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

STATEMENT OF
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ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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Mr. Chairman, Ranking Member Burr and other Members of the Committee:

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

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

S. 2273-Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act of 2007

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

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

S. 2377-Veterans Health Care Quality Improvement Act

This bill would direct the Secretary of Veterans Affairs to prescribe standards for appointment and practice as a physician within the VHA of the VA. The bill would require appointees to VA physician positions, and physicians already employed by VA at the time of enactment, to disclose certain private information, including each lawsuit, civil action, or other claim against the individual for medical malpractice or negligence, and their results. Each appointee would be

required to disclose any judgments that had been made for medical malpractice or negligence and any payments made. The bill would require all new physician appointments to be approved by the responsible director of the Veterans Integrated Services Network (VISN) in which the individual would be assigned to serve and require all VA specialty physicians to be board certified in the specialties in which the individuals would practice. Also the bill would require State licensure by VA physicians in the State of practice.

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

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

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

S. 2383-A bill to require VA to establish a pilot program on the mobile provision of care and service for veterans in rural areas

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

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

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

S. 2573-Veterans Mental Health Treatment First Act

This bill would establish a new approach to dealing with veterans who are diagnosed with post traumatic stress disorder (PTSD), depression, anxiety disorder or co-morbid substance abuse disorder that, in the judgment of a VA physician, is related to military service. Financial support, known as a "wellness stipend," would be provided to veterans who were willing to commit to a VA treatment plan with substantial adherence to that plan for a specified period of care. In order to be eligible for the wellness stipend, the veteran would be required to agree not to file a VA disability compensation claim for the covered conditions for one year or the duration of the treatment program, whichever time period would be shorter. Duration of treatment would be individualized and determined by the attending VA clinician. Under the program, there would be two proposed levels of wellness stipends. Receipt of the full wellness stipend would depend on the veteran having no service-related rating for PTSD, depression, anxiety disorder, or related substance abuse, and having no claim pending for one of the conditions mentioned.

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

Mr. Chairman, DAV has a growing concern about the effects of wartime exposures especially those being identified in the newest generation of disabled veterans of the wars in Iraq and Afghanistan. Military deployments in Iraq and Afghanistan are among the most demanding since the War in Vietnam nearly four decades ago. In addition to causing the heavy physical injuries and casualties, the rates of "invisible" wounds of war (primarily PTSD, depression, substance abuse, suicidal ideation, and family distress) for those who have served in Operations

Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) are dramatically high and still rising. All too often these conditions go unreported and even unrecognized. There are several reasons for the emergence of PTSD in these veterans of Iraq and Afghanistan. Many studies have shown that more frequent and more intense involvement in combat operations increases the risk of developing associated mental health conditions. Military commanders report that the combat environment in Iraq is intense and constantly dangerous, and some serving members are being returned for second, third or even fourth deployments. Furthermore, our military is fighting an insurgency absent clearly identifiable fronts or marked enemy soldiers; these conditions demand vigilance because there are no safe military occupational specialties or safe harbors. For an increasing number of veterans of these types of conflicts, these stressors result in devastating mental health consequences and historically high rates of PTSD, and other post deployment mental health issues.

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

A recent review of the scientific literature addressing this issue dispels this erroneous belief and demonstrates that there is no conclusive evidence of differences in health care utilization among compensation seeking and non-compensation seeking veterans with PTSD, nor is there evidence that compensation seeking veterans demonstrate less symptom improvement after PTSD treatment than veterans who are not seeking compensation. These careful, peer-reviewed scientific studies contradict the OIG findings. While it is possible that a small fraction of veterans exaggerate symptoms or fail to participate in treatment in order to receive more disability compensation, the evidence does not support this behavior as a major factor hindering treatment or recovery from PTSD.

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

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

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

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

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

Over the years, science has broadened our knowledge about mental health and illnesses including the effects of combat stress and trauma. These studies have shown us new paths to effective treatment and recovery for military service members and combat veterans. The Institute of Medicine (IOM) recently compiled and analyzed all of the research on the evidence for treatments proven effective for PTSD . The IOM reported there is sufficient evidence to conclude that prolonged exposure and cognitive behavior therapies are effective in treatment of PTSD. While many military service members and veterans have access to these treatments, gaps still remain in system-wide availability, not only in both VA and the Department of Defense (DoD), but also in the private mental health sector.

There is an overwhelming body of knowledge that documents the growing needs of OIF/OEF veterans for effective mental health services. In April 2008, Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery was

published by RAND. In addition to a comprehensive literature review, this study undertook a population-based telephone survey of 1,965 service members and veterans who had deployed to Iraq or Afghanistan. This survey found substantial rates of mental health problems in the 30 days before the interviews, with 14 percent screening positive for PTSD, 14 percent for major depression and 19 percent for reporting a probable traumatic brain injury (TBI) during deployment. Assuming that the prevalence of these conditions is representative, this study suggests that approximately 300,000 individuals who served in OIF/OEF suffer from PTSD or major depression, and 320,000 individuals may be at risk for TBI. RAND concluded at least one third of all OIF/OEF veterans have one of these conditions and 5% report symptoms of all three. RAND also found that OIF/OEF veterans seek treatment for PTSD and major depression at about the same rate as the general civilian population, and like the civilian population, many are not receiving any mental health care. Over the past year, only 53% of those who met criteria for current PTSD or major depression had sought health care from a physician or behavioral health provider.

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

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

However, DAV strongly opposes any provision that attempts to link wellness stipend payments to a veteran's commitment not to file a disability claim. While science has enhanced our ability

to recognize and treat the mental health consequences of service in combat including PTSD, the treatments are not universally effective. Using the best research and evidence-based treatment, complete remission can be achieved in 30-50% of cases of PTSD and partial improvement can be expected in most patients. PTSD and major depression tend to remit and recur. There is no justification for the view that participation in evidence-based therapy will eradicate the illness or eliminate the need for a subsequent claim for disability.

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

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

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

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

S. 2639-Assured Funding for Veterans Health Care Act

Mr. Chairman, as you well know, this bill would reform VA health care funding by moving it from its current status as a discretionary appropriation to that of mandatory status. The formula proposed by this bill is well recognized and has been pending before Congress for the past five years. As we testified before your Committee on July 25, 2007, VA has been unable to manage or plan the delivery of care as effectively as it could have, as a result of perennially inadequate

budget submissions from Presidents of both political parties; annual Continuing Resolutions in lieu of approved appropriations; late arriving final appropriations; offsets and across-the-board reductions; plus the injection of supplemental and even "emergency supplemental" appropriations to fill gaps. In 13 of the past 14 years, VA has begun its year with Continuing Resolutions, creating a number of challenging conditions that are preventable and avoidable with basic reforms in funding for VA health care.

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

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

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

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

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

Mr. Chairman, DAV will continue to support S. 2639 as a reasonable and responsible means to solve funding problems experienced by VA. However, we and the other members of the Partnership understand there is strong opposition by some to mandatory funding and so we have been developing an alternative approach to achieve the goals of mandatory funding-sufficient,

timely and predictable funding-while addressing the concerns over PAYGO, Congressional oversight, and fiscal responsibility. Over the last several weeks, we have briefed both majority and minority staffs of this and other relevant Congressional committees and Leadership on our alternative proposal. Essentially, this new proposal would shift VA medical care appropriations to a one-year advance appropriation, and require that VA's health expenditure forecasting model be audited and reported to Congress by the Government Accountability Office (GAO) on an annual basis.

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

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

Having addressed sufficiency, we next propose that VA's medical care funding be done through a one-year advance appropriation to ensure that it arrives on time in a manner that is easily predictable from year to year. Congress can and has provided advance appropriations for a number of important programs for both financial and political reasons. In some cases, such as in the Department of Housing and Urban Development (HUD) Section 8 housing vouchers, and in Head Start, the advance appropriation is a partial-year advance. In other cases, such as LIHEAP, the Low Income Home Energy Assistance Program, the appropriation is done a year in advance to assure that this assistance can be delivered before the onset of winter and to allow for the purchase of heating oil during the best market conditions of the year prior. Other advance appropriations, such as for the Corporation for Public Broadcasting, were authorized to allow the program to plan and operate without needing to worry that partisan, political debates might negatively impact the program at the last moment. Advance appropriations are different from biennial budgets: advance appropriations pass a one-year budget one or more years in advance, whereas a biennial budget approves a two-year budget each two years.

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

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

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

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

S. 2796-To require a pilot program on the use of community-based organizations to ensure that veterans receive the care and benefits they need, and for other purposes.

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

While we have no adopted resolution from our membership supporting this precise concept, DAV believes this is a well-intentioned proposal. We have some concern about VA as a granting

agency for such broad purposes, but we believe if it is targeted and carefully managed by VA, this function could be an important and creative new tool in rural and remote areas where establishing a direct VA service presence would be impractical. If the bill is enacted, we also recommend VA carefully craft the services expected from a grantee in the area of aiding these veterans with their VA disability benefits claims. These are highly technical matters and require the assistance of expert service officers from the States, the veterans service organization (VSO) community and the Veterans Benefits Administration through its veterans benefits counselor function. Finally, for any health care involvement associated with these grants, we urge VA to coordinate this new grant program through its Office of Rural Health. With these caveats, DAV supports the enactment of this bill.

S. 2797-To authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 2009, and for other purposes.

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

DAV supports this bill and urges its enactment.

S. 2799-Women Veterans Health Care Improvement Act of 2008

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

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

annual report on the number of primary care and mental health professionals who received the required training, the number of full-time employees providing treatment for MST and PTSD in each VA facility, and the number of women veterans who had received counseling, care and services associated with MST and PTSD.

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

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

Mr. Chairman, women veterans are a dramatically growing segment of the veteran population. The current number of women serving in active military service and its reserve and Guard components has never been larger and this phenomenon predicts that the percentage of future women veterans who will enroll in VA health care and use other VA benefits will continue to grow proportionately. Also, women are serving today in military occupational specialties that take them into combat theaters and expose them to some of the harshest environments imaginable, including service in the military police, medic and corpsman, truck driver, fixed and rotary wing aircraft pilots and crew, and other hazardous duty assignments. VA must prepare to receive a significant new population of women veterans in future years, who will present needs that VA has likely not seen before in this population.

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

S. 2824-To amend title 38, United States Code, to improve the collective bargaining rights and procedures for review of adverse actions of certain employees of the Department of Veterans Affairs

We do not have an approved resolution from our membership on this specific labor-management issue, but we do have concerns about the reported deteriorated state of labor relations in the VA. DAV typically concentrates on matters dealing with quality, access, and convenience of VA health care and other services and benefits for veterans, and relies on VA to manage its system properly to meet those ends. However, we believe labor organizations that represent employees

in recognized bargaining units within the VA health care and benefits system have an innate right to information and participation that results in making VA a workplace of choice, and particularly to fully represent VA employees on issues impacting working conditions and ultimately patient care.

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

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

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

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

S. 2889-The Veterans Health Care Act of 2008

Mr. Chairman, you requested DAV's views only on sections 2 through 6 of this bill. Section 2 would provide VA specific contracting authority to obtain specialized residential care and rehabilitation services for OIF/OEF veterans who are suffering from TBI, and who are exhibiting such cognitive deficits that they would otherwise require admission to nursing home facilities. Section 3 would provide full-time VA board-certified physicians and dentists the opportunity for continuing medical education, with VA reimbursement of expenses up to $1,000 per year for

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

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

S. 2899-The Veterans Suicide Study Act

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

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

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

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

S. 2921-The Caring for Wounded Warriors Act of 2008

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

Section 2 of the bill would establish up to three VA pilot programs for assessing the feasibility of providing training and certification for, and subsequent compensation to, family caregivers of severely disabled veterans and severely injured service members who remain on active duty status but are presumably under VA care. In developing the pilot programs the VA Secretary would be required to do so in conjunction with the Secretary of Defense. In selecting the locations of the pilot programs, the Secretary would be required to give special emphasis to the VA's poly-trauma center locations. The bill would require curricula to be developed to incorporate applicable standards, protocols and best practices to govern this pilot program. Under the terms of the bill, the Secretary would determine the eligibility of a family member for participation, and the type of care a family member would provide would be based on the needs of the veteran as determined by the veteran's attending physician. The bill would authorize compensation to be paid to a family caregiver for care and services rendered to the veteran or service member (in the case of a severely disabled service member, the bill would require reimbursement to VA by TRICARE for benefits provided under this authority). The bill would authorize VA to provide certain supportive services to a family caregiver, including an assessment of needs and referral to services that can assist them in continuing in that crucial role. This bill would not preclude VA reimbursement for health care services provided by a non-family member, nor would it bar access to other services and benefits otherwise available to disabled veterans with brain injury.

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

These two ideas are worthy and if implemented carefully, could provide major new approaches to the care of severely injured veterans, and provide welcome relief to their family caregivers. DAV was pleased that Senator Clinton's staff consulted with DAV in developing this proposal to aid caregiver families. Also, these proposals are fully consistent with recommendations of the

Fiscal Year 2009 Independent Budget. Thus, DAV strongly supports this bill and urges the Committee to work toward its enactment.

S. 2926-The Veterans Nonprofit Research and Education Corporations Enhancement Act of 2008

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

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

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

S. 2937-To provide permanent treatment authority for participants in Department of Defense chemical and biological testing conducted by Deseret Test Center and an expanded study of the health impact of Project Shipboard Hazard and Defense, and for other purposes.

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

DAV has no objection to the enactment of this bill.

S. 2963-To improve and enhance the mental health care benefits available to members of the Armed Forces and veterans, to enhance counseling and other benefits available to survivors of members

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

be determined by the Secretary. The bill would authorize $2 million annually to carry out its purposes.

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

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

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

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

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

S. 2969-The Veterans' Medical Personnel Recruitment and Retention Act of 2008

Section 2 of the bill would provide authority to the Secretary of Veterans Affairs to establish additional "hybrid Title 38-Title 5" occupations (32 such occupations have been established by previous acts of Congress in section 7401, title 38, United States Code, including psychologist, physician assistant, licensed vocational or practical nurse, social worker, and numerous technical health fields). Under this section the Secretary would be required to report any such reclassification of VA occupations to the OMB, to your Committee and its House counterpart. This section would also add "nurse assistant" as a specific new occupational class in this hybrid category. Section 2 would clarify probationary periods and appointment policies for full-time and part-time registered nurses. The section also would authorize VA on a case-by-case basis to reemploy federal annuitants with temporary appointments in selective health care positions under

sections 7401 and 7403, title 38, United State Code, without offsetting their retirement annuities paid to them under title 5, United States Code. This section would provide VA additional authority to raise compensation of personnel employed in the immediate Office of the Under Secretary for Health; provide VA pharmacist executives eligibility for special incentive pay; and provide clarification on compensation policy for VA physicians, including cost of living adjustments and market pay provisions in chapter 74, title 38, United States Code. Finally, it would provide additional policy on nurse pay caps, special pay for nurse executives; locality pay systems for VA nurses; part-time nurse pay rules; weekend pay rules, as well as clarified direction on the use and disclosures on wage surveys in nurse locality pay determinations.

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