**Future Program = FY 2008 and Beyond - Deferred for focus on OIF/OEF**

Issue a national directive to facility leadership on the creation of local Peer Support programs. A. Identify a facility coordinator for the development of peer programs. B. Develop a progressive performance measure that addresses incremental steps to the implementation of a facility Peer Support program. C. Create data capture mechanisms for peer support and peer training that include implementation of clinic stop codes and modification of encounter forms to include fields for peer support as well as peer training.

AA Rec. #	Mental Health Strategies	Initiatives
2.3.20 A, B, C	See 2.3.18 and 5.3.61	

Make housing with support more available for those veterans who are homeless or at risk for homelessness, particularly older veterans and those veterans who are new to the system.

AA Rec. #	Mental Health Strategies	Initiatives	
2.3.21 Initiatives 1-6	Provide additional homeless housing.	***Future Program Office MHSHG and ORD:*** Task HSR&D with creating a Management Consultation Project to develop a demand model for residential services at all facilities. The needs of older veterans and veterans new to the system will addressed in this model.	**Future Program = FY 2008 - MHSG needs to work with ORD on developing this initiative.**
		Near Term Program Office MHSHG: Work with HUD to maintain current capacity and create new capacity in the HUD/ VASH.	**Ongoing**
		Immediate Program Office MHSHG : Continue support of joint VA/HUD/HHS collaborative initiative in chronic homelessness.	**Ongoing**
		Near Term Program Office MHSHG and GEC: Expand grant and per diem and domiciliary care programs.	**Ongoing**
		Immediate Program Office MHSHG: Develop programs focused on prevention of homelessness and unemployment for DoD patients with mental health problems (Legislative authority may be required).	**Ongoing**
		Immediate Program Office CARES: **Make underutilized space at VA facilities available for community organizations to provide programs.**	**Ongoing**

Work with state, local and community partners to increase opportunities for veterans to participate in supported employment programs. Support legislation to increase VA's authority to form partnerships to provide supported employment opportunities for veterans.

AA Rec. #	Mental Health Strategies	Initiatives	
2.3.22 Initiatives 1-3	Increase opportunities for veterans to participate in supportive employment.	***Future Program Office MHSHG:*** Partner with Department of Labor (DOL) to develop Work Restoration services that promote entrepreneurship and private enterprise; Develop contract with Department of Defense (DOD) to expand the CWT Veterans Construction Team (VCT) to assist veterans in restoring lost construction skills; Develop policy and procedures for utilization of non-appropriated CWT Special Therapeutics Rehabilitation Activities Fund (STRAF) to contract with state, local and community partners to provide job development and coaches for Supported Employment services; Increase outreach by providing CWT, IT, CWT/TR programs in shelters for homeless veterans.	**Ongoing**
		Future Program Office MHSHG: Improve outcomes for patients eligible for VA services and/or benefits thru use of recovery approach to provision of services.	**Ongoing**
		Near Term Program Office MHSHG: MHSHG to create a RFP for the development of new or expanded CWT/TR programs and that they be provided with $500,000 annually to support these programs. This alternative centralized funding mechanism would be established and supported to sustain the provision of residential rehabilitation in the CWT/TR program for SMI veterans until authority is restored for use of non-appropriated dollars.	**Ongoing each FY**

Commission Recommendation 2.4 Create a comprehensive State Mental Health Plan

Ensure that VISNs participate in State Mental Health Plan development.

AA Rec. #	Mental Health Strategies	Initiatives	
2.4.23 Initiatives 1-3	All VISNs will actively participate in the development of their State mental health plans.	***Future Program Office MHSHG:*** **Participate in President's 10 Year Plan to End Chronic Homelessness.**	**Ongoing**
		Near Term VISNs: Peer: FY-05/06: Partner with state-funded Consumer-run services to provide supports for housing, employment and other community services to veterans.	**Ongoing**
		Immediate VISNs: VISNs will work with their state(s) and The National Association of State Mental Health Program Directors to develop strategic plans and processes for collaboration of the delivery of mental health service. The VISNs submit their proposals to 10N and the MHSHG for consideration.	**Ongoing**

Encourage development of state plans that provide supported housing, employment and other community services to veterans.

AA Rec. #	Mental Health Strategies	Initiatives
2.4.24	collapsed with 2.2.23	

Commission Recommendation 2.5 Protect and enhance the rights of people with mental illnesses.

Identify a family point of contact within each facility to coordinate services, education and liaison with National Alliance for the Mentally Ill.

AA Rec. #	Mental Health Strategies	Initiatives	
2.5.25	Ensure facility coordination with NAMI.	***Near Term Program Office MHSHG:*** MHSHG will initiate a Task Force including representatives from the Mental Health QUERI FPE/FE Task Force, and charge it with developing a process for implementing FE.	**Future program = FY 2008 and Beyond - PSR Section of Office of Mental Health Services will need to partner with Mental Health QUERI to develop**

Assist with development of an Advanced Directive for every veteran with serious mental illness who desires one. Advanced Directives can designate power of attorney at times the veteran is deemed not competent to make decisions for him/herself.

AA Rec. #	Mental Health Strategies	Initiatives	
2.5.26	Across the age span, there will be no disparity between mental health and medical health of veterans in completing a mental health and a medical advanced directive.	***Near Term Program Office MHSHG and VISNs:*** Develop and disseminate to the VISNs a mental health advanced directive policy. This policy will address the following issues: Across the age span, there will be no disparity between mental health and physical health in completing a medical advance directive. When data on advanced directive compliance are reviewed by facility, rates of completion for veterans with and without SMI will be compared. If rates are not equivalent, training for staff described under Goal 1 (re: destigmatization) should be repeated for relevant staff, with an emphasis on the rights and abilities of veterans with SMI and veterans of all ages to state their advanced directive wishes.	**Near Term = FY 2007**

Partner with academic institutions that have a commitment to the understanding and development of psychosocial rehabilitation (e.g. Robert Wood Johnson Foundation).

AA Rec. #	Mental Health Strategies	Initiatives	
2.5.27 Initiatives 1-3	Provide psychosocial rehabilitation expertise to VHA staff.	***Future Program Office MHSHG:*** Create working group to expand partnerships by participating in research and training activities.	**Future = FY 2008 and Beyond**
		Near Term Program Office MHSHG: Identify current partnerships through a survey of MIRECCs, PSR fellowship programs, Mental Health QUERI, and field clinicians and researchers.	**Near Term = FY 2007**
		Future Program Office OAA and MHSHG: Partner with OAA to develop VHA psychosocial internships in association with universities and foundations. Increase linkages in Supported Education with state and regional colleges and training schools. Supported education must increase marketability in an ever-changing job market in which all employees rapidly become obsolete as technology continually transforms.	**Future Program = FY 2009/10**

Explore grants awarded to not for profit groups targeted at Peer Development and Education.

AA Rec. #	Mental Health Strategies	Initiatives	
2.5.28 Initiatives 1-2	Refer to 2.3.18	***Near Term Program Office MHSHG and VISNs:*** Peer: FY-05. Explore development of a VA Technical Assistance Center for Peer Support Services and/or develop grant/contractual arrangement with established technical assistance organizations.	**Ongoing**
		Immediate Program Office MHSHG: Part of the Special Needs Grant for Homeless Chronically Mentally Ill Veterans MHSHG is requiring non-profit organizations that receive funding to develop "Vet-to-Vet" peer counseling model. Ten such programs are planned for funding.	**Ongoing**

Charge Veterans Benefits Administration (VBA)'s Vocational Rehabilitation Service with identifying and developing opportunities for training veteran/consumers as mental health service providers.

AA Rec. #	Mental Health Strategies	Initiatives	
2.5.29	Align VBA work restoration efforts with VHA work restoration efforts.	***Near Term Program Office MHSHG and VBA:*** Expand the partnership with VHA/CWT Program to improve access and services to VR&E programs for veterans with mental illness by development of supported employment models that include veteran/consumers as employment specialists, job coaches, and other support roles. MHSHG will prepare memo to USB from USH with this proposal.	**Ongoing**

Strengthen and expand local partnerships with NAMI and with National Mental Health Association (NMHA) for consultation on the development of peer facilitated programs.

AA Rec. #	Mental Health Strategies	Initiatives
2.5.30	Refer to 2.5.25	

President's New Freedom Commission Goal 3: Disparities in mental health services are eliminated.

Commission Recommendation 3.1 Improve access to quality care that is culturally competent.

Develop a culturally competent health care workforce A. Intensify efforts to improve the cultural diversity of health care staff and seek to recruit professional staff that better reflect the veteran enrollee population. B. Institute health professional scholarship programs targeted to attract minority candidates. C. Provide incentives for university affiliates to send undergraduate and graduate health care professional trainees to VA health care sites with large minority populations.

AA Rec. #	Mental Health Strategies	Initiatives	
3.1.31 A, B, C Initiatives 1-2	Ensure that VHA workforce is culturally diverse in ethnicity, gender, and age.	***Near Term Program Office OAA and MHSHG:*** The Office of Academic Affiliations to develop and fund health professional scholarship programs targeted to attract minority candidates.	**TABLED in favor of expanding other PSR-related training initiatives**
		Near Term Program Office OAA and MHSHG: The Office of Academic Affiliations to develop incentives for university affiliates to send undergraduate and graduate health care professional trainees to VA health care sites with large minority populations.	**Future = FY 2008 and Beyond - Deferred to focus on OIF/OEF**

Request that the Office of Research and Development (ORD) support research on minority mental health treatment. A. Identify areas of research specifically needed to close the gap in providing mental health care for minority veterans.

AA Rec. #	Mental Health Strategies	Initiatives	
3.1.32 A	Conduct research to assess and remedy potential disparities in treatment for minorities, including ethnicity, gender, age.	***Near Term Program Office MHSHG and ORD:*** SOTA conference with HSR&D and HSR&D COE on minorities will review existing portfolio and develop solicitations as appropriate for research on minority mental health treatment. The research will cover psychobiology of ethnicity, service/treatment disparities, and health related characteristics of other special emphasis groups.	**Future = FY 2008 and Beyond - Deferred to focus on OIF/OEF**

Collaborate in national interagency efforts to address minority issues, staff training needs, and assessment instruments, etc

AA Rec. #	Mental Health Strategies	Initiatives	
3.1.33 Initiatives 1-3	Ensure that there are effective interagency relationships to address minority issues, staff training needs, and assessment instruments, etc.	***Immediate Program Office MHSHG:*** MHSHG will designate a liaison to other Federal agencies to collaborate with their efforts in this area.	**Ongoing**
		Immediate Program Office MHSHG: MHSHG will explore options to collaborate with HHS minority offices in this area.	**Ongoing**
		Immediate Program Office MHSHG and the Office of Health Policy Coordination: VA will initiate collaboration with National Federal Partners' work group in this area.	**Ongoing**

Incorporate a cultural competence strategy in the VHA Strategic Plan.

AA Rec. #	Mental Health Strategies	Initiatives	
3.1.34 Initiatives 1-2	Ensure that all VHA staff are culturally competent	***Immediate Program Office MHSHG:*** By January of 2005, the MHSHG to establish a Cultural Competency Task Force to focus on clinician education and health care services. Representation to be from VACO and the field as well as MIRECCs, QUERI and EES. This Task Force to provide an action plan to be implemented by end of FY2006 and to include an evaluation component to assess effectiveness of the implementation in improving cultural competency. Refer to 3.1.31 and 3.1.37.	**Ongoing**
		Immediate Program Office MHSHG: Convene a work group to review literature and track the implementation of the recommendations of the Commission's Cultural Competence Subcommittee, the Surgeon General's Report on Mental Health, Minority Supplement, and evaluate the effectiveness of VA's cultural competence training program.	**Ongoing**

Fund EES to develop and implement comprehensive, cultural competence training, including a module on aging, for all VA employees.

AA Rec. #	Mental Health Strategies	Initiatives
3.1.35	Refer to 1.2.7	

Develop a knowledge management system to disseminate timely, program specific education that will keep staff continuously apprised of new information on best practices and research related to racial and ethnic differences in care needs and interventions.

AA Rec. #	Mental Health Strategies	Initiatives	
3.1.36 Initiatives 1-3	Enhance the current information dissemination system to speed the dissemination of information on research findings and best clinical and management practices throughout the VHA mental health community.	***Near Term Program Office MHSHG:*** MHSHG to urge VHA to develop information systems such as data warehouses and associated tools that allow real-time access to clinical data, and to encourage training of managers and providers in use of these tools as well as sharing of best practices.	**Future = FY 2008 and Beyond**
		Future Program Office EES: Develop web-based educational programs on best practices and research related to racial and ethnic differences in care needs and interventions.	**Future= FY 2008 and Beyond**
		Immediate Program Office MHSHG: Develop a registry of best practices similar to SAMHSA's National Registry of Effective Programs.	**Near Term = FY 2007**

Partner with Indian Health Service (IHS) to improve access to culturally competent mental health and substance abuse care for American Indian and Native Alaskan veterans.

AA Rec. #	Mental Health Strategies	Initiatives	
3.1.37 Initiatives 1-2	Partner with IHS to improve access to the full continuum of MH care for Native Americans and Alaskan Indians.	***Immediate Program Office MHSHG and Office of Health Policy Coordination:*** VHA will designate a VA liaison to work with IHS to promote this collaboration, specialty groups will be included in the planning.	**Ongoing**
		Near Term Program Office OAA: OAA will review and disseminate the cultural competence education pilot in VISN 1 MIRECC. Refer to 3.1.31 and 3.1.34.	**TABLED in favor of expanding other PSR-related training initiatives**

Commission Recommendation 3.2 Improve access to quality care in rural and geographically remote areas.

Identify national, state and local partners who are focused on improving health care in rural America. VHA is a stakeholder in any process involving rural healthcare and should request to participate in national initiatives and activities. This should include any actions taken on the part of the Department of Health and Human Services (HHS) to establish a State rural health initiative, especially those involving National Institute of Mental Health (NIMH), Health Resources and Services Administration (HRSA), IHS or the Substance Abuse and Mental Health Services Administration (SAMHSA).

AA Rec. #	Mental Health Strategies	Initiatives	
3.2.38 Initiatives 1-2	Collaborate with other agencies in delivering quality health care to veterans in rural areas.	***Immediate Program Office MHSHG and Office of Health Policy Coordination:*** VHA to have a designated liaison from the MHSHG to focus on rural mental health care issues and participate in the activities of HHS, NIMH, IHS, HRSA, SAMHSA.	**Near Term = FY 2007**
		Immediate VISNs: VA liaisons will advocate inclusion of veterans located in rural areas in all state MH plans.	**Near term = FY 2007 - VA State Liaisons appointed**

VHA should pursue a wide range of options for providing rural mental health care; particular attention should be paid to the needs of older veterans living in rural areas. VHA should examine existing and planned community access sites to ensure that they have mental health access that meet veteran's needs. Options for providing mental health services include but are not limited to on site staffing, tele-mental health, use of mid level providers, partnerships with State agencies, and fee for services with local private providers.

AA Rec. #	Mental Health Strategies	Initiatives	
3.2.39 Initiatives 1-5	Ensure that veterans in rural areas have access to quality mental health care.	***Future Program Office EES and MHSHG:*** Develop internet-based services to facilitate Peer Support services for veterans.	**Future = FY 2008 and Beyond**
		Near Term NEPEC: Case management models in rural areas where MHICM is not feasible/practical will be developed by NEPEC.	**Near Term = FY 2007**
		Future Program Office MHSHG and Office of Care Coordination: Design and launch a major demonstration project on telehealth addiction and mental health services for veterans, including recently separated military personnel, living in remote and rural areas.	**Near Term = FY 2007**
		Near Term Program Office MHSHG and VISN: VHA to examine existing and planned community access sites to ensure that they have mental health access that meets the veteran needs in those areas Mental health providers to be available in all CBOCs, and they will provide training using the psychoeducational modules described in the various recommendations above. Tele-mental health options, as described in later recommendations, will be widely available for use of older adults, PTSD, women, SA, etc.	**Near Term = FY 2007**
		Near Term Program Office MHSHG: MHSHG will collaborate with SAMHSA's Registry of Effective Programs to establish a parallel mechanism to have a VHA registry of best practices/demonstration programs including, for example, telemedicine programs and practices in remote areas and best practices for rural communities.	**Near Term = FY 2007**

VHA should request participation in SAMHSA efforts to identify and disseminate best practices to the rural community.

AA Rec. #	Mental Health Strategies	Initiatives
3.2.40	collapsed 3.2.39	

There are no items for Commission recommendations 4.1 and 4.2, as these deal with children & schools.

President's New Freedom Commission Goal 4: Early mental health screening, assessment, and

Commission Recommendation 4.3. Screen for co-occurring mental and substance use disorders and link with
Ensure that every clinician knows that mental health and substance use disorders can and do co-occur with other disorders that

AA Rec. #	Mental Health Strategies	Initiatives	
4.3.41 Initiatives 1-3	Implement a broad range, self-administered screening for mental health disorders. The screening will be conducted annually throughout the veteran's lifespan by the veteran's primary care team or identified care manager.	***Near Term Program Office HSR&D and MHSHG:*** HSR&D will evaluate current instruments and pilot a proposed mental health screening instrument	**Ongoing**
	Provide education to primary care providers regarding mental health disease management and to mental health providers regarding common medical conditions found in psychiatric patients.	***Future Program Office EES:*** Require 8 hours annually of CMEs on mental health for primary care providers and on medical health for mental health providers. Recommend increasing medicine residency training program requirements for mental health electives and/or training	**Ongoing**
	Improve diagnosis and treatment of mental health disorders among returning service personnel with serious physical injuries.	***Near Term Program Office MHSHG and VISN:*** Provide outreach to active duty, especially those with life altering injuries, and recently deactivated military personnel and their families to make them aware of VHA and VBA programs and eligibility requirements for persons with mental health problems. Develop partnership between the MHSHG and RCS to lead VHA outreach to special populations ; 1. Partner with DoD MTFs to screen all patients for mental health and substance abuse problems ; 2. Expand use of clinical reminder currently used to screen for mental health and substance abuse in OIF and OEF veterans to all new patients coming into the VA health care system.	**Ongoing**

Ensure that screening and evaluation for these disorders are part of accepted clinical practice for every health care provider.

AA Rec. #	Mental Health Strategies	Initiatives
4.3.42	collapsed with 4.3.41	

Ensure that diagnosis of a mental health or substance abuse disorder results in an automatic screen for the other disorder as a

AA Rec. #	Mental Health Strategies	Initiatives
4.3.43	See above 4.3.41	

Require cross training in the two areas including the acquisition of a minimum number of CME/CEU credits in the assessment

AA Rec. #	Mental Health Strategies	Initiatives	
4.3.44 Initiatives 1-2	Mental health and substance abuse providers will be competent in assessment and treatment for both mental health and substance abuse disorders and these competencies will be documented.	***Immediate Program Office MHSHG:*** MICA Task Force is working on specific recommendations on mandatory CMEs.	**Future = FY 2008 and Beyond**
		Future Program Office MHSHG: Link with SAMHSA Co-occurring Disorders Project to develop educational program.	**Future = FY 2008 and Beyond**

Commission Recommendation 4.4. Screen for mental disorders in primary health care, across the lifespan, and
Require annual screening for mental health and substance abuse disorders across the life span by the veteran's primary care

AA Rec. #	Mental Health Strategies	Initiatives	
4.4.45 A, B	Require annual screening for Mental Health and Substance Abuse Disorders across the lifespan by the veterans' primary care provider.	***Immediate Program Office MHSHG and MIRECCs:*** Work with MHSHG and MIRECCs to develop and test a comprehensive tool for annual screening.	**Ongoing**

Evaluate the dual diagnosis/co-occurring VA programs to identify best practices and to determine which programs were most

AA Rec. #	Mental Health Strategies	Initiatives	
4.4.46 Initiatives 1-4	Suicide prevention.	***Near Term Program Office MHSHG:*** Endorsement and implementation of the National Strategy for Suicide Prevention (2001) and the Institute of Medicine's report, Reducing Suicide: A National Imperative (2002).	**Ongoing**
		Near Term Program Office MHSHG and VISNs: Develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care.	**Near Term = FY 2007**
		Future Program Office MHSHG and EES: EES in conjunction with MHSHG develop mandatory education programs for VA health care providers about suicide risks and ways to address these risks. Incorporate best practices for suicide prevention.	**Ongoing**

		Immediate Program Office MHSHG and USH: Recommend support for new MIRECC with focus on suicide prevention, in collaboration in other MIRECCs working in this area.	**Ongoing**

Increase collaboration with VBA to provide the full range of supports and services that are needed by patients with mental

AA Rec. #	Mental Health Strategies	Initiatives	
4.4.47 Initiatives 1-2	Eliminate the disincentives in the work restoration program for veterans.	***Future Program Office MHSHG and VBA:*** MHSHG will evaluate and address these disincentives. Link VA work restoration program to Supported Employment in the Veterans Benefits Administration (VBA) that focuses on competitive work, rapid job search, coupled with job coaching, and training veteran/consumers as mental health service providers. MHSHG will prepare memo to USB from USH with this proposal.	**Ongoing**
	Increase collaboration with VBA.	***Immediate Program Office MHSHG and VBA:*** Recommend that VARO Benefits Counselors annually assess all veterans in the G&PD programs to determine eligibility for benefits. MHSHG will prepare memo to USB from USH with this proposal.	**Near Term = FY 2007**

Work with Residency Review Committees to encourage incorporation of mental health modules into all residency programs.

AA Rec. #	Mental Health Strategies	Initiatives	
4.4.48	Incorporate mental health education and training into residency programs.	***Future Program Office OAA and MHSHG:*** The Coordination Council for education program, "Mental Health for Primary Care Providers," described in Action Agenda recommendation 5.3.65, will work through VHA clinical services & OAA to promote inclusion of a mental health module in all residency training programs. The Council will also work with professional organizations to include such a module as a requirement by Residency Review Committees.	**Future Program = FY 2008 and Beyond**

Contract with the Institute of Medicine for a literature review to determine effective prevention strategies for mental illness in

AA Rec. #	Mental Health Strategies	Initiatives	
4.4.49	Determine effective prevention strategies for mental illness in combat veterans with/without physical injuries.	***Future Program Office MHSHG:*** VHA will contract with IOM, and other pertinent agencies, for literature review after consultation with specialty groups.	**Future Program = FY 2008 and Beyond**

President's New Freedom Commission Goal 5: Excellent mental health care is delivered and

Commission Recommendation 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and
Convene an Evidence Based Practices (EBP) Steering Committee to focus on recovery and rehabilitation. Representatives

AA Rec. #	Mental Health Strategies	Initiatives	
5.1.50 A, B, C Initiatives 1-5	**Emphasize recovery and rehabilitation in mental health care.**	***Near Term Program Office MHSHG:*** MHSHG will propose a structure and resources to facilitate recovery, including supporting the work of the EBP Steering Committee.	**Ongoing**
		Future Program Office MHSHG and VA/DoD Liaison: *1.* Establish a joint DoD/VA "Center of Excellence" focused on traumatic brain injury and other life altering injuries; 2. Develop longitudinal tracking system for veterans from OIF and OEF; 3. Evaluate the effectiveness of the mental health transition program.	**Ongoing**
		Near Term Program Office MHSHG: FY-05: Pilot and research State Peer Specialist certification programs; Pilot partnership with NY Assoc of Psych Rehab Services to develop Peer Bridgers in VISNs 2 and/or 3.	**Ongoing**
		Near Term Program Office MHSHG: Task the MIRECCs to review the role and function of Day Hospitals and Day Treatment Center to ensure adequate dissemination of recovery based care in the centers.	**Ongoing in Revised version**
		Near Term Program Office MHSHG: Identify recovery-oriented research across the age span that is ready to be tested for generalizability or developed into best practice models. Develop demonstration pilots to test implementation strategies prior to national program dissemination.	**Ongoing**

Facilitate the work of the Steering Committee by tasking the MIRECCs to: A. Identify recovery-oriented research across the age

AA Rec. #	Mental Health Strategies	Initiatives
5.1.51 A, B	Refer to 5.1.50	

Task the National Center for PTSD to develop a research agenda to close the gap in developing prevention and evidence based

AA Rec. #	Mental Health Strategies	Initiatives

5.1.52	Develop a research agenda to close the gap in developing prevention and evidence based early interventions for acutely traumatized veterans.	***Near Term Program Office MHSHG and ORD:*** Present suggestions to NCPTSD Scientific Advisory Board & ORD and jointly develop a plan to conduct targeted research.	**Ongoing**

Emphasize and strengthen the VA mental health research portfolio focused on rehabilitation/recovery; A. Establish a

AA Rec. #	Mental Health Strategies	Initiatives	
5.1.53 A, B, C Initiatives 1-6	Promote research related to rehabilitation and recovery.	***Immediate Program Office MHSHG and ORD:*** Convene a MHSHG/ORD workgroup to analyze the ORD mental health research portfolio and develop solicitations for clinical trials and large-scale demonstration projects in the area of rehabilitation and recovery.	**Deferred - ORD successfully manages mental health and substance abuse related projects within its current structures**
		Future Program Office MHSHG and ORD: Establish a Cooperative Study Program Center of Excellence in Mental Health.	**Deferred - ORD successfully manages mental health and substance abuse related projects within its current structures**
		Immediate Program Office ORD: Create a Mental Health Liaison position in ORD to monitor the mental health portfolio across research services, to coordinate development of solicitations for new research, and to coordinate mental health research initiatives across services.	**Ongoing**
		Immediate Program Office ORD: Develop position description and hire a high-level scientific program manager to facilitate strategic planning for ORD mental health research, to monitor mental health portfolios in consultation with research leadership and investigators in the field, and to serve as a liaison to mental health leadership and the mental health community.	**Deferred - ORD successfully manages mental health and substance abuse related projects within its current structures**
		Immediate Program Office MHSHG and ORD: Establish a steering committee of researchers and chief officers to advise on research efforts in this area.	**Deferred - ORD successfully manages mental health and substance abuse related projects within its current structures**
	Evaluate the interdisciplinary fellowship program in PSR to determine its impact in disseminating the rehabilitation/recovery model.	***Near Term Program Office MHSHG and OAA:*** Commission an evaluation of PSR fellowship programs to determine program impact on career trajectory, job duties (extent to which current position involves PSR), attitudes toward PSR and recovery, dissemination of PSR and recovery principles to other staff, and perceived barriers and facilitators to implementing PSR and recovery-oriented programs.	**Deferred to allow expansion of PSR fellowship and establishment of a training "hub" site**

Commission Recommendation 5.2 Advance evidence-based practices using dissemination and demonstration

Develop a knowledge management system to disseminate almost real-time, program specific education that will keep staff

AA Rec. #	Mental Health Strategies	Initiatives	
5.2.54	Develop a knowledge management system to link research, guideline development and implementation, clinical tools, sharing of best practices, and real-time data analysis related to racial and ethnic differences in care needs and interventions in order to create continuous expansion of the evidence base and increased knowledge generated by a spirit of inquiry.	See also 3.1.36	**Future = FY 2008 and Beyond**

Implement an improved Clinical Practice Guideline (CPG) process to reduce the time between initiation of development and

AA Rec. #	Mental Health Strategies	Initiatives

5.2.55 Initiatives 1-4	Ensure regular and timely updates of mental health CPGs.	***Immediate Program Office MHSHG and CPG Council:*** Establish a working group to monitor the literature and provide focused additions and revisions for expedited approval. Renew CPGs every 3 years or sooner as indicated by the development of new treatment methodologies.	**Ongoing**
		Immediate Program Office MHSHG: The National Clinical Practice Guidelines Council will have a member with expertise in evidence-based mental health care.	**Near Term = FY 2007**
	Expedite the approval of mental health CPGs, including updates.	***Immediate Program Office MHSHG:*** Once approved by MHSHG and the National Clinical Practice Guidelines Council, final approvals must be completed within 60 days.	**Future Program = FY 2008 and Beyond - Relevant discussions are in progress**
		Immediate Program Office MHSHG: Ensure that draft recommendations from the Medication Advisory Panel (MAP) are approved by the National Clinical Practice Guidelines Council to be consistent with CPGs.	**Future Program = FY 2008 and Beyond - Relevant discussions are in progress**

Implement QUERI-MH current priorities & major projects including: A. Measure care gaps in depression & schizophrenia B.

AA Rec. #	Mental Health Strategies	Initiatives	
5.2.56 A - G Initiatives 1-11	Promote implementation of research on evidence based practices.	***Near Term Program Office MHSHG and OQP:*** Put treatment initiation, engagement and continuation measures in official VA performance system. Implement benchmarked performance measures.	**Ongoing**
		Immediate Program Office MHSHG: Appoint a representative from the MHSHG to the national CPG work group.	**Near Term= FY 2007**
		Future Program Office MHSHG and ORD: Collaborate with Mental Health QUERI to continue development of clinical tools and implementation strategies to improve medication management for schizophrenia and to implement a collaborative care approach.	**Future Program = FY 2008 and Beyond**
		Future Program Office MHSHG and ORD: Support Mental Health QUERI, Substance Use Disorders QUERI, and MHSHG Informatics Section to develop and implement clinical practice tools.	**Ongoing**
		Future Program Office MHSHG and ORD: Support Mental Health QUERI initiatives to measure gaps in depression and schizophrenia care	**Ongoing**
		Future Program Office MHSHG and ORD: Support Mental Health QUERI and SMITREC in creating and analyzing national registries for psychosis and schizophrenia. Collaborate with Mental Health QUERI on development, testing, and implementation of outcomes monitoring.	**Ongoing**
		Future Program Office MHSHG and ORD: Solicit new research and promote Mental Health QUERI implementation research efforts in management of individuals with depression or schizophrenia who have comorbid substance use disorders or medical disorders.	**Ongoing**
		Future Program Office MHSHG and ORD: Prioritize the study and implementation of psychosocial and recovery-oriented interventions, including family psychoeducation, behavioral family management, intensive case management or assertive community treatment, work restoration programs, and peer support.	**Ongoing**
		Future Program Office MHSHG and OQP: Collaborate with the Office of Quality and Performance in developing and implementing evidence-based guidelines and performance measures across the adult age span; Implement an evidence-based collaborative care model for depression in primary care settings with particular attention to the elderly, evaluating its impacts on quality and outcomes and measuring its cost effectiveness.	**Near Term = FY 2007**
		Future Program Office MHSHG and ORD: Solicit new research and promote Mental Health QUERI implementation research efforts in psychosocial rehabilitation and recovery.	**Ongoing**
		Future Program Office MHSHG: Implement the QUERI-Mental Health current priorities and major projects in EBPs.	**Future Program = FY 2008 and Beyond**

Investigate strategies for sustaining treatment adherence and retention for individuals with major depressive disorder and

AA Rec. #	Mental Health Strategies	Initiatives	
5.2.57	Promote treatment adherence and retention for veterans with Major Depression and Schizophrenia.	***Future Program Office MHSHG and ORD:*** Continue to solicit new research in this area through Mental Health QUERI solicitation.	**Ongoing**

Commission Recommendation 5.3 Improve and expand the workforce providing evidence-based mental health

Work with the Senate and House Veterans Affairs Committees to enact the physician salary reform legislation to maintain our

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.58	VHA must have competent MDs, who are adequately reimbursed.	***Near Term Program Office MHSHG and HR:*** A market survey of MD salaries to be performed in all markets, and the physician pay bill amended to reflect the results of the survey.	**Near Term = FY 2007**

Implement legislation designating psychologists and social workers as Title 38 hybrid employees.

AA Rec. #	Mental Health Strategies	Initiatives
5.3.59	Done	

Collaborate and affiliate with Historically Black Colleges and Universities (HBCUs) and Hispanic Association of Colleges and

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.60	Expand diversity in the VHA workforce.	***Near Term Program Office MHSHG and OAA:*** Collaborate and affiliate with Historically Black Colleges and Universities (HBCUs) and Hispanic Association of Colleges and Universities (HACUs) to help us in developing diversity in our workforce and cultural competence among the providers. The previously (3.1.34) recommended Cultural Competency Task Force will be responsible for accomplishing this collaboration.	**Ongoing**

Train veterans who have recovered from mental illness in peer support, to develop a cadre of peer counselors.

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.61 Initiatives 1-5	VHA will have veterans trained and competent as peer counselors. Reference AA Recommendations 2.3.16, 2.3.18, 2.3.19 and 2.3.20.	***Immediate Program Office MHSHG and ORD:*** 1. MH QUERI to develop an RFP in 2005 for the assessment of the effectiveness of peer support. 2. MHSHG recommends the development of peer support programs consistent with the recovery model and would become Centers of Excellence to disseminate best practices.	**Near Term = FY 2007**
		Near Term Program Office MHSHG: Peer: **FY-06:** Pilot Peer Specialists and Peer Bridgers models in selected VISNs; **FY-07:** Develop VHA Peer Certification process and implement nationwide.	**Ongoing**
		Future Program Office MHSHG and HR: Identify additional formal Peer-Specialist training programs (colleges, foundations, etc.) for targeted recruitment into paid Peer-Provider/Specialist positions and for additional peer specialist training venues FY 07.	**Future Program = FY 2008 and Beyond**
		Near Term Program Office MHSHG and the Office of Health Policy Coordination: Work with SAMHSA's Center for Mental Health Services and National Association of State Mental Health Directors to develop strategy for collaborative initiatives to improve veteran access to premier community-based, consumer-run services.	**Near Term = FY 2008/09 - Program deferred to focus on OEF/OIF and Polytrauma emerging needs**
		Near Term Program Office MHSHG: Issue national Information Letter promoting and providing broad guidance on the recruitment of peer professionals/para-professionals, and the development of paid Peer-led support services (directly or through contract with community providers) as an adjunct to traditional mental health services at all facilities serving veterans with serious mental illness.	**Near Term = FY 2007 - IL is being drafted and expected to be distributed in FY 07**

Enhance clinical pastoral programs to connect to faith-based initiatives, and to add a spiritual dimension to the biopsychosocial

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.62 Initiatives 1-2	Spiritual assessment will be a routine part of mental health evaluation, and treatment provided according to the veteran's preference.	***Immediate Program Office MHSHG and National Chaplin Center:*** Establish MHSHG liaison to the National Chaplain Center to provide input into the Clinical Pastoral Education Program and other training programs. Include education about initial presentation and referral to enhance mental health outreach to veterans. MHSHG Liaison will also participate in activities of the National Chaplain Center Faith Based Initiative.	**Future = FY 2008 and Beyond**
		Near Term Program Office MHSHG and National Chaplin Center: Link the registry of mental health best practices to the Best Practices in Chaplaincy program.	**Future = FY 2008 and Beyond**

Extend Mental Health Liaison/Consultation to primary and specialty care to support and educate that workforce.

AA Rec. #	Mental Health Strategies	Initiatives

5.3.63 Initiatives 1-2	Implement collaborative care models for MH care.	***Future Program Office MHSHG and EES:*** Implement collaborative care models for depression care, etc. to promote the mental health liaison role and provide multi-modal education on mental health for non-mental health clinicians and staff.	**Near Term = FY 2007**
		Future Program Office MHSHG and EES: Develop a mechanism to account for liaison and teaching time of mental health providers.	**Future = FY 2008 and Beyond**

The MHSHG should enhance the Mental Health Leaders' training and support the annual meetings of the VISN Mental Health

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.64 Initiatives 1-8	Ensure highly competent Mental Health Leadership.	***Future Program Office MHSHG and EES:*** Reestablish and enhance the Behavioral Health Leadership Training program.	**Ongoing**
	Ensure effective organizational leadership in addressing the treatment of mental disorders.	***Immediate USH:*** **Develop options for effective mental health leadership that will further the goals of the PNFC on mental health incorporate this process into the ongoing patient care services review and add a mental health task force member to that committee for continuity. The Mental Health Chief Consultant will become a member of the NLB and Executive Committee by July/August 2004.**	**Ongoing**
		Immediate Program Office MHSHG and VISNs: **Require that a mental health leader, representing care of veterans with mental disorders, be a member of the highest level decision-making body in every VISN.**	**Ongoing**
		Immediate USH and Secretary's VA Mental Health Task Force: **Extend the mission of the Secretary's Task Force for three years; request this task force submit a progress report to the Secretary by 9/30/04.**	**COMPLETED - MH Task Force submitted final report in FY 2006**
		Immediate Chief of Patient Care Services (PCS) or designee: The PCS will provide quarterly reports to the task force on implementation of the recommendations. Resource needs and budget implications will be addressed in these reports. This information will be utilized in the preparation of the ELDA and FY 2006 budget.	**COMPLETED - Reports were sent during the time the Task Force was meeting**
	Promote, expand, and support the annual "Best Practices in Network Mental Healthcare Systems" conference.	***Future Program Office MHSHG and VISNs:*** Expand the size of the meeting to allow attendance of all VISN mental health leaders and at least one representative from each facility.	**Deferred - Meeting structure is being revised to be more inclusive**
		Future Program Office MHSHG and VISNs: Each VISN must support the annual attendance of at least one VISN mental health leader or representative. VISN Directors, CMOs and QMOs will be invited.	**Deferred - Meeting structure is being revised to be more inclusive**
		Immediate Program Office EES: Link ECF program and HPDM for preparation of future MH leaders.	**Ongoing**

EES should develop a CME/CEU training program: "Mental Health for Primary Care Providers;" in coordination with the Mental

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.65 Initiatives 1-2	Develop CME/CEU training program on mental health care in the primary care setting.	***Immediate Program Office MHSHG and EES:*** Form a Coordination Council involving EES, MHSHG, Acute Care SHG, Geriatrics and Extended Care SHG, and Mental Health QUERI to oversee education program and plan implementation of collaborative care for depression.	**Near Term = FY 2007**
		Future Program Office MHSHG and EES: MHSHG and EES will develop training programs for mental health managers, providers, and staff. Programs will emphasize evidence base for collaborative care and recovery programs.	**Near Term = FY 2007**

Expand Office of Academic Affairs and the Mental Health Strategic Healthcare Group's programs for training of interdisciplinary

AA Rec. #	Mental Health Strategies	Initiatives	
5.3.66	Build on the model Psychosocial Rehabilitation Special (PSR) Fellowship program, expanding it to training at more than the fellowship level.	***Future Program Office MHSHG:*** Work with OAA to expand the PSR Fellowship Program to provide training in life span issues in recovery. The program will fund stipends for a wide variety of mental and physical health disciplines, provide training in sites with interprofessional recovery-oriented care, and include a didactic component on the recovery model and interprofessional collaboration in implementing the model.	**Near Term = FY 2007**

Commission Recommendation 5.4 Develop the knowledge base in four understudied areas: mental health disparities, Enhance research programs and EBP related to treatment of minority veteran populations and cultural competence.

AA Rec. #	Mental Health Strategies	Initiatives

5.4.67	Increase research that expands the evidence base related to ethnic variability in disease manifestations and treatment response; to inequities in access; and to disparities in evaluation and treatment. Conduct research on gaps in cultural competency and strategies to close gaps.	***Future Program Office MHSHG and ORD:*** Solicit research on variation in treatment response among ethnic groups to inform evidence-based guidelines; solicit research on disparities in access and availability of services, treatment practices, and outcomes. Solicit research on cultural competency, including descriptive studies and intervention research.	**Future program = FY 2008 and Beyond - Under control of ORD; OMHS can advise**

Enhance trauma research related to combat trauma, terrorism, and prevention of chronic PTSD after exposure to traumatic

AA Rec. #	Mental Health Strategies	Initiatives	
5.4.68 Initiatives 1-2	Enhance trauma research.	***Future Program Office MHSHG and ORD:*** Engage NCPTSD, MIRECCs, ORD, DoD/ USUHS in these projects. Include minority & collaborative care issues.	**Ongoing**
		Future Program Office MHSHG and VA/DoD Liaison: Establish a joint DoD/VA "Center of Excellence" focused on traumatic brain injury and other life altering injuries; Develop longitudinal tracking system for veterans from OIF and OEF. Trauma research agenda to also include trauma related to MST.	**Ongoing**

Assess the effects of long-term medications: A. Task a Work Group consisting of the Pharmacy Benefits Management (PBM),

AA Rec. #	Mental Health Strategies	Initiatives	
5.4.69	Develop algorithm for use of atypical antipsychotics.	***Immediate Program Office MHSHG:*** MHSHG will take responsibility for organizing a work group that will utilize the National Consensus Guidelines to develop an algorithm for : use of atypical antipsychotics with consideration of medical complications and cost, including recommendations for changing therapy when medical complications develop; develop monitors for medical complications related to the use of the atypical antipsychotics; and education of primary care and mental health providers on the complications of atypical antipsychotics.	**Near Term = FY 2007**

Assess the VHA's provision of Acute Mental Health Care: A. Develop and test a valid VA demand model for acute inpatient and

AA Rec. #	Mental Health Strategies	Initiatives
5.4.70 A, B	See recommendation 1.2.8	

President's New Freedom Commission Goal 6: Technology is used to access mental health care

Commission Recommendation 6.1: Use health technology and telehealth to improve access and coordination of

Expand the charge to the VHA Telemental Health Field Work Group to coordinate the implementation of the 6.1 action agenda

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.71 Initiatives 1-2	Expand the charge to the VHA Telemental Health Field Work Group.	***Immediate Program Office MHSHG and VISN:*** The Telemental Health Field Work Group to continue to meet virtually or in person to coordinate the implementation of 6.1 action agenda items, in conjunction with VISN leadership, VISN mental health clinicians, and VISN telemental health coordinators.	**Near Term = FY 2007**
		Near Term Program Office MHSHG and Office of Care Coordination: Expand telemental health to target homeless veterans.	**Near Term = FY 2007**

Commission the VHA Telemental Health Work Group to perform a needs assessment for telemental health services. The needs

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.72 Initiatives 1-5	Improve access through use of technology.	***Near Term Program Office MHSHG and Office of Care Coordination:*** Together, the Office of Care Coordination, the Mental Health Strategic Healthcare Group, VISN Leadership, and each VHA Telemental Health Field Work Group VISN representative will assure that the need for telemental health services are clearly determined, in conjunction with other mental health needs assessments already being undertaken by VISN mental health clinicians, VISN CBOC administrators, and VISN telemedicine coordinators.	**Near Term = FY 2007**
		Near Term Program Office MHSHG, Office Health Policy Coordination and VA/DoD Liaison: Improve transition planning, referral/placement and information exchange for patients with mental illness coming into VHA health care system.	**Near Term = FY 2007**
		Future Program Office MHSHG and VISNs: *1.* Ensure that all mental health programs within VHA, including RCS, have standardized systems of electronic technology to access information while maintaining confidentiality and informed consent; 2. Explore "at home" mental health care coordination for recently discharged veterans, especially those in rural areas or in areas where specialty care is limited.	**Near Term = FY 2007**

		Immediate Program Office MHSHG and VA/DoD Liaison: Improve the electronic exchange of information from DoD to VA on patients awaiting MEBs and PEBs.	**Near Term = FY 2007 - Relevant discussions with DoD in progress**
		Near Term Program Office MHSHG and VISN: Include questions on screening tools for older veterans to determine difficulties with transportation or other resources that restrict ability to attend outpatient appointments; **and to identify needs of caregivers for older veterans who are home bound due to medical problems and/or who have a dementing illness.**	**Near Term = FY 2007 - Mental health establishing a formal presence in HBPC**

Based on the results of the needs assessment, each VISN should be tasked with the development of a telemental health

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.73 A, B, C Initiatives 1-5	Expand mental health telehealth care to all facilities, CBOCs, and Vet Centers.	***Near Term Program Office MHSHG, Office of Care Coordination and VISNs:*** Each VISN will: submit a Telemental Health plan to Office of Care Coordination (OCC) by 6/30/05; Outcomes approved on National Performance Measures will be developed to assure implementation is successful; All Telemental Programs will be approved by OCC.	**Near Term = FY 2007**
		Near Term Action Agenda Steering Committee: Action Agenda Steering Committee to appoint a group to review the data on pilot telemental health use and make recommendations on an outcomes monitoring system and feedback mechanism.	**COMPLETED by Action Agenda Steering Committee**
		Near Term Program Office MHSHG and Office of Care Coordination: Together with the Office of Care Coordination, the Mental Health Strategic Healthcare Group and VISN Leadership, each VHA Telemental Health Field Work Group VISN representative will assure that their VISN Telemental Health Plans are viable, and that they identify adequate equipment and staffing resources to assure that it can be successfully implemented.	**Near Term = FY 2007**
		Near Term Program Office MHSHG and Office of Care Coordination: Together with the Office of Care Coordination, the Mental Health Strategic Healthcare Group and VISN Leadership the VHA Telemental Health Field Work Group will work to assure that implementation of the VISN Telemental Health Plans be assessed through accountability strategies such as official reports to VACO on a regular basis, and the establishment of applicable VHA performance measures/monitors.	**Near Term = FY 2007**
		Near Term Program Office MHSHG and Office of Care Coordination: Together with the Office of Care Coordination, the Mental Health Strategic Health care Group and VISN Leadership, the VHA Telemental Health Field Work Group will extend its annual telemental health service inventory by formalizing the registration of telemental health programs throughout VHA.	**Near Term = FY 2007**

Expand use of existing telemental health and telehome care technologies as well as develop new technologies, including : A,

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.74 A - F Initiatives 1-6	Combine with 6.1.73	***Near Term Program Office MHSHG and Office of Care Coordination:*** A: Together with the Office of Care Coordination (OCC), the Mental Health Strategic Healthcare Group (MHSHG) and VISN Leadership, the VHA Telemental Health Field Work Group will identify mental health care coordination opportunities using in-home messaging devices, mental illness management dialogues, interactive voice response programs, and other new technologies to bring mental health services to the patients' homes, to half-way houses, to homeless shelters, and the state veterans homes.	**Near Term = FY 2007**
		Near Term Program Office MHSHG and Office of Care Coordination: Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will expand on the existing telemental health collaborations with VHA and the Readjustment Counseling Services.	**Near Term = FY 2007**
		Near Term Program Office MHSHG and Office of Care Coordination: Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will identify existing sharing programs and evaluate telemental health opportunities with the DHHS, IHS, DoD.	**Near Term = FY 2007**

		Future Program Office MHSHG and Office of Care Coordination: Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will develop and implement family psychoeducational video programs and telehome care family therapy programs.	**Deferred - Telehome care family therapy programs require further development**
		Near Term Program Office MHSHG and Office of Care Coordination: Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will increase telemental health consultation between mental health specialists at the medical centers and CBOC staff.	**Near Term = FY 2007**
		Future Program Office MHSHG and VISN: Together with the Office of CC, the MHSHG and VISN Leadership and Office of Geriatrics and Extended Care, the VHA Telemental Health Field Work Group will utilize telemental health technologies that make telemental health and telehome care compliant with ADA.	**Ongoing - Attention continuously paid to ADA requirements**

Charge Northeast Program Evaluation Center (NEPEC), the MIRECCs, SMITREC and Health Services Research and

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.75 Initiatives 1-2	Develop outcomes monitoring and feedback system.	***Near Term Program Office MHSHG and Office of Care Coordination:*** Together, the Office of CC, the MHSHG and VISN Leadership and the VHA Telemental Health Field Work Group to establish a plan to monitor outcomes of telemental health activities, utilizing existing mental health and VHA venues.	**Near Term = FY 2007**
		Future Program Office MHSHG and Office of Care Coordination: Charge workgroup with exploring outcome measures specifically related to older adults' access and utilization.	**Future = FY 2008 and Beyond**

Establish a full-time position for a VHA Telemental Health Coordinator. Provide adequate administrative staff and resources for

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.76	Provide full time coordination of telemental health care.	***Near Term Program Office MHSHG and Office of Care Coordination:*** The Office of CC and the MHSHG to facilitate adequate leadership and administrative staff resources necessary to successfully implement these action items.	**Ongoing**

Work with the HHS in the review recommended by the Commission of how best to deliver and finance telehealth services.

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.77 Initiatives 1-2	Optimize telehealth mental health delivery both in VA and the private sector.	***Near Term Program Office of Health Policy and Coordination, Office of Care Coordination and MHSHG:*** Work with HHS in the review recommended by the Commission of how best to deliver and finance telehealth services.	**ITEM REVISED; VA implementing on faster time table than HHS efforts**
		Near Term Action Agenda Steering Committee: Explore financial and other incentives to increase the use of telemental health.	**Ongoing - DSS work load capture for TMH are an area of emphasis**

Develop and implement adequate means to accurately capture and reflect workload generated by telemental health and

AA Rec. #	Mental Health Strategies	Initiatives	
6.1.78	Capture workload generated by telemental health services.	***Near Term Program Office MHSHG and Office of Care Coordination:*** Develop and implement adequate means to accurately capture and reflect workload generated by telemental health providers. Charge Office of Care Coordination with developing a system of secondary stop codes and guidelines for using correctly to capture data accurately. Ensure mental health review of plans to finalize and implement telemental health stop codes.	**Near Term = FY 2007**

Commission Recommendation 6.2: Develop and implement integrated electronic health record and personal health

Establish a Mental Health IT Work Group to enhance VHA's electronic health record (VistA/CPRS and MHP/MHA) and personal

AA Rec. #	Mental Health Strategies	Initiatives	
6.2.79 Initiatives 1-2	Establish a MH IT Work Group to work with IDMC and MHSHG.	***Near Term Program Office MHSHG and Action Agenda Steering Committee:*** Charge this group with developing in more detail the other recommendations included under Action Agenda items 6.2.	**Deferred until IT reorganization fully implemented**

		Near Term Program Office MHSHG and NEPEC: Develop electronic method to monitor community employment in the CWT supported employment program. Include NEPEC monitoring of Supported Employment.	**Partially deferred until IT reorganization fully implemented - NEPEC monitoring of Supported Employment an Ongoing effort, including refining approach based on CWT monitoring**

VISTA/CPRS should be modified to provide optimal functionality for the care of veterans with serious mental illness.

AA Rec. #	Mental Health Strategies	Initiatives	
6.2.80 Initiatives 1-2	Ensure that all mental health programs within VHA, including RCS, have standardized systems of electronic technology to access information while maintaining confidentiality and informed consent.	***Future Program Office MHSHG and VA/DoD Liaison:*** Improve Transition planning, referral/placement and information exchange for patients with mental illness coming into VHA health care system.	**Ongoing**
		Near Term Program Office MHSHG: Modify CPRS to include the identification of a Primary Mental Health Provider as well as Primary Care Provider.	**Deferred as a result of developing integrated care**

Develop a mental health treatment planning tool. VHA should consider build/buy options including the Commercial Off the Shelf

AA Rec. #	Mental Health Strategies	Initiatives	
6.2.81	Develop a MH treatment planning tool.	***Near Term Program Office MHSHG:*** Mental Health IT Work Group will review treatment planner options including review of the planner developed in VISN 3. The treatment planner will facilitate the participation of the patient and his/her family in the treatment planning process. The Mental Health IT Work Group to submit a formal request to the Informatics & Data Management Committee (IDMC) for the development of a treatment planner.	**Deferred until IT reorganization is fully implemented**

Develop MyHealtheVet to better serve the needs of veterans with mental illnesses. A. Provide adequate resources to the

AA Rec. #	Mental Health Strategies	Initiatives	
6.2.82 A, B, C, D	Develop a MH component within MyHealtheVet.	***Near Term Program Office MHSHG and MH IT Workgroup:*** The MH IT Work Group will implement this Action Agenda recommendation.	**Ongoing**

Question 2. Please provide a listing of Community Based Outpatient Clinics (CBOCs) and outreach clinics that will be opening. What is the status of the Secretary's decision on the proposed list?

Response: The only approved Outreach Clinic not yet activated is in Craig, CO. The following locations were approved by the Secretary for a Community Based Outpatient Clinic (CBOC) in FY 2007:

Morgantown (Monongalia County), WV	Dover, DE
Norfolk, VA	Childersburg, AL
Stockbridge, GA	Bessemer, AL
Morristown (Hamblen County), TN	Hamilton, OH
Daviess County, KY	Conroe, TX
NW Tucson, AZ	Metro East, OR
Canyon County, ID	Central Washington, WA
American Samoa, HI	Fallon, NV
South Orange County, CA	Bellevue, NE
Carroll, IA	Cedar Rapids, IA
Marshalltown, IA	Shenandoah, IA
Wagner, SD	Watertown, SD
Bemidji, MN	Holdrege, NE
Spirit Lake, IA	Western Wisconsin, WI

The following three locations were opened in FY 2007: Conroe, TX; NE Bexar County, TX; and Williston (Outreach Clinic), ND.

The following locations have been approved for a CBOC in FY 2008:

Southern Prince George County (Andrews AFB), MD	Charlottesville, VA
Hickory, NC	Lynchburg, VA
Franklin, NC	Hamlet, NC
Aiken, SC	Spartanburg, SC
Eastern Puerto Rico (Fajardo), PR	Putnam County, FL
Camden County, GA	Jackson County, FL
Hawkins/Sullivan County/Bristol, TN	Berea, KY
Madison County, TN	Grayson County, KY
Morehead City, KY	Perry County/Hazard, KY
Parma, OH	Clare County, MI
Elkhart County, IN	Alpena County, MI
Knox County, IN	Hutchinson, KS
Jefferson City, MO	Eglin AFB, FL
Pine Bluff, AR	Branson, MO
SE Tucson, AZ	Globe/Miami, AZ
Thunderbird (North Central Maricopa County), AZ	West Salt Lake Valley City, UT
Cut Bank, MT	Lewiston, MT
North Idaho, ID	Metro West, OR
Bellingham Area (Whatcom County/ NW Washington (Skagit County), WA	

RESUMPTION OF PRIORITY 8 ENROLLMENT

Message. Reopening Priority 8 enrollment would require a significant increase in budgetary requirements. In addition, VA has serious concerns that this additional demand will strain VA's capacity to provide timely, quality care for all enrolled veterans and lead to longer waits for care.

Key points

• The Veterans' Health Care Eligibility Reform Act of 1996 opened VA's health care system to all veterans and provided a uniform medical benefits package of health care services to all enrollees.

• The legislation also established a priority-based enrollment system, and each year, the VA Secretary is required to assess veteran demand and determine if resources are available to provide timely, quality care to all enrollees.

• Since Eligibility Reform, veteran demand for VA health care has escalated and the actuarial model predicts continued growth in demand. In FY 2002, this escalating demand led to waiting lists for care.

• As a result, VA suspended enrollment in Priority 8 on January 17, 2003, to focus on those veterans who need VA most—those with service-connected disabilities, those with low income, and veterans with special health care needs.

Question 3. How much additional funding would VA need to resume Priority 8 enrollment?

Response. Reopening Priority 8 enrollment in FY 2008 is estimated to increase enrollment in Priority 8 by approximately 1.6 million and require an increase in budgetary requirements of $1.7 billion. VA has serious concerns that this additional demand will strain VA's capacity to provide timely, quality care for all enrolled veterans and lead to longer waits for care. VA must also consider the impact of this policy in future years. In 2017, this policy would increase Priority 8 enrollment by an estimated 2.4 million and would require $4.8 billion in budgetary requirements. Over the next 10 years, resumption of Priority 8 enrollment would require $33.3 billion in budgetary requirements.

Question 4. VA estimated that $1.7 billion is needed to resume Priority 8 enrollment. How did VA calculate this estimate?

Response. The VA Enrollee Health Care Projection Model (Model) is extremely robust. Data used in developing the Model includes VHA's survey of 42,000 enrolled veterans, utilization and cost information from VA data systems, Medicare utilization information for enrolled veterans, a detailed analysis of enrollee reliance on VA health care, and information from the Census 2000 long form which enables VA to assign veterans into the income-based priorities (Priorities 5, 7 and 8). The Model is built from the bottom up which determines the expected veteran demand for health care and is used to lay the foundation for developing resource requirements.

One of the Model's features is its capability to project future VHA enrollment under a variety of policy scenarios, including the resumption of enrollment. The rates at which veterans are expected to enroll are calculated at a very detailed level. The Model has over 13,000 enrollment rate factors which consider veterans priority level, age and geographic location.

The Model tracks Priority 8 veterans who have applied for enrollment but were denied. The Model presumes that those veterans who have been denied eligibility to enroll will be very likely to enroll in the future if their eligibility status changes and VA resumes enrollment of Priority 8 veterans.

Reopening Priority 8 enrollment in FY 2008 is estimated to increase enrollment in Priority 8 by approximately 1.6 million enrollees and require an increase in budgetary requirements of $1.7 billion.

Priority 8 Veterans—Talking Points

• The Veterans' Health Care Eligibility Reform Act of 1996 opened VA's health care system to all veterans and provided a uniform medical benefits package of health care services to all enrollees.

• The legislation also established a priority-based enrollment system, and each year, the VA Secretary is required to assess veteran demand and determine if resources are available to provide timely, quality care to all enrollees.

• Priority 8 veterans and eligibility—Veterans who agree to pay specified copay with income and/or *net worth* above VA Means Test threshold and the *Geographic Means Test Threshold*.

• Since Eligibility Reform, veteran demand for VA health care has escalated and the actuarial model predicts continued growth in demand. In FY 2002, this escalating demand led to waiting lists for care.

• As a result, VA suspended enrollment in Priority 8 on January 17, 2003, to focus on those veterans who need VA most—those with service-connected disabilities, those with low income, and veterans with special health care needs.

• Reopening Priority 8 enrollment in FY 2008 is estimated to increase enrollment in Priority 8 by approximately 1.6 million and require an increase in budgetary requirements of $1.7 billion.

• VA has serious concerns that this additional demand will strain VA's capacity to provide timely, quality care for all enrolled veterans and lead to longer waits for care.

• VA must also consider the impact of this policy in future years.

• In 2017, this policy would increase Priority 8 enrollment by an estimated 2.4 million and would require $4.8 billion in budgetary requirements.

• Over the next 10 years, resumption of Priority 8 enrollment would require $33.3 billion in budgetary requirements.

Question 5. Please provide written clarification on eligibility for National Guard members and Reservists.

Response: Reservists and National Guard members activated for Federal service who completed the period for which they were called to active duty qualify for VA health care, but generally must be enrolled to receive services, just like any other veteran.

Reservists and National Guard members who served on active duty in a theater of combat operations during a period of war after the Gulf War or in combat against a hostile force after November 11, 1998, are eligible for enrollment in Priority Group 6 unless otherwise eligible for enrollment in a higher priority group. All Reservists and National Guard members are eligible for free health care services for conditions potentially connected to combat service for 2 years following separation from active duty.

Veterans who enroll with VA under this authority will retain enrollment eligibility even after their 2-year post discharge period ends under current enrollment policies. At the end of that 2-year period, VA reassesses the veteran's information (including all applicable eligibility factors) and makes a new enrollment decision. If the veteran was in Priority Group 6 and no other eligibility factors apply, the veteran will continue enrollment in either Priority Group 7 or Priority Group 8, depending on income level, and will be required to make applicable copayments.

Note: For veterans who do not enroll during the 2-year post-discharge period, eligibility for enrollment and subsequent care is based on other factors, including a compensable service-connected disability, VA pension status, catastrophic disability determination, or the veteran's financial circumstances. Combat veterans are strongly encouraged to apply for enrollment within 2 years of release from active duty to take advantage of the special eligibility conditions for combat veterans, even if no medical care is currently needed.

Additional information for VA health care benefits is available at: *http://www.va.gov/healtheligibility/, http://www1.va.gov/environagents/docs/SVABENEFITS.pdf,* and *http://www.seamlesstransition.va.gov/res—guard.asp.*

Chairman AKAKA. Thank you very much for your testimony, Dr. Cross.

Before I ask any questions, I call on Senator Brown for any comments.

Senator Brown. I have no opening remarks.

Chairman AKAKA. Thank you, Senator Brown.

Dr. Cross, I am delighted that this Administration is now supporting the idea of extending the window for easy access to care for separating servicemembers from two to 5 years. Can you please elaborate on how you see the extension of this window enabling VA to better serve younger veterans, especially those with mental health issues?

Dr. CROSS. Yes, sir, I can. By extending this time period, sir, we will be able to provide with very little enrollment issues access to care for all the combat veterans that are returning to us for a period of 5 years. I think your concern and our concern was that sometimes the need for care, the symptoms, particularly perhaps related to PTSD, may not show up within that time period. The individual may not feel the need to come see us.

This would extend that time period to make sure that if those symptoms arise, we have an easy mechanism automatically allowing them access to care without copays for anything related to their combat service. We think that this is a positive thing to do and we will work with you to support that.

Chairman AKAKA. Thank you. Dr. Cross and Mr. Hall, I note that VA has offered no legislative proposals concerning veterans' health care. Am I to infer that there is nothing the Administration needs from Congress? I believe Congress has valuable input to offer and that we serve veterans best by working together, and I just wanted to mention the lack of by request legislation from VA. We

look forward to, of course, working together with you to help the veterans.

Dr. Cross, the Administration has chosen not to prepare official views on our TBI legislation introduced nearly one month ago. I am sure you would agree that enhancements can be made to the care received by veterans with TBI. What more do you think can be done on TBI care to improve services to veterans who suffer with this injury? Are you willing to work with us on improving VA TBI health care?

Dr. CROSS. Senator, I would like to answer that absolutely yes. Of course, we are willing, and if I have a moment, sir, can I tell you where we are with TBI? We started TBI centers back in 1992 and we developed four of them. We have expanded them now to encompass polytrauma because of the nature of the injuries that we are seeing coming back from OIF and OEF. Congress has been very much involved with us in that. We want to continue that participation.

We added on the OIF/OEF screen so that everyone that we see gets screened for TBI. We are screening everyone who comes in to see us for PTSD. We are screening everyone for depression. We are screening everyone for substance abuse. And I think that is the advantage of our integrated health care system, that we can do these kinds of things comprehensively, that we can, with our electronic health record, we can institute these types of screens so that we look for these conditions and when we identify them, help get those individuals into the kind of care they need.

We are multi-disciplinary and we are working on new programs, such as the emerging consciousness program that I just mentioned, for individuals who were severely affected, who are in basically a non-responsive state to help them, shall we say, wake up. Our research, I think, will lead the way for the Nation in understanding these conditions. And so, yes, sir, we are very proud to work with you on any of these issues.

Chairman AKAKA. Mr. Hall, I note that with regard to the legislation that would lift the ban on enrollment of Priority 8 veterans, you mentioned that enacting this measure would threaten VA's ability to manage the priority system set forth in law. Would your concerns be addressed if we were merely to suspend the current prohibition for one year to test the impact it would have on the system in light of all the substantial funding increases VA is slated for?

Mr. HALL. Mr. Chairman, one of our concerns is that lifting the ban is going to create stress on our current infrastructure. There is going to be a significant delay in being able to provide all the services we would need to care for the veterans we are currently seeing, the new veterans coming back from OEF/OIF, particularly if S. 383 were enacted with the 5-year extension, as well as the new veterans that would be eligible if the ban were lifted. If we had the money, it would take a while to build the infrastructure up enough to provide care to all those folks.

Chairman AKAKA. Thank you very much for your response.

Senator Craig?

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

Senator CRAIG. Thank you very much, Mr. Chairman.

Thank you for holding this hearing and looking at all of these important pieces of legislation.

Let me focus—and let me ask unanimous consent that my full statement be a part of the record.

Chairman AKAKA. It will be included in the record.

[The prepared statement of Senator Craig follows:]

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

Thank you, Mr. Chairman, for holding this hearing and good morning ladies and gentlemen.

Mr. Chairman, as you know, I have two bills on the agenda that I've introduced and one that I am very proud to have introduced along with you. Of course, I think our legislation on caring for veterans with Traumatic Brain Injuries is an important, bipartisan effort.

I know everyone on this Committee shares our concern about the immediate, acute care needs of those veterans suffering with TBI as well as the long-term implications of living with a traumatic brain injury. With this bill, Mr. Chairman, I think we are attempting to address many of those concerns as well as focus on the need to do more research on traumatic brain injury. Unfortunately, the fact remains that medically there is so much we don't know about TBI. I hope we can advance this bill quickly.

As I mentioned earlier, I also have two other bills on the agenda: S. 815, the Health Care Empowerment Act and S. 1441, a bill to modernize our successful State Veterans Home program.

First, Mr. Chairman, I am sure you have seen CBO's preliminary cost estimate of S. 815. Needless to say, it came in *much higher* than I had expected. I want to assure my colleagues that I am still a fiscally conservative Senator.

With that said, I still believe we must consider some way to ensure that those who receive care at VA have confidence in that care. And if they don't have confidence, we should consider some recourse for them.

Frankly, I have been heartened by the reaction S. 815 has received. I have gotten numerous letters and e-mails supporting the legislation. And, of course, a few witnesses, including those today, have offered positive comments as well as some thoughts on changes that should be considered.

I intend to review all of those thoughts and others while I work to address the scope and cost of this bill before ever asking for a vote on it.

Finally, Mr. Chairman, I'd like to say a word about the state home bill I've just introduced. I recognize that few people have had a chance to review it. As such, I anticipate receiving more comments in the future on the legislation.

What's important to me, Mr. Chairman, is the goal of the bill. That is—to transition the state home program from one focused heavily on beds to one that also offers the options of home and community-based care.

I hope none of you see this bill as a shot of disapproval aimed at the state homes. *It is nothing of the sort*. Rather, it simply reflects my view that this program needs to have a more forward-looking, family oriented approach to long-term care.

At the current rate of Congressional funding, it will take us 9 more years to fund all of the new construction on VA's list today. That doesn't include any new applications that will come in. I fear that if we don't begin to transition to a more non-institutional approach to care, we may find ourselves 15 years from now, staring at 30,000 state home beds wondering what to do with half of them.

There's an old saying that goes "when all you have is a hammer, the whole world looks like nails." I fear that if the state homes only have beds, then beds will be the way we care for aging veterans.

I believe we should begin to establish non-institutional care programs to complement the current institutional program. In this way, we will be able to offer veterans a less restrictive alternative long-term care setting while supporting the idea of aging gracefully in the home with one's family.

I hope my colleagues, VA, VSOs, and the States, are willing to work with me on this legislation. I welcome all suggestions and, of course, support.

With that, Mr. Chairman, thank you again for holding this hearing. I look forward to receiving the testimony of our witnesses.

Senator CRAIG. Thank you, Mr. Chairman. Let me focus on one bill that I have introduced for a variety of reasons and that I think testimony over the last several months has proven has some significant value, but obviously cost-wise is prohibitive. I don't want anybody on this Committee to feel I have lost my conservative feelings by introducing a bill that scores at $38 billion over two years.

But it was to dramatize a concern that I have heard constantly expressed, and since the introduction of the bill more loudly expressed by some veterans, that there are services that VA can't provide. And, in fact, we have heard it here, whether it is certain types of prosthetics, whether it is certain types of concerns about brain damage or mental problems. There is a private sector out there that in some areas is leading VA as it relates to certain types of care.

But there seems to be an attitude that, in some instances, if VA doesn't provide it, the veteran can't have it, and that was where I drew a line. If we are concerned about providing care to veterans, and I think we are, and I think VA does a wonderful job; I don't need to sing its praises—I do 24/7, and appropriately so. But I must tell you that in looking at some of your comments, I must say, Dr. Cross, I understand the Administration strongly opposes S. 815 and I appreciate some of your reasons. However, I am a little troubled by the tone of the statement which suggests that if VA offers care, then veterans should take what they offer.

If veterans lose faith in care provided by VA, doesn't it concern you that VA's position is essentially that the veteran should be stuck with VA? Now, being stuck with a first-class health care system ain't all bad. But where health care isn't being provided in a New World and you are rushing to catch up with it, it is kind of like, stand in line and wait until we get good at it because you are only going to get it from us.

And that was the intent of S. 815. I will fine-tune this a little bit. In fact, I would suggest that the Chairman's bill of, which I am a cosponsor, S. 1233, moves us in that direction. And so I would like your views and comments on this type of an approach of non-VA-delivered care as it is reflected in S. 1233. I would like your comments on that.

Dr. CROSS. Sir, may I start with S. 815?

Senator CRAIG. Sure.

Dr. CROSS. We are working with—we want to work with you and Congress to make sure that we remain the veterans' first choice, the veterans' first choice for care——

Senator CRAIG. And I don't disagree with that.

Dr. CROSS [continuing].—just as we believe we are now. What we are concerned about is something that is very serious to me as a physician and this is fragmentation of care. To promote individuals going out into other systems, whereas we have a comprehensive, integrated system with a unique fully integrated information system so that we have a complete picture of that individual, that causes us some concerns when that happens, that fragmentation, so that one system doesn't necessarily know what the other is doing. That system doesn't have electronic records, perhaps, in the private environment, and so that we don't have access to what they

are doing and perhaps they don't have access to what we are doing with a veteran.

The cost, of course, is an issue, and you have already addressed that.

Senator CRAIG. Sure.

Dr. CROSS. But I want to say this on the positive side. We are spending about $3 billion per year already to identify and care for individuals when they need something that we can't provide in-house. We are very much attuned to that. But we want to do it on a case-by-case basis. But I want to point out that we are already spending about $3 billion in this effort, not an insignificant amount, to make sure that when those cases arise, that we will reach out to the community and provide the care if there is something that the veteran needs that we don't offer.

And I want to emphasize again, comprehensive care, continuity of care, but we provide the care over the lifetime of the individual. We want to build that record for the lifetime care of the individual. And when you put this total package together, having the integrated system that we have, I think is what becomes so valuable to the individual.

But yes, sir, we do recognize that there are cases that we can't fully care for and we are quite willing, case by case, to spend the money and do what is necessary to care for them.

Senator CRAIG. Well, I am trying to comprehend, Doctor, the extend of your comments in relation to safeguarding and protecting a health care system. You seem to be worried about fragmentation. You seem to be worried about continuity. I focus, and this is going to sound critical—I am worried about an individual veteran who cannot get the service from the system. I am not worried about fragmentation at that point and I am sure in the heck not worried about continuity.

I am worried that veteran getting the state-of-the-art in prosthetics, state-of-the-art in mental care and brain damage treatment when we know there are facilities outside of the VA that are ahead simply because they have been dealing with the civilian sector, and now we have got a new kind of veteran patient coming in that is a product of this war that you have not dealt with in the past that is now being thrust upon you. And you are running to catch up, and we are going to fund you to the tune of billions to catch up. But in the meantime, are they going to stand in line and wait?

I guess that is my concern. I am not worried about fragmentation at that point and I am certainly not worried about continuity. Those are all going to happen, because in the broad sense, in the broad sense, VA will remain the health care provider of first choice to all veterans.

Dr. CROSS. Sir, I understand your concerns. I wanted to emphasize, we didn't start treating TBI when the war started. We started our centers about 15 years ago and we were treating, of course, TBI before that. We started special centers for them about in 1991, 1992. We looked at our outcomes. We looked at our quality. We measured that. We are very finely attuned to that. I think as an organizational characteristic, we do more in the way of quality and performance measures than anybody I am aware of. We have no intent to provide anything except the best treatment possible for the

individual, and if we can't, case by case, we will send them elsewhere.

Senator CRAIG. Thank you. My time is up. Mr. Chairman, I guess I would say that my legislation, I hope, has provoked a reasonable and appropriate debate, as it should, because I know that Senator Murray and I have had discussions about the best and the highest of quality and making sure that it is out there, and I am not always convinced that just adding money into a current system that isn't prepared and can't handle it at the time is the way you get there when, in fact, there is a private system that can deliver it.

And I know that I tread on sacred ground when I talk about any fragmentation whatsoever when it comes to VA health care. But frankly, at this point, I don't care. I am caring about the veteran and I am going to continue to reflect that. I look forward to working with the Administration and certainly with VA to see where we can do those kinds of things and find alternative care when necessary and appropriate.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Craig.

Senator Murray?

Senator MURRAY. Thank you very much, Mr. Chairman.

Dr. Cross, I wanted to ask you, when our veterans sign up for military service, they take an unqualified oath to serve our country and defend the Constitution, and in return for that service and their commitment, they are promised that they are going to receive all necessary veterans' health care when they come home. There weren't any asterisks on the paper they signed. There wasn't any small print that I am aware of that they wouldn't be eligible if their income reaches a certain level. So I wanted to ask you, if our promise to those who sign up when they serve is not restricted, why is it right to restrict benefits for some veterans?

Dr. CROSS. Thank you, Senator. I understand your concern and I think you are, of course, referring to the Priority 8s——

Senator MURRAY. Correct.

Dr. CROSS [continuing].—and you are referring to S. 1147, as well. We understand. Our focus was at the time on commitment to quality and continues to be, and our focus has been and continues to be on commitment to access. We wanted to put our priorities to make sure that those who were injured, who have some residual from their experience and service connection, some injury, some illness, we wanted to make sure that within our system, that we devoted the assets necessary to take care of them, and that is what we did.

Senator MURRAY. Well, it seems to me that you had a choice at the time. The VA recognized that they were hitting a backlog of people and didn't have the resources to deal with it. So rather than coming to Congress and telling us that we needed to keep a promise to our veterans and in order to do that, we needed additional dollars, you decided that you were going to change the system so that by whatever income you had, that you would be denied service.

I believe you should have come and told us, we need additional dollars, because as I just told you, when you sign up, there is no asterisk. There is no fine little line that says if you get a certain

level—and in fact, as you know, some veterans who make less than $27,000 a year are denied service. Do you think that is high income?

Dr. CROSS. I don't consider that to be high income, but I understand the threshold varies depending on marital status and the number of children.

I would like to add two understandings to this that we can discuss for a bit. It is not really a matter of money. It is a matter of capacity, the physical facility, the staffing. All of those things would have to be modified to some degree. It would take time to do that. And so I wanted to emphasize it is not just simply a matter of money.

Secondly, we are, in fact, expanding the Priority 8 enrollment through our eligibility under our 2-year provision, and if Congress passes it, the 5-year provision, because here is how it works. It is our policy that once a combat veteran returns and enters our system in the 2-year eligibility period, even though that person would ultimately be classified as a Priority 8, he does not lose his enrollment. He can stay with us permanently.

Senator MURRAY. Well, let me ask you about that, but first, let me go back and comment that I still believe that what the VA should have done is come and said to us, we don't have enough resources. We need to serve those who have signed up and we give a promise rather than making an eligibility based on income that they never signed up for.

But on that 2-year that you are now referring to, you have the authority to enroll our Iraq and Afghani combat veterans, but that applies only to active duty. For our National Guard and Reserves, it is my understanding that under the current policy, if you are active duty, you are eligible. If you are in Guard and Reserve, you are not. Is that correct?

Dr. CROSS. Senator, I don't believe so. I think—I will ask Walt to support me on this, but I think that is incorrect.

Senator MURRAY. I am told time and time again by our Guard and Reserve members who sit on the ground in Iraq doing the same thing as active duty that it only applies to active duty.

Mr. HALL. I can confirm that, but I don't believe that is correct, ma'am.

Senator MURRAY. OK. I would like to get a written response from you on that. We need some clarification.

Senator SANDERS. Would the gentle lady yield for that?

Senator MURRAY. Well——

Senator SANDERS. I am sorry.

Senator MURRAY. I want to ask one more question and I will let you get back to that on your time, because I did want to ask about the Gulf War study really quickly in my time remaining. Two recent studies—one was conducted by the DOD, one by VA and Boston University—told us that long-term brain damage among troops exposed to nerve agents from the bombing of an arms depot in Iraq in March 1991 caused significant brain damage. This is overwhelming, Mr. Chairman. This says that over 100,000 men and women were exposed to sarin gas in the Gulf War, to the so-called Gulf War syndrome, actually had brain damage that is caused to them.

I wrote to you along with Senators Bond and Rockefeller asking you how the VA is going to notify these Gulf War veterans, many of them wondering for the last 14 years why they are so ill and what is wrong with them and how we were going to do better research and affect that. You have responded to me and basically the answer was, we are going to study this issue.

Well, I can tell you as the daughter of someone with multiple sclerosis, a World War II veteran, you are told constantly, well, it is going to take another study. So I would like you to inform us what the VA is going to do.

Dr. CROSS. Well, first of all, I would like to point out our role in the study, since we sponsored it. This was a proactive thing that the VA has done time and again and continues to do research to look at these questions, and I think no other organization is doing more of that toward the rest of these issues.

I have read the study. My staff are continuing to evaluate it. I regret to use that phrase, but yes, we are continuing to study it. I noticed——

Senator MURRAY. I just have to tell you the frustration, because many of those Gulf War veterans came home. They were told, oh, it is all in your head. You are making it up. They have lived with that. They have struggled with this for a long time and now there is a study with a direct link.

Dr. CROSS. Yes.

Senator MURRAY. And I think it is imperative that it isn't another study that takes another three or four years, but that we do this quickly and rapidly and get the information to those Gulf War veterans because there is nothing like being told it is all in your head when actually there is a real connection and they deserve to know the answer to that.

Dr. CROSS. Senator, I agree.

Senator MURRAY. Thank you very much, Mr. Chairman. I hope we can pursue that, as well, in the Committee.

Chairman AKAKA. Thank you, Senator Murray.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

Dr. Cross, Mr. Hall, let me thank you for your service.

What you do is very important. I think you can already sense the great frustration on this dais with the status quo, with maybe not the same urgency that we have displayed within the VA, and I will treat you as the messenger and not necessarily the evaluator of all the comments that are made today.

Let me share with you some facts. One-third of our Nation's homeless have served our country in the armed services. On any given day, approximately 200,000 veterans are living on the streets or in shelters. As many as 400,000 veterans experience homelessness at some point during the course of a year. This is the outcome. That is today.

I presented to this Congress and to the VA, it is the same bill as I presented last year, where the VA had some concerns over the form of assistance we had provided and preferred grants over per diem payments. I said then, I say today, I am more than willing to change it. I have had no contact with the VA on the bill since last year when it was introduced, no effort on the VA's part to

reach out and to try to perfect a bill if, in fact, one felt that it was not perfect to start with. I have never written a perfect piece of legislation. It requires a degree of cooperation on both sides. I am not sure that that cooperation has existed.

Now let me go to what you said earlier to Senator Craig. It is about outcome. Well, it is about outcome. Our veterans are living on the streets and in shelters. What I have proposed is not putting a shelter over their head, it is providing the services that are absolutely essential to make sure that that housing is permanent and not temporary.

I would like to go through some of the points that you have raised that are objections. One, the application process fails to require applicants to demonstrate the need for services. Well, my legislation gives the VA full authority to establish the criteria for the selection of eligible entities to be provided financial assistance under this section. In fact, we empower the VA to determine what the criteria is, and you are being critical of us of not providing the criteria for you. Well, you are on the front line. Who better to write it?

Support services should not include health care because it is duplicative services already provided by the VA. My bill states that health care services can be provided only if such, and I quote the bill, "if such services are not readily available through the Department's medical center serving the geographical area in which the veteran's family is housed." Well, if it is not available, then why wouldn't we offer it? I think that is a pretty simple point.

Next, supportive services provided by VA and other Federal programs typically include referrals to legal services but not actual legal services. Referral, but not services. My bill provides legal services to assist veterans with reconsiderations of appeals of veterans and public benefit claim denials and to resolve outstanding warrants that interfere with the family's ability to retain housing or supportive services. If the attempt is to make sure that these individuals become permanently housed, then it is a heck of a lot cheaper for us to provide the legal services to end the dispute than it is for us to have these individuals homeless and actually not receiving the medical care that they need except when it is in an emergency case or a trauma case.

The last point I want to make, the definition of veteran's family differs from that used in 42 U.S. Code 11302, the McKinney-Vento Homeless Assistance Act. Actually veteran family is not defined in that section at all. McKinney-Vento defines homelessness and we use that definition of homelessness in our bill. A veteran family is not defined in U.S. Code there, but it does define a homelessness definition of which we use the exact definition.

Gentlemen, I have got to share with you that I find the objections petty. They are not objections I would expect from a stakeholder who wishes to see legislation that addresses the problems. Instead, I think it suggests they come from an agency that would like to continue the band-aid approach to the services that affect, as I said, 200,000, 400,000 veterans who find a home not a permanent part of their life.

We will work with you in every way, shape, or form to try to make sure that this bill meets the criteria, meets the definitions.

But if we don't have the same goal, and that is to make sure that individuals who are veterans don't have the services that they need to be permanently housed versus temporary, then those conversations will end very quickly. I think that is a mission of the Veterans' Administration. I believe the Secretary believes that we should do everything we can to put these individuals in permanent housing and I am committed to do that with or without the VA.

I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Tester?

Senator TESTER. Thank you, Mr. Chairman, and I, too, want to thank the panelists for being here today.

I want to go to S. 479 first. You had mentioned the name of a commission. This was the Omvig Act. You mentioned the name of a commission that you said you were following. They had made some observations and you were following up on their recommendations. Could you give me the name of that commission again? I didn't get it?

Dr. CROSS. It would be the President's New Freedom Commission on Mental Health.

Senator TESTER. The President's what?

Dr. CROSS. The President's New Freedom Commission on Mental Health.

Senator TESTER. New Freedom? And how many recommendations did they put forth? Do you know off the top of your head, and how many have been implemented?

Dr. CROSS. It was a bunch, sir, but I don't have the number off the top of my head.

Senator TESTER. But they haven't all been implemented?

Dr. CROSS. No, but we have plans for implementation.

They are well on the way.

Senator TESTER. All right. Could you get me a list of the ones that have been implemented and the ones that are in process?

Dr. CROSS. Yes, sir. We can do that.

Senator TESTER. That would be good. I want to talk a little bit about S. 994, which is a bill that I have got for mileage reimbursement, and I would assume—I don't want to put words in your mouth, but I would assume you are going to—I assume you oppose it because it takes away money from health care, that would otherwise be appropriated toward health care or used for health care? Is that correct? And if it is not, just tell me if you oppose it or support it.

Dr. CROSS. On S. 994, sir, we are not supporting that. We do have some concerns. I can go through those with you.

Senator TESTER. OK. What are they? What are they, quickly?

Dr. CROSS. Well, it eliminates the deductible and it relates to beneficiary travel. The size of this investment, I think, would be—we haven't fully costed it yet—would be certainly in the hundreds of millions of dollars. We think that would be better spent in direct health care for our veterans.

Senator TESTER. OK. If there was a separate stream allocated for the travel reimbursement, would that take care of some of your problems with it?

Dr. CROSS. There would still be some issues, particularly in regard to the deductible, which we think makes it an inefficient way to carry that out. We can work with your staff on that and go through some of the details of what our concerns are.

Senator TESTER. OK. Well, my concern is that we have got people, especially in rural States like Montana, that have a long ways to drive to get health care, and last time I checked, gas went up about 30 cents a gallon this last month. And when you are talking about 11-cent reimbursement, you are talking about a veteran that needs health care and it takes away from their ability to get access to the program, which is something I think we are all concerned about on this panel.

And so my question is, if we don't reimburse them for reasonable costs on transportation, how do you propose that the veterans get the health care, the veterans that live in these rural communities that are 140, 150 miles away in some cases, round-trip, from health care?

Dr. CROSS. We, of course, share that concern about the rural environment. We, in fact, had a separate hearing on that. Ninety-two-point-five percent right now are within 60 minutes of a VA facility. Ninety-eight percent are within 90 minutes of a VA facility. That is a remarkable transition that we have executed over a period of years because we have gone from very much of a tertiary focus to more of an outpatient primary care focus. In that process, we have created 717 community-based outpatient clinics and we are going to create a bunch more and then go beyond them with what we call outreach clinics, part-time clinics that lease space reaching out even to smaller communities, and perhaps in the State of Montana that would be a good example. The State of Maine would be a good example.

Senator TESTER. Could I see your plans for construction of these clinics, the additional clinics, where they are going to be and when they are going to be built?

Dr. CROSS. Yes, sir. I think we have an announcement coming up on the community-based outpatient clinics here shortly, but we will share that with you immediately.

Senator TESTER. I would love to see them. I can tell you that just from my perspective, 11 cents a mile doesn't even begin to pay the gas, much less insurance, tires, depreciation, all that stuff, and this is for disabled veterans whom it applies to. It would seem to me that if you are concerned about taking money away from health care, which I think is a valid concern, you would also be promoting mandatory funding for the VA because as long as it is discretionary, if we build a cemetery, it takes money away from health care. If we put money into research for prosthetics, it will take money away from health care. And the list goes on and on and on.

So I think that it is critically important, and what I have heard with the questions that go around this table is it deals with access to the system and it deals with our veterans getting the health care that they were promised. And I think that if some veterans happen to live in Scobey, Montana, they should still have access to that health care.

And I will tell you point blank, unequivocally, they don't.

So I would hope that when you look at these bills, every one of them as it goes forth—whether I oppose them or I support them is irrelevant—you need to look at it from a standpoint of accessibility and improved veterans' health care. I agree with what Senator Murray said. I hear it at home all the time. Once you get in the system, once you get through the door, it is very, very good and you need to be commended for that. Getting through the door oftentimes is very, very difficult for our veterans.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Isakson, followed by Senator Sanders.

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you very much, Mr. Chairman, and I deeply apologize for being late and I apologize in advance for leaving early in just a minute, but I am in between about five different things.

I have three quick points, Mr. Chairman. First is to thank the VA for the recent opening of the clinic in Rome, Georgia. These clinics provide immeasurable service, and that has been extremely helpful to the Atlanta VA and the Atlanta region.

Secondly, Mr. Chairman, for the record, I have introduced S. 1396, which is an authorization for a $20 million-plus renovation of the VA hospital on Clairmont Road in Atlanta. This is a repeat of an authorization that was made 6 years ago—I think it was 6 years ago. It lapsed this past year while the VA was negotiating the final bids to actually do the work. The money has been appropriated, but because the bids that came in were higher than expected, the negotiations took longer and now we have a contract but no authorization. They are nodding their heads, so I think I am saying it right.

I would appreciate the Chair and the Members of the Committee's help in getting this authorization back through the Committee so this VA renovation can take place. The money is there, the need is great, as all of us have attested to in terms of health care, and we just have a technical problem that we have an expired authorization and money in the bank. So I would ask for the Chair and the other Members of the Committee to help in that if at all possible.

And then last, on behalf of Senator Chambliss and myself, Senator Chambliss has introduced legislation to rename the Augusta VA medical facility for Congressman Charlie Norwood, who passed away of cancer earlier this year. Congressman Norwood was a Vietnam veteran, served as a medic and later as a physician in Vietnam, and worked tirelessly on behalf of the veterans of Georgia and the Veterans' Administration. So we hope that, too, can be expedited through the Committee, and as I understand it, there is no opposition in the VA to doing that.

Dr. CROSS. Sir, we note that Representative Norwood was a proud member of the military medical system. He was a military dentist and we will defer to Congress on the naming of facilities.

Senator ISAKSON. Thank you very much. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Isakson.

Senator Sanders?

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

Senator SANDERS. Thank you very much, Mr. Chairman.

Let me concur with Senator Murray. It seems to me that the fundamental issue that we are dealing with is the following, and I would like a comment from the representatives of the VA. We have had Secretary Nicholson coming before us and speaking with a good deal of pride about the very high quality health care that is provided by the VA for those people who get into the VA. We have also heard evidence that the VA is providing some of the most cost effective health care in the country at a time when health care costs are soaring. That is very good news.

It would seem to me, given those basic premises, that what you should be coming before us and saying is, look, we have got very good quality health care. It is cost effective. Give us the money so that we can expand it to more veterans. That is what you should be
saying.

And then what our job is as Members of the Senate is to say, well, we have got to get our priorities straight. Yes, there are a lot of needs out there. How much are we concerned about veterans as opposed to, for example, tax breaks for billionaires? That is not your job, that is our job.

I happen to think that every person who served in this country is, in fact, entitled to the health care that they were promised. Like Senator Murray, I also have introduced legislation that says that there is something wrong when President Bush threw about 1.5 million Category 8 veterans off of VA health care.

Let me, Mr. Chairman, put into the record an e-mail I recently received. "Dear Senator Sanders, I read in the *Rutland Herald* yesterday about the veterans' benefits and the veterans that fall into the Category 8. My husband applied and he fell into that category because he had not signed by 2003, but he was denied any medical benefits. He needs to have medical care because he has diabetes and we are unable to afford health insurance for him. I am hoping you can do something about this situation for veterans. Thank you."

Well, I am certainly going to try to do something about it. Once again, let me pick up from where Senator Murray left off. A million-and-a-half veterans, people who put their lives on the line, are no longer eligible for VA health care because they are too wealthy, i.e., according to the President, their incomes are over $27,000. I believe those Category 8s should be brought back into the system. Do you?

Dr. CROSS. Sir, as we discussed earlier, I share your concerns. Our focus, though, is to make sure that the veterans that we do take care of, that we do the very best that we can, that we provide the adequate access and the adequate quality——

Senator SANDERS. A question. I have heard that answer for several years. How much more money do you need to provide the highest quality care for all of our veterans? Nobody here does not want

the highest quality care for those returning from Iraq and Afghanistan. We also want Category 8 veterans to get care. How much more do you need to do that?

Dr. CROSS. We are costing the bill. We haven't arrived at the final number but we can give you that in writing.

Senator SANDERS. Mr. Hall, do you have any thoughts on that?

Mr. HALL. No, sir, I do not.

Senator SANDERS. OK. I would like to receive as soon as possible your estimates as to what it would cost to make sure that every—that this gentleman who put his life on the line for the country who now has diabetes, whose family cannot afford health care, be entitled to get into the VA.

Dr. CROSS. Sir, I need to remind you of one thing.

Senator SANDERS. Yes?

Dr. CROSS. It is not merely a matter of money. It is a matter of capacity, the physical facility, the staffing, the equipment and so forth that would be—it wouldn't be an instantaneous process even if the money were to arrive today. So——

Senator SANDERS. What you are saying is it could not be done tomorrow and it would take time. We appreciate that. But your job is to tell us how much money you would need to provide expanded capacity, because I start off again with the premise, the Secretary tells us that the care is excellent and it is cost effective. Why wouldn't the U.S. Congress be supporting an expansion of a program which ultimately will save taxpayers money? So I would appreciate hearing from you as to your estimates as to how much providing health care to Category 8s will cost.

Dr. CROSS. Yes, sir. We will get you that.

Senator SANDERS. Number two, let me also ask for the information that Senator Tester asked for. Do I understand you are going to be expanding the community clinics?

Dr. CROSS. Yes.

Senator SANDERS. I think that is a very good idea.

They work very well in Vermont. I would also like to know where those clinics will be.

Thirdly, I want to pick up again on a point that Senator Murray raised. As somebody who in the House of Representatives was involved for many, many, many years on Gulf War illness issues, certainly the recent study coming from, I believe, Boston University, is a very significant one. I can well remember, Mr. Chairman, where the VA even denied that one soldier was impacted by sarin. They started off by denying there was any problem whatsoever. We have been, believe me, around the block with the VA on this for many, many years.

But if this study is, in fact, accurate, it is, as Senator Murray indicated, very profound. It suggests that many soldiers may have suffered brain damage which was not—one didn't know it instantaneously, unlike a large dose of sarin. And the impact not only for Gulf War soldiers but for the civilian population is important, as well, because a number of scientists have pointed out the similarity between various illnesses associated with the Gulf War as similar to those in the civil society, such as multiple chemical sensitivity, chronic fatigue, fibromyalgia, and other types of illnesses. So this is a very big deal and we hope that you will pursue that.

Dr. CROSS. We absolutely will, Senator, and I wanted to point out again that we were involved in the research——

Senator SANDERS. Yes.

Dr. CROSS [continuing].—and we were proactive in doing this. The way you characterize the findings may be a bit different than the way I read them. We would be happy to bring our experts over and sit down and talk with you or your staff and go through it in some more detail——

Senator SANDERS. What do you understand the key findings to be?

Dr. CROSS. One of the findings was a slight anatomical variation that was noted in one group more so than in the other. That was perhaps the lead finding. And whatever the consequences——

Senator SANDERS. That was brain——

Dr. CROSS. Yes.

Senator SANDERS [continuing].—brain anomaly.

Dr. CROSS. So we can go through that in more detail. It is a very technical issue. I would be happy to go through it——

Senator SANDERS. Is this consistent with the work that Dr. Haley in Texas was doing?

Dr. CROSS. I don't think it is involved with that, sir.

Senator SANDERS. No, I know it is not involved, but are the conclusions somewhat similar, do you think?

Dr. CROSS. I would be stretching my knowledge if I answered that one way or the other.

Senator SANDERS. Mr. Hall, do you have any knowledge about that?

Mr. HALL. No.

Senator SANDERS. OK. Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

I want to thank our panelists. Thank you very much, Dr. Cross and Mr. Hall, for your testimony and your responses. We really appreciate it. It will be helpful to us.

Mr. HALL. Mr. Chairman, if I could clarify one thing——

Chairman AKAKA. Mr. Hall?

Mr. HALL. Senator Murray had the question about the eligibility for Reservists. Reservists are eligible.

Combat veteran Reservists are eligible upon their discharge or separation for care on the same basis as——

Senator MURRAY. But after two years, the National Guard is not.

Mr. HALL. If they are combat veterans, they are.

Senator MURRAY. After two years?

Mr. HALL. Upon their discharge.

Senator MURRAY. We are talking about Priority 8?

Mr. HALL. Pardon me? No, they are eligible under the current two-year basis. Oh, excuse me. You are talking about after the two years of——

Senator MURRAY. After two years, Priority 8 regular service get additional health care. Guard and Reserve do not. There is a difference between the two, after two years.

Mr. HALL. No, ma'am. Once they are enrolled, once they are—combat veterans would come back. They would have the eligibility as combat veterans to be enrolled as Priority 6s and then they would—once enrolled in the system, they would continue on as pre-

viously enrolled. If they qualified as 8s then, they would be previously enrolled and would continue their enrollment.

Senator MURRAY. If you are correct, there are a lot of people who are misinformed throughout the system. If I am correct, there are a lot of people who aren't getting what they should be getting.

Dr. CROSS. Senator Murray, I think we will send you a written response to make sure we have got this absolutely clear for you.

Chairman AKAKA. Thank you very much for that clarification and thank you again, Dr. Cross and Mr. Hall.

I would like to now welcome the representatives of the second panel, the representatives of the veterans service organizations to our panel today, Carl Blake with the Paralyzed Veterans of America; Dennis Cullinan of the Veterans of Foreign Wars; Joy Ilem of the Disabled American Veterans; Shannon Middleton of the American Legion; and Bernard Edelman of Vietnam Veterans of America.

I thank you all for appearing before the Committee today. Of course, your full statement will appear in the record of the hearing.

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

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

Mr. BLAKE. Mr. Chairman, Members of the Committee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today. In light of the fact there are numerous bills on the agenda, I will limit my comments to only a few of the bills.

The PVA supports S. 472 that would authorize the funding necessary to construct a new major medical facility in Denver, Colorado. PVA has been involved in the planning and development process for this new facility since the beginning. PVA also appreciates the fact that the Capital Asset Realignment for Enhanced Services, CARES, commission report identified the need for a new spinal cord injury center in the Denver area. We hope to remain an active partner in the development and completion of this project to ensure that the needs of veterans and SCI veterans are also being met.

PVA fully supports S. 479, the Joshua Omvig Veterans Suicide Prevention Act. The instances of suicide among veterans, particularly OEF and OIF veterans, is a serious concern that needs to be addressed. PVA particularly appreciates the emphasis placed on peer support counseling. This is something that PVA as an organization does in all of the spinal cord injury centers around the country. Every PVA chapter designates individual members to pair up with newly injured veterans to help them get through the early stages of the recovery process.

I know firsthand that being able to talk to someone who has experienced what you have experienced and has dealt with the same problems you are dealing with can help you overcome bouts of depression, anger, and sadness as you first come to grips with your condition. The peer counselor serves as a motivator to get you moving in the right direction.

PVA finds it difficult to comprehend the rationale for establishing a precedent for veterans in the VA health care system to

leave that system and seek services elsewhere, as S. 815 would do. Over the past year, we have read, and as I am sure every Member of Congress has, all of the accolades given to the VA health care system. While this legislation may be well intentioned, the potential unintended consequences far outweigh any benefit that this bill might provide. It would almost certainly be a diminution of established quality, safety, and continuity of VA care if veterans were to leave the system.

While as a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, its evidence-based medicine, the electronic medical records, and the medication verification program. These unique VA features culminate in the highest-quality care available, public or private. Loss of these safeguards that are generally not available in private sector systems would equate to diminished oversight and coordination of care and ultimately may result in lower quality of care for those who deserve it most. With all of these considerations, PVA opposes this proposed legislation.

PVA fully supports S. 994, the Disabled Veterans Fairness Act, which would align the mileage reimbursement rate afforded to eligible veterans with the rate that all Federal employees get when they are on travel. It is wholly unacceptable that veterans have to live with the 11 cents per mile reimbursement rate that the VA currently provides when all Federal employees receive 48 cents per mile. In fact, PVA believes that some of the difficulty in providing care in rural and limited access areas, particularly rural areas, might be eliminated with a sensible reimbursement rate. We believe that veterans would be less likely to complain about access issues as a result of their geographic location if they know that they will not have to foot the majority of the travel expense out of their own pocket. This is a change that has been long overdue and we urge the Committee and all of Congress to take immediate action to correct this inequity.

PVA fully supports S. 1147, the Honor Our Commitment to Veterans Act. The provisions of this legislation are in accordance with the recommendations of the Independent Budget. However, we must emphasize that if this policy is overturned, additional adequate funding must be provided to meet this demand. It would make no sense to make this change without providing the funding necessary.

Finally, PVA generally supports the provisions of S. 1233, the Veterans Traumatic Brain Injury Rehabilitation Act. It is fair to say that TBI is considered the signature health crisis for OEF and OIF veterans. We believe that the provisions of this legislation will enhance the ability of the VA to provide comprehensive care for veterans with TBI. With this in mind, it only makes sense that the VA be required to develop a comprehensive treatment plan to address the individualized treatment needs of these veterans. We believe that this approach gives these severely disabled veterans the best chance to succeed in their recovery.

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

[The prepared statement of Mr. Blake follows:]

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

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

S. 117, THE "LANE EVANS VETERANS HEALTH AND BENEFITS IMPROVEMENT ACT"

PVA supports the provisions of this legislation that allow veterans who experience mental health conditions to receive treatment from the Department of Veterans Affairs (VA). Likewise, despite the fact that it deals with Title 10 issues—an area that PVA does not typically work in—we support the requirement that post-deployment medical and mental health screening be conducted within 30 days. We would suggest that it should be done even sooner. PVA has expressed concerns repeatedly that pre-deployment and post-deployment screenings are not being handled properly. In fact, we believe that it should not be a screening, but instead, a full medical evaluation and physical. The only way to properly assess the men and women returning from combat theaters of operations is to examine them fully.

PVA also supports the intent of Section 103 of the legislation that requires every servicememberber released from active duty to be given an electronic copy of his or her military records, to include military service, medical, and any other relevant records. We have long felt that electronic transfer of all military service and medical records from the Department of Defense to VA would expedite the claims process. This provision would certainly move the departments in that direction. However, we believe that this could take quite some time to implement and that additional resources should be provided to meet the demands of this legislation.

S. 383

PVA fully supports this legislation which would extend the eligibility for hospital care, medical services, and nursing home care from 2 years to 5 years for a veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force after November 11, 1998. This provision has proven especially important to the men and women who have recently served in Iraq and Afghanistan and have exited military service.

However, PVA believes that the ability of the VA to provide this essential care will continue to be threatened as long as adequate funding is not provided to meet this specific demand. As we have stated in testimony previously, we believe that the VA is underestimating the number of men and women from the Global War on Terror who are seeking care in the VA, and by extension, has not requested sufficient funding to meet this demand. We appreciate that Congress has recognized the need for more funding than has been requested in recent years, and we hope that you will continue to do what is necessary to care for all of these men and women who choose to come to the VA.

S. 472

PVA supports S. 472 that would authorize the funding necessary to construct a new major medical facility in the Denver, Colorado area. PVA has been involved in the planning and development process for this new facility since the beginning. PVA also appreciates the fact that the Capital Asset Realignment for Enhanced Services (CARES) commission report identified the need for a new spinal cord injury (SCI) center in the Denver area. We hope to remain an active partner in the development and completion of this project to ensure that the needs of SCI veterans are also being met.

We must emphasize that a new spinal cord injury center should move forward along with any decisions concerning a new Denver VA medical center. Any new SCI center must be operated as all current centers are, with dedicated services and staff. The development of a new SCI center must follow the requirements of the Memorandum of Understanding between VA and PVA allowing for architectural review,

must operate in compliance with all existing VA policies and procedures, and must continue the relationship between VA and PVA allowing for site visits of SCI center facilities.

S. 479, THE "JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT"

PVA fully supports S. 479, the "Joshua Omvig Veterans Suicide Prevention Act." The incidence of suicide among veterans, particularly Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans, is a serious concern that needs to be addressed. We believe that this legislation addresses one major hurdle by attempting to break the stigma of mental illness. Clearly, veterans with mental illness are at a higher risk for suicide. And yet, these veterans have been pushed to the edge because they believe they are looked down upon because of their mental conditions. If this program and outreach is going to succeed, it is absolutely essential that the providers, to include doctors, nurses, and other health professionals, are properly trained. In some cases, the first biggest challenge that veterans with mental illness face is a provider who does not handle such a delicate situation properly.

PVA also appreciates the emphasis placed on peer support counseling. This is something that PVA as an organization does in all of the spinal cord injury centers around the country. Every PVA chapter designates individual members to pair up with newly injured veterans to help them get through the early stages of their recovery. I know firsthand that being able to talk to someone who has experienced what you have experienced and has dealt with the same problems you are dealing with can help you overcome bouts of depression, sadness, and anger as you first come to grips with your condition. The peer counselor serves as a motivator to get you moving in the right direction. I credit my own peer counselor while I went through spinal cord rehabilitation with driving me to help other veterans.

S. 610

PVA has no objection to this legislation. The legislation is meant to correct an apparent inequity in the statute governing full-time retirement benefits for nurses who were recruited by the VA to do part-time work. If this was a benefit that was promised to these nurses, then we see no reason why they should be denied it.

S. 692, THE "VA HOSPITAL QUALITY REPORT CARD ACT"

Although PVA has no objection to the requirements for a Hospital Quality Report Card Initiative outlined in this legislation, we remain concerned that this wealth of information will go unused. Collecting this information and assessing it without acting on any findings from that information would serve no real purpose. We would hope that the congressional committees will use this information published in these reports each year to affect positive change within the VA. However, we must emphasize that additional resources should be provided to allow the VA to properly compile this information as we believe that this could be a major undertaking.

S. 815, THE "VETERANS HEALTH CARE EMPOWERMENT ACT"

PVA finds it difficult to comprehend the rationale for establishing a precedent for veterans in the VA health care system to leave that system and seek services elsewhere, as this proposed legislation would do. Over the past year we have read, as I am sure every Member of Congress has, all of the accolades given to VA health care by independent observers, newsweeklies and other publications. While we believe VA represents the best available care, oversight is needed to provide an additional guarantee that VA-provided services are of the highest quality for all veterans who use VA, especially for those with service-connected disabilities.

While this legislation may be well intentioned, the potential unintended consequences far outweigh any benefit that this bill might provide. There would almost certainly be a diminution of established quality, safety and continuity of VA care if veterans were to leave the system. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans from those programs. The VA's medical and prosthetic research program, designed to study and hopefully cure the ills of disease and injury consequent to military service, would lose focus and purpose were service-connected veterans no longer present in VA health care. Additionally, Title 38, United States Code, section 1706(b)(1) requires VA to maintain the

capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104–262 was enacted.

As a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience; however, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most. With all of these considerations, PVA strongly opposes this proposed legislation.

S. 874, THE "SERVICES TO PREVENT VETERANS HOMELESSNESS ACT"

PVA has no objection to the provisions contained in the proposed legislation. Clearly, the most important factor in combating the problem of homelessness among veterans is preventing homelessness in the first place. This legislation would seem to accomplish that task by offering financial assistance to organizations or entities that provide permanent housing and support services to very low income veteran families. In the mean time, we believe that additional resources should be invested in programs that actually target veterans and their families who are experiencing homelessness as well. With more than 200,000 veterans on the street on any given night, it is time to make real, meaningful efforts to end this problem.

S. 882

PVA supports the concept of the proposed legislation that would establish "navigators" to assist veterans and disabled veterans as they enter the VA system for health care and benefits. This legislation would offer $25 million in grants over 5 years to support these navigators. This legislation would particularly allow veterans service organizations and other organizations to apply for grants so that they could hire and train navigators to provide assistance, on an individualized basis, to members of the Armed Forces as they transition from military service to VA health care and as they seek benefits provided by VA. The only point that we must emphasize is that as the VA begins awarding these grants, it must ensure that the absolute best qualified entities are chosen for this assistance. The VA must ensure that rigorous qualification standards are established and subsequently met by organizations applying for the grants. This will ensure that veterans do not receive inadequate assistance as they navigate the VA system.

S. 994, THE "DISABLED VETERANS FAIRNESS ACT"

PVA fully supports S. 994, the "Disabled Veterans Fairness Act," which would align the mileage reimbursement rate afforded to eligible veterans with the rate that all Federal employees get when they are on travel. It is wholly unacceptable that veterans have to live with the 11 cents per mile reimbursement rate that the VA currently provides when all Federal employees receive 48 cents per mile. In fact, PVA believes that some of the difficulty in providing care to veterans in limited access areas, particularly rural areas, might be eliminated with a sensible reimbursement rate. We believe that veterans would be less likely to complain about access issues as a result of their geographic location if they know that they will not have to foot the majority of the travel expense out of their own pocket. This is a change that has been long overdue, and we urge the Committee and all of Congress to take immediate action to correct this inequity.

S. 1026

PVA generally concedes to the wishes of our local chapters, as well as other local veterans service organization members and State Congressional delegations on issues involving naming VA facilities. At this time, PVA has no position on S. 1026.

S. 1043

PVA has no specific position on the proposed legislation. However, we do concur with the principle of the legislation that the needs of veterans in the Los Angeles area should trump any outside considerations.

S. 1147, THE "HONOR OUR COMMITMENT TO VETERANS ACT"

PVA fully supports S. 1147, the "Honor Our Commitment to Veterans Act." The provisions of this legislation are in accordance with the recommendations of The Independent Budget. We have continued to advocate for this policy to be overturned since it was put into place. It is unacceptable that these veterans, many of whom have served in combat, are being denied access to health care simply because the Administration and Congress have been unwilling to provide the necessary funding to reopen the VA health care system to them. We believe this policy should be overturned and that adequate resources should be provided to overturn this policy decision.

VA estimates that more than 1.5 million category 8 veterans will have been denied enrollment in the VA health-care system by Fiscal Year 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, The Independent Budget estimates that VA will require approximately $366 million in discretionary dollars.

S. 1205

PVA supports this proposed legislation that would establish a pilot program to assist veterans service organizations and other organizations in developing and implementing peer support programs. The peer support program would help veterans reintegrate into their local communities. As we stated in our testimony regarding suicide prevention and peer support, the benefits of any type of peer support or counseling are invaluable. PVA chapters lead the charge at each spinal cord injury center to provide peer counseling to newly injured veterans coming through the system. The program authorized by this legislation could allow these local level veterans service organization representatives to expand their reach and provide better support to the veterans who need the most assistance.

Veterans service organizations understand better than any other entity that community reintegration is vital because most of their members have likely experienced this situation. We believe it makes perfect sense to tap into this knowledge and expertise to help new veterans return to civilian life easier.

S. 1233, THE "VETERANS TRAUMATIC BRAIN INJURY REHABILITATION ACT"

PVA generally supports the provisions of S. 1233, the "Veterans Traumatic Brain Injury Rehabilitation Act." It is fair to say that traumatic brain injury (TBI) is considered the signature health crisis for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. We believe that the provisions of this legislation will enhance the ability of the VA to provide comprehensive care for veterans with TBI. With this in mind, it only makes sense that the VA be required to develop a comprehensive treatment plan to address the individualized treatment needs of these veterans. We believe that this approach gives these severely disabled veterans the best chance to succeed in their recovery.

PVA is concerned about the authority provided by Section 4 of the legislation. We understand that outside facilities and programs can bring some level of expertise to this population of veterans. However, we would hope that the VA would see fit to invest the majority of its resources in improving its own TBI programs, even as it taps into outside expertise. We do appreciate the effort of the legislation to ensure that outside facilities meet certain standards before the services are acquired. We would hope that this provision would ensure a level of care that should be expected from any facility treating these veterans.

Meanwhile, we think that the legislation also unnecessarily rewrites contracting authority that already currently exists in the fee basis statute. The legislation seems to explain medically unfeasible and geographic inaccessibility in new language, when the VA already has authority to follow these guidelines under fee basis. This would simply require the VA to more judiciously apply its own regulation.

PVA supports the establishment of a research, education, and clinical care program to provide intensive neuro-rehabilitation to veterans with severe traumatic brain injury. We would hope that this program will be coordinated with the polytrauma centers that are currently providing complex care to severely disabled veterans, to include veterans with TBI.

Likewise, we support the provision for a pilot program to assess the effectiveness of assisted living services for these veterans. PVA believes that age-appropriate VA non-institutional and institutional long-term care programming for young OIF/OEF veterans, particularly the severely disabled including veterans with TBI, must be a priority for VA. New VA non-institutional care programs must come on line and

existing programs must be re-engineered to meet the various needs of a younger veteran population. VA's non-institutional long-term care programs will be required to assist these younger severely injured veterans who need a wide range of support services such as: personal attendant services, programs to train attendants, peer support programs, assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and transportation services. These younger veterans need expedited access to VA benefits such as VA's Home Improvement/Structural Alteration (HISA) grant, and VA's adaptive housing and auto programs so they can leave institutional settings and go home as soon as possible. PVA also believes that linking these assisted living programs to the polytrauma centers and possibly the proposed research, education, and clinical care program is a must.

Lastly, we fully support the inclusion of research on TBI as part of existing research programs. If the long-term effects of the injuries of these veterans have not even been identified yet, it is essential that the VA makes its best effort to stay ahead of the needs of these men and women as they arise. The best way to accomplish that is through additional research.

THE "COMPREHENSIVE VETERANS BENEFITS IMPROVEMENT ACT"

As with S. 1147, PVA supports the provision of this proposed legislation that would overturn the policy decision to prohibit Category 8 veterans from enrolling in the VA health care system. However, we must emphasize that if this policy is overturned additional adequate funding must be provided to meet this demand. It makes no sense to make this change without providing the funding necessary to meet the new demand.

PVA fully supports Section 102 of the proposed legislation in accordance with the recommendations of The Independent Budget. We are particularly pleased with the emphasis that Category 4 veterans with catastrophic disabilities that are non-service connected be exempted from paying copayments and fees. This has been a longstanding initiative of PVA. The veterans affected by this proposal are not casual users of VA health care services. Because of the nature of their disabilities they require substantial, ongoing care and a lifetime of services. Private insurers don't offer the kind of sustaining care for spinal cord injury found at the VA even if the veteran is employed and has access to those services. Other Federal or state health programs fall far short of VA. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury, and yet, these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. It is certainly time for Congress to correct this financial penalty.

Mr. Chairman and Members of the Committee, PVA once again thanks you for the opportunity to testify. We look forward to working with you to ensure that veterans continue to have access to the best health care services in America.

I would be happy to answer any questions that you might have.

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

Mr. Cullinan?

STATEMENT OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Chairman Akaka, Senator Murray, on behalf of the 2.4 million men and women of the Veterans of Foreign Wars and our Auxiliaries, I thank you for this opportunity to testify at today's hearing on veterans' health care legislation.

The VFW has no objections to S. 610 and S. 1233. We support all other bills under discussion today with the exception of S. 815, which I will address momentarily. On behalf of the VFW membership, I will be very pleased to outline our strong support for S. 1233. For the sake of timeliness, I will limit my presentation to these two initiatives.

S. 815, the Veterans Health Care Empowerment Act, the VFW strongly opposes this legislation, which would allow any veteran to elect to receive contracted care basically wherever and whenever they choose. As we have acknowledged in our comments on pre-

vious legislation, there are certainly cases where contract care is appropriate, even essential. Indiscriminate use of it, however, will place the utilization of VA's own health care resources at risk.

First, we reiterate our concerns with the cost of such care. Fee-based care is more expensive than that of VA and we believe that it would do great harm to those veterans who elect to stay in the high-quality VA health care system by taking funding away from the system as a whole.

Second, we have strong concerns about the viability of the health care system should this bill be enacted. VA has four essential missions, all of which depend on one another and which greatly improve the quality of care for all Americans, not just veterans. It serves as the health care system for its Nation's sick and disabled veterans, first and foremost. Second, it acts as the primary education and training ground for America's health care professionals.

Third, it provides world class research opportunities in the development of new medical technologies. And fourth is the back-up to the Department of Defense health care system during times of national emergency. We cannot lessen one of these missions without sacrificing elements of the others. Reducing the number of veterans seeking care from VA would undermine the others, affecting all Americans.

Further, contract care would present problems especially with the continuum of care and VA's ability to monitor and track the health care needs of veterans over their entire lives. It would also potentially erode the quality of the care VA provides, especially with respect to illnesses and disabilities veterans suffer such as gunshot wounds, the use of prosthetics, SCI, and so forth. VA is uniquely qualified to treat these particular maladies.

Although this legislation aims to expand the coverage available to veterans, we believe it would only dilute the quality and quantity of services provided to new and existing veterans today and into the future.

Next under discussion is S. 1233, the Veterans Traumatic Brain Injury Rehabilitation Act of 2007. The VFW is pleased to support this legislative initiative introduced by you, Chairman Akaka, as well as Ranking Member Craig, to provide enhanced intervention, rehabilitative treatment, and services to veterans with traumatic brain injury. Traumatic brain injury, or TBI, is the signature wound of the current war in Iraq and Afghanistan. Improvements in body armor and more rapid and effective medical interventions are resulting in individuals surviving bomb blasts and the like and other concussive injuries that would not have been possible in the previous conflicts.

Tragically, though, along with amputations, many of these survivors now suffering with TBI, resulting in varying degrees of cognitive impairment, reduced concentration and ability to focus on more than one thing at a time, and emotional distress. This has profoundly negative implications for these injured warriors as well as their families and dependents.

While in all likelihood, TBI has been one of the injuries of modern warfare, it went unrecognized and there may be no doubt that it has never been as prevalent as it is today. The severity of the resulting impairment, the psychological and physiological con-

sequences, and the duration of the disability are at this point in time but vaguely understood. Modern medicine and medical science are just now addressing TBI.

It is for this reason that the measures called for in S. 1233 are so important. The VFW supports all the recommendations and findings contained in this bill. We place special emphasis on Section 3's requirement that the Secretary develop and implement individual rehabilitation plans, as well as Section 5's establishment of severe traumatic brain injury research, education, and a clinical care program under the Department of Veterans Affairs.

Mr. Chairman, this concludes my testimony. Thank you.

[The prepared statement of Mr. Cullinan follows:]

PREPARED STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of This Committee:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify at today's hearing on veterans health care legislation.

S. 117

The VFW is pleased to support this legislation, introduced by Senator Obama, which makes a number of improvements in the care and treatment of those servicemen and women who are separating from service.

Title I of this bill would require these men and women to receive a mental health evaluation within 30 days of their return from deployment, and would extend medical care and services to these veterans based upon the results of these evaluations regardless of whether they are directly connected with a service connection if they seek treatment within 5 years of separation.

This is important because it gives the benefit of the doubt to these veterans for their illnesses and mental health problems they may suffer, and provides them access to these essential services without having to endure the VA disability claims process for access to care beyond their initial 2 years of eligibility. The bottom line is that if veterans are having problems, under this legislation, they would be cared for.

We support other sections of this legislation that would require the Department of Defense to provide servicemembers with an electronic copy of their medical and military records. This has been a long-time goal of the VFW, and we view it as an essential component of the seamless transition. We understand that DOD has made limited progress in this regard, but the time for action is now. We also support this bill's efforts to improve outreach to members of the National Guard and Reserves, and its reporting requirements to provide meaningful statistics on the health care and services provided to veterans of the Global War on Terrorism.

S. 383

Introduced by Senator Akaka, the VFW is pleased to support S. 383, legislation that would extend the period of eligibility for health care for combat service during the Persian Gulf War from 2 years to 5 years.

Currently, veterans OEF/OIF veterans who enroll in the VA health care system are included as category six veterans and are entitled to use VA as their health care provider for 2 years following their discharge. For those who enroll after this 2-year period, they are enrolled as any other veteran would be and, if they fall in category 8, are excluded from the system.

As we learn more about the illnesses, disabilities and health care needs of those returning, this is an important change, and would allow many of these veterans to receive the care and benefits they need. For those suffering from mental health issues—such as PTSD—the symptoms they show might not immediately manifest themselves, or they may need time to come to terms with the knowledge that they need treatment. If they fall outside the 2-year window and qualify for health care under category 8, they cannot access VA health care unless they can demonstrate a service connection—a process that takes, on average, 6 months or more.

For those suffering from the effects of mental health illnesses, or for veterans who are affected by Traumatic Brain Injuries, changing the law to extend their eligibility is a compassionate and right thing to do.

S. 472

The VFW is pleased to support this legislation, introduced by Senator Allard that would authorize $523 million to construct a replacement VA Medical Center in Denver, CO. This facility, to be built on the former Fitzsimons Army hospital site, has received prior year's authorization for a portion of the construction costs.

The VFW has long supported the Capital Asset Realignment for Enhanced Services process (CARES) and we continue to support the process, especially in how it prioritizes VA's construction needs. Table 4–9 of VA's 5-Year Capital Plan identifies and prioritizes VA's construction needs, and Denver's project is ranked 3rd on the list. Accordingly, Congress must authorize and appropriate sufficient funding to complete this project.

S. 479—THE JOSHUA OMVIG SUICIDE PREVENTION ACT

The VFW is pleased to support this legislation, which aims to create a comprehensive program of suicide prevention among veterans. Due to the nature of high-stress combat in the current war and the beginning of a de-stigmatization of mental-health disorders, many veterans are beginning to seek the care they need, and diagnosis of post-traumatic stress disorder (PTSD) are on the increase, but more can be done.

This legislation, introduced by Senator Harkin, would require VA to train its employees to identify suicide risk factors and protocols for responding to veterans who are at risk. Additionally, it would create programs of outreach among veterans and—importantly—their families, a critical system of support.

These programs are essential because we can and must do more to ensure that no veteran slips through the cracks, and that they all have access to the highest quality mental health services they need to make them whole. It is a national tragedy that so many are suffering, but with a proactive VA, we can all make a positive impact on the lives and care of thousands of our returning heroes.

S. 610

The VFW has no objection to this legislation, introduced by Senator Rockefeller that would make changes to the retirement annuity for certain health-care professionals within VA.

S. 692

Introduced by Senator Obama, the VFW is pleased to support the VA Hospital Quality Report Card Act, legislation that would require VA to develop and implement a system to measure data about its health care facilities.

This data would be of great service. It would allow veterans to compare the quality of service VA provides, letting them make informed judgments about their health care. It would allow VA to identify areas of improvement, and it would provide essential data for Congress to better use its essential oversight authority.

S. 815—VETERANS HEALTH CARE EMPOWERMENT ACT

The VFW strongly opposes this legislation, which would allow any veteran to elect to receive contracted care whenever they choose. As we have acknowledged in our comments to previous legislation, there are certainly cases where contract care is appropriate. Indiscriminate use of it in place of utilizing VA's own health care resources, however, is misguided.

First, we reiterate our concerns with the costs of such care. Fee-basis care is more expensive than that of VA, and we believe that it would do great harm to those veterans who elect to stay in the high-quality VA health care system by taking away funding for the system as a whole.

Second, we have strong concerns about the viability of the health care system should this bill be enacted. VA has four essential missions, all of which depend on one another, and which greatly improve the quality of care for all Americans, not just our veterans. (1) It serves as the health care system for this Nation's sick and disabled veterans; (2) It acts as the primary education and training grounds for America's health care professionals (48,000 medical residents and students receive training at VA each year); (3) It provides world-class research opportunities and the development of new medical technologies, and; (4) It is the backup to the Department of Defense health system in national emergencies.

We cannot lessen one of these missions without sacrificing the others. Reducing the number of veterans seeking care from VA would do irreparable damage to the others, affecting all Americans.

Further, contract care would present problems, especially with the continuum of care and VA's ability to monitor and track the health care needs of veterans over their entire lives. It would also potentially erode the quality of care VA provides, especially with respect to the illnesses and disabilities veterans suffer from, such as gunshot wounds or prosthetics, and for which VA is uniquely qualified to treat.

Although this legislation, introduced by Senator Craig, aims to expand the coverage available to veterans, it would only dilute the quality and quantity of the services provided to new and existing veterans today and into the future. That is unacceptable.

S. 874

The VFW supports S. 874, "The Services to Prevent Veterans Homelessness Act of 2007," introduced by Senator Burr of this Committee. A great tragedy and embarrassment, now confronting, this Nation is the high level of homelessness among the veteran population. This legislation, directing the Secretary of Veterans Affairs to provide financial assistance to eligible private nonprofit organizations or consumer cooperatives to provide and coordinate the provision of various supportive services for very low-income veteran families occupying permanent housing, addresses this issue. It is directed toward preventing homelessness from occurring in the first place. We also support that the Secretary is required to conduct a 2-year study of the effectiveness of the assistance program in meeting the needs of very low-income veteran families.

S. 882

The VFW supports this legislation, introduced by Senator Menendez, which would create a pilot program to improve the seamless transition for separating servicemembers. It would award grants to organizations who help veterans, especially those with serious wounds, women and members of the Guard and Reserves with applying for benefits and services within VA.

Expanding outreach efforts so that all our veterans understand the benefits that they are entitled to is a worthy goal, and would be of great benefit to those who truly need VA's services to transition back into society.

S. 994

The VFW supports and appreciates S. 994, the Disabled Veterans Fairness Act introduced by Senator Tester together with Senator Salazar. This bill eliminates a $3 per round trip deductible charged by the Secretary of Veterans Affairs in connection with the veterans beneficiary travel program. It further directs the Secretary, in determining the amount of such allowance or reimbursement, to use the mileage reimbursement rates for the use of privately owned vehicles by government employees traveling on official business. For many veterans who live far from a VA hospital or community health center, transportation remains the single biggest obstacle to care. Today, disabled veterans are eligible to have only a small fraction of their transportation costs reimbursed.

This legislation will go a long ways in addressing this unfortunate situation.

S. 1026

The VFW supports this bill introduced by Senator Chambliss to designate the Department of Veterans Affairs Medical Center at 1 Freedom Way in Augusta, Georgia, as the "Charlie Norwood Department of Veterans Affairs Medical Center." Congressman Norwood was a lifetime VFW member and a staunch supporter of veterans as well as our active duty military.

S. 1043

The VFW has no objection to this legislation introduced by Senator Feinstein directing the Secretary of Veterans Affairs to report to Congress on the master plan of the Department of Veterans Affairs (VA) relating to the use of VA lands of the West Los Angeles Department of Veterans Affairs Medical Center, California, as originally required under the Veterans Programs Enhancement Act of 1998. This bill also requires an alternative report, on the development of the master plan, if the master plan does not exist as of the date of enactment of this Act and further prohibits the Secretary from implementing any portion of the master plan until 120 days after its receipt by the congressional veterans' and appropriations committees.

S. 1147

The VFW applauds the introduction of S. 1147 by Senator Murray of this Committee. The Honor Our Commitment to Veterans Act directs the Secretary of Veterans Affairs to administer the health care enrollment system of the Department of Veterans Affairs so as to enroll any eligible veteran who applies. The fact that tens of thousands of so called category 8 veterans are denied access to VA medical care simply because their incomes exceed an unreasonably low threshold is a travesty. This bill would rectify this situation.

S. 1205

The VFW supports S. 1205. A bill, introduced by Senator Smith, to require a pilot program on assisting veterans service organizations and other veterans' groups in developing and promoting peer support programs that facilitate community reintegration of veterans returning from active duty. The effectiveness of peer support has been well documented in the wake of the Vietnam conflict. Specifically, for mental health disorders like PTSD and depression, peer-support programs have shown that participation yields improvement in psychiatric symptoms and decreased hospitalizations, the development of larger social support networks, enhanced self-esteem and social functioning, as well as lower services costs. Unfortunately peer support is not as readily available as might be expected. This bill to increase the presence of the VFW and other VSOs and members of the veteran's community in this vital area is a very sound initiative to provide much needed support to veterans in need on a highly cost effective basis.

S 1233

The final bill under discussion today is S. 1233, the Veterans Traumatic Brain Injury Rehabilitation Act of 2007. The VFW is pleased to support this legislative initiative introduced by Chairman Akaka and Ranking Member Craig to provide enhanced intervention, rehabilitative treatment and services to veterans with traumatic brain injury. Traumatic Brain Injury or TBI is the signature wound of the current war in Iraq. Improvements in body armor and more rapid and effective medical interventions are resulting in individuals surviving bomb blasts and other concussive injuries that would not have been possible in previous conflicts. Tragically, though, along with amputations many of these survivors now suffer from TBI resulting in varying degrees of cognitive impairment, reduced concentration and ability to focus on more than one thing at a time and emotional distress. This has profoundly negative implications for these injured warriors as well as their families and dependents.

While in all likelihood TBI has always been one of the injuries of modern warfare, it went unrecognized. And there may be no doubt that it has never been as prevalent as it is today. The severity of resulting impairment, the physiological and psychological consequences and the duration of this disability are at this point in time but vaguely understood. Modern medicine and medical science are just now addressing TBI.

It is for this reason that the measures called for in S. 1233 are so important.

The VFW supports all of the recommendations and findings contained in this bill. We place special emphasis on Section 3's requirement that the Secretary develop and implement individual rehabilitation plans as well as Section 5's establishment of severe traumatic brain injury research, education and clinical care program within the Department of Veterans Affairs.

Mr. Chairman, this concludes my testimony. I would be happy to respond to any questions you may have.

Thank you.

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

Ms. Ilem?

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

Ms. ILEM. Thank you, Mr. Chairman and Members of the Committee. We appreciate the opportunity to testify on behalf of the Disabled American Veterans. As your staff requested, I am focusing on only a few of the proposals being considered by the Committee

today, specifically the measures of special interest to DAV and its members.

I will begin with S. 383, a bill that would extend combat veterans' eligibility for VA health care from two to five years. DAV has a resolution calling for this extension of eligibility. This bill would help to ensure that our newest generation of combat veterans, those from Iraq and Afghanistan, are given ample time to access VA's specialized programs and services, if needed. We believe this is especially important with regard to mental health as well as for veterans with mild traumatic brain injuries. Therefore, DAV fully supports this measure and we look forward to its enactment.

We are also pleased to support. S. 479, the Joshua Omvig Veterans Suicide Prevention Act. The hearing recently held by this Committee clearly illustrated the need to address this issue of suicide in the veteran population, especially among our newest generation of combat veterans. The testimony provided by Joshua Omvig's parents and other members of that particular witness panel was very moving and brought out the need for improvement in VA's programs designed to help veterans who are struggling with readjustment issues following wartime service. Every possible thing that can be done to prevent such personal tragedies is warranted. This measure is very thorough and highlights the need to provide targeted outreach, mandatory training, and peer counseling for veterans who may be at risk. We commend the Committee for its efforts on addressing this very difficult issue.

Likewise, DAV is pleased to support S. 994, the Disabled Veterans Fairness Act. DAV has a longstanding resolution supporting repeal of the beneficiary travel reimbursement deductible for service-connected veterans and to increase travel reimbursement rates. The lack of travel reimbursement can act as a barrier to gaining essential health care for sick and disabled veterans. S. 994 offers a fair and equitable resolution to this problem. We would recommend, however, that the Committee authorize funding for VA's travel reimbursement program in an appropriation separate from medical services.

Mr. Chairman, we are also pleased to support S. 1233, the Veterans Traumatic Brain Injury Rehabilitation Act of 2007. We commend you and Senator Craig for working together on this very important issue. This comprehensive measure would enhance and strengthen VA's rehabilitation programs for veterans with severe and moderate traumatic brain injury, or TBI. S. 1233 would help VA to develop the needed expertise, programs, and capacity to meet the lifeline needs of veterans with these devastating injuries.

Finally, Mr. Chairman, I would like to call your attention to S. 815, the Veterans Health Care Empowerment Act. DAV, along with the other veterans service organizations that author the Independent Budget, have already expressed our concerns to the Committee about the potential negative consequences of this bill, if enacted, but let me summarize them again today.

S. 815 would authorize health care for veterans with service-connected disabilities at virtually any private medical facility rather than requiring VA to meet their needs. If this bill were enacted, some service-connected veterans might, in fact, choose private care

in lieu of VA as a personal convenience. But in doing so, they would lose the many safeguards built into the VA system for their benefit. VA is well known for its patient safety program, use of evidence-based medicine, and reliance on the electronic medical record. These unique qualities, along with VA's policies, combine to produce the highest documented quality of care, public or private. We fear loss of these critical safeguards would equate to diminished clinical oversight and coordination of service-disabled veterans' care and ultimately might result in a lower quality of care for those who need it most.

Additionally, VA has to its credit done an excellent job of holding down costs by effectively managing in-house health programs and services. We know this Committee wants to ensure service-disabled veterans have timely access to the best care available. We believe VA can deliver that level and quality of care. We recognize and acknowledge that VA is not always perfect in addressing veterans' needs, but we believe it is working hard to address identified shortcomings. Congress has historically protected VA's specialized medical programs, such as its world renown PTSD, spinal cord injury, amputation, and blind rehabilitation programs. If enacted, this bill may negatively impact those unique programs. For this and other reasons, we cannot support this bill. We do, however, encourage Congress to continue thorough oversight of VA programs and services rather than authorize outsourcing of care as a solution.

That completes my statement. Thank you.

[The prepared statement of Ms. Ilem follows:]

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

Mr. Chairman, Ranking Member Craig and other Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important legislative hearing of the Committee on Veterans' Affairs. DAV is an organization of 1.4 million service-disabled veterans, and along with its auxiliary, devotes its energies to rebuilding the lives of disabled veterans and their families.

You have requested testimony today on fifteen bills primarily focused on health care services for veterans under the jurisdiction of the Veterans Health Administration, Department of Veterans Affairs (VA). While my oral remarks will focus on only those bills about which we are particularly concerned, this statement reviews our position on all of the proposals before you today. The comments are expressed in numerical sequence of the bills, and we offer them for your consideration.

S. 117—LANE EVANS VETERANS HEALTH AND BENEFITS IMPROVEMENT ACT OF 2007

S. 117 would establish eligibility for a mental health evaluation on demand by any veteran who served on or after September 11, 2001, and would require VA to provide that evaluation within 30 days of its request. It would also establish eligibility for these veterans for hospital, outpatient and nursing home care, and for marital and family counseling, for a 2-year period from commencement of such services. Remaining sections of the bill would require a series of data gathering and reporting by the Secretaries of Veterans Affairs and Defense, of the populations of active duty personnel and veterans defined in the bill as "Global War on Terror" veterans—essentially those who have served in a number of theaters of war, conflicts and other deployments since September 11, 2001.

DAV is generally supportive of any effort to improve access to care for sick and disabled veterans. Also, accurate data to aid understanding of these populations' needs by the agencies responsible for their care is beneficial in any population that benefits from Federal programs. Nevertheless, some of the emphases of this bill seem problematic. The bill would require a comprehensive medical and mental health evaluation by a qualified professional within thirty days of request. We appreciate the intent of the provision to secure timely assessments, but based on our

review of VA's general efforts to meet its workload requirements within those constraints, it is doubtful VA could routinely meet this requirement within available resources.

With respect to the data gathering and reporting requirements of the bill, we believe thousands of staff hours and millions of dollars for other support likely would be necessary to enable VA and DOD to comply with these requirements, assuming they would be able to comply. Also, some of the reporting cycles in the bill would be highly challenging for both agencies to meet, given the amount of work the bill would require to assemble the databases that would reveal those facts. Since these new requirements would need to be accomplished from within available funding, this bill troubles us. We ask the Committee to further study the proponent's goals to see if other approaches may be fashioned to produce the desired results sought.

S. 383—A BILL TO EXTEND THE PERIOD OF ELIGIBILITY FOR HEALTH CARE FOR COMBAT SERVICE IN THE PERSIAN GULF WAR OR FUTURE HOSTILITIES, FROM 2 YEARS TO 5 YEARS AFTER DISCHARGE OR RELEASE

Servicemembers after having served in combat theaters often experience unique health care challenges related to military service. Therefore, the DAV believes these brave men and women deserve open access to the unique and specialized services provided by VA. This bill would help ensure that our newest generation of combat veterans returning from Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) gains access by extending the period of eligibility for VA health care services and programs.

The members of our most recent National Convention in Chicago, Illinois, passed Resolution No. 217 supporting legislation to extend the period of eligibility for free health care for combat veterans for conditions potentially related to their combat service from 2 years to 5 years after military service. Especially in regard to mental health sequalae related to combat exposure, veterans may not recognize within the current 2-year window allowed that they need VA services. This bill gives such veterans and their families the benefit of the doubt and is in the best spirit of supporting veterans' needs without pre-judging or shortchanging them. Therefore, the DAV proudly supports this measure and looks forward to its enactment.

S. 472—A BILL TO AUTHORIZE A NEW MAJOR MEDICAL FACILITY PROJECT IN DENVER, COLORADO, IN THE AMOUNT OF $523 MILLION

S. 472 would authorize a major medical facility project in Denver, Colorado. The DAV has no resolution from its membership concerning this issue; however, we would not oppose the enactment of this bill.

S. 479—THE JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT

S. 479 would establish a broad based suicide prevention initiative in the VA. We support the goals of this bill and are pleased to endorse it. We do ask that the Committee consider modifying the bill to make clear that the suicide prevention programs the bill would establish are intended to be applied to programs within the Department and for veterans who are enrolled in VA health care under section 1705 of Title 38, United States Code, and to veterans otherwise in close contact with other programs of the Department (i.e., the Veterans Benefits Administration regional offices, the Readjustment Counseling Service Vet Centers, etc.). We do not believe the bill is intended to be applied to all veterans, irrespective of their circumstances.

S. 610—A BILL TO ESTABLISH JANUARY 23, 2002, AS THE EFFECTIVE DATE OF THE MODIFICATION OF TREATMENT FOR RETIREMENT ANNUITY PURPOSES OF PART-TIME SERVICE PERFORMED BEFORE APRIL 7, 1986, BY VA NURSES, PURSUANT TO THE VA HEALTH CARE PROGRAMS ENHANCEMENT ACT OF 2001

S. 610 would retroactively authorize full-time work credits for Federal retirement purposes for VA registered nurses who worked part-time and retired from active service prior to April 7, 1986. This bill would address the opinion of the Office of Personnel Management that a prior act of Congress failed to establish clear policy that these nurses be included in Congressionally mandated service recalculations for part-time VA nurses. Although these particular VA nurses retired long ago, in equity DAV believes these individuals, who provided vital services to sick and disabled veterans during their professional careers, deserve this benefit as accorded to other VA part-time nurses at that time. We applaud the sponsor's efforts to champion this cause for this small group of VA retirees.

S. 692—THE VA HOSPITAL QUALITY REPORT CARD ACT OF 2007

S. 692 would establish a "hospital report card" covering a variety of activities of hospital care occurring in the medical centers of the Department. Validation of the delivery of high quality care to service-disabled veterans is important. Therefore, we support this bill. We believe that veterans under VA care have the same rights as private sector patients to review the quality and safety of the care they receive while hospitalized. We do note, however, that the purposes of this bill do not cover the grand majority of overall patient care workload in VA health care, namely primary (outpatient) care and extended care services provided in VA's nursing home care units and its various contracted programs. Nevertheless, this is a good bill and one that is supported by DAV. We do note for the Committee's purposes, that the term "VA hospital" was supplanted by the term "VA medical center" in prior legislation. You may wish to consider conforming this bill accordingly, should the Committee decide to approve and report it.

S. 815—THE VETERANS HEALTH CARE EMPOWERMENT ACT OF 2007

This measure, which seeks to provide health care benefits to veterans with service-connected disabilities at virtually any private medical facility, raises a number of concerns for the DAV. We and several other veterans service organizations sent a letter describing our concerns about this measure, which I will outline.

While well intentioned, this measure could result in a series of potential unintended consequences chief of which is the diminution of established quality, safety and continuity of VA care, as well as to rekindle debate on the so-called "Medicare subvention" policy proposal that Congress and the Administration have been unable to resolve in 10 years.

It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the special needs of combat wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans from those programs. The VA's medical and prosthetic research program, designed to study and hopefully cure the ills of disease and injury consequent to military service, would lose focus and purpose were service-connected veterans no longer present in VA health care. Additionally, Title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104–262 was enacted.

In light of the escalating costs of health care in the private sector, VA has, to its credit, done an excellent job of holding down costs by effectively managing its in-house health programs and services for veterans. While as a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

An additional possible consequence if this measure were enacted would be to most likely shift care for service-connected veterans from discretionary to mandatory spending. While we are devoted to proposals that Congress move VA health accounts into the mandatory funding arena, we could not support a bill that would move VA from a primary provider of health care to an insurer, even if funding for that function were made mandatory.

We believe that mixing complex chronically ill service-disabled veterans with other veterans in VA care creates a needed critical mass and properly balanced case mix. A diverse case mix with the variety of acute and chronic clinical patients that motivates excellence in the academic health center environments cements solid relations between those tertiary VA facilities and their health professions schools—another guarantor of quality of care.

We know this Committee wants to ensure service disabled veterans have access to the best care available. We believe VA can deliver that level of care. We recognize that VA is not always perfect, but we believe VA is working hard to address its shortcomings and in the long term offers the highest quality care available to veterans with special needs. If there are problems with VA care we would encourage

VA to address these problems and for Congress to support critical oversight of programs and services, rather than recommending outsourcing of care as a solution.

S. 874—THE SERVICES TO PREVENT HOMELESSNESS ACT OF 2007

S. 874 would direct the VA to provide financial assistance for supportive services for very low-income veterans' families in permanent housing. Under the bill VA would provide grants to certain eligible entities such as private nonprofit organizations or consumer cooperatives to provide various supportive services.

Funding for the supportive services would be taken from amounts appropriated to the VA for medical care. Amounts would be $15 million for Fiscal Year 2008; $20 million for Fiscal Year 2009; and, $25 million for Fiscal Year 2010.

The DAV statement of policy specifies that we will not oppose legislation unless it is evident that it will jeopardize benefits for service-connected disabled veterans. As such, while we support the intent of the bill to better address homeless veterans' needs, and to help them move toward independent living, we would strongly oppose offsetting the costs associated with S. 874 against other vital VA health care programs. Also, with regard to the health care and counseling services this bill would provide, we are concerned that as well-intentioned as it may be, that a grant under which health care services would be provided by private providers versus VA providers raises questions about cost, quality, continuity and safety similar to our views on other proposals with these goals.

S. 882—A BILL TO REQUIRE A PILOT PROGRAM ON THE FACILITATION OF THE TRANSITION OF MEMBERS OF THE ARMED FORCES TO RECEIPT OF VETERANS HEALTH CARE BENEFITS UPON COMPLETION OF MILITARY SERVICE

This measure seeks to ensure that military servicemembers receive a continuity of care and assistance in and after the transition from military service to veteran status. Specifically, this bill would require the VA to conduct a 5-year pilot program to assess the feasibility and advisability of awarding grants to "eligible entities" to assist transitioning military servicemembers, particularly those with serious wounds, injuries, or mental disorders, women members, and members of the National Guard and Reserves, in applying for and receiving VA health care benefits and services.

Further, this bill requires at least one location of the pilot program to be in the vicinity of: (1) a military medical treatment facility that treats OIF/OEF servicemembers who are seriously wounded; (2) a VA medical center located in a rural area; and (3) a VA medical center located in an urban area.

The DAV believes that both VA and DOD have complementary and critical roles in ensuring servicemembers and returning combat veterans scheduled for discharge, receive prompt, comprehensive quality care and services from each agency; however, there remains a clear need for additional services and better coordination for transitioning servicemembers from military to veterans status and reintegration into the community as a productive member of society. However, DAV has no resolution on this issue, and does not accept grants from the U.S. Government.

S. 994—THE DISABLED VETERANS FAIRNESS ACT

S. 994 would make significant changes to the VA beneficiary travel program, authorized under section 111 of Title 38, United States Code. The VA beneficiary travel program is intended by Congress to assist veterans in need of VA health care to gain access to that care. As you are aware, the mileage reimbursement rate is currently fixed at eleven cents per mile, but actual reimbursement is limited by law with a $3.00 per trip deductible capped at $18.00 per month. The mileage reimbursement rate has not been changed in 30 years, even though the VA Secretary is delegated authority by Congress to make rate changes when warranted. The law also requires the Secretary to make periodic assessments of the need to authorize changes to that rate. Unfortunately, no Secretary has acted to make those changes, despite the obvious need to update the rate of reimbursement to reflect rises in travel and transportation costs.

In 1987, the DAV, in coordination with VA's Voluntary Service Program, began buying and donating vans to VA for the purpose of transporting veterans for outpatient care. Since that time, the DAV National Transportation Network has formed a very significant and successful partnership with VA and DAV. We have donated almost 1,800 vans to VA facilities at a cost exceeding $20 million. These vans and their DAV volunteer drivers and medical center volunteer transportation coordinators have transported nearly 520,000 veterans over 388 million miles. We plan to continue and enhance this program, not only because the VA beneficiary travel rate is so low, but also we have found our transportation network serves as a truly vital

link between veterans and crucial VA health care. Its absence would equate to the actual denial of care for many eligible veterans.

DAV has a long-standing resolution (Resolution No. 212) supporting repeal of the beneficiary travel pay deductible for service-connected veterans and to increase travel reimbursement rates for all veterans who are eligible for reimbursement. We believe S. 994 offers a fair and equitable resolution to this dilemma about which we have been concerned for many years. We urge this Committee to approve and enact legislation this year to reform the VA beneficiary travel program. Bringing reimbursement rates into line with those paid to Federal officials and Federal employees, is a fair resolution.

Mr. Chairman, given the situations and dislocations of the families of severely injured veterans of OIF/OEF who now are in VA facilities for long-term rehabilitation, DAV hopes Congress also will address and appropriate funding consistent with enabling the immediate family members of these several hundred veterans to be reimbursed their travel and lodging expenses while their loved ones remain incapacitated. These families are suffering greatly and are making extreme sacrifices in relocating to be close to their loved ones, often far from home, without good accommodations, and without any authorized reimbursement for their expenses. We believe consideration of some relief, even if temporary, is warranted.

S. 1026—A BILL TO DESIGNATE THE VA MEDICAL CENTER IN AUGUSTA, GEORGIA, AS THE "CHARLIE NORWOOD DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER"

S. 1026 would name the VA medical center in Augusta, Georgia, as the Charlie Norwood Department of Veterans Affairs Medical Center. The DAV has no resolution from its membership concerning this issue; however, we would not oppose the enactment of this bill.

S. 1043—A BILL TO REQUIRE THE SECRETARY OF VA TO SUBMIT A REPORT TO CONGRESS ON PROPOSED CHANGES TO THE USE OF THE WEST LOS ANGELES, CALIFORNIA, VA MEDICAL CENTER

S. 1043 would require the VA to submit a report to Congress on proposed changes to the use of the West Los Angeles Department of Veterans Affairs Medical Center in California. Since this deals with a local matter, we do not have a resolution on this issue.

S. 1147—HONOR OUR COMMITMENT TO VETERANS ACT

This bill would legislatively moot Title 38, section 1705, thereby rescinding the Secretary's authority to establish and operate a system of annual enrollments for VA health care, and it would make every American veteran entitled to enrollment for VA health care on request. Over 1,000,000 veterans have unsuccessfully attempted to enroll in VA health care since the cutoff of new enrollments for Priority 8 veterans occurred in 2003. While we certainly support the proponent's premise that every veteran who wants it should be able to enroll in VA health care, without a major infusion of new funding, enactment of this bill would worsen VA's financial situation, not improve it, and would likely have a negative impact on the system as a whole. We recommend the Committee defer action on this bill until after Congress enacts mandatory, guaranteed or assured funding for VA health care.

S. 1205—A BILL TO REQUIRE A PILOT PROGRAM ON ASSISTING VETERANS SERVICE ORGANIZATIONS AND OTHER VETERANS GROUPS IN DEVELOPING AND PROMOTING PEER SUPPORT PROGRAMS THAT FACILITATE COMMUNITY REINTEGRATION OF VETERANS RETURNING FROM ACTIVE DUTY, AND FOR OTHER PURPOSES

This bill would establish a pilot grant program with veterans service organizations, and other organizations, to provide "navigators" to aid veterans in obtaining the VA health care services they need. While we appreciate the sponsor's intention to provide veterans service organizations more means to outreach to and provide veterans greater opportunity to reintegrate after serving their deployments, DAV does not accept grants from the U.S. Government.

Our programs are operated by the generosity of private donors and through paid memberships by our members and their families. DAV already employs a cadre of 260 National Service Officers, whose job is to outreach to veterans in every community. Also, DAV has an army of volunteers on the ground in VA health and benefits offices and working in our National Transportation Network nationwide. Our DAV members and volunteers are in touch with literally millions of veterans to help raise awareness about VA benefits and services.

Mr. Chairman, we commend your efforts in crafting S. 1233. The provisions of S. 1233 would greatly enhance and strengthen VA's rehabilitation program for veterans with severe and moderate Traumatic Brain Injury (TBI). TBI is a life-altering and devastating injury. Even with the best of care and the most seamless transition back to home, TBI can disrupt and test the resources of even the most resilient and financially secure families.

The consequences of TBI usually involve a range of disabilities and symptoms, which are often not clearly delineated. Indeed, the International Classification of Diseases and Health Problems, commonly known as ICD, does not list a single code for TBI but does contain codes for many of the common consequences of TBI, such as epilepsy. The neurological, cognitive, and behavioral changes due to TBI are complex, varied, and diverse and may change in severity or develop over time. Longer-term neurological problems often include movement disorders, seizures, headaches, and sleep disorders. Common residual cognitive problems include memory, attention and concentration impairments. Depending on the area of the brain injured, judgment, planning, problem-solving and other executive functioning skills may also be impaired. Visual perception problems and language impairments are usual but often go undiagnosed. Prevalent behavioral issues include personality changes, aggression, agitation, learning difficulties, shallow self-awareness, altered sexual functioning, impulsivity, and social dis-inhibition. Many individuals self-medicate with alcohol to deal with the dis-inhibitory symptoms and disruption to their sleep cycle.

S. 1233 would take many significant steps to ensure that veterans with TBI receive high quality rehabilitation in their communities and to encourage VA to develop the needed expertise and capacity to meet the lifelong needs of veterans with this injury. Therefore, DAV supports this bill.

Rehabilitation and Community Reintegration Plan

Section 3 of the bill would require VA providers to develop and implement a detailed comprehensive multidisciplinary and individualized rehabilitation and community reintegration plans. This plan would be based upon an assessment, and periodic reassessment, of the physical, cognitive, vocational, and psychosocial impairments of veterans and the family support needs of veterans after discharge from inpatient care.

It is appropriate that the individualized plan be developed and discussed with the injured veteran and his or her family, to the maximum extent feasible, before the veteran is discharged from inpatient acute rehabilitation. This provision would be empowering for veterans and their families and could help improve rehabilitation outcomes.

Section 3 also would give veterans and their families the option to trigger a review of the rehabilitation and reintegration plan and its implementation. Affording an injured veteran, and in cases of incapacity, family members or guardians, with an opportunity to request a review of the rehabilitation plan would ensure that veterans and families, have a systemic way to maximize an injured veteran's functioning.

In developing a rehabilitation plan for an active duty servicemember, S. 1233 would require VA providers to collaborate with Department of Defense (DOD) providers. We support the clear objective of this provision to address a significant vulnerability in injured active duty servicemembers must navigate a labyrinth to receive continued post-acute rehabilitative care from VA, with DOD approval. Implicit in the provision is the promise that collaboration would prompt each agency to address any challenges in coordinating the delivery of services before the servicemember is transferred.

Access to High Quality and Community Based Rehabilitative Services

Section 4 of S. 1233 would require the VA to implement the individualized rehabilitation plan through non-VA providers in situations where VA lacks the capacity to provide the intensity of required care or the distance from the veteran's home to a VA facility renders treatment infeasible. The provision also requires that non-VA providers be accredited by an independent peer-review program for specialized TBI programs. This provision clarifies that veterans have a right to community based rehabilitation, but only when VA cannot provide the care and when the non-VA provider is accredited.

We support the two key implied presumptions in this provision; (1) that the VA must have the capacity to be the provider of choice and (2) that proximity to care is a key component to ongoing rehabilitation and community reintegration.

We support the implicit goal of this bill to give VA an incentive to develop its capacity to provide high quality care. VA's four lead Polytrauma Rehabilitation Centers have achieved and maintained, without qualification, accreditation from the Commission on the Accreditation of Rehabilitation Facilities for acute inpatient TBI rehabilitation program but not a single VA facility has achieved accreditation for outpatient, home-based, residential or community based TBI rehabilitation. We urge this Committee to encourage VA to seek such accreditation at Level II and Level III polytrauma sites.

Research, education, and clinical care program on TBI

Sections 5 and 8 of S. 1233 would expand VA's TBI research, education and clinical programs. Section 5 would give VA providers, in collaboration with the Defense and Veterans Brain Injury Center, the incentive to conduct innovative research and intensive treatment to increase the functioning of such veterans with severe TBI, who are minimally conscious. While the number of veterans in this population is small, it is imperative that we care for these very vulnerable veterans. This proposed program for intensive neuro-rehabilitation is highly commendable.

Because the screening, diagnosis and treatment of mild or moderate TBI is so significant we would urge the Committee to address the issue of education on this issue in a separate and more expansive provision. We would welcome the opportunity to work with the Committee to discuss ways to enhance VA's current screening program, to establish a VA TBI registry which would include OEF/OIF veterans at risk for TBI, to develop outreach programs to target veterans with mild TBI, and identify effective treatments for veterans with mild TBI.

Section 8 also improves VA's research program on two prevalent conditions which result from TBI, seizures and visually related neurological conditions, by encouraging the VA to use its research programs to study the diagnosis, treatment and prevention of these conditions. The proposed provision also leverages the expertise of federally funded model TBI treatment systems by requiring the VA to collaborate with these academic and non-VA based programs. We support this provision and also support expanding VA's capacity to diagnose and treat veterans who develop epilepsy. Given our understanding of the relationship between TBI and epilepsy, we believe VA needs a national program for epilepsy care, and we encourage the Committee to support the revitalization of VA Epilepsy Centers of Excellence.

Expanding Residential and Long-term Care Options for Veterans with TBI

Section 6 of S. 1233 would establish a 5-year pilot TBI assisted living program to assess the effectiveness of assisted living programs in enhancing the rehabilitation, quality of life and community integration of veterans with TBI. The provision also ensures that VA continues to provide case management for the care of these veterans. We support this provision, since it will help veterans with TBI to have more independent lives in their communities. In that connection, we call your attention to the July 2004 VA report to Congress in response to Public Law 106–117, The Veterans Millennium Health Care and Benefits Act, which authorized VA to establish a pilot program to determine the "feasibility and practicability of enabling veterans to secure needed assisted living services as an alternative to nursing home care." We believe veterans suffering from mild-to-moderate TBI, as well as their families, would benefit from assisted living arrangements. We also believe the report to Congress in 2004 validated an important role for assisted living facilities in VA long term care.

Section 7 would require VA to provide age-appropriate nursing home care for younger veterans who need such care. While it is our hope that the number of young veterans who are so disabled by TBI as to require nursing home care is small, we applaud the Committee for ensuring that these disabled veterans have care that is consistent with their needs.

Other Issues in Need of Legislative Action

S. 1233 is an important bill which takes significant and bold steps toward improving access and quality of care for veterans with TBI. As the Committee moves forward during this Congress to continue its oversight and legislative efforts in the area of TBI we would welcome the opportunity to work with the Committee on the following areas:

- Ensuring all enrolled (new and established) OIF/OEF veterans are screened, assessed and treated for their mild or moderate TBI.
- Expanding vocational rehabilitation programs for veterans with TBI.
- Development of specialized substance use disorder programs to help veterans with TBI who self-medicate.

• Develop specialized outreach and education programs related to TBI for members of the National Guard and Reserves.
• Developing an independent patient advocacy system for veterans with TBI.
• Development of support programs to help families of veterans with TBI.

Mr. Chairman, again, the members and auxiliary of DAV appreciate being represented at this hearing today, and I appreciate being asked to testify on these bills. I will be pleased to respond to any of your or other Members' questions.

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

Ms. Middleton?

STATEMENT OF SHANNON MIDDLETON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Ms. MIDDLETON. Mr. Chairman and Members of the Committee, thank you for this opportunity to present the American Legion's views on the several pieces of legislation being considered by the Committee today. The American Legion commends the Committee for holding a hearing to discuss these very timely and important issues. I will address just a few of the bills in my comments.

The American Legion supports the intent of S. 117, the Lane Evans Veterans Health and Benefits Improvement Act of 2007. Specifically, the American Legion is in support of tracking veterans who serve in the Global War on Terror in a new database. This bill will make data on these veterans more accessible upon request and these veterans require their own tracking system since the exposures and experiences they encounter are different from veterans of the First Gulf War. They have experienced more combat time, multiple deployments, continuous urban warfare, and blast traumas. Also, more women have participated. Differentiating veterans who served in OIF and OEF, those who served in both, and those who served in neither will also be important when anticipating long-term health effects.

S. 479, the Joshua Omvig Veterans Suicide Prevention Act, seeks to reduce the incidence of suicide among veterans. This bill contains very important components that will likely mitigate the incidence of suicide among veterans by promoting outreach to educate veterans and their families about available services, making services available on a continuous basis, and training VA employees on suicide prevention.

Family education and outreach is significantly important, since family members may notice changes in the veterans before anyone else. When the family and the veteran know what services are available, it is easier to seek assistance. It is even more important that VA ensures that these veterans gain access to mental health services when they need them.

Designating a point of contact at each VA medical facility that will work with local emergency rooms, law enforcement, local mental health organizations, and veterans service organizations will make mental health coordination easier and timely. Outreach into those who will provide support to veterans and making the community more aware of VA's mental health services will also facilitate the goals of research and help to establish best practices.

S. 1147, Honor Our Commitment to Veterans Act, seeks to lift the health care enrollment restriction on Priority Group 8 veterans that has been instituted since 2003. The American Legion opposes

any decision to deny enrollment to any eligible veteran. A more efficient method of ensuring that VA can continue to provide quality care to veterans would be to ensure that VA is sufficiently funded to care for their needs, not limiting access for those who have incomes that fall above means test thresholds. The American Legion supports the lifting of the current health care enrollment restriction for Priority Group 8.

The American Legion supports the provisions of S. 1233, the Veterans Traumatic Brain Injury Rehabilitation Act of 2007. Among other things, the bill mandates that VA establish a research, education, and clinical care program to address severe traumatic brain injury. This is a very important component in providing the best quality of care for those who suffer from this type of injury. Since not much information is available on long-term effects of combat-related traumatic brain injury, research on the current war's veterans will be beneficial in establishing standards of care provided to veterans.

The American Legion supports research that would improve care available for veterans with service-connected injuries and that would attempt to ascertain possible secondary health outcomes. Since many of the symptoms of secondary conditions have delayed onset or have subtle manifestations, research on improving the diagnosis, treatment, and prevention on traumatic brain injury will ensure the best quality care for future generations of combat veterans.

Again, thank you, Mr. Chairman, for giving the American Legion this opportunity to present its views on such important issues. We look forward to working with you and the Committee to enhance the access to quality health care for all veterans.

[The prepared statement of Ms. Middleton follows:]

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

PREPARED STATEMENT OF SHANNON MIDDLETON, DEPUTY DIRECTOR FOR HEALTH, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

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

S. 117, THE LANE EVANS VETERANS HEALTH AND BENEFITS IMPROVEMENT ACT OF 2007

The American Legion supports the intent of S. 117. Specifically, The American Legion is in support of tracking veterans who serve in the Global War On Terrorism (GWOT) in a new database. This bill would make data on these veterans more accessible upon request. GWOT veterans require their own system, since the exposures and experiences they encountered are different from veterans of the first Gulf War. GWOT veterans experience more combat time, multiple deployments, continuous urban warfare, blast traumas and more women have participated. The veterans of the 1991 Gulf War experienced widespread oil well fires, possible nerve agent exposure and a shorter combat time.

This bill also addresses the need to differentiate veterans who served in OIF and OEF, those who served in both and those who served in neither. The environmental exposures may differ and the combat experiences may differ. The American Legion suggests that under the Health, Counseling and Related Benefits section (section 3), the conditions should also be tracked according to whether the veteran served in OIF, OEF or both or in neither—not just by inpatient outpatient status. This would demonstrate trends in illnesses developing among the groups. It should also show a breakdown by gender to determine if there are manifestations of illnesses specific to each gender, i.e., birth defects or developmental disorders in their offspring.

S. 383, A BILL TO EXTEND THE PERIOD OF ELIGIBILITY FOR HEALTH CARE FROM TWO YEARS TO FIVE YEARS AFTER DISCHARGE OR RELEASE

The American Legion has no official position on extending the period of eligibility for healthcare for combat veterans after discharge or release. However, past combat experiences—to include the Vietnam War and the Gulf War—demonstrated that many ailments have delayed manifestation and may be difficult to associate with military service years later. Extending the eligibility period would increase the likelihood that subtle symptoms of combat-related ailments would be detected by professional who have the expertise to recognize the relationship between the veteran's combat experience and symptoms that manifest later.

S. 472, A BILL TO AUTHORIZE A NEW MAJOR MEDICAL FACILITY PROJECT IN DENVER, CO

Although The American Legion has no official position on this proposal, we believe that VA should do everything in its power to improve access to its health care benefits.

S. 479, THE JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT

This bill seeks to reduce the incidence of suicide among veterans. It contains very important components that will likely mitigate the incidence of suicide among veterans by promoting outreach to educate veterans and families about available services, making services available on a continuous basis and training VA employees on suicide prevention.

Family Education and Outreach is significantly important, since family and friends may notice changes in the veteran's mental health first. The American Legion receives contact from veterans themselves who openly admit they need immediate help because of thoughts of harming themselves. When the family and the veteran know what services are available, it is easier to seek assistance. It is even more important that VA ensures that these veterans gain access to mental health services when they need them.

Designating a point of contact—like a suicide prevention counselor—at each VA medical facility that will work with local emergency rooms, law enforcement, local mental health organizations and veterans service organizations will make mental health coordination easier and timely.

Outreaching to those who provide support to veterans and making the community more aware of VA's mental health services will also facilitate the goals of research and establishing best practices. The more veterans seek VA care, the more research opportunities VA will have to develop strategies to enhance prevention mechanisms.

S. 610, A BILL TO ESTABLISH JANUARY 23, 2002, AS THE EFFECTIVE DATE OF THE MODIFICATION OF TREATMENT FOR RETIREMENT ANNUITY PURPOSES OF PART-TIME SERVICE PERFORMED BEFORE APRIL 7, 1986, BY VA NURSES, PURSUANT TO THE VA HEALTH CARE PROGRAMS ENHANCEMENT ACT OF 2001

The American Legion has no position on this issue.

S. 692, THE VA HOSPITAL QUALITY REPORT CARD ACT OF 2007

This bill seeks to establish the Hospital Quality Report Card to ensure quality measures data on VA hospitals are readily available and accessible.

The state of VA health care/medical facilities are an important issue for The American Legion. Each year the organization is mandated by resolution to conduct a series of site visits to various VA medical facilities and submit a report to the President, Congress and the VA.

The bill is similar in scope to our report—A System Worth Saving. Periodic assessments would enable VA to get a clearer picture of its system-wide needs and assist lawmakers in determining adequate funding for the VA health care system.

S. 815, THE VETERANS HEALTH CARE EMPOWERMENT ACT OF 2007

This bill seeks to provide health care benefits to veterans with service-connected disabilities at non-VA medical facilities that receive payments under the Medicare program or the TRICARE Program. Although The American Legion has no official position on this issue, we believe that veterans should receive their medical care from the VA—except when there is very limited access to VA health care, as in the case of rural veterans.

S. 874, THE SERVICES TO PREVENT HOMELESSNESS ACT OF 2007

The American Legion would like to submit its views on this bill for the record at a later date.

S. 882, A BILL TO REQUIRE A PILOT PROGRAM ON THE FACILITATION OF THE TRANSITION OF MEMBERS OF THE ARMED FORCES TO RECEIPT OF VETERANS HEALTH CARE BENEFITS UPON COMPLETION OF MILITARY SERVICE

This bill would establish a pilot program for facilitating the receipt of VA health care benefits for those separating from the military. The American Legion supports efforts to assist servicemembers with transitioning to VA and accessing their veteran benefits. The bill—which targets the severely injured, women veterans, rural veterans, the National Guard and Reserves, and those with mental health conditions—may improve access to timely care for many who would otherwise face difficulty receiving coordinated care.

Services offered by veterans service organizations can enhance the ability of the "Veteran Navigator," since they are linked to the communities and provide other means of assisting veterans. For instance, The American Legion has a program designed to assist severely injured servicemembers reintegrate into their communities by linking veterans and their families to local resources to address many of their needs.

S. 994, THE DISABLED VETERANS FAIRNESS ACT

This bill seeks to eliminate the deductible and to change the method of determining the mileage reimbursement rate under the beneficiary travel program administered by the Secretary of VA in an effort to increase it to the rate authorized for government employees on official business.

Although The American Legion has no official position on the beneficiary travel program, we have historically supported an increase in the mileage reimbursement rate paid to veterans for travel to medical appointments. It is currently 11 cents and has not increased since 1978. With the rising cost of gas, this rate presents a hardship for veterans who have to travel long distances for their appointments. The American Legion has encountered many veterans over the years who expressed frustration, anger, and desperation due to financial strain caused by accommodating this inadequate reimbursement rate.

S. 1026, A BILL TO DESIGNATE THE VA MEDICAL CENTER IN AUGUSTA, GA, AS THE "CHARLIE NORWOOD DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER"

The American Legion has no position on this initiative.

S. 1043, A BILL TO REQUIRE THE SECRETARY OF VA TO SUBMIT A REPORT TO CONGRESS ON PROPOSED CHANGES TO THE USE OF WEST LA VA MEDICAL CENTER

The American Legion has no official position on this issue. However, since the issue of land at West LA VA Medical Center has had no resolution for decades, The American Legion would support a mandate requiring VA to submit a master plan detailing its intended utilization of the land.

S. 1147, HONOR OUR COMMITMENT OF VETERANS ACT

In 2003, former VA Secretary Anthony Principi instituted a restriction for enrollment of new Priority Group 8 veterans, therefore, prohibiting access to VA medical care to hundreds of thousands of Priority Group 8 veterans due primarily to limited resources. The American Legion disagrees with the decision to deny access to any eligible veterans.

The American Legion believes that a more effective method of ensuring that VA can continue to provide quality care to veterans would be to ensure that VA is sufficiently funded to care for their needs, not limiting access for those who have incomes that fall above means tests thresholds. These veterans are required to make copayments, in addition to identifying their third-party health insurance that will reimburse VA for reasonable charges. Many of these Priority Group 8 veterans may very well be VA employees, Medicare beneficiaries, TRICARE or TRICARE for Life beneficiaries, or enrolled in the Federal Employees Health Benefits Program. The American Legion supports the lifting of the current prohibition on healthcare enrollment restriction for Priority Group 8 and exploring effective means to improve third-party reimbursement collections.

S. 1205, A BILL TO REQUIRE A PILOT PROGRAM ON ASSISTING VETERANS SERVICE ORGANIZATIONS AND OTHER VETERANS GROUPS IN DEVELOPING AND PROMOTING PEER SUPPORT PROGRAMS THAT FACILITATE COMMUNITY REINTEGRATION OF VETERANS RETURNING FROM ACTIVE DUTY AND FOR OTHER PURPOSES

The American Legion has no position on this issue. However, there is concern that the bill does not mention any standardized training or oversight to ensure that the organizations selected are qualified to provide peer support services.

S. 1233, VETERANS TRAUMATIC BRAIN INJURY REHABILITATION ACT OF 2007

The American Legion supports the provisions of this bill.

Section 3 discusses community reintegration plans for veterans with traumatic brain injury. It requires the Secretary of VA to develop an individualized plan for each veteran to address his or her specific rehabilitation needs. This plan must be available prior to the veteran's discharge for the medical facility. It prescribes for the designation of a case manager who would be responsible for implementing the plan. Identification of a case manager and reintegration plan would ensure that these veterans receive the necessary rehabilitation in a timely manner and provide a contact that could coordinate on behalf of the veterans in the event that the plan needs to be enhanced or amended. It also assigns accountability in the event that the veterans does not receive the care he or she was promised.

Section 4 requires VA to authorize the use of non-VA facilities under very specific conditions: if the VA is unable to provide needed treatment for any reason and if the veteran lives at a distance that would make it difficult to implement the plan. The American Legion believes that it is acceptable for veterans to receive medical care from non-VA facilities in the absence of available VA healthcare, or when traveling presents a hazard or hardship for the veteran.

Section 5 mandates VA establish a research, education, and clinical care program to address severe traumatic brain injury. This is a very important component in providing the best quality of care for those who suffer from this type of injury. Since not much information is available on long-term effects of combat-related traumatic brain injury, research on the current war's veterans would be beneficial in establishing standards of care provided to veterans of future conflicts.

Section 6 discusses the creation of a pilot program to assess the effectiveness of providing assisted living services for veterans with traumatic brain injury to enhance rehabilitation, quality of life and community integration of veterans. This will be especially important in rural areas where there may be a lack of specialty care and veterans may be forced to travel long distances.

Section 7 discusses age-appropriate nursing home care. Younger veterans are generally more technologically advanced. Facilities providing long term care for them should provide an environment that reflects their interests.

Section 8 discusses research on traumatic brain injury. The American Legion supports research that would improve care available for veterans with service-connected injuries and that would attempt to ascertain possible secondary health outcomes. Since many of the symptoms of secondary conditions have delayed onset or have subtle manifestations, research on improving the diagnosis, treatment and prevention on traumatic brain injury will ensure the best quality care for future generations of combat veterans.

Again, thank you Mr. Chairman for giving The American Legion this opportunity to present its views on such an important issue. The hearing is very timely and we look forward to working with the Committee to enhance access to quality health care for all veterans.

Mr. Edelman?

STATEMENT OF BERNARD EDELMAN, DEPUTY DIRECTOR, POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. EDELMAN. Good morning, Mr. Chairman, Senator Murray. Vietnam Veterans of America appreciates the opportunity to testify before you here this morning on behalf of our officers, our Board of Directors, our members, and their families who want to thank you and your colleagues for the work you are doing and the initiatives you are taking on behalf of our Nation's veterans.

This morning, I would like to focus our comments on three bills that we support and endorse and one bill that we have major concerns about.

S. 1147, the Honor Our Commitment to Veterans Act, would reopen the VA health care system to Priority 8 veterans. I think some history is instructive here. Back in 1996, when Congress passed the Veterans Health Care Eligibility Reform Act, the VA was able to implement major cornerstones of its plan to reform how it provided health care. The rationale behind this initiative was to ensure a patient base that would support the infrastructure that was needed to develop a modern, integrated health care system.

This the VA has accomplished, and in the process a mediocre and inefficient system has been transformed into a national model.

However, the law gave the Secretary of Veterans Affairs the authority and indeed the responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding or standard of care, it did establish an annual enrollment process and categorized veterans into priority groups.

In January 2003, as you all know, the Secretary of Veterans Affairs made a decision to temporarily suspend priority veterans from enrolling. This temporary decision is hardly temporary. No VA planning document that we have read accepts or accommodates Priority 8s in the near future.

We strongly urge that this Committee and your colleagues get behind this most important piece of legislation and truly honor the commitment we as a Republic have made to those who have donned the uniform and served our country. Of course, we recognize the bottom line is funding and the funding Congress provides to enable the VA to accommodate those Priority 8 veterans who want to avail themselves of the VA's health care services. We recognize the realities of pay-go, but we hope you will recognize the inherent justice in reopening the VA health care system to those who have earned the right to utilize it. They also will not, we believe, overly burden the system. In fact, it is our understanding that Priority 7 and 8 veterans account for some 40 percent of third-party collections by the VA.

S. 1233, the Veterans Traumatic Brain Injury Treatment Act, would be instrumental in assuring troops afflicted with this debilitating condition that help is there for them. We believe it is a sensible, comprehensive piece of legislation for long-term TBI rehabilitation and it should go a long ways toward healing the wounded from these latest military ventures.

S. 479, the Joshua Omvig Veterans Suicide Prevention Act, attempts to grapple with one of the tragic consequences of war. Too many of our young people whom we have sent off to fight halfway around the globe return markedly different. Some of them, as you know, have taken their lives. This is a tragedy for their family. It is a tragedy for this country. We heartily endorse S. 479.

We have major issues, though, with S. 815, the Veterans Health Care Empowerment Act of 2007, because it has a great potential to undercut the VA health care system and it is simply not worth the risk. If enacted, this bill would effectively erode the VA's ability to service veterans by permitting service-connected veterans to re-

ceive care and medical services for any condition at any hospital or medical facility or from any medical provider eligible to receive payments under Medicare or TRICARE. We do not believe the VA health care system is inefficient or corrupt. It is at a point in time when the VHA is meeting the needs of the veterans it serves.

One out of ten VA health care dollars today goes to clinicians and facilities outside the VA system through what is called fee-basis. The VA is also instituting a scheme called Project HERO, which is the acronym for Healthcare Effectiveness through Resource Optimization. The VA is attempting to get a better handle on the dollars spent by VA medical centers for care provided outside the system. We believe that HERO and S. 815 will only serve to hurt what has developed into one of the best and finest managed-care systems in the world.

Please keep this in mind. The VA's electronic health record system is simply not matched by other public sector or private sector hospitals, clinics, or doctors. If you want to create an administrative nightmare, try to maintain an effective, efficient VA health care system and at the same time let veterans go wherever they wish for their health care. This is only going to create chaos, we believe, and more problems than it solves, and it solves very little.

That concludes my oral testimony. Thank you for the opportunity to speak with you today.

[The prepared statement of Mr. Edelman follows:]

PREPARED STATEMENT OF BERNARD EDELMAN, DEPUTY DIRECTOR, POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Chairman Akaka, Ranking Member Craig, and Members of the Senate Committee on Veterans' Affairs, Vietnam Veterans of America (VVA) appreciates the opportunity to testify before you here today. On behalf of our officers, our Board of Directors, our members and their families, we want to thank you for the important work you are doing, and the initiatives you are taking, on behalf of our Nation's veterans.

We would like to focus our comments this morning on four of the bills up for your consideration that we endorse: S. 117, the "Lane Evans Veterans Health and Benefits Improvement Act of 2007"; S. 479, the "Joshua Omvig Veterans Suicide Prevention Act"; S. 1233, the "Veterans Traumatic Brain Injury Rehabilitation Act of 2007"; and, most assuredly, S. 1147, the "Honor Our Commitment to Veterans Act." And also one bill, S. 815, the "Veterans Health Care Empowerment Act of 2007," that we feel will only serve to undermine the VA health care system.

S. 1147, the "Honor Our Commitment to Veterans Act," would re-open the VA health care system to Priority 8 veterans. These are veterans with an income of less than $28,000 a year who are not afflicted with a service-connected disability and who agree to make a copayment for their health care and prescription drugs.

Back in 1996, when Congress passed the Veterans Health Care Eligibility Reform Act, the VA was able to implement major cornerstones of its plan to reform how it provided health care. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health care system. This the VA has accomplished, and in the process a mediocre, inefficient system has been transformed into a national model.

However, the law—that's Public Law 104–262—gave the Secretary of Veterans Affairs the authority and responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding or a standard of care, it did establish an annual enrollment process and categorized veterans into "priority groups" to manage enrollment.

On January 17, 2003, the Secretary made the decision to "temporarily" suspend Priority 8 veterans from enrolling. While this decision may be reconsidered on an annual basis, every budget proposal from the Administration since has omitted funding for Priority 8 veterans not previously enrolled and has attempted to discourage use by and enrollment of those "higher income" veterans.

Priority 8 veterans are, for the most part, working- and middle-class Americans without compensable disabilities incurred during their military service. In its budg-

et proposal for Fiscal Year 2007, the VA estimated that some 1.1 million of these "higher income" veterans would be discouraged from using their health care system because of an enrollment fee and increased copays for prescription drugs. Thankfully, you in Congress have not let this scheme get much beyond the proposal phase.

We strongly urge that you get behind this most important piece of legislation and truly honor the commitment we have made that honors our veterans. Of course, we recognize that the bottom line is funding—the funding Congress provides—to enable the VA to accommodate those Priority 8 veterans who want to avail themselves of the VA's health care services. We recognize the realities of "pay-go." But we hope you will recognize the inherent justice in reopening the VA health care system to those who have earned the right to utilize it. They will not overly burden the system; in fact, Priority 7 and 8 veterans account for some 40 percent of all third-party collections by the VA.

TBI/Traumatic brain injury suffered by our troops in Afghanistan and Iraq has become so relatively common that its acronym, TBI, is becoming almost as infamous as PTSD. This affliction is not new; it has only been so codified because of the carnage caused by IEDs, improvised explosive devices, and another acronym that has been incorporated into the dialect of war.

It is our understanding that the Administration is going to order the military to screen all returning troops for mild to moderate cases of TBI; those whose brain injuries are more serious are quite obvious to clinicians. S. 1233, the "Veterans Traumatic Brain Injury Treatment Act of 2007," would be instrumental in assuring troops afflicted with this debilitating condition that help will be there for them. It is a sensible, comprehensive piece of legislation for long-term TBI rehabilitation; it should go a long way toward healing the wounded from these latest military ventures.

S. 479, the Joshua Omvig Veterans Suicide Prevention Act, attempts to grapple with one of the unfortunate consequences of war. Too many of our young men and women whom we've sent off to fight halfway around the globe return markedly different. The lingering trauma of things they've experienced haunts them. These memories affect their daily living, and too many succumb to the emotional numbing and hurt. To not support this bill would do a grave injustice to those troops still fighting their demons.

The potential of S. 815, the "Veterans Health Care Empowerment Act of 2007," to harm veterans by undercutting the VA health care system is simply not worth the risk. If enacted, this bill would effectively erode the Veterans Health Administration (VHA) by permitting service-connected veterans to receive hospital care and medical services for any condition at any hospital or medical facility or from any medical provider eligible to receive payments under either Medicare or the TRICARE program. If you want to destroy the VA system, S. 815 is a good start.

We do not believe the system is inefficient or corrupt. It is at a point in time when the VHA is meeting the needs of the veterans it serves. Besides, one out of every ten VA health care dollars today goes to clinicians and facilities outside the VA system, and through a scheme called Project HERO—the acronym for Healthcare Effectiveness through Resource Optimization—the VA is attempting to get a better handle on the dollars spent by VA medical centers for care provided outside of the system. We believe that HERO—and S. 815—would only serve to hurt what has developed into one of the best managed-care systems in the Nation.

And keep this in mind: The VA's electronic health records are not matched by other public sector and private hospitals, clinics, and doctors. If you want to create an administrative nightmare, try to maintain an effective, efficient VA health care system and at the same time let veterans go wherever they wish for their health care. This will only create more problems than it solves, and it solves very little.

As for the other bills under consideration by the Committee today:

- VVA supports wholeheartedly S. 383, which would extend the period of eligibility for VA health care for combat service from two years to five. This is a no-brainer. With a shooting war going on, we have the obligation and responsibility of keeping our promises to those who don the uniform. When they come home, when they leave the military, they need to know that their government hasn't forgotten about them, that as they establish themselves in civilian life they can avail themselves of VA health care.
- We understand that Congress has previously sought to fix a glitch that occurred in calculating the retirement pay for annuitants who worked part-time as VA nurses. S. 610 would accomplish this. VVA has no opposition to this provision.
- S. 692, the "VA Hospital Quality Report Card Act of 2007," would require the VA to provide grades for its medical centers on measures such as effectiveness, safety, timeliness, efficiency, patient-"centeredness" and equity. Health care quality researchers have long thrived trying to objectively define some of these measures. As

this Committee knows, the VA has a number of performance measures it regularly assesses in order to reward its medical center and network directors, among others. Some of these outcomes, such as immunizations for flu, foot care and eye care for diabetics, set the "benchmark" for care in the community. In addition to these internal performance measures, VHA voluntarily submits to Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, and managed care quality review standards.

VVA understands the importance of quality measurement; there is an expression with which we agree, "what's measured, matters." We also agree that VA officials should be held to the highest degree of accountability, and whatever measures are available to allow this to better occur we wholeheartedly endorse. But perhaps before enacting this clearly well intended legislation, which could require significant retooling of quality measurement systems in VA, the Committee should hold a hearing to identify gaps and deficiencies in current performance and quality measurement systems. It would also be useful to understand how report cards would be used and reported to improve VHA processes and performance rewards. Would poor grades be dealt with by changes in management? With more funding? How would good grades be rewarded? Such questions should be addressed before requiring a significant new quality measurement program to be installed.

• VVA understands that S. 874 would pay certain providers for delivering medical care, mental health care, case management and other services to very low-income veterans who have permanent housing. VVA supports efforts to target veterans who may be at risk of becoming homeless, but these individuals are often difficult to identify until it is too late. In addition, funding for VA mental health, in addition to homeless grant and per diem providers, is also already too scarce. VVA supports the addition of this benefit if VA is funded appropriately to provide it without taking resources away from these other programs.

• While the VA Secretary has had the discretion to raise beneficiary travel rates, no Secretary has chosen to do so in decades. The result is an almost meaningless benefit for veterans who seek it. S. 994 would allow the VA to reimburse certain veterans for travel at a rate that the government pays its own employees. That sounds fair to VVA.

• VVA has no objection to S. 1043, under which Congress would require a report on proposed land use changes on the campus of the West LA VA Medical Center.

• S. 1205 would require the VA to develop a pilot program to make grants to veterans service organizations and other veterans groups to develop peer-support groups to assist with veterans' reintegration. As an organization whose creed is "Never again will one generation of veterans abandon another," VVA has expended considerable resources in assisting newly minted veterans as well as some new veterans groups—particularly Veterans of Modern Warfare—in developing a robust program to advocate for their members' needs. We have certainly not done so contemplating financial gain. Assisting veterans' reintegration with peer-support groups is and should be a function of VSOs; organizations should not have to compete for funding for providing veterans' services, which would significantly change the nature of the game.

• Designating the VA medical center in Augusta, Georgia, the "Charlie Norwood Department of Veterans Affairs Medical Center" acknowledges the contributions of a recently deceased Member of Congress who served in the military as well as in the House of Representatives. VVA applauds the spirit and endorses the intent of this bill.

• Additional legislation to enhance the VA's programs for homeless veterans, introduced by Senator Akaka, deserve support, too. It is a national disgrace that so many veterans—upwards of 200,000, according to most estimates—do not have a place to call home. There are many causes of homelessness; in the case of too many veterans, their experiences in combat are likely one of the reasons they have "dropped out" of society and self-medicate with alcohol and other drugs. Furthermore, it is our position that VA Homeless Grant and Per Diem funding must be considered a payment rather than a reimbursement for expenses, an important change that will enable the community-based organizations that deliver the majority of these services to operate effectively.

Per Diem dollars received by service centers are not capable of supporting the "special needs" of the veterans seeking assistance. Currently they are receiving less than $3.50 per hour per veteran that the veteran is onsite. The work of assisting the homeless veterans who utilize these services goes on long after they have left the service center, a center that is providing a full array of services and case management.

These service centers are unique and indispensable in the VA process. In many cases they are the front and first exposure to the VA and VA Homeless Grant and

Per Diem programs. They are the door from the streets and shelters to substance abuse treatment, job placement, job training, VA benefits, VA medical and mental health care and treatment, and homeless domiciliary placement. Veteran-specific service centers are vital in that most city and municipality social services do not have the knowledge or capacity to provide appropriate supportive services that directly involve the treatment, care, and entitlements of veterans. Additionally, since many local municipalities have removed "supportive services" from their HUD Continuums of Care, providing staffing dollars through a VA Homeless Grant and Per Diem staffing grant program, similar to the Special Needs Grant process, to those agencies operating service centers, would allow the service centers to provide these vital services with appropriate level of qualified personnel. Without consideration of staffing grants the result may well be the demise of these critical services centers. Some are currently assisting upwards of 50 veterans a day, with more than 900 individual veterans seeking services annually.

The VA acknowledges this problem exists. It is yet to be specifically identified by them as to how many awarded service center grantees have been affected by either the inability to establish these centers or retain operation because of this very funding issue. If we intend to fully address the issue of veterans who remain on the streets, then we urge you to not make light of this very important element in this bill. It will be especially critical to the new veterans who find themselves in this very disturbing situation of life. They deserve our best efforts.

In addition, as highlighted in the 2006 recommendations made by the Secretary's Advisory Committee on Women Veterans, a survey of homeless women veterans showed that fewer women veterans are seeking services in VA domiciliary settings and residential treatment facilities because of concerns about safety, privacy, and what is a male-dominated environment. Ideally, separate area/space designed for women veterans will support this need. Flexibility in design will allow appropriate utilization of space.

We also advocate that all VA domiciliary settings be evaluated with regard to gender-specific needs related not only to the safety and security, but also to positive therapeutic environments and successful treatment modalities.

This concludes our testimony. VVA is appreciative of having been afforded the opportunity to testify on the merits of these bills. We would be pleased to respond to any questions you might have.

VIETNAM VETERANS OF AMERICA'S VIEWS ON RURAL VETERANS HEALTH CARE

The topic of accessibility to VA medical services for veterans who live in rural areas has been percolating of late. We believe that S. 1146, the "Rural Veterans Health Care Improvement Act of 2007," offers pragmatic solutions to address the problems of access to health care experienced by too many rural veterans. The bill would increase travel reimbursement for veterans who travel to VHA facilities to the rates paid to Federal employees. The current reimbursement rate was established decades ago and does not adequately compensate for the costs of gasoline, "wear and tear" on the vehicle or increased insurance that might be necessary in order to travel to distant medical centers. In the same vein, the grant program for rural veterans service organizations to develop transportation programs could be an innovative way to strengthen community resources that may already assist with veterans' travel needs.

The establishment of centers of excellence for rural health research, education, and clinical activities, another component of this bill, should fill a gap in VA health care and should lead to innovation in long-distance medical and telehealth care. These centers have brought the synergies of clinical, educational and research experts to bear in one site. Such centers have allowed VA to make significant contributions to the fields of geriatric medicine and mental illness. It would require demonstrations of rural treatment models. Demonstrations on treating rural veteran populations would be extremely useful in assessing effective ways to offer health care to individuals who are generally poorer, more likely to be chronically ill, and almost, by definition, more likely to have challenges in access to regular health care.

And establishing partnerships—with the Indian Health Service and with the Department of Health and Human Services—also should add to greater cooperation and collaboration in meeting the needs of rural veterans.

We would caution, however, that we would not like to see these demonstration projects exploring more opportunities to do widespread contracting out of veterans' health care services. Demonstration models should be assessed according to a number of outcomes such as quality of care, cost, and patient satisfaction and the results reported to Congress.

Chairman AKAKA. Thank you very much, Mr. Edelman. I thank all of you.

I would like to ask one question and then ask Senator Murray for any questions she might have. This question is to all of you. While the bills being considered today address very, very different issues, many have a common thread of pushing VA to contract for more and more care in the community. My question to you is, do you each believe that VA care should and can be the very best? When is it desirable for VA to purchase outside care? Mr. Blake?

Mr. BLAKE. Well, I would say the short answer, Mr. Chairman, is yes, it should be and it is the best. We have testified on a number of occasions as it relates to fee-basis, and kind of as a way to quickly address Senator Craig's question earlier about individual veterans who maybe are not able to get a particular kind of service, it has been our contention all along, and we have testified to this also on the issue of rural health care, that the VA has the authority to meet the needs of these veterans if it is not being met within the VA health care system now under their fee basis regulations.

However, we have testified in the past that we don't believe the VA is very judicious in how it applies its regulations. It is overly conservative, if anything, which on its face goes against principally what we believe against contracting out health care. But we also recognize that there are situations where it is absolutely necessary.

Now, doing it on a broader basis is far more problematic in our eyes for reasons that we have outlined here in our testimony and in previous forums.

Chairman AKAKA. Thank you. Mr. Cullinan?

Mr. CULLINAN. Thank you, Mr. Chairman. It is the VFW's contention, as well, that the VA must be maintained as the premier health care provider in the world. Having said that, I would associate myself with something Senator Craig said earlier, that when it comes to the individual needs of veterans in need, by all means, we should take advantage of such things as contract care, fee-basis care, and so forth. Our objection, as you know, with S. 815 was the fact that it was too broad in scope and has the very definite potential of undermining the system. But when it comes to those cases where the care is not accessible or in those instances when the care is—VA is simply unable to provide a certain care modality, then fee-basis contract care is the way to go.

Chairman AKAKA. Ms. Ilem?

Ms. ILEM. I would echo my colleagues' comments, but just add to that that in terms of contracting care, especially for PTSD or some other mental health issue, one of the concerns that we would have is if there is the cultural competence. VA is a unique system. They have done a lot of work in very specialized areas in terms of mental health and combat-related trauma and the most effective treatments. And so at all times, whenever possible, we want VA to provide that care because we feel they are the very best, and as Dr. Cross pointed out, as well, within traumatic brain injury, the unique setting is that these veterans have a polytrauma, often other very severe injuries associated with their brain injury which the private sector likely hasn't seen, as well, and they are very complicated cases.

But in individual cases, if VA is unable to provide that care for some reason, you know, certainly we want veterans to get access to that care. We just don't want that to be—we want the VA to take primary responsibility. If there is a problem with a veteran in getting some type of care or they are not doing a good job, that issue should be addressed and it should be maintained within the system. VA should be responsible for that care and continue that lifetime relationship with that patient who will ultimately be responsible for their care, most likely. Thanks.

Chairman AKAKA. Ms. Middleton?

Ms. MIDDLETON. Yes, sir. Well, I will have to echo all three of my colleagues. The American Legion also believes that when absolutely necessary, care should be provided by non-VA health care providers in the community, and that is in the case of maybe rural veterans or in the case where travel for the veteran might present a danger to him. If coordinating care might be just complicated because of the special needs of the veteran, then non-VA care would be appropriate. But we, as I said, echo the other VSOs that it should be provided by the VA. They are the people who can provide the best quality care for those who have military-related injuries.

Chairman AKAKA. And Mr. Edelman?

Mr. EDELMAN. Yes, sir. I will associate our position with that of my colleagues here. There is a need for fee-basis care when the care cannot be provided by VA, particularly for individual veterans' needs, particularly for rural veterans. We have no problem with that, nor should we. At the same time, the integrity of the VA health care system, which we have all worked to buildup over these past several years, should not be undermined by indiscriminate use of fee basis or outsourcing of contract care.

Chairman AKAKA. Thank you very much.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman. I just have a couple of questions.

One of them is on a bill that we were not able to get on the calendar today but it has to do with veterans who live in rural areas. We heard several Senators talk about the challenges that they face, and last year, we recognized the disparity for our veterans who live in more remote communities with the passage of the Office of Rural Health to put an office within the VA to start looking at how we better implement care and policies for veterans who live in more rural communities. It was a good start. I think much more needs to be done.

And Senator Salazar has introduced legislation, Rural Veterans Health Care Improvement Act, to build on that and to develop some demonstration projects and centers of excellence and a transportation grant program and I just wondered if any of you could comment quickly on whether or not you support that. I know you weren't prepared for it. It is not on the agenda. But I wanted to make sure we were all aware of it.

Mr. CULLINAN. Senator Murray, on behalf of the VFW, we are familiar with that issue and how problematic it really is and we are certainly supportive as described of an initiative which would have VA undertake a look into what can be done.

And the thing I would add to that, and one thing that should be done right away is Senator Tester's bill, which would provide for increased beneficiary travel. That alone would solve the problem for many, many veterans in the——

Senator MURRAY. Right, and I believe that is incorporated in Senator Salazar's legislation, as well.

Does anyone else want to comment on that? Mr. Blake?

Mr. BLAKE. Senator, I think this sounds a lot like a bill that he introduced in the previous Congress and we worked with Senator Salazar's office and made some comments about concerns that we had, particularly as it relates to broader contracting, recognizing that we have concerns there. Having not seen the bill, I won't comment as far as an actual position, but we certainly will work with you and Senator Salazar and all the Members of the Committee to develop the best bill. I mean, we recognize that rural health care is probably one of the most important issues facing this Committee and all of Congress right now and how to address the needs of the men and women who are kind of scattered to the four winds, so to speak.

Senator MURRAY. Well, maybe if I could ask, Mr. Chairman, if I could just get some quick written comments back from all of you on that legislation, that would be great, because I did want to ask one other question on the Priority 8 veterans.

The issue of funding has come up over and over again, and the VA, although they didn't testify to it today, has estimated it to be a cost of over a billion dollars. The Independent Budget estimated it at $366 million. Can anyone comment on why the disparity in that?

Mr. BLAKE. Well, Senator, I don't necessarily know what exactly the disparities would be other than to say that our cost estimate is based on the assumption of needed discretionary dollars, considering that those new Category 8s would also add money into the system through their co- pays and associated fees that may be necessary, whereas I believe the VA's estimate—I believe, I am not absolutely certain—is just an actual total cost for that group of veterans.

Senator MURRAY. It doesn't count into their third-party insurance?

Mr. BLAKE. As I understand it. The other thing to consider is, and I would have to go back and review the budget, the Administration's budget submission from earlier this year, but our dollar figure reflects the fact that although most estimates pinpoint more than a million veterans being denied enrollment since this policy was put into place in 2003, the real factor is that the utilization rate for Category 8 veterans is only about 20 percent.

So you can cost out a cost for the million-plus veterans that would be denied enrollment, but looking back at historically how it has worked out, you would only assume that about 20 percent of those veterans would use the system. So there would be a cost associated with 20 percent of that million-plus veterans. So our cost estimate for the Independent Budget reflects that, as well.

Senator MURRAY. OK. I really appreciate that, and maybe the VA could give us back a response, as well, on that, because that

is a critical issue and I do think we have to really look at the reality of what that would do.

So I appreciate your comment.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

We may have follow-up questions that we will include in the record. I want to thank you all again. You know that we look to you to hear your ideas about our bills and I thank you so much, for what you have testified before us and responded to us will certainly help. Thank you very much.

Now, I would like to call on our third panel to come forward. Our third panel of witnesses to today's hearing is Meredith Beck of the Wounded Warrior Project; Dr. John Booss, representing the American Academy of Neurology; and Jerry Reed, Executive Director of Suicide Prevention Action Network USA.

I thank you all for appearing before the Committee today. You know that your full statements will appear in the record of the hearing.

Meredith Beck, will you please proceed with your statement.

STATEMENT OF MEREDITH BECK, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT

Ms. BECK. Mr. Chairman, thank you for the opportunity to testify before you today regarding pending health legislation. The Wounded Warrior Project is a nonprofit, nonpartisan organization dedicated to assisting the men and women of the Armed Forces, who have been severely injured during the recent conflicts. As a result of our direct daily contact with these wounded warriors, we have gained a unique perspective on their needs and the obstacles they face as they attempt to recover and reintegrate into their respective communities.

First, WWP is pleased that the Chairman and Senator Craig have highlighted the issues surrounding traumatic brain injury with the introduction of S. 1233, the Veteran Traumatic Brain Injury Rehabilitation Act of 2007. The signature wound of the war, as it has come to be known, TBI is an extremely challenging injury to treat and poses some new and complex issues for the Department of Veterans Affairs.

As such, and because the families of wounded servicemembers have named increased access to treatment options as their number one request, WWP supports the concept included in the legislation allowing TBI patients to use private facilities for rehabilitation. At the same time, however, we would like to see a provision added authorizing and encouraging the VA to collaborate with experienced private sector hospitals in addition to medical universities so that the Department can continue to develop long-term rehabilitation capabilities and perhaps one day become the facility of choice for severely injured TBI patients.

We are also extremely concerned with the method by which the legislation determines the TBI patients' eligibility for such a health care benefit. According to the provision as currently written, the Secretary would have the discretion to enter into individual agreements with facilities to provide care based in part on geographic lo-

cation. But no care criteria for the participating private facilities are enumerated.

Even more importantly, by determining eligibility based on geographic proximity to a VA facility and the discretion of the Secretary for the Department's ability to provide the necessary services, the legislation would limit the range of patients who can qualify for placement in a private facility and thus not provide the options for care that our wounded warriors and their families are seeking.

While WWP does not question the intent or the effort of the VA to care for these patients, we are concerned that the understandable need to further develop their capability for the benefit of future patients may disqualify current patients who would otherwise benefit from private rehabilitation.

For example, several weeks ago, many of you heard the testimony of Denise Mettie before this Committee regarding her son, Evan's, experiences in both DOD and VA facilities. As you may recall, Evan bypassed the VA polytrauma system for a period of time and experienced several setbacks once he finally reached the VA's Tier 1 facilities. After much discussion, debate, and effort, Evan was finally sent to the Kessler Institute for Rehabilitation, a private facility in New Jersey where only after a few weeks it had been discovered that Evan is not blind in one eye, as it was believed. His nystagmus has almost completely stopped, and he even gave a physical therapist a thumbs up with his left hand, which he has not used for almost a year. Of course, no one can guarantee that type of progress for every wounded veteran, but whether in a VA facility or a private rehabilitation hospital, every one of them deserves the chance to try.

For these and other reasons, WWP is grateful for Senators Akaka's and Craig's leadership on this legislation and we would like to continue to work with you to enhance S. 1233 to better meet the needs of the severely wounded servicemembers, veterans, and their families.

With respect to S. 383, a bill to extend the period of eligibility for health care for 2 years to 5 years after discharge, WWP is generally supportive of the provision. Often, especially in cases of delayed onset PTSD or mild to moderate TBI, veterans do not quickly recognize that they are in need of assistance or care. In other cases, veterans are simply not prepared to navigate another bureaucratic system after having just escaped the burdensome and administrative process of the Department of Defense.

WWP cautions, however, that while we want to make sure that every service-connected veteran is able to access the care he or she needs, extending the period of presumptive eligibility for VA care will add more veterans to an already overburdened system. Therefore, if this provision is adopted, Congress must ensure that the required resources are added, as well.

In theory, WWP generally supports the concept behind S. 815, the Veterans Health Care Empowerment Act of 2007, but has concerns about the implementation of and the long-term effects of such action on the VA. This legislation would allow service-connected veterans to receive health care at any facility or through any provider eligible to receive Medicare or TRICARE payments. As men-

tioned previously in our testimony, the top request of wounded veterans and their families is to have more involvement and choice in their care and this legislation would certainly help to accomplish that goal.

However, we are concerned that, as written, the VA would play no role in the coordination of care for the veterans who choose outside facilities, and without proper management by the VA, such a system could lead to confusion and contradiction among physicians in the provision of the care to the wounded. In addition, the legislation does not include any specifics on the implementation of such a large policy shift and therefore the final plan could differ greatly from that sought by Congress.

At this time, WWP unfortunately has grave concerns regarding S. 1147, the Honor Our Commitment to Our Veterans Act, which would require the Secretary to lift the current freeze on the enrollment of Category 8 veterans into the VA health care system. According to the Veterans Health Care Eligibility Reform Act of 1996, the legislation would first authorize the VA to provide health care services to veterans without service-connected disabilities or low income. If sufficient resources are not available to provide care that is timely and acceptable in quality for all priority groups, the Act requires VA to limit enrollment based on the priority groups themselves.

Just over the past several weeks, many in this room have identified waiting times for appointments, quality of care, and limited resources as just some of the challenges facing the VA. With the addition of relatively higher-income non-service-connected veterans, Congress would be placing an additional strain on a system it has called overburdened and complicated. With that said, those at the VA are working very hard to accommodate their current patients and WWP asks that we work with them to improve the care for those currently in the system, especially those who are severely injured, before adding another category of veterans.

Mr. Chairman, thank you again for this opportunity to testify and I look forward to your questions.

[The prepared statement of Ms. Beck follows:]

PREPARED STATEMENT OF MEREDITH BECK, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT

Mr. Chairman, Senator Craig, Members of the Committee, thank you for the opportunity to testify before you today regarding pending health legislation.

The Wounded Warrior Project (WWP) is a non-profit, non-partisan organization dedicated to assisting the men and women of the United States Armed Forces who have been severely injured during the War on Terrorism in Iraq, Afghanistan and other hot spots around the world. Beginning at the bedside of the severely wounded, WWP provides programs and services designed to ease the burden of these heroes and their families, aid in the recovery process and smooth their transition back home. As a result of our direct, daily contact with these wounded warriors, we have gained a unique perspective on their needs and the obstacles they face as they attempt to recover and reintegrate into their respective communities.

Today, I would like to comment on several pieces of legislation listed on the hearing agenda. First, WWP is pleased that the Chairman and Senator Craig have highlighted the issues surrounding Traumatic Brain Injury (TBI) with the introduction of S. 1233, Veterans Traumatic Brain Injury Rehabilitation Act of 2007. The "signature wound of the war" as it has come to be known, TBI is an extremely challenging injury to treat and poses some new and complex issues for the Department of Veterans Affairs (VA). As accurately stated in the legislation, those who are severely injured require individualized, comprehensive care, and, while the VA has made tre-

mendous progress in a short period of time, they are still in the process of establishing an extensive, long term continuum of care that can be accessed throughout the Nation. As such, and because the families of wounded servicemembers have named increased access to treatment options as their number one request, WWP supports the concept included in the legislation allowing TBI patients to use private facilities for rehabilitation. At the same time, however, we would also like to see a provision added authorizing/requiring the VA to collaborate with experienced private sector hospitals in addition to medical universities so that the Department can continue to develop long-term rehabilitation capabilities and, perhaps, one day become the facility of choice for severely injured TBI patients.

We are also extremely concerned with the method by which the legislation determines the TBI patient's eligibility for such a health care benefit. According to the provision as currently written, the Secretary would have the discretion to enter into individual agreements with facilities to provide care based on in part on geographic location, but no care criteria for the participating private facilities are enumerated. Even more importantly, by determining eligibility based on geographic proximity to a VA facility and the discretion of the Secretary for the Department's ability to provide the necessary services, the legislation will limit the range of patients who can qualify for placement in a private facility and thus not provide the options for care that our warriors and their families are seeking.

While WWP does not question the intent or effort of the VA to care for these patients, we are concerned that their need to further develop their capability for the benefit of future patients may disqualify current patients who would otherwise benefit from private rehabilitation. For example, several weeks ago many of you heard the testimony of Denise Mettie before this Committee regarding her son, Evan's, experiences in both DOD and VA facilities. As you may recall, Evan bypassed the VA Polytrauma System for a period of time and experienced several setbacks once he finally reached one of the VA's Tier I facilities where he had seemed to plateau, if not regress, in terms of improvement. After much discussion, debate, and effort Evan was finally sent recently to the Kessler Institute for Rehabilitation, a private rehabilitation facility in New Jersey where, after only a few weeks it has been discovered that Evan is NOT blind in one eye as was believed, his Nystagmus has almost completely stopped, and he even gave his physical therapist a thumbs up with his left hand which he has not used for almost a year. Of course no one can guarantee that type of progress for every wounded veteran, but, whether in a VA facility or a private rehabilitation hospital, every one of them deserves the chance to try. For these and other reasons, WWP is grateful for Senators Akaka and Craig's leadership on this legislation and we would like to continue to work with you to enhance S. 1233 to better meet the needs of severely wounded servicemembers, veterans, and their families.

With respect to S. 383, a bill to extend the period of eligibility for health care from 2 years to 5 years after discharge or release from the Armed Forces, WWP is generally supportive of the provision. Often, especially in cases of delayed-onset Post Traumatic Stress Disorder or mild to moderate Traumatic Brain Injury, veterans do not quickly recognize that they are in need of assistance or care. In other cases, veterans are simply not prepared to navigate another bureaucratic system after having just "escaped" the burdensome administrative process of the Department of Defense. WWP cautions, however, that while we want to make sure that every service-connected veteran is able to access the care he or she needs, extending the period of presumptive eligibility for VA care will add more veterans to an already overburdened system. Therefore, if this provision is adopted, Congress must ensure that the required resources are added as well.

In theory, WWP generally supports the concept behind S. 815, The Veterans Health Care Empowerment Act of 2007 but has concerns about the implementation of and the long-term effects of such action on the VA. This legislation would allow service-connected veterans to receive healthcare at any facility or through any provider eligible to receive Medicare or TRICARE payments. As mentioned previously in our testimony, the top request of wounded veterans and their families is to have more involvement and choice in their care, and this legislation would certainly help accomplish that goal. However, we are very concerned that, as written, the VA would play no role in the coordination of care for the veterans who choose outside facilities. Without proper management by the VA, such a system could lead to confusion and contradiction among physicians in the provision of care to the wounded. In addition, the legislation does not include any specifics on the implementation of such a large policy shift, and, therefore, the final plan could differ greatly from that sought by Congress.

At this time, WWP has grave concerns regarding S. 1147, The Honor Our Commitment to Veterans Act, which would require the Secretary to lift the current

freeze on the enrollment of Category 8 veterans into the VA healthcare system. According to The Veterans' Health Care Eligibility Reform Act of 1996, the legislation which first authorized VA to provide health care services to veterans without service-connected disabilities or low incomes, if sufficient resources are not available to provide care that is timely and acceptable in quality for all priority groups, the Act requires VA to limit enrollment based on the priority groups.

Just over the past several weeks, many in this room have identified waiting times for appointments, quality of care, and limited resources as just some of the challenges facing the VA. With the addition of relatively higher income, non-service connected veterans, Congress would be placing an additional strain on a system it has called overburdened and complicated With that said, those at the VA are working very hard to accommodate their current patients, and WWP asks that we work with them to improve the care for those currently in the system, especially those who are severely injured, before adding another category of veterans.

Finally, WWP is concerned that while well-intentioned, S. 882, requiring a pilot program to facilitate the transition of members of the Armed Forces to VA healthcare upon completion of service, and S. 1205, requiring a pilot program to assist veterans service organizations in developing peer support programs would create programs redundant to those already provided by the government or non-profit groups. For example, each of the services within the DOD operates its own organization to care for their respective wounded servicemembers. The Marine for Life Program currently offers services to transitioning Marines including job opportunities and information on veterans' benefits. In addition, many non-profits, including WWP, operate successful peer support programs funded through individual donations. This type of assistance is not only beneficial to the warrior, but is also an important means by which those in the community can support our returning veterans. Because many of our families often state they are confused by the number of different entities approaching them and, "need a case manager to manage their case managers," WWP would suggest improved coordination and integration among existing organizations and agencies before adding more layers and a review of current services, both governmental and non-profit to determine the best use of limited funds.

Mr. Chairman, thank you again for this opportunity to testify, and I look forward to your questions.

Chairman AKAKA. Thank you very much for your testimony.

Dr. Booss?

STATEMENT OF JOHN BOOSS, M.D., PROFESSOR EMERITUS OF NEUROLOGY AND LABORATORY MEDICINE, YALE UNIVERSITY SCHOOL OF MEDICINE; ON BEHALF OF THE AMERICAN ACADEMY OF NEUROLOGY

Dr. BOOSS. Thank you and good morning.

Chairman AKAKA. Good morning.

Dr. BOOSS. I am John Booss, an Air Force veteran and the former National Director of Neurology for the Department of Veterans Affairs. I am proud to have had over 30 years of service to the VA. I am Professor Emeritus of Neurology and Laboratory Medicine at Yale University School of Medicine and a fellow of the American Academy of Neurology, the AAN.

On behalf of the AAN and the more than 20,000 neurologists and neuroscience professionals we represent, I applaud you for introducing S. 1233. It will improve the rehabilitation of veterans with traumatic brain injury, or TBI.

TBI involves neurological cognitive behavioral changes which are complex and diverse and may change in severity or develop over time. Longer-term neurological problems include post-traumatic epilepsy, headache, sleep disorders, and sensory complications.

First, some general comments on S. 1233. We strongly support the team approach. Individualized rehabilitation plans based on a comprehensive assessment of a veteran's physical, cognitive, voca-

tional, and psycho-social impairments using a multi-disciplinary team that includes specialists in neurology are essential to the rehabilitative process. We endorse involving the veteran and the family in the plan. TBI is a devastating and life-altering condition for veterans and their families. Families of veterans with TBI need support and education and they should be part of the rehabilitative team.

Families also should not have the burden of traveling significant distances to access VA quality care. The AAN supports the use of non-VA facilities in cases where the VA is unable to provide easily accessible care as long as those facilities conform to the high standards of VA care.

We underscore the importance of the sections of the bill which provide for long-term care needs of those veterans for assisted living and long-term care.

I turn now to Section 8. Section 8 improves research on visually related neurological conditions and seizure disorders, which are frequent complications from TBI. The American Academy of Neurology is particularly supportive of the bill's recognition that seizure disorders will be a significant and frequent problem of TBI and that research on treatment is necessary. We do not have long-term data on post-traumatic epilepsy from the current conflicts, but the statistics from the Vietnam era are alarming.

Research in VA and DOD found that 53 percent of veterans who suffered a penetrating head wound in Vietnam developed epilepsy within 15 years. The relative risk for developing epilepsy more than 10 to 15 years after the injury was 25 times higher than their age-related civilian counterparts. Indeed, 15 percent did not manifest epilepsy until 5 or more years after their combat injury.

Neurologists are concerned, too, that the rate of post-traumatic epilepsy from blast TBI will also be high.

Given the high rate of post-traumatic epilepsy that veterans with TBI are likely to endure, the VA must have a strong national epilepsy program. We believe that Section 8 takes a step in recognizing that need.

Decades ago, the VA was, in fact, the national leader in the care and research for patients with epilepsy, but since that time, the VA epilepsy centers have languished due to a lack of funds. We appreciate S. 1233's proactive recognition of epilepsy as a significant consequence of TBI and support VA research in this area. The Academy believes that this could help lead the way to centers of excellence much in the way the VA leads on Parkinson's disease and multiple sclerosis. This could restore the VA to its earlier prominence in taking care of veterans with epilepsy.

In conclusion, the Academy wholeheartedly supports S. 1233 as needed legislation. Epilepsy is a major concern for those with TBI and we look forward to working with you to ensure that America's veterans who suffer TBI have access to a system that provides lifelong care and support.

Thank you for the opportunity to provide our support and comments on S. 1233.

[The prepared statement of Dr. Booss follows:]

PREPARED STATEMENT OF JOHN BOOSS, M.D., PROFESSOR EMERITUS OF NEUROLOGY AND LABORATORY MEDICINE, YALE UNIVERSITY SCHOOL OF MEDICINE; ON BEHALF OF THE AMERICAN ACADEMY OF NEUROLOGY

Good morning, Mr. Chairman and Members of the Committee. My name is Dr. John Booss. I am a veteran of the Air Force and the former National Director of Neurology at the Department of Veterans Affairs (VA), and proud to have over thirty years of service to the VA. I am currently a Professor Emeritus of Neurology and Laboratory Medicine at Yale University and a fellow of the American Academy of Neurology (AAN). On behalf of the AAN, I am pleased to present our support of S. 1233. The AAN, which represents over 20,000 neurologists and neuroscience professionals, believes that our veterans deserve the best possible care for neurological injuries sustained in their service to our country.

I applaud this Committee for holding hearings earlier on how the conflicts in Iraq and Afghanistan have created an emerging epidemic of traumatic brain injury (TBI) among combat veterans. TBI, which has been called the signature wound of the wars, involves neurological, cognitive and behavioral changes which are complex, varied, diverse and may change in severity or develop over time. Longer-term neurological problems often include post-traumatic epilepsy, headaches, sleep disorders and sensory complications.

The AAN strongly supports the "team approach" laid out in section 3 of S. 1233. Each veteran who suffers a TBI should receive ongoing individualized, comprehensive and multidisciplinary rehabilitation after inpatient services. Rehabilitation plans that are based upon a comprehensive assessment of the veteran's physical, cognitive, vocational, and psychosocial impairments, using a multidisciplinary team that includes neurologists (as required by S. 1233), are essential to rehabilitative success.

We support the provision in section 3 which requires involving the family and veteran in the development and review of the rehabilitation plan. TBI is a devastating and life-altering event which affects the veteran and his or her family. Families of veterans with TBI need support and education, and should be part of the rehabilitative team to the greatest extent possible.

We also support the periodic assessment of the rehabilitation plan. The consequences of a TBI may change over time and new symptoms may develop. For example, individuals with TBI may develop post-traumatic seizures months or years after the injury. Epilepsy requires regular monitoring. For many patients, changes in their anti-seizure medications are required. This makes this periodic assessment crucial.

The AAN also appreciates the recognition of seizure disorders as a common outcome of TBI in S. 1233. Post-traumatic epilepsy is going to be a significant long-term consequence of TBI.

Although we do not have data on post-traumatic epilepsy from the current conflicts, the statistics from the Vietnam era are alarming. VA-funded research conducted in collaboration with the Department of Defense found that 53 percent of veterans who suffered a penetrating TBI in Vietnam developed epilepsy within 15 years. For these service-connected veterans, the relative risk for developing epilepsy more than 10 to 15 years after their injury was 25 times higher than their age-related civilian cohorts. Indeed, 15 percent did not manifest epilepsy until five or more years after their combat injury. As neurologists, we believe that the rate of epilepsy from blast TBI will also be high.

Given the high rate of post-traumatic epilepsy that veterans with TBI are likely to endure, the AAN believes that Congress should authorize and the VA must establish a strong national epilepsy program with Research, Education and Clinical Centers, to include Epilepsy Centers of Excellence. We are concerned that the VA lacks a national program for epilepsy with clear guidelines on when to refer patients for further assessment and treatment of epilepsy. VA Centers of Excellence have been the model of innovation in the delivery of highly specialized health care and research for other disabling and chronic diseases in the veteran population. VA has infrastructure to address many of the other common consequences of TBI, such as psychosocial changes and vision problems but not post-traumatic epilepsy.

At one point, the VA was a national leader in care and research for patients with epilepsy. As early as 1972 the VA recognized the need for VA health centers that specialized in epilepsy. But starting in the 1990s these epilepsy centers have languished due to lack of funds.

Six strategically located facilities could develop the necessary capacity to function as centers of excellence in research, education, and training in diagnosis and treatment of epilepsy. For example, a VA health care facility affiliated with a medical school that trains residents in the diagnosis and treatment of epilepsy, including

epilepsy surgery, would be able to attract the participation of clinicians and scientists capable of driving innovation in the prevention and treatment of post-traumatic epilepsy.

Because so many of our recent veterans are returning to rural areas, access to state-of-the art care for post-traumatic epilepsy will be a challenge of the VA. Epilepsy Centers for Excellence could help address this challenge by expanding the VA's telemedicine capacity. Through the transmission and review of neurological diagnostic tests, such as EEGs and MRIs, the VA Epilepsy Centers of Excellence could provide a nationwide monitoring program to improve the quality of life for veterans with post-traumatic epilepsy who live in rural areas.

We appreciate that S. 1233 contains a provision to establish a broad TBI research, education and clinical care program. Still, more research into epilepsy is needed. Without a strong national program on epilepsy, post-traumatic epilepsy may not receive adequate focus and support. As you move S. 1233 forward in the legislative process, we ask that you clarify that these centers must include a significant focus on the prevention, diagnosis and treatment of epilepsy. We ask that you give the VA an incentive to establish the VA Epilepsy Centers of Excellence with a clear statutory foundation and the authorization of appropriations.

Both the American Academy of Neurology and I thank you for the opportunity to provide our support and comments on S. 1233.

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

Mr. Reed?

STATEMENT OF JERRY REED, EXECUTIVE DIRECTOR, SUICIDE PREVENTION ACTION NETWORK USA

Mr. REED. Chairman Akaka, thank you for inviting me to speak regarding the Joshua Omvig Veterans Suicide Prevention Act, S. 479. My name is Jerry Reed and I serve as the Executive Director of the Suicide Prevention Action Network, USA. SPAN USA is the Nation's only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors, those who have lost a loved one to suicide, and others to help advance public policies that help prevent suicide. We strive to turn grief to action by engaging those touched by suicide to help us open minds, change policy, and ultimately to save lives.

Before I begin, I would like to thank Randy and Ellen Omvig for their courage in speaking out on this important public health issue. Like other survivors, their courage will make a difference. I would also like to thank your Committee and Senators Harkin and Grassley for their leadership on this issue here in the Senate.

The Veterans Health Administration estimates that of the approximately 31,000 suicides in the United States each year, 1,000 of these suicides occur among veterans receiving care within the VHA, and as many as 5,000 suicides per year among all living veterans. These figures suggest that at least 16 percent of suicides in this country in a given year are veterans. Other studies suggest a slightly higher rate.

What the statistics show us is that suicide is not just a mental health problem experienced by one. It is a public health problem experienced by many. As the recent VA OIG report states, suicide is not a single illness with one true cause. It is a final outcome with multiple potential antecedents, percipients, and underlying causes.

Regarding substance abuse and suicide, it is estimated that 25 percent of those who die by suicide are intoxicated at the time of death, and studies suggest that between 34 and 56 percent of individuals who die by suicide met the criteria for alcohol abuse or dependence. Accordingly, I wish to state my agreement with the VA

OIG report recommendation that the VA ensure that sustained sobriety should not be a barrier to treatment in specialized mental health programs for veterans, returning combat veterans. This specific recommendation may be a provision to consider for inclusion.

A majority of veterans who complete suicide are not currently receiving medical care through the VHA. Therefore, family members and friends of veterans need to recognize the warning signs for suicide and learn about services for their loved ones before it is too late. The VA's awareness and outreach program must be focused not just on veterans who seek care at the VA, but also on veterans who have returned to their home communities, family members of veterans, and veterans service organizations.

Beyond outreach and education, I support the provisions in S. 479 that encourage peer support programs. While there is no substitute for licensed mental health professionals with respect to diagnosis and treatment of PTSD, depression, and anxiety, it is often fellow veterans who provide the support needed to convince a veteran to visit a licensed professional.

With respect to the provision that each VA facility designate a suicide prevention counselor, my understanding is that the VA is in the process of filling these positions as we speak. I would recommend that any report on VA suicide prevention programs and activities as outlined in Section 4 of the bill include information on the total number of suicide prevention counselors to date, where they are located, what their job descriptions entail, and how they are reaching out to veterans who do not receive care through the VHA. In short, what are the counselors expected to accomplish and how do we measure if they are successful? Having outcomes is key.

Regarding best practices, agencies and departments of the Federal Government should work together and not act in a vacuum with respect to information sharing. These entities should also work with the Suicide Prevention Resource Center. The SPRC is a federally funded and already established center to provide prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions, and policies. The capacity of the SPRC to conduct these activities with respect to veterans should be increased.

With respect to the telephone hotline provision, an additional 800 number has been recommended by some. I do not believe adding an additional hotline is the correct approach or the only approach. For most individuals in suicidal crisis, what is most important when utilizing a hotline is simply knowing that someone is listening and that they are not alone. A caller needs a competent counselor at the other end of the line who can conduct a lethality assessment and provide direction on next steps.

Already in existence, the federally funded National Suicide Prevention Lifeline is a 24-hour, toll-free suicide prevention service available to all those in suicidal crisis who are seeking help. Individuals seeking help can simply dial 1–800–273–TALK. They will be seamlessly routed to the certified provider of mental health and suicide prevention services nearest to where they are calling from. The network is currently comprised of over 120 individual crisis centers around the country. I think we should build on what Con-

gress has already funded and let 1–800–273–TALK be the door all callers in crisis, including veterans, enter.

Once callers dial the number, an option can easily be provided to be transferred to a VA call center if the individual wants the services and support of the VHA. For the non-VA crisis centers, the VA could easily provide up-to-date information on all VA suicide prevention counselors, hospitals, medical centers, CBOCs, and peer support groups where appropriate. This national network of crisis centers should reliably be able to transfer cases to a VHA call center as appropriate.

I want to close by restating my strong support for the Joshua Omvig Veterans Support Act and look forward to its inclusion in a larger veterans' health care bill. We can all work together to open minds, change policy, and save lives. Enactment of the provisions in S. 479 will hopefully bring us one step further in this journey with respect to veteran suicide prevention.

Thank you for the opportunity to speak with you today.

[The prepared statement of Mr. Reed follows:]

PREPARED STATEMENT OF JERRY REED, EXECUTIVE DIRECTOR, SUICIDE PREVENTION ACTION NETWORK USA

Chairman Akaka, Ranking Member Craig and Members of the Committee:

Thank you for inviting me to speak regarding the Joshua Omvig Veterans Suicide Prevention Act (S. 479). My name is Jerry Reed and I serve as the Executive Director of the Suicide Prevention Action Network USA. SPAN USA is the Nation's only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors (those who have lost a loved one to suicide) and others to advance public policies that help prevent suicide. We strive to turn grief to action by engaging those touched by suicide to help us open minds, change policy and ultimately to save lives.

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What the statistics show is that suicide is not just a mental health problem experienced by one; it is a public health problem experienced by many. As the recent VA OIG report states "[s]uicide is not a single illness with one true cause, it is a final outcome with multiple potential antecedents, percipients, and underlying causes."

While the text of S. 479 does not address the issue of substance abuse specifically, it is estimated that 25 percent of those who die by suicide are intoxicated at the time of death and studies suggest that between 34 and 56 percent of individuals who die by suicide met the criteria for alcohol abuse or dependence. Accordingly, I wish to state my agreement with the VA OIG report recommendation that the VA ensure that sustained sobriety should not be a barrier to treatment in specialized mental health programs for returning combat veterans. This recommendation may be a provision to consider for inclusion.

A majority of veterans who complete suicide are not currently receiving medical care through the VHA. Therefore, family members and friends of veterans need to recognize the warning signs for suicide and learn about services for their loved ones before it is too late. The VA's awareness and outreach program must be focused not just on veterans who seek care at the VA, but also on veterans who have returned to their home communities, family members of veterans, and veterans service organizations (VSO).

Beyond outreach and education, I support the provisions in S. 479 that encourage peer support programs. While there is no substitute for licensed mental health professionals with respect to diagnosis and treatment of PTSD, depression, and anxiety, it is often fellow veterans who provide the support needed to convince a veteran to visit a licensed professional.

With respect to the provision that each VA facility designate a suicide prevention counselor, my understanding is that the VA is in the process of filling these positions. I'd recommend that any report on VA suicide prevention programs and activities, as outlined in Section 4 of the bill, include information on: the total number of suicide prevention counselors to date; where they are located; what their job description entails; and how they are reaching out to veterans who do not receive care through the VHA. In short, what are these counselors expected to accomplish and how do we measure if they are successful. Having outcomes is key.

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For most individuals in a suicidal crisis, what is most important when utilizing a hotline is simply knowing that someone is listening and that they are not alone. A caller needs a competent counselor at the other end of the line who can conduct a lethality assessment and provide direction on next steps.

Already in existence, the federally funded National Suicide Prevention Lifeline (NSPL) is a 24-hour, toll-free suicide prevention service available to all those in suicidal crisis who are seeking help. Individuals seeking help can dial 1–800–273–TALK (8255). They will be seamlessly routed to the certified provider of mental health and suicide prevention services nearest to where they are calling from. The network is comprised of over 120 individual crisis centers across the country.

I think we should build upon what Congress has already funded and let 1–800–273–TALK be the door all callers in crisis, including veterans, enter. Once a caller dials the number, an option can be provided to be transferred to a VA call center if the individual wants the services and support of the VHA. For the non-VA crisis centers, the VA should be providing up-to-date information on all VA suicide prevention counselors, hospitals, medical centers, outpatient clinics, and peer support groups and, where appropriate, this national network of crisis centers should reliably transfer cases to the VHA call center.

I want to close by restating my strong support for the Joshua Omvig Veterans Suicide Prevention Act and look forward to its inclusion in a larger veterans' health care bill. We can all work together to open minds, change policy, and save lives. Enactment of the provisions in S. 479 will hopefully bring us one step further in this journey with respect to veterans' suicide prevention.

Thank you for the opportunity to speak with you today.

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

My first question is for Dr. Booss and Ms. Beck. This has to do with working with the private sector, collaborating with them. In your view, how can VA better collaborate with the private sector in order to adopt and exchange best practices for TBI and rehabilitation care?

Dr. Booss, and Ms. Beck after him.

Dr. BOOSS. Thank you, Mr. Chairman. I think that is an extremely important point, because I think that it is vitally important that the VA and the private sector and the university sector interact so that there is a mutually supportive integration of the advancement of care.

I think one of the ways that the VA has worked very well has been to work to integrate private practitioners and also university practitioners into their outpatient clinic systems, often on a WOC—that is a without compensation basis—and I think that is a benefit to veterans and I think it is also a benefit to the broader community.

In terms of specific initiatives, I think that as the Congress goes forward, I think looking toward those areas that would best ben-

efit, I think there is a risk. The risk is if the VA is not doing something as well as might be wished by the private sector, that the push ought to be to push VA to do it better rather than to push it out into the private sector. So I think that is a very important question.

Chairman AKAKA. Thank you very much for that. Ms. Beck?

Ms. BECK. I agree with Dr. Booss on his final point that our whole goal in this is to encourage the VA to become the facility of choice for these servicemembers, and by working together with the private sector on a broad and constant basis, we think that they can do that. The VA has excellent capabilities in many areas and they have made tremendous progress in TBI, especially in their Tier 1 facilities.

But as they have said and as they are establishing their Tier 2 and Tier 3 components, we would strongly encourage them to work with the private sector, whether it is developing criteria for the private sector hospitals that would be treating veterans and TBI patients, but exchanging ideas on those. Exchanging doctors is a possibility, and that is, as I have said, the number one request of our servicemembers and their families.

Chairman AKAKA. Thank you so much for your responses.

Mr. Reed, we like to look for the best ways of preventing suicide, and the question that comes to mind, and this is a searching one, what more can be done that is being done already, specifically in areas of outreach and education, as you mentioned in your testimony, to let veterans know what services and assistance are available to them so that we can prevent the tragedy of suicide? So we are looking at outreach and education. What more can be done?

Mr. REED. Senator, I think the Congress back in the 105th Congress took a very bold step when they passed a resolution that said suicide is a national problem that warrants a national solution. That really opened up the dialogue for this country to talk about something that has been claiming 32,000 people a year for a long, long time and another 1.4 million who make an attempt every single year. The stigma and the barriers to even talk about suicide or thoughts of suicide were enormous, and I think we have begun to talk about it, and we have done some national polling to measure our success. The American people are willing to talk about it. When you talk about it, then you encourage research into it and you promote access to services for those conditions.

We know that 90 percent of suicides have a mental illness or a substance abuse relationship. Just like any other organ that has an illness, when the brain has an illness, those who suffer should be just as eligible for treatment and for services.

So I think we are starting to talk about it. A veteran should know there is no shame in these feelings. There are services available and there should be no more stigma for that intervention than there should be for a heart ailment, a kidney ailment, or a liver ailment. So I think we just have to give the Nation permission when they struggle to go for help. It is a completely normal and acceptable thing to seek help for.

Chairman AKAKA. I want you to know that I really appreciate your presence and your testimonies, your responses, as well. Our attempt here is to try to bring as many voices as we can to help

us ensure that VA can provide the kinds of services that we need. I like your statements about helping VA do the best they can before we move on to look at other sectors, as well. We are trying to make many improvements, as you know, by raising the funding level of VA, and that is not the only answer but it helps. We have addressed that by passing a budget resolution that increases VA health care by more than $3 billion.

So we are looking towards working together with the VA and all of you to try to help our veterans across the country. We have a tremendous task before us. As we all know, we owe it to our veterans, and we are going to do the best we can to do that.

In closing, I again want to thank all of our witnesses for appearing today. We truly appreciate your taking the time to give us your views on all of the issues and the legislation we have before us. I reiterate that the hearing record will remain open for 2 weeks to provide time for additional views.

Again, I want to say thank you for being with us and the hearing is now adjourned.

[Whereupon, at 11:38 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. WAYNE ALLARD,
U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman, for affording me the opportunity to present before the Committee an issue of great importance to the veterans of Colorado. I strongly support the replacement of the current Denver VA medical center with a new facility at the former Fitzsimons Army Medical Center. I have introduced S. 472 with my colleague, Senator Salazar, to authorize the remaining funds needed to complete this new facility.

Last month, Secretary Nicholson announced the VA's commitment to this project after funds were appropriated, allowing for the initial land purchase to begin. This announcement was a strong victory for Colorado's veterans and full authorization of the hospital would demonstrate the government's continued commitment to our veterans.

The Denver VA hospital was built more than fifty years ago and medical technology has far surpassed what the builders of the Denver VA originally envisioned. This facility, which hosted the first liver transplant in 1963, has provided tremendous care over the years, but simply does not have the infrastructure to continue to provide our veterans the care they need through the 21st century. While I cannot say enough about the care and service our veterans receive at the current facility, many changes and improvements can and should be made, and a new facility is the only way to accomplish these goals.

This new VA hospital to be located at the Fitzsimons campus and the former home of the Fitzsimons Army Medical Center will carry on a strong tradition of providing exceptional medical care for our Nation's best and bravest citizens. The current Fitzsimons campus first began treating wounded veterans in 1918, specializing in assisting those that were victims of chemical weapons during World War I. The facility continued to grow through the 20th century and became one of the premiere Veterans hospitals through World War II. Fitzsimons was even unofficially deemed the "White House of the West" when President Eisenhower spent seven weeks in the facility while recovering from a heart condition in 1955.

The new facility will serve as an example of successful collaboration between numerous parties and will be the culmination of years of hard work. The Denver VA, the University of Colorado Health Sciences Center and the University of Colorado Hospital already have a complex and rewarding partnership in meeting veterans' healthcare needs in the region, and all are partnered together on this unique project. The University of Colorado, who currently owns the land for the new hospital, strongly supports the move of the existing Denver VA medical facility to the Fitzsimons Campus in Aurora, Colorado and looks forward to strengthening their partnership with the Veterans' Administration. This project allows each entity to focus on its strengths.

Of course, the biggest endorsement of this new facility comes ultimately from the end-users: our veterans. The United Veterans Committee of Colorado, a coalition of 45 federally chartered veterans service organizations, strongly supports the relocation of the Denver VA medical center to the Fitzsimons campus and has worked closely with my office and the Colorado Congressional delegation over the years to ensure its success.

In the past year, the VA reached an agreement with the Fitzsimons Redevelopment Authority, the entity that manages the land at the former Fitzsimons Army Medical Center, and Congress granted the needed authorization to begin site acquisition and construction of the new hospital. This was an important first step, but full authorization of the project is still required to assure the project's completion. To that end, I have introduced S. 472, in order to meet this need. Specifically, the language of bill S. 472 authorizes the Secretary to carry out the entire project and provides authority to the VA purchase the land with current year dollars.

There was a time when it looked like this project was in peril. Thankfully, in 2005 Secretary Nicholson brought a much-needed, fresh perspective to this project. He made it a priority and made it clear to the entire Colorado delegation that he would pursue every opportunity to make the project a reality. I commend his efforts and thank him for his support. It is also important to mention the hard work and diligence of those in Colorado who have also worked to ensure the success of this new hospital. Without the extraordinary efforts put forth by the Fitzsimons Redevelopment Authority and its chairman, City of Aurora Mayor Ed Tauer, an agreement would not have been reached on the ultimate location of the hospital.

Again, I thank you, Chairman Akaka, for the opportunity to speak here today. I would also like to recognize the strong support my colleague Senator Salazar has shown for this project. Without a bipartisan effort we would not be this close on realizing our goal. I look forward to working with the Committee on my legislation and making this project a reality.

PREPARED STATEMENT OF ANN HUSTON, EXECUTIVE DIRECTOR AND CEO, AMERICAN THERAPEUTIC RECREATION ASSOCIATION

On behalf of the American Therapeutic Recreation Association (ATRA), I am submitting the following statement in support of "The Traumatic Brain Injury Rehabilitation Act of 2007" (S. 1233), including recommendations to improve the impact of the legislation on returning soldiers with serious injuries and rehabilitative needs.

BACKGROUND ON ATRA

The American Therapeutic Recreation Association (ATRA) is the largest, national membership organization representing the interests and need of recreational therapists. Recreational therapists are health care providers using recreational therapy interventions for improved functioning of individuals with illness or disabling conditions. According to the U.S. Department of Labor, Bureau of Labor Statistics, in 1996 there were approximately 38,000 recreational therapists. "Employment of recreational therapists is expected to grow faster than the average for all occupations through the year 2006 because of anticipated expansion in long term care, physical and psychiatric rehabilitation and services for people with disabilities."

By way of background, in 1917, the American Red Cross developed convalescent houses in military hospitals and in 1931 began hiring recreation hospital workers. The formative years of the recreational therapy profession occurred from 1945–1953 following World War II with the development of formal undergraduate education programs, and the establishment of three professional organizations for hospital recreation workers. ATRA was formed in response to recreational therapists' demand for an independent organization solely representing the needs of the therapeutic recreation profession within health care delivery system.

The Practice of Recreational Therapy

Recreational therapy plays a critical role in the comprehensive rehabilitation of individuals with disabling conditions by contributing to the broad spectrum of health care through delivery of treatment services and through the provision of physical and recreational activities—each of which is instrumental in improving and maintaining physical and psycho-social functioning, preventing secondary health conditions, enhancing independent living skills and overall quality of life.

Recreational Therapy services utilize various methods to promote the independent physical, cognitive, emotional and social functioning of persons requiring rehabilitation as a result of trauma or disease, by enhancing current skills and facilitating the establishment of new skills for daily living and community functioning. Recreational therapy is particularly important in terms of community reintegration once a disabling condition has been incurred.

Recreational therapy also includes components that enable individuals to become more informed and active partners in their health care. Prescribed activity assists individuals in coping with the stress of illness and disability and prepares them for managing their disability so they may achieve and maintain optimal levels of independence, productivity, and well being. Quality services include the provision of recreational opportunity and physical activity (e.g. wheelchair sports, exercise and swimming programs) which allow individuals with functional deficits to prevent declines in physical, cognitive, social, and emotional health status, and therefore, reduce the need for medical services.

With an academic degree in recreational therapy, a qualified provider may work in a variety of organizations and settings such as VA polytrauma centers as well as free-standing rehabilitation hospitals, rehabilitation units in general hospitals, psychiatric hospitals, long-term care or skilled nursing facilities, home health care agencies, amongst many others.

Recreational therapists are standard treatment team members in psychiatric rehabilitation, substance abuse treatment, physical rehabilitation and long term care services in both in-patient and out-patient settings. The Centers for Medicare and Medicaid Services (CMS) includes recreational therapy in the mix of treatment and rehabilitation services used to determine compliance with the Federal Government's commitment to quality care in rehabilitation, skilled nursing and long term care facilities.

Recreational Therapy as a Viable Option

The therapeutic recreation profession is in support of cost-effective health care services for individuals with disabilities. The number of Americans requiring health and rehabilitation services continues to increase due to an aging population, disabling conditions, improved treatment services, and greater survival rates. Therefore, the need to access a broad range of available services is crucial.

The provision of quality services that lead to expected outcomes while reducing overall health care costs is the bottom line in therapeutic recreation services. Recreational therapy should be included as a viable option to meet the needs of consumers with disabilities. Ultimately, the ability to choose the most appropriate mix of health care options will afford the provider the most cost-effective approach to meet the unique needs of individuals with illnesses and disabilities. Reducing the length of stay and hospital or system recidivism, promoting independent community living, and maximizing individual productivity in society are all positive outcomes of recreational therapy services.

SUPPORT FOR S. 1233

ATRA is enthusiastic about the introduction of S. 1233, the "Traumatic Brain Injury Rehabilitation Act of 2007," and thanks the sponsors for ensuring that veterans have access to quality rehabilitative care in the most appropriate setting.

The VA is the largest employer of recreational therapists in the Nation and ATRA has gained from the VA's involvement in the professional association. ATRA has had VA employees serve as team leaders, task force chairs, committee members and ATRA board members. Two VA employees currently serve as board members to ATRA.

In the four VA Polytrauma Centers (Minneapolis, Palo Alto, Tampa, Richmond), recreational therapists are identified as "core staff." Each Polytrauma Center is required to have at least one recreational therapist as a core team member and some have more recreational therapists based on bed census, each providing services to veterans returning from the Iraq war. This "team involvement" is an integral part of rehabilitation for these patients. In addition, ATRA hosts the national VA Institute at the ATRA Annual Conference each year, coordinated by the VA Recreation Therapy Central Office staff.

One of the key components that RT adds for these patients is community reintegration or transitional living skills. These skills are introduced and the basics taught at the Polytrauma Centers but the skills need to be fine-tuned and customized at the local VA facilities when the patient returns to his local community. Some of the Polytrauma Centers have recognized this need and added more recreational therapists.

Comprehensive Team and Rehabilitation Plan

ATRA is particularly pleased to see that S. 1233 would provide each veteran with traumatic brain injury (TBI) a comprehensive and flexible rehabilitation team and plan to include neurologists, physiatrists, physical therapists, occupational therapists, recreational therapists and other rehabilitation providers with a goal of regaining and then maintaining the veteran's maximum level of independent function. ATRA believes that "team involvement" is an integral part of the rehabilitation treatment plan for these patients.

In addition, it is a customary practice of rehabilitation care plans to require an individual rehabilitation plan, as the bill does, upon discharge from inpatient rehabilitation care. Such plans focus on optimal function for the individual in the community and specify functional progress. They also often rely on numerous providers and community support. Therefore, ATRA strongly supports this type of plan requirement, recognizing the difficulty of continuing such plans for the long term needs of TBI survivors.

Private Partnerships

Very importantly, S. 1233 also provides each veteran with TBI access to the best, most appropriate and most accessible care, whether through the VA or through an outside provider.

The VA has an excellent history of providing quality care to its wounded warriors and, as stated before, ATRA knows that the VA's four TBI Lead Centers and regional referral centers are no exception. Additionally, we recognize current VA efforts to create residential facilities and community-based long term rehabilitation care with nearly 21 polytrauma rehab networks being put into place.

However, it is important to acknowledge that gaps in coverage and care still exist. In particular, we note the VA's capability to provide community-based care to successfully reintegrate these soldiers into society. ATRA supports the Committee's efforts to allow more collaboration between the VA and the private sector in order to ensure the best and most accessible care for our veterans. Therefore, ATRA supports provisions allowing private facilities to provide care on an outpatient basis in the community where VA cannot feasibly supply the service needed.

We also strongly support the supplementation of VA rehabilitation services in the community for TBI soldiers with professionals who may be utilized from the private sector who are not part of VA system. Examples would be recreational therapist involvement with veterans with TBI/polytrauma injuries and physical or recreational therapists who are familiar with brain injury and could provide local therapy when other providers and treatment is unavailable.

Rehabilitation Research

Additionally, while we are supportive of the bill's provisions on research of intense rehabilitation needs of TBI soldiers, we would suggest broader language authorizing research on therapies, cognitive and physical, to determine the most efficacious therapies for TBI soldiers.

The problem of physical and cognitive disability in America is substantial as noted in the 1997 IOM Report, *Enabling America*. The need to enhance medical rehabilitation research to attack the problem is paramount and was a key conclusion of the IOM Report. Between 25 and 30 million individuals have impairments which limit substantially their ability to perform activities of daily living (ADLs) and 7 percent of all individuals age 65 to 75 (24 percent of those over age 85) have disabilities limiting their ADL function.

There are civilian agencies with well-established TBI research programs with which the VA should collaborate. The mission of the National Center for Medical Rehabilitation Research (NCMRR) within the National Institutes of Health is to plan, coordinate and stimulate rehabilitation research within NIH and across other Federal agencies. As such, we think NCMRR would enhance the VA's ability to identify the most efficacious therapies for TBI soldiers and suggest that this program be carried on in conjunction with NCMRR's TBI clinical trials network. In addition, the TBI centers and TBI model systems, funded by the National Institute of Disability and Rehabilitation Reseach (NIDRR) within the Department of Education has significant and valuable capacity with which the VA should seek to coordinate their TBI efforts.

Assisted Living

Finally, recreational therapists support the inclusion of the pilot program to assess the effectiveness of providing assisted living services to veterans. The provision will give veterans who might otherwise be forced into institutional long-term care an opportunity to live in group homes or under other arrangements. For veterans with TBI, such a provision will maximize rehabilitation, independence, quality of life, and community reintegration of veterans with TBI who are unable to manage routine activities of daily living. The effect of such a pilot program will only be enhanced by the other provisions of this bill that buildupon the rehabilitation plan and focus on community reintegration to maximize the independence of these returning veterans.

CONCLUSION

In conclusion, ATRA strongly supports the Traumatic Brain Injury Rehabilitation Act of 2007 (S. 1233) and applauds the Committee's commitment to improving access to and quality of care for veterans with traumatic brain injury. ATRA thanks Chairman Akaka and Ranking Member Craig, the sponsors of S. 1233, for ensuring that veterans have access to quality rehabilitative care in the most appropriate setting and we stand ready to assist the sponsors and the Committee in passing this much needed legislation.

ATRA thanks the Veterans' Affairs Committee for the opportunity to submit comments.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) submits the following statement in support of "The Traumatic Brain Injury Rehabilitation Act of 2007" (S. 1233). Additionally, we would like to offer recommendations to improve the impact of the legislation on returning soldiers with serious injuries and rehabilitative needs.

BACKGROUND ON AAPM&R

AAPM&R is the national medical society representing approximately 7,800 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation. Physiatrists treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, or traumatic brain injury, rheumatologic conditions, musculoskeletal injuries, and individuals with neuralgic disorders such as strong multiple sclerosis, polio, amyotrophic lateral sclerosis (ALS) or any other disease process that results in impairment and/or disability.

During World War II, programs in rehabilitation medicine were begun by Howard Rusk, M.D., in a number of Army Air Force hospitals. After the War, Dr. Rusk and Frank Krusen, M.D., were consultants to the Department of Veterans Affairs as it expanded its health care programs to meet the increased demand for services from the War. Paul Magnuson, M.D., who founded the Rehabilitation Institute of Chicago in 1954, was Medical Director of the VA when its expansion of rehabilitation services took place. Rusk and Krusen established the specialty of Physical Medicine and Rehabilitation just after the war.

Today, AAPM&R offers well developed expertise in rehabilitation for traumatic brain injury and amputations of upper or lower extremities, two of the disabilities afflicting soldiers returning from battle. AAPM&R members are also experts in the rehabilitation of spinal cord injured (SCI) patients and were involved in the creation of federally funded traumatic brain injury (TBI), burn and SCI model care systems in the 1970s and 1980s and, more recently, involved in the development and use of high technology in prosthetics.

AAPM&R physicians are trained to provide the medical rehabilitation needed by military personnel returning with TBI, SCI, amputations, and other severe disabilities. These physicians provide a comprehensive approach to the restoration of function and return to the community. Multidisciplinary services are utilized where needed including physical therapy, occupational therapy, speech therapy, psychological services, vocational rehabilitation, job placement, recreational therapy and independent living assistance.

Today many specialists in PM&R provide services in the VA health care system and many residents train in VA affiliated PM&R residency training programs. For example, the AAPM&R President-elect, David Cifu, M.D., is Chairman of the Medical College of Virginia Department of Physical Medicine and Rehabilitation and is a VA physician and head of the polytrauma rehabilitation center at Richmond, Virginia. Additionally, one of our members, Barbara Sigford, M.D., works at the Minneapolis VA Polytrauma Center, where she is chief of Physical Medicine and Rehabilitation Services for the Veterans Health Administration.

SUPPORT FOR S. 1233

AAPM&R supports the "Traumatic Brain Injury Rehabilitation Act of 2007" (S. 1233) and thanks the cosponsors for their commitment to ensuring that veterans with TBI have access to quality rehabilitative care. The bill focuses on the needs of TBI victims for outpatient services to enable reintegration in the community. The bill establishes a number of programs to facilitate this optimum rehabilitation in-

cluding a comprehensive assessment and plan for rehabilitation, the use of private sector resources when the VA system has insufficient capacity to serve TBI victims or when the VA program available is too remote to be feasible for the patient

Since approximately 20 percent of soldiers wounded in Iraq or Afghanistan have TBI, amputations or spinal cord injury, and TBI is the most prevalent of the three, focusing a special effort on TBI victims is good policy. Despite the expansion of polytrauma rehabilitation centers, networks and clinical teams for outpatient care, the system is likely to have gaps in the outpatient service system given the numbers of victims, the duration of their disabling condition and the paucity of TBI experts. Focusing on these gaps is essential.

We suggest some areas however, in which we believe the bill might be strengthened to better achieve its goals.

REHABILITATION PLAN

S. 1233 would provide each veteran with TBI a comprehensive assessment by a rehabilitation team (including neurologists, physiatrists, social workers, mental health specialists, occupational therapists, physical therapists, vocational rehabilitation specialists and rehabilitation nurses) and a plan with the goal of regaining, and then maintaining, the veteran's maximum level of independent function in the community.

The legislation's requirement of an individual rehabilitation plan upon discharge from inpatient rehabilitation care is the customary practice of physical medicine and rehabilitation. These plans are intended to specify functional progress and focus on optimal function for the individual in the community. They often rely on numerous providers and supports available in the community. AAPM&R strongly supports this type of plan requirement, recognizing the difficulty of continuing such plans for the long term needs of TBI victims which may well reach 50 years.

Private Partnerships

S. 1233 would also provide all veterans with TBI access to the best, most appropriate care, whether through the VA or a private sector facility when the VA is unable to supply the necessary services or the VA facility is too remote from the veterans' residence. The VA has an excellent history of providing quality care to its wounded warriors. Additionally, AAPM&R recognizes current VA efforts to create residential facilities and community-based long term rehabilitation care with nearly 21 polytrauma rehabilitation networks being put into place.

However, it is important to acknowledge that gaps in the capability of the VA health system to provide the community-based care necessary to successfully reintegrate its soldiers into society will likely exist. AAPM&R supports the bill's efforts to allow more collaboration between the VA and the private sector in order to ensure that care is accessible to all TBI victims of the wars in Iraq and Afghanistan. The private sector involvement intended by the provision, particularly if expanded as we suggest below, will strengthen the ability of the VA to respond to possible gaps in outpatient rehabilitation care.

We suggest an addition to the legislation which we believe would make the use of private sector services more effective. The legislation is limited to arrangements with "facilities" to assist the VA in delivering rehabilitation services to veterans with TBI on an outpatient basis. We believe there may be instances when a TBI victim may need a specialist in rehabilitation medicine who is not available within the VA system to provide outpatient care. In such instances the professional may not be affiliated with a rehabilitation hospital or other "facility". They may be in a professional group practice. Examples would be physical medicine and rehabilitation physicians who understand brain injury and can serve as consultants or primary physicians; neuropsychologists who may be needed for counseling; occupational or physical therapists who are familiar with brain injury and could provide necessary therapy services.

OTHER COMMENTS AND SUGGESTED ADDITIONS

AAPM&R recognizes that it is appropriate for Congress to focus on traumatic brain injuries, as it is among the most prevalent polytrauma conditions and has a dramatic impact on the veteran's long-term outcomes. Additionally, too little is known today about the nature of TBI, its sequelae, and the therapies to potentially treat it. Nearly eight years ago, the National Institutes of Health held a consensus conference on TBI, Chaired by Kris Ragnarsson, M.D., of Mt. Sinai Hospital, New York City, New York, which reported that far too little was known from research about therapies. We fear that little has changed in the last eight years.

However, we also believe that there is a need for post acute rehabilitation services, particularly on an outpatient basis, for other victims of polytrauma. AAPM&R would encourage the Committee to consider expanding the focus of S. 1233, or passing additional legislation, to connect veterans with other polytraumatic conditions, such as amputations, spinal cord injury or burns, to the necessary post acute rehabilitation services.

Additionally, while AAPM&R is supportive of the bill's provisions on research of intense rehabilitation needs of TBI soldiers, we would suggest broader language authorizing research to determine the most efficacious therapies, cognitive or physical, for TBI victims. We suggest that this program be carried on in conjunction with the TBI clinical trials network of the National Center for Medical Rehabilitation Research within the National Institutes of Health and the model systems of TBI supported by the National Institute on Disability and Rehabilitation Research in the Department of Education.

CONCLUSION

AAPM&R supports the "Traumatic Brain Injury Rehabilitation Act of 2007" (S. 1233). We encourage the Committee to expand the scope of the legislation to allow VA contracting with appropriately licensed or credentialed private practice professionals with TBI expertise, broaden the research authority and cover other conditions and disabilities such as amputations, spinal cord injuries, and burns so that all veterans may have access to the highest quality and most appropriate rehabilitative care in order to live as independently as possible.

We thank you for this opportunity to submit comments.

PREPARED STATEMENT OF THE AMERICAN CONGRESS OF REHABILITATION MEDICINE

The American Congress of Rehabilitation Medicine (ACRM) submits this written statement in support of S. 1233, the Traumatic Brain Injury Rehabilitation Act of 2007.

The mission of the American Congress of Rehabilitation Medicine (ACRM) is to enhance the lives of persons living with disabilities through a multidisciplinary approach to rehabilitation, and to promote rehabilitation research and its application in clinical practice. ACRM serves people with disabling conditions by promoting rehabilitation research and facilitating information dissemination and the transfer of technology. We value rehabilitation research that promotes health, independence, productivity, and quality of life for people with disabilities, injuries, and chronic illnesses. We are committed to research that is relevant to consumers, educates providers to deliver care through best practices, and supports advocacy efforts that ensure adequate public funding for rehabilitation and disability research priorities.

ACRM strongly supports S. 1233, recognizing the immediate need for improved capacity to provide comprehensive, quality care to our Nation's veterans with traumatic brain injury (TBI). Recent press reports have repeatedly highlighted the high incidence and tragic consequences of TBI both in soldiers returning from Iraq and Afghanistan and, by extension, in the civilian population. The Centers for Disease Control and Prevention (CDC) estimates that 5.3 million Americans live with the consequences of TBI, many of whom never seek medical help, resulting in systematic under-counting of so-called "mild" or "moderate" traumatic brain injury.

INDIVIDUAL REHABILITATION AND REINTEGRATION PLANS

Although each person with a traumatic brain injury is unique, most people experience cognitive, behavioral, emotional and physical challenges. Cognitive limitations may include memory loss, impaired thinking, s slowed learning, and difficulty concentrating. Physical limitations may include spasticity, limits in walking, hemiparesis, speech impairments, loss of the use of one's arms and hands, severe fatigue, headaches, changes in sense of smell and taste, balance problems, seizures and endocrine disorders. Behavioral and emotional consequences may include depression, anxiety, and impulsive behavior that may be dangerous to both the individual with brain injury and others.

Because of the complexity of treating TBI, S. 1233 would require that all veterans with TBI be provided case-managed individual rehabilitation and community reintegration plans. ACRM believes these multidisciplinary, long-term plans are vital to the rehabilitation of individuals with TBI as the extended needs of TBI-impacted individuals go beyond the medical response. The needs extend into the social, psychological, physical, and vocational arenas.

PRIVATE PARTNERSHIPS

ACRM also applauds provisions in the legislation that would allow the VA to contract with private providers when it is not feasible for the VA to provide TBI care for a particular individual. It is important that veterans with TBI receive the most appropriate and accessible care possible, whether that care is provided through VA facilities or through a non-VA provider. ACRM believes this provision will open the door to the development and strengthening of partnerships between the VA and private rehabilitation providers that will significantly benefit our returning soldiers. Stronger partnerships between the VA and the private rehabilitation provider system will enable veterans with TBI to receive long term services in close proximity to their support network, including their families, friends and communities.

TRAUMATIC BRAIN INJURY RESEARCH

ACRM strongly supports the provisions in S. 1233 that focus on research on traumatic brain injury. Currently, many answers are not available from research findings that address even basic questions asked by people with TBI and their families. The relative lack of research in this area limits the recovery of people with TBI and hampers clinicians trying to best treat their patients. Despite existing research efforts in both the military and civilian sectors, the pool of "solid answers" remains too small.

Under S. 1233, in carrying out TBI-related research, the VA would be required to collaborate with TBI Model Systems funded by the National Institute on Disability and Rehabilitation Research (NIDRR), under the Department of Education. ACRM applauds the Committee for recognizing the expertise and valuable research available through NIDRR-funded programs.

Currently, NIDRR funds 16 national TBI Model Systems. These Model "Systems" are essentially TBI centers that provide regional TBI treatment capacity as well as collect and analyze longitudinal data from people with TBI. The Model Systems also conduct valuable outcomes research on evidence-based TBI rehabilitation services. A Model System must demonstrate outstanding care to individuals with traumatic brain injury, from the emergency medical services, to acute care in the hospital, to long-term rehabilitation and community integration.

Additionally, NIDRR currently funds several research and training centers which focus on improved outcomes for TBI rehabilitation services. This research helps ensure that people with TBI regain their maximum level of function and return to independent living. All of these civilian resources will be invaluable to the VA as it accelerates the development of treatment systems for returning veterans with TBI. If not for the collaboration required in this bill, ACRM believes that it would take the VA years to develop the treatment and research capacity that the NIDRR-funded Model Systems and the TBI centers currently possess.

THE NEED FOR ADDITIONAL TBI RESEARCH FUNDING AND COLLABORATION

Compared to both the civilian and military need, the funding available for these TBI systems and centers in the past several years has been very modest and has not kept pace with the growing needs of the TBI survivor community. ACRM is concerned, however, that the requirement that the VA collaborate with the NIDRR-funded TBI Model Systems and TBI centers may be a hollow promise if additional funding is not available through the VA budget. The legislation does not authorize additional funding for the systems and centers and the NIDRR budget simply has not funded them adequately to date. In fact, NIDRR has been flat-funded for over 4 years. In order to ensure that the VA's partnerships with NIDRR-funded programs are as efficacious as possible, ACRM suggests that S. 1233 be modified to include authorization of an additional $19 million in Fiscal Year 2008 and in subsequent years to the TBI Model Systems and TBI centers including:

- $6 million to supplement the research efforts of the TBI Model Systems Centers;
- $3 million to fund three additional Rehabilitation Research and Training Centers on TBI;
- $3 million for Field-initiated Research projects on TBI;
- $4 million for 4 centers to develop and evaluate technology to improve outcomes and quality of life;
- $2 million to train diverse professional disciplines for the rehabilitation of individuals with TBI; and

• $1 million for a Knowledge Translation Center to evaluate and report on these TBI projects to Congress and ensure that clinicians incorporate the outcomes studies into clinical practice.

ACRM believes this additional funding for evidenced-based research and regional TBI treatment capacity will benefit our returning veterans with TBI, and, in-turn, all individuals with an acquired brain injury. This additional funding would be extremely timely and an important national investment.

CONCLUSION

In conclusion, ACRM strongly supports S. 1233, the Traumatic Brain Injury Rehabilitation Act of 2007, and thanks Chairman Akaka, Ranking Member Craig, and the Committee and the bill's cosponsors for their commitment to serving our veterans with TBI. ACRM looks forward to working with Congress toward enactment of this important legislation.

Thank you for this opportunity to submit comments.

PREPARED STATEMENT OF THE BRAIN INJURY ASSOCIATION OF AMERICA

The Brain Injury Association of America (BIAA) and its nationwide network of state affiliates representing survivors of traumatic brain injury (TBI), their families, researchers, clinicians and other professionals, believes strongly that Congress must facilitate greater cooperation between the military and civilian health care sectors to ensure returning servicemembers with TBI get the right care, right now. TBI is a growing public health problem in U.S. military and civilian populations. Reports indicate 12,274 servicemembers have sustained a TBI in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) as of March 24, 2007, and some projections estimate that number could ultimately grow as high as 150,000.

The standard of care for TBI is early, intensive acute treatment and rehabilitation, followed by timely post acute rehabilitation of sufficient scope, duration and intensity to restore maximum function and accommodate residual disability. To optimize their independence and maintain the best possible health throughout their lives, individuals with brain injury need access to a full continuum of TBI care.

The BIAA supports S. 1233, as it sets forth a pivotal mechanism for enhancing cooperation between the private sector and the VA health care system. Such cooperation is vitally necessary in order to provide access to, and choice within, the full continuum of care that returning servicemembers with TBI need and deserve.

Efforts within the Department of Defense and the Department of Veterans Affairs (VA) to increase TBI research and treatment capacity in response to the influx of returning servicemembers with brain injuries should be recognized and applauded. Nevertheless, there is a broad consensus that most VA medical facilities have not yet attained the TBI specialty care capacity that is available from private TBI rehabilitation facilities. These civilian facilities have been developing and refining brain injury treatments, including cognitive rehabilitation, for more than three decades, and are ready on a widespread basis to stand side-by-side with the Department of Defense and the Department of Veterans Affairs to help provide the highest quality services to returning servicemembers with TBI, both now and in the long-term.

The BIAA also strongly supports language and provisions in the bill recognizing that rehabilitation for individuals with TBI should be individualized, comprehensive, and multidisciplinary with the ultimate goal of maximizing independence and reintegration into the community. The bill's recognition of the importance of family support to rehabilitation and the need for lifelong case management for veterans with TBI also represents a significant step forward. Further, the BIAA strongly recommends that all allied health professionals, including case managers and support staff, who work with servicemembers with TBI obtain brain injury specialty training and certification.

Research on TBI should be intensified and accelerated on a national level, in large part by augmenting existing research programs of the National Institute on Disability and Rehabilitation Research (NIDRR) TBI Model Systems. Line-item funding of $30 million should be allocated in Fiscal Year 2008 to continue and expand NIDRR's applied research results through TBI Model Systems. The BIAA applauds instructions within S. 1233 for research on TBI to be pursued through collaboration with existing NIDRR TBI research grantees. It is extremely important, and makes the most sense in terms of health care quality and cost efficiency, for the VA to use the extensive work regarding TBI that has been done in the civilian sector and is ongoing in the areas of TBI research, treatment and rehabilitation services. The BIAA further hopes that adequate funding will be appropriated to support this collaborative research, in addition to increased funding of $30 million for TBI Model

Systems overall. Clearly, there is a pressing national need to increase research efforts on TBI in general, and in particular, to leverage the existing civilian TBI research and treatment capacity to improve outcomes measurement capabilities and augment care systems in both the military and civilian sectors.

The Brain Injury Association of America appreciates the opportunity to comment on S. 1233, and stands ready to assist the Committee in all efforts to help improve access to the full continuum of care for returning servicemembers with traumatic brain injuries.

PREPARED STATEMENT OF THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES

The Commission on Accreditation of Rehabilitation Facilities ("CARF") submits the following statement for the record in support of S. 1233, the Traumatic Brain Injury Rehabilitation Act of 2007.

BACKGROUND

CARF is a forty-one-year-old nonprofit organization that establishes standards and assesses conformance with these standards for the continuous improvement of service quality to persons with disabilities and other needs. CARF's mission is to promote the quality, value, and optimal outcomes of rehabilitation and other human services through a consultative accreditation process that centers on enhancing the lives of persons served. CARF uses an independent, professional, nonprofit peer review system recognized by multiple Federal and state agencies, national and international associations, all Canadian provinces, several major insurers, advocacy groups, and professional organizations.

Of great relevance at the moment is the eleven-year partnership between CARF and the Veterans' Administration. In 1996, CARF and the VA initiated an agreement to promote continuous quality improvement in rehabilitation services through national accreditation. Since the first VA accreditations in medical rehabilitation, employment and community services, and behavioral health in 1997, the scope and number of CARF-accredited VA programs and services has grown to include both mandated and voluntary accreditations across the rehabilitation and human service continuum.

The partnership between the VA and CARF has expanded accreditation both in the types of programs and the number of programs. This increase in diversity of accredited programs was in direct response to veterans' needs and the VA and CARF developed new programs or new standards, respectively. However, as successful as the VA–CARF collaboration has been, there are many VA programs that are not CARF accredited, nor accredited by other organizations. CARF looks forward to continuing its work with the VA to help ensure that—through accreditation—veterans, including those with traumatic brain injuries (TBI) and their families, receive the high quality services they deserve.

CARF SUPPORT FOR S. 1233

CARF strongly supports the Traumatic Brain Injury Rehabilitation Act of 2007 (S. 1233) and the Committee's efforts to ensure that veterans with TBI have access to the highest quality and coordinated care in the most appropriate, least restrictive setting. We applaud the Committee's emphasis on comprehensive, long-term rehabilitation and community integration for TBI survivors for once the immediate medical needs of those with brain injuries are met, the physical, behavioral, cognitive psychosocial, vocational, and often residential needs must be addressed.

VA and Private Partnerships

S. 1233 would provide all veterans with TBI access to the most appropriate services, whether through VA facilities or through non-VA providers. The legislation recognizes that while the VA provides excellent medical and rehabilitative care for veterans, such care for TBI survivors is complex, long-term in nature, and not always accessible in the veteran's community environment, where their support system is strongest. Therefore, the legislation would allow the VA to enter into agreements with private providers to implement a veteran's individualized rehabilitation plan when VA services are not feasible or accessible.

CARF applauds the bill's requirement that all private partners be accredited by, or meet the standards of, an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury. CARF believes that this independent accreditation requirement is vital to ensuring quality of care for our wounded warriors receiving services outside the VA health system.

The proposed requirement parallels the move to accreditation by CARF of the VA's own programs serving the rehabilitation needs of veterans.

CARF has developed a comprehensive set of standards for TBI programs, focusing on the unique medical, physical, cognitive, psychosocial, behavioral, vocational, educational, and recreational needs of persons with acquired brain injuries. These standards encompass specialty programs for persons with brain injury provided in a variety of settings including brain injury home- and community-based rehabilitation programs, outpatient rehabilitation programs, comprehensive integrated inpatient rehabilitation programs, residential rehabilitation programs, long-term residential services, and vocational services. Currently, CARF accredits 288 programs within the VA nationwide, including five comprehensive brain injury programs, multiple inpatient rehabilitation, vocational rehabilitation, and homeless veterans' health care programs.

The CARF accreditation process is a rigorous one, involving the development of consensus quality standards subjected to peer review. The accreditation process is also based on peer review with a strong focus on the person served by the program and the impact that those services actually have on the recipient of care.

We are confident that CARF-accredited TBI programs meet the Department's, the Committee's, and our veterans' high standards of quality and comprehensive care.

Individual Rehabilitation and Community Reintegration Plans

CARF strongly supports the legislation's requirement of individualized rehabilitation and reintegration plans for each veteran with TBI leaving inpatient therapy.

It is commonplace for inpatient rehabilitation programs, and required by CARF-accredited inpatient rehabilitation programs, to provide patients with reintegration plans that not only address the future medical needs of the individual, but his/her psychological, transitional residential, social, and vocational needs as well. And, because some of our returning veterans have unique injuries and complicated behavioral and psychological issues, a case management model for outpatient, community rehabilitation is extremely appropriate.

Given CARF staff and surveyors' significant expertise in the areas of social, medical, and vocational services and TBI rehabilitation, CARF would like to serve as a resource to the Committee and the Department as they develop and implement these individual rehabilitation and reintegration plans.

Assisted Living Services

CARF supports the Committee's effort to examine the effectiveness of long-term residential services for veterans with TBI. However, CARF has concerns regarding the use of the term "assisted living."

The legislation defines assisted living services as "services of a facility in providing room, board, and personal care and supervision of residents for their health, safety and welfare." However, CARF is concerned that the popular interpretation of the term "assisted living" commonly describes a facility that has adequate staff to assist the residents with very limited and often aging-related needs.

However, given our experience with TBI rehabilitation, CARF recognizes the more extensive and specific residential needs of these individuals. We suggest that the Committee use the term "brain injury long-term residential services" If you do not get them to understand that these are Brain Injury programs first rather than residential programs first then I think they will still have assisted living facilities saying they can do brain injury work to describe the types of facilities which could best serve veterans with TBI and in which these pilot programs would take place. In this manner, if the VA requires accreditation of these assisted living providers, it will more likely engage accreditation organizations that will truly understand the residential and long-term needs of TBI survivors.

CARF currently accredits 262 brain injury residential and 261 long-term residential brain injury programs in the private sector and would appreciate that opportunity to work with the Committee to identify the types of residential programs most appropriate for returning soldiers with TBI and therefore, most appropriate for these pilot programs.

CONCLUSION—SUPPORTING VA FUTURE DIRECTIONS

In conclusion, CARF is vested in growing and changing with the VA as its programs and services move into the twenty-first century. To maximize the quality of services and amount of care the VA provides to veterans, CARF standards can be used to help align the VA to deliver the greatest amount of consumer benefit possible from each dollar of funding the service networks receive. CARF will continue to anticipate changes in the field and begin developing specific service unit standards as veterans' needs change and service delivery progresses.

CARF strongly supports S. 1233 and applauds the Committee's commitment to improving access to and quality of care for veterans with traumatic brain injury. We are pleased to see language in the bill that recognizes the value of independent accreditation as a means of ensuring quality and look forward to working with Congress toward enactment of this important legislation.

[Note: The following is an e-mail from a Vermont resident sent to Senator Bernard Sanders on May 17, 2007.]

DEAR SENATOR SANDERS: I read in the *Rutland Herald* yesterday about the Veterans benefits and the veterans that fall into the catagory "8". My husband applied and he fell into that catagory because he had not signed by by 2003, he was denied any medical benefits. He needs to have medical care because he has diabetes and we are unable to afford health insurance for him. I am hoping you can do something about this situation for veterans. Thank you.

EPILEPSY FOUNDATION,
Landover, MD, May 22, 2007.

Hon. DANIEL K. AKAKA,
Chairman, Committee on Veterans' Affairs,
412 Russell Senate Office Building,
Washington, DC.

DEAR CHAIRMAN AKAKA: On behalf of the over 3 million Americans with epilepsy, the Epilepsy Foundation is pleased to support S. 1233, The Veterans Traumatic Brain Injury Rehabilitation Act of 2007. The Foundation is deeply concerned with the high incidence of epilepsy that results from traumatic brain injury. Although we do not have data on post-traumatic epilepsy from the current wars, the statistics from the Vietnam era are alarming. VA-funded research conducted in collaboration with the Department of Defense found that 53 percent of veterans who suffered a penetrating TBI in Vietnam developed epilepsy within 15 years. For these service-connected veterans, the relative risk for developing epilepsy more than 10 to 15 years after their injury was 25 times higher than their age-related civilian cohorts. Indeed, 15 percent did not manifest epilepsy until five or more years after their combat injury.

Because of these alarming statistics from the Vietnam War, the Epilepsy Foundation is thankful that S. 1233 addresses the periodic assessment of the rehabilitation plan. The consequences of a TBI may change over time and new symptoms may develop. For example, individuals with TBI may develop post-traumatic seizures months or years after the injury. Because epilepsy requires regular monitoring and, for many patients, frequent changes in their anti-seizure medications, this periodic assessment is crucial. The Foundation strongly supports the "team approach" laid out in section 3 of S. 1233. Each veteran who suffers a TBI should receive ongoing individualized, comprehensive and multidisciplinary rehabilitation after inpatient services. Rehabilitation plans that are based upon a comprehensive assessment of the veteran's physical, cognitive, vocational, and psychosocial impairments, using a multidisciplinary team that includes neurologists (as required by S. 1233), are essential to rehabilitative success. Additionally, we support the provision in section 3 which requires involving the family and veteran in the development and review of the rehabilitation plan. TBI is a devastating and life-altering event which affects the veteran and his or her family. Families of veterans with TBI need support and education, and should be part of the rehabilitative team to the greatest extent possible.

Perhaps the most important aspect of S. 1233 is the recognition of seizure disorders as a common outcome of TBI (Sec. 8). We know that post-traumatic epilepsy is going to be a significant long-term consequence of TBI, and this language will help create awareness of the growing problem.

Given this high rate of post-traumatic epilepsy that veterans with TBI are likely to endure, the Epilepsy Foundation believes that Congress should also authorize, and the VA must establish a strong national epilepsy program with research, education and clinical-care components, to include Epilepsy Centers of Excellence. We are concerned that the VA lacks a national program for epilepsy with clear guidelines on when to refer patients for further assessment and treatment of epilepsy. VA Centers of Excellence have been the model of innovation in the delivery of highly specialized health care and research for other disabling and chronic diseases in the veteran population. VA has infrastructure to address many of the other common

consequences of TBI, such as psychosocial changes, vision problems and movement disorders but not post-traumatic epilepsy.

I personally look forward to working with you on moving this legislation forward. Please feel free to contact me or Donna Meltzer, Senior Director of Government Affairs at 301–918–3764 or *dmeltzer@efa.org*. Thank you again for your leadership and commitment to our Nation's veterans.

Sincerely,

TONY COELHO,
Immediate Past Chair,
Epilepsy Foundation Board of Directors.

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