

**LEGISLATIVE HEARING ON H.R. 3051,
H.R. 6153, AND H.R. 6629**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS

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**LEGISLATIVE HEARING ON H.R. 3051,
H.R. 6153, AND H.R. 6629**

TUESDAY, SEPTEMBER 9, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Hare, Berkley, Salazar, Miller, and Brown of South Carolina.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call this hearing to order. And I would like to thank everyone for coming today. Today's legislative hearing is an opportunity for Members of Congress, veterans service organizations (VSOs), the U.S. Department of Veterans Affairs (VA), and other interested parties to provide their views and discussion on the legislation that has been introduced within the Subcommittee's jurisdiction. I do not necessarily agree or disagree with these bills before us today, but I believe that this is an important part of the legislative process that will encourage frank discussion of new ideas.

We have three bills before us today. Congressman Salazar's bill, H.R. 3051, the "Heroes at Home Act of 2007," H.R. 6153, Congresswoman Johnson's bill, the "Veterans' Medical Personnel Recruitment and Retention Act of 2008," and H.R. 6629, Congresswoman Shea-Porter's bill, the "Veterans Health Equity Act of 2008." I look forward to hearing the views of our witnesses on these bills before us. Due to the late inclusion of H.R. 6629 we do not expect to have written testimony today. However, I would ask the witnesses if they would submit their views in writing on H.R. 6629 within ten legislative days after the ending of this hearing.

[The prepared statement of Chairman Michaud appears on p. 29.]

Mr. MICHAUD. I would like to ask Mr. Hare if he has an opening statement.

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. I do. Thank you, Mr. Chairman. First, let me thank you and Ranking Member Miller for holding this hearing today.

The three bills before us today address important issues, all of which have huge impacts on the welfare of our Nation's veterans.

Secondly, I would like to thank the sponsors of these bills, the three Members that are testifying before the Subcommittee today. Mr. Salazar is a fellow Committee Member and I know from sitting next to him over the past 2 years that he is a tireless advocate for veterans, especially the many rural veterans that live in his large district in the State of Colorado. His bill addresses family caregivers of veterans suffering from Traumatic Brain Injuries (TBI), and also telehealth services. These are crucial matters that are directly in line with Mr. Salazar's passion for improving the lives of veterans and their families.

Ms. Johnson is also a big supporter for veterans. For fifteen years she worked at the Dallas VA Medical Center (VAMC) as a medical and psychiatric nurse. Appropriately, her bill aims to help VA recruit and retain more nurses and other healthcare professionals.

Ms. Shea-Porter and I came into Congress at the same time, and I know without a doubt that there is nobody more dedicated to serving our veterans than she is. It is a paradox then that her home State, the great State of New Hampshire, does not have a VA Medical Center. Her bill attempts to resolve this injustice.

Third, I would like to thank all of our witnesses for testifying today, including Dr. Cross of the VA, and each representative of the three VSOs present. I would also like to congratulate the Disabled American Veterans (DAV) for recently electing Raymond Dempsey, a fellow Illinoisan, as National Commander. Speaking on behalf of this great State of Illinois I take pride in knowing that such a well respected organization is under the leadership of Mr. Dempsey.

Mr. Chairman, thank you again for holding this important hearing. I look forward to our witnesses testifying this morning. Thank you.

[The prepared statement of Congressman Hare appears on p. 29.]

Mr. MICHAUD. Thank you very much, Mr. Hare, for your opening statement. Mr. Miller.

Mr. MILLER. Thank you very much, Mr. Chairman. I apologize for being late. I would like to just submit my opening statement for the record.

[The prepared statement of Congressman Miller appears on p. 29.]

Mr. MICHAUD. Without objection so ordered.

Now I would like to thank our first panel for coming here this morning. I look forward to your testimony. We will start off, in the order that you arrived, with Congresswoman Johnson of Texas to introduce her piece of legislation first. Thank you.

STATEMENTS OF HON. EDDIE BERNICE JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS; HON. JOHN T. SALAZAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO; AND HON. CAROL SHEAPORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE

STATEMENT OF HON. EDDIE BERNICE JOHNSON

Ms. JOHNSON. Thank you very much, Mr. Chairman, and other distinguished members of the panel. I will submit my written statement and try to summarize.

As has been said, I worked as a professional psychiatric nurse at the Veterans Administration Hospital for fifteen years before entering public office, and I opened the psychiatric unit. And I know how important the psychiatric unit became day after day as veterans started coming back from active wars. Recently there were four suicides of psychiatric patients at the VA hospital that made the front page of the paper. The VA hospital is in my district so I went to visit to see what the problem was. And they explained that the real problem is they are not attracting enough professional nurses to do what they need done to observe psychiatric patients. As you know, psychiatric patients are supposed to be observed at least every fifteen minutes. It is also very important for consistency. It is important that they develop a relationship with the nurses. And the nurses remain the profession with the most trust of the public.

They are using part-time nurses because the work in the VA hospital for nurses is a little more stringent than in other facilities. And they identified their problem as not having nurses in the Medical Personnel Recruitment and Retention Act. And it actually came out because nurses were so tight, there was such a shortage, that they thought that this would give more even distribution of nurses to other facilities as well. But they found that they lost many, many nurses because of the work. It is just hard in facilities like the VA.

It does not take much to observe that. You can go into a private facility and if you find a professional nurse they are usually seated at the desk. You go into a VA hospital and they are usually walking, taking care of patients. So it is really a difference, and I can tell you that from experience.

So I came back to see what I could do. They specifically asked for this type of legislation. And I saw where Senator Akaka had introduced a bill, it is Senate Bill 2969, that address the same problem. And so this simply is a companion bill to his. It is an urgent need. Very early I put an amendment on one of the bills to see that when patients were admitted to psych, admitted, coming directly from war, that they got a psychiatric evaluation by professionals right away because most of them come back with post traumatic stress disorder (PTSD) even if they do not have head injuries, and many are coming back with head injuries. The earlier they are diagnosed, the earlier the intervention, the better the outcome.

When I worked at the VA hospital, there were long-term patients because at the time the modality was not experienced enough to

have very early intervention. Consequently, we had a number of long-time, chronic patients. The approach has changed now. But in order to make it successful, the professionals must be available. And this legislation directly addresses that issue by placing nurses in the same category of physicians and dentists, and other therapists, so that their pay rate pays them back into it. So that their pay will be on the scale that it had been on the professional level.

I know that this is asking for additional money, probably not right away but in the scale as it comes. But if we want to give the appropriate attention to those people that have given much of their lives in defending this country, I think it is only right to make sure that they have adequate care, and a large enough and professionally qualified staff; especially nurses, who spend more time with the patient than any other professional. They are in their care, they are there 24 hours. And especially on a psychiatric ward you cannot depend on people coming in part-time, hitting it one time this week and another time next month. You have got to have consistency.

I see that my time is up and I will be available for any questions.

[The prepared statement of Congresswoman Johnson appears on p. 30.]

Mr. MICHAUD. Thank you very much, Congresswoman. Congressman Salazar, thank you for introducing your piece of legislation and for your ongoing commitment to our veterans. I open it up for your comments.

STATEMENT OF HON. JOHN T. SALAZAR

Mr. SALAZAR. Well, thank you Mr. Chairman, Ranking Member Miller, and Members of the Subcommittee. I surely enjoy being a Member of this wonderful Committee and all the work that we all do for veterans. I appreciate the trip that we took to Iraq. That was a very enlightening trip.

Mr. Chairman and Ranking Member Miller, first I would like to thank Dr. Jim Schraa, a neuropsychologist at Craig Hospital, and Anna Frese, with the Wounded Warrior Project, who submitted testimony for the record on the bill that I introduced, H.R. 3051, the "Heroes at Home Act," on July 17, 2007.

The purpose of this bill is to improve the diagnosis and treatment of traumatic brain injury in current and former members of the Armed Forces. The program will be located in VA healthcare centers across the Nation. This is especially important in rural districts like mine where making healthcare accessible is a constant challenge. H.R. 3051 addresses the needs for access to care by expanding the U.S. Department of Defense (DoD) and VA telehealth, and telemental health programs. Ultimately the bill will ease the burden on our veterans suffering from TBI and the families who care for them.

Our Committee has heard testimony from many veterans, VSOs, and the VA on mounting cases of TBI, PTSD, and other invisible wounds of war. I think that many of us agree that veterans are often worse off with those unseen injuries than those with visible, physical injuries. Unlike injuries that can heal, brain injuries are often permanently disabling. In addition, TBI can sometimes take

years to develop and diagnose. Even when discovered, the road to recovery is long and is borne by families of our brave men and women in uniform.

We have also heard of the link between TBI and other mental conditions such as epilepsy. A DoD study after Vietnam found that 15 percent of soldiers with a penetrating TBI developed epilepsy soon after their injury. H.R. 3051 creates a program to train family members of the TBI patients to become their personal care attendants. Participants going through the program would also become certified and receive compensation from the VA so that they can focus their energy on caring for their loved one.

By taking place at home with family, the healing process is made more comfortable for our veterans. The cost to the VA for having someone cared for at home is less than having them at a medical facility and allows the VA to allocate the resources they have to serve more veterans. We have soldiers in Iraq and Afghanistan spending longer periods of time in harm's way and away from their families, and with this in mind we need to ensure that there are programs in place to care for them when they return home.

A program that provides quality care for our veterans and a financial benefit for the family seems appropriate for the difficult economic times our country is facing. Most importantly, the bill will help us reach our goal of ensuring our veterans the best care.

Mr. Chairman, I still have 2 minutes and I anticipated some of the questions that you might have. If you do not mind, I would like to address some of those. I know that one of the questions is how much is this going to cost? The Congressional Budget Office has not scored this bill. However, the cost of having someone cared for at home is much less than having them at a medical institution. In fiscal year 2006, San Diego VAMC spent \$825,000 for Personal Care Attendants (PCA) services for 52 veterans. This year they expect the service's cost to be \$1 million. They are currently providing home care services to 56 individuals. I believe that it is much less expensive to take care of these veterans at home with family members. We must keep in mind that a family member rate is less than \$16 per hour versus a professional at a medical facility that may be charging \$30 or more.

The training will actually take place at home. Currently the Department operates a similar PCA training and certification program for the spinal cord injury (SCI), SCI population out of San Diego. Senate Bill 3421, the "Veterans Benefits Healthcare and Information Technology Act of 2006," includes a provision which, in section 214, requires the establishment of a pilot program to improve caregiver assistance. I think that the language specifically mentions caregiver training and certification as part of the pilot and authorizes \$10 million over the next 2 years.

With that, Mr. Chairman, I think my time is up. I do appreciate your time.

[The prepared statement of Congressman Salazar appears on p. 31.]

Mr. MICHAUD. Thank you very much, Mr. Salazar. Ms. Shea-Porter, I want to thank you for coming this morning and presenting your piece of legislation, and thank you for fighting for our veterans as well.

STATEMENT OF HON. CAROL SHEA-PORTER

Ms. SHEA-PORTER. Mr. Chairman, thank you for the opportunity to speak to your Subcommittee about a critical inequity facing New Hampshire veterans, the lack of full service in State healthcare. New Hampshire has not had a full-service veterans hospital since 2001. New Hampshire is the only State without a full-service VA hospital or comparable facility. Veterans in Alaska and Hawaii receive care at military hospitals on base. While New Hampshire may be a small State, it has a veteran population of 130,000. Unlike many New England States whose populations are declining for veterans, New Hampshire's veterans population is projected to grow over the next 10 years.

Because New Hampshire does not have a full-service veterans hospital, our veterans are forced to travel out of State for some medical care. Veterans traveling from the most northern parts of the State can travel for 3 hours to Manchester and then be forced to travel another hour to Boston if referred there for care. Then they have to wait while everybody on that van receives their care. So we are sending our sickest and our most vulnerable to Boston to wait all day after traveling several hours to get to the central meeting point. This routinely happens. In 2007, 704 of our veterans were transferred out of State for acute care. Three-hundred forty-six of those veterans were sent to Boston.

I have been calling for the VA to either restore the Manchester facility to full-service hospital care, or allow New Hampshire vets to receive care locally since I came to Congress. I have been working with both the VA and my colleagues to realize that goal. Chairman Filner visited the Manchester facility earlier this year and held a series of events, including a round table hearing in which we heard about the serious burdens placed on the New Hampshire veterans and their families simply because we do not have a full-service hospital. And again, I would like to emphasize, the only State in the country.

Despite these efforts, the administration refuses to either provide local access to care or restore the full-service hospital care to New Hampshire. I met with Secretary Peake at the Manchester VA Medical Center in June to express my interest in working with him to either restore the facility to a full-service hospital or provide local access. Unfortunately, after our meeting, Secretary Peake told the local press that there would be no full-service hospital in Manchester.

The administration's failure to act is just unacceptable. New Hampshire veterans deserve the best care possible and the current system is not delivering that. That is why I introduced H.R. 6629, the "Veterans Health Equity Act of 2008." This legislation will ensure that veterans have access to at least one full-service VA hospital, or that they can receive care locally. That would mean that the VA would have to do one of two things, either restore the facility to a full-service hospital or provide more local care providers. The men and women in our local VA facility have done a herculean job caring for these vets despite the limits placed on them. The administration has recently shown some willingness to allow radiation therapy to be provided locally, but this is not enough. Our veterans, regardless of whether they need radiation therapy, men-

tal health services, acute care, or anything else, need and deserve the care their counterparts in every other State receive. It is unconscionable that we deny them this full-service care and instead we offer ad hoc services.

Mr. Chairman, I appreciate your leadership in providing the best healthcare for our Nation's veterans. I am sure you and other members of your Subcommittee appreciate the challenges created by the lack of the full-service hospital. I look forward to working with you and the Subcommittee to address these challenges. Again, thank you for the opportunity to come and speak to you about this important issue and I look forward to answering any questions that you might have. Thank you.

[The prepared statement of Congresswoman Shea-Porter appears on p. 31.]

Mr. MICHAUD. Thank you very much, Congresswoman. And once again I would like to thank our first panel for your willingness to come before us this morning. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. Ms. Shea-Porter, you only talk about the 48 contiguous States and you do not talk about Alaska. You talk about Hawaii, but what about the territories as well? Is there a reason—

Ms. SHEA-PORTER. Well my understanding, and again we were just looking at the ones coming from our States, but they can receive access at military bases. And so when we looked at just the 50 States, and because that was the best comparison that we could make, we are the only State without it. And the others have access to military base hospitals. And so, it has really created a tremendous burden on these vets, especially as I indicated the oldest and the sickest. Because they are the ones who are being sent the farthest. And up until now, the families were not properly reimbursed for the travel. And when you look at who generally has to travel, it is an extra burden on the family and the community. If an 80-year-old man, for example, needs to go to the VA and he has got a 5-hour trip, that means his wife is probably about 80 years old herself, needs to find help to bring him at least to the first part to the Manchester VA, where they can then head off to Boston.

So the burden is awful and is unfair. And New Hampshire veterans are aware of this. And here is the other problem. We need people to enlist in the service. And we have young men and women in New Hampshire looking at that and saying, "You know, that just does not seem fair." And so, if we also want to make sure we recruit and bring our fine New Hampshire men and women into the service, we need to make sure that they know we will keep our promise to them and our commitment, and care for them when they return.

Mr. MILLER. So, it is your understanding that veterans in American Samoa and the Virgin Islands have access to military hospitals?

Ms. SHEA-PORTER. Well, I do not know what they do. I am just looking at the 50 States. And as I said, we are looking strictly at our 50 States and saying, "What do they do in every other State?"

Mr. MILLER. Actually, you said the 48 contiguous States.

Ms. SHEA-PORTER. Well, that is because the other two have comparable care. And what I am asking for is either or. I am just asking for comparable care. I am not saying it has to be a full-service VA hospital as long as they allow contracts locally so that our servicemen and women are not forced to take on an undue burden.

Mr. MILLER. Thank you. That is all.

Mr. MICHAUD. Mr. Hare. Questions? Mr. Brown. Ms. Berkley. Okay. I just have one. Thank you, Mr. Salazar, for answering the question I had for you. I appreciate that.

Ms. Shea-Porter, you had mentioned that Secretary Peake said no hospital. Did Secretary Peake at least acknowledge that there is a concern with veterans accessing healthcare? Is he willing to do some type of comparable care, whether it is contracting our services in different regions of New Hampshire?

Ms. SHEA-PORTER. Well, actually I could not get an answer from him. I finally said to him, "Mr. Secretary, are you saying yes or no?" and he said, "Neither." And so, you know, I could not get an answer. But I do know that shortly thereafter they talked about providing radiation care in the community. But this really has been a long festering problem. And when we looked at the numbers of veterans from other States, and we looked at their ability, there cannot be any explanation for it. You know, we have looked at the stats and there is just no explanation for New Hampshire being without some kind of care there.

And, again, I am not insisting that they build a full-service VA hospital. I want to do whatever is the most economical and practical. But we have to keep our commitments to our veterans and that is why I am sitting here today. We owe it to these New Hampshire vets.

Mr. MICHAUD. Now, you mentioned the time it takes for veterans to travel to Boston. My concern is access to healthcare and Maine, as you know, is a very rural State and we have to travel long distances. Normally, when we say it is going to take 4 hours to travel from one end to Togus, that is at, the speed limit. When you say it is going to take 4 hours, how does that traffic affect your veterans traveling? Is it 4 hours because of congestions? Or is it 4 hours depending on what time they go during the day?

Ms. SHEA-PORTER. Right. Well, when they start off, and the furthest point from my district could be an hour and a half to 2 hours from the tip of the district down. And it is not that heavy. I mean, it is New Hampshire. It does not look like Washington traffic for sure, but the roads are slower, because if you get in front of a car. So you add that time. And then when they get to Manchester and they have to take a van, and that is when the traffic really becomes very difficult. And so many of our older vets simply must travel in a van for a number of reasons. Their unfamiliarity with the roads and with urban districts and driving in cities, they are elderly, and they are ill. And it is pretty hard to find people in your neighborhood who are happy about driving 4 hours to Boston, you know, and going through, and picking their way through that traffic in that very heavily congested area in an area that they are not familiar with.

So that means they have to come to Manchester and be loaded on the van. And there are other people who are receiving services

as well. And so they come to an urban VA, which is very busy, and they have to wait all day. And so these trips are absolutely exhausting them. They can go, you know, for hours and hours and hours. From Manchester to the VA can take an hour and a half. It does take an hour and a half, it can take 2 hours. Add that in addition to the 2 to 3 hours, you know, each way, 5 hours, and then the wait. And you get a sense of what we are putting them through. And again, they are our oldest and our sickest that are being sent down.

Mr. MICHAUD. Thank you very much. Once again, I would like to thank our first panel for your testimony this morning. I look forward to working with you as we work to make sure our veterans get the adequate healthcare that they need. Once again, thank you very much.

I would like to welcome the second panel. As they come, it is Joy Ilem who works for the Disabled American Veterans (DAV), Joseph Wilson from the American Legion, and Dr. Thomas Berger from the Vietnam Veterans of America (VVA). I would like to thank our second panel for your willingness to come today and to give your testimony on the bills that we have heard from our first panel.

I would like to start off with Ms. Ilem.

STATEMENTS OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; AND THOMAS J. BERGER, PH.D., SENIOR ANALYST FOR VETERANS' BENEFITS AND MENTAL HEALTH ISSUES, VIETNAM VETERANS OF AMERICA

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you Mr. Chairman and Members of the Subcommittee. Thank you for inviting the Disabled American Veterans to testify at this legislative hearing. We appreciate the opportunity to provide our views on the bills under consideration by the Subcommittee today.

DAV supports the provisions in H.R. 3051, which would establish a program for training and certification of family caregivers of servicemembers and veterans with traumatic brain injury, and authorize these personal care attendants to receive compensation for such services. This program would allow these family members to have standardized and consistent training and to receive compensation that recognizes their efforts that will help to ensure the stability of the family at an extremely difficult and vulnerable time. We note, however, this section of the bill only addresses veterans with traumatic brain injuries but could also benefit other catastrophically injured veterans with long-term personal assistance needs, such as veterans with spinal cord injuries or severe physical trauma without brain injury. If successful, we would like to see this provision related to training and support for caregivers expanded to other catastrophically disabled veterans requiring caregiver assistance.

DAV also supports provisions in the bill requiring outreach to educate and make veterans and the public aware of the symptoms of PTSD and TBI, and make available best practices for these conditions to non-VA healthcare providers. Often a family member is the first to notice cognitive changes in the veterans' behavior and mood. Thus informing the general public is an important element of this bill. Likewise, we appreciate the dissemination of best practices on TBI and PTSD to non-VA providers to help ensure that veterans who may seek care outside the VA and DoD systems benefit from their expertise.

Mr. Chairman, DAV also supports but with some concerns Section 4 of this bill to assess the feasibility of using telehealth technology to assess cognitive functioning of military members and veterans who have sustained TBI, with a priority in rural areas. We support efforts to assess new web-based diagnostic tools for the prevalent cognitive conditions that are emerging among our returning veterans. However, we ask the Subcommittee to ensure that any partnership with the private sector to expand telemedicine in rural areas include coordination through VA's Office of Rural Health and be supplemented by appropriate resources.

On a final note, we ask the Subcommittee to also consider expanding this measure to include a standardized and more comprehensive package of support services for caregivers, including financial support, health and homemaker services, respite, education, training, and other necessary relief services. Family members of severely injured veterans often shoulder great and lifelong responsibility as home and institutional caregivers, giving up or severely restricting their own employment and educational advancement, and social opportunities. Not surprisingly, family caregivers often suffer severe financial and personal hardships as a consequence of providing care to a severely disabled veteran. Yet, in their absence, an even greater burden of direct care would fall to VA and DoD at significantly higher cost to the Government and reduced quality of life for these veterans who have sacrificed so much.

H.R. 3051 would provide welcome relief to family caregivers of severely disabled veterans and is consistent with DAV Resolution 165 and recommendations of the fiscal year 2009 *Independent Budget*. Therefore, we support this measure and urge the Subcommittee to work toward its enactment.

The next bill for discussion is H.R. 6153, the "Veterans Medical Personnel Recruitment and Retention Act of 2008." Along with our partners in *The Independent Budget*, DAV has called for improvements in VA policies and procedures used to recruit and retain highly qualified VA clinical staff. VA needs new authority to achieve and sustain its goal to be competitive with private sector providers and become a preferred employer for physicians, nurses, dentists, and other medical personnel needed to care for our enrolled veterans.

This bill aimed at providing meaningful financial and professional incentives to encourage VA medical personnel to pursue full careers in the VA healthcare system is timely and appropriate given all of the challenges VA faces to maintain delivery of timely, high quality, comprehensive healthcare services to our Nation's

veterans. *The Independent Budget* conveys a series of recommendations that are fully consistent with the intent of this bill. Therefore, DAV has no objection to its enactment.

Mr. Chairman, on the final bill under consideration, since we did not have a chance to really review that thoroughly, we will be happy to submit in writing our views on that final bill. Thank you.

[The prepared statement of Ms. Ilem appears on p. 32.]

Mr. MICHAUD. Thank you. Mr. Wilson.

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on these three important pieces of legislation.

H.R. 3051, the "Heroes at Home Act of 2007." This bill seeks to improve the diagnosis and treatment of traumatic brain injury in members and former members of the armed services, to review and expand telehealth and telemental health programs of the Department of Defense and Department of Veterans Affairs, and for other purposes. Section 2 of H.R. 3051 requests the Secretary of VA to establish a program on training and certification of family caregivers of veterans and members of the active-duty armed forces with traumatic brain injury as personal care attendants.

Pursuant to Section 744(a)(2) of Public Law 109-364, the Veterans Traumatic Brain Injury Family Caregiver Panel was established in 2007. The 15-member panel was created by the DoD to operate under the Department of Health as a Subcommittee to advise and specifically provide DoD and VA with independent advice and recommendations on the development of training curricula to be utilized by the above mentioned family members on techniques, strategies, and skills for care and assistance for such individuals with TBI, or traumatic brain injury. The panel was convened on occasions, to include a recent townhall meeting to discuss matters related to the development of this curriculum and to hear from the public about the issue.

Now, the American Legion asserts that the advice of this subcommittee, incorporated into the provisions of this piece of legislation, is vital and that its absence may deprive such a bill of an effective stance and approach to treatment and care of TBI. The American Legion, in its continuing efforts to increase access and quality of care to all eligible and potentially eligible veterans, supports this proposal as it would help to accomplish this ongoing challenge.

H.R. 6153, the "Veterans Medical Personnel Recruitment and Retention Act of 2008." This bill seeks to amend Title 38 of the United States Code to enhance the capacity of VA to recruit and retain nurses and other critical healthcare professionals in addition to addressing other issues. The American Legion applauds this proposal to amend the methods of hiring and retain an additional medical personnel of various disciplines to adequately equip VA medical facilities to ensure the adequacy and quality of treatment and care. The American Legion supports the proposal requested in section 2(j), which seeks to amend 7451(c)(2) to allow critical fields

such as nurse anesthesiologists to exceed rate limitations on authorized competitive pay.

Although VA has various anecdotal programs in place to include recruitment, relocation, and retention incentives for these hard to fill positions, there remains a shortage of such nurses and specialty medical physicians. The overall response to the question of shortage indicated that salaries and delays in appointments were key causative factors. The American Legion, during its VA Medical Center site visits to 49 facilities in 2008, encountered various recruitment issues, including such delays in the appointment of nursing assistants. Management attributed these delays to the 3- to 4-month hiring process. By the time management completed the hiring process, applicants had accepted a position in the private sector.

Also in their site visits, the American Legion representatives ascertained other areas with difficulty recruiting. These included mental health positions, specifically psychologists and psychiatrists, dermatology, gastroenterology, orthopedics, and anesthesia. A study published in the New England Journal of Medicine ascertained there were shorter inpatient delays and lower complication rates in hospitals with higher staffing levels while there were longer inpatient stays and increased urinary infections, gastrointestinal bleeding, pneumonia, and shock or cardiac arrest in hospitals with lower staffing levels.

We hereby urge Congress to act on this piece of legislation by incorporating it into the VA system to prevent the healthcare system from being included in the casualties of the projected shortage of medical professionals through the year 2020.

And I will briefly comment on H.R. 6629, the "Veterans Health Equity Act of 2008." The bill seeks to amend Title 38, United States Code, to ensure that veterans in each of the 48 contiguous States are able to receive services in at least one full-service hospital of the Veterans Health Administration (VHA) in the State or receive comparable services provided by contract in the State. The American Legion wholeheartedly concurs with one proposal portion of this bill, which urges the Secretary of VA to allow veterans equal access to full-service hospitals. However, in Section 2, the terminology, "certain States," leaves question of an alternative or adverse motive unfavorable to proposals to further enhance access and quality of care across the board within the VA healthcare system. In addition, under Section 2 the proposal to insert the language, "access to full-service hospitals in certain States," once again does not warrant unanimous support for this piece of legislation. The term "certain" implies some States as opposed to all.

The purpose of this piece of legislation, which is also the leading opening statement of the bill, seems to be contradicted by Section 2, which includes such language as stated in the above mentioned paragraph. The uncertainty of this legislation leads the American Legion to avoid a position on this bill.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates the opportunity to submit testimony. Thank you.

[The prepared statement of Mr. Wilson appears on p. 38.]

Mr. MICHAUD. Thank you very much. Dr. Berger.

STATEMENT OF THOMAS J. BERGER, PH.D.

Mr. BERGER. Mr. Chairman, Ranking Member Miller, and distinguished Members of this Subcommittee and guests, the Vietnam Veterans of American, VVA, thanks you for the opportunity to present our views on these important pieces of legislation affecting the healthcare of America's troops and veterans. With your permission, I shall try and keep my remarks brief and to the point.

In general, Vietnam Veterans of American supports the intent of H.R. 3051. But remember, medical experts say that traumatic brain injuries are the signature wound of the Iraq War in particular and in fact TBIs have become so commonplace that we are yet again focused on them today in this hearing. Certain TBI symptoms, such as seizures, can be treated with medications. But the most devastating effects, such as depression, agitation, and social withdrawal are difficult to treat with medication, especially when there is loss of brain tissue. In troops with documented TBIs, the loss of brain function is often compounded by other serious medical conditions that affect physical coordination and memory functions. These patients need a combination of psychological and physical treatment that is difficult to coordinate in a traditional medical setting, even when properly diagnosed at an early date. And we must remember that both concussive and contusive brain injuries are never just isolated injuries. Over time, without proper diagnoses, care, and treatment, TBI can affect nearly everything about the survivor, including one's cognitive, motor, auditory, olfactory, and visual skills, perhaps ultimately resulting in behavioral modifications and definitely not a mental illness. Families say that they struggle with the military and the VA medical systems that were unprepared for these wounded. In some cases, new equipment and specially trained staff needed for the most catastrophic cases are not available, or have not kept pace with the advances in battlefield medicine that kept these servicemembers alive. In addition, there are issues about intensity and drain of needed family support that will be hard to sustain, as well as the significant issues regarding the complexity of the medical and other specialized needs that need to be addressed with TBIs. Of all the War's medically challenging injuries, brain injuries require the most personal involvement, dedication, and cost over time.

As you are well aware, one of the recommendations of the Dole-Shalala Commission was to significantly strengthen support for families. This will not be an easy task, but VVA believes that H.R. 3051 can be a key step in achieving this recommendation and providing a mechanism for empowering the families of brain-injured servicemembers if, and only if, the VA can develop effective implementation strategies for certification, competency evaluations, and meaningful outcome measurements to carry it out. As they say, the devil remains in the details. And part of our concern, of course, lies with the fact that there is so much variation amongst the States' regulations relative to training, certification, outcome measurements, et cetera, for brain-injured persons. It will be a difficult task. But if the VA can pull it off, it certainly holds hope for family members.

Regarding H.R. 6629, we certainly, we did not submit any written testimony but we certainly support equitable pay and hiring

processes that will permit our professional staff at the VA facilities to at least achieve comparable pay and salaries with those in the private sector to provide the care that is needed by our veterans.

Regarding the, excuse me, that was not H.R. 6629. That was H.R. 6153. On H.R. 6629, we just got that on Friday and we have not had an opportunity. Now we have heard some background information and we will submit written testimony in 10 days. Thank you very much for the opportunity to do this.

[The prepared statement of Dr. Berger appears on p. 39.]

Mr. MICHAUD. Thank you very much, doctor. Once again, I would like to thank the panel. A couple of questions. Ms. Ilem, you had raised concerns with implementing the caregivers' training program in each of the VA Medical Centers due to the lack of capacity, and recommend that the program be limited to polytrauma centers and other units within the Defense and Veterans Brain Injury Network to ensure the training is high quality. Do you have any suggestions on how we can address, the challenges you highlighted so that the program can be implemented in all VA Medical Centers?

Ms. ILEM. Well, we did note that so that, you know, initially because we felt that probably that is where the families would be. You know, where those patients would be and have the initial opportunity to work with those families. So to keep consistency, you know, hopefully to be able to develop some best practices to make sure it is consistent, standardized training, to do that, and then to, you know, be able to press that out, if necessary, you know, depending on, you know, the need for that. But since so many of those veterans are either going to the Veterans Integrated Services Network (VISN) area, one of the polytrauma, you know, level one polytrauma centers, or then, you know, to their VISN level polytrauma center we felt that would be the most appropriate place to start just to maintain that high quality and consistency of training.

Mr. MICHAUD. Mr. Wilson, I did not expect you to comment on the Congresswoman's legislation, but since you did and did not take any position on it, would you, having heard her testimony, agree that it is important for veterans, regardless of where they live, to have access to healthcare? I can understand the concern with building a brand new hospital. I want to make sure that veterans get the services they need versus bricks and mortar. But it appears that the concern is that there is a large number of veterans who have to travel 4 hours to get the care that they need. Would you agree that it is important that, if there is care that is needed, whether it is fee-for-service or otherwise, that that be provided?

Mr. WILSON. Well, in terms of access, and from my experience in traveling throughout various VISNs in this Nation, and even to include Puerto Rico, there is an issue with access in addition to New Hampshire. The American Legion does not exclude any one particular VA Medical entity within the VA healthcare system. That's where we have concerns regarding the overall piece of legislation itself. However, there were portions, in regards to the access of care, level of care, and quality of care at New Hampshire. And I am sure someone can attest to access as an issue. Let's use Nevada, because with Nevada has a large catchment area. There is

an issue with traveling to various VA medical facilities in Nevada. And I can name quite a few, actually, in regards to access. We have "A System Worth Saving" booklet, our annual publication that we disseminate to Congressional Members. You can read it in the 2008 publication, regarding access issues. So we do support the issue of improving access to care. However, regarding that it is not a competition here. We would like to take all VA medical facilities to that level of quality access and care.

Mr. MICHAUD. Thank you. Mr. Miller. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman, I just have a couple of quick questions here on, for the VVA on H.R. 3051. You highlight the need to ensure that VA develop effective implementation strategies for certification, competency, evaluation, and meaningful outcome measurements. I wonder if you could expand on that point? And then, is there additional legislative text that you would recommend adding to the bill to ensure that the provisions in the bill are implemented effectively?

Mr. BERGER. Thank you, sir. In regard to the first part of the question, I refer to my comment that there is a great deal of variation amongst the States relative to private and not-for-profit institutions or agencies that offer these kinds of services, particularly in rural areas across the country. And I am not hinting that they are bad in this State or they are better in this State, I am just saying there is no standardization across the country.

My own personal experience in working both with Easter Seals of Illinois and United Cerebral Palsy brings this to the forefront. The standards for caregivers for brain-injured persons in these organizations in two parts of the country were extremely different. I think that if the VA were to develop a standardized process, for lack of a better term, not to run through everything that I said, this would help greatly. And then the family members could take advantage of this.

We are going to have a problem down the road, particularly in rural areas, with family caregivers taking care of folks if they do not receive proper, standardized training.

Mr. HARE. I just wanted, maybe all three of you could comment on this, on H.R. 6153, supporting the legislation. Are there other health professionals who are not included in H.R. 6153 who face recruitment and retention challenges and would benefit from flexibilities provided in the bill? For example, I know the Paralyzed Veterans of America (PVA) in their statement for the record identified a shortage of spinal cord injury disease nurses and the need to apply the specialty pay provisions to the groups. So I guess what I am asking you, are there other health professionals that ought to be included in the bill, or concerns that you may have with that?

Mr. WILSON. In regards to specialty medical positions, I do not want to, I cannot specify further than what I have recorded on paper. However, speaking from our various site visits I can; we will soon disseminate the "System Worth Saving" publication in which you could actually read for yourself from the horse's mouth, if I can say in regards to the various shortages. The concern, in discussion, comes from management within each respective VA medical facility.

Mr. BERGER. Mr. Hare, I would certainly add those specialized social workers that deal with brain injury and seizure disorders.

Ms. ILEM. I would agree with PVA's statement and I am not, any other ones have not been brought to our attention, that have been missed. But if we are made aware of any of those we will certainly forward those on.

Mr. HARE. Thank you very much. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you, Mr. Hare. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. Mr. Wilson, I wanted to follow up a little bit on this issue that Mr. Michaud asked about with regard to Carol Shea-Porter's bill. Because I think we are all in agreement, you know, we want access for all veterans. It is just, I guess it is the reality of the human condition is we tend to nibble off things that we can, you know, bite-sized morsels and move on. I mean, we have a bill coming out on the floor I think tomorrow, or this week, or something, Jerry Moran's bill. It came out through this Committee and it, what do we call it, highly rural areas because we recognize that distances in rural areas are, can make it prohibitive. So I, while I understand we are trying to equalize everything, I would also hope we would recognize there may well be a peculiar nature of New Hampshire.

I have traveled in Nevada a fair amount. I have traveled some in New Hampshire. It can be hard to get around New Hampshire some times of the year. I had trouble walking in New Hampshire at certain times of the year. I just want us to appreciate that driving 100 miles in certain parts of the country is probably a whole lot different than driving 100 miles in New Hampshire in the wintertime. And so I do not think we should be afraid of doing something that helps one State that for probably historical reasons never got themselves a VA hospital for whatever reasons in years ago in the past. I do not think we should not be willing to deal with that problem hoping that somehow we are going to correct all of the problems of access to healthcare before we deal with New Hampshire. That does not seem a very good approach. And I use as a model as somebody already did the highly rural area we are trying to, as a pilot, that Jerry Moran's bill, which I think you all supported. I think the American Legion did support Jerry Moran's bill and it does not deal with nationally. So thank you, Mr. Chairman.

Mr. MICHAUD. Thank you, Dr. Snyder. Ms. Berkley.

Ms. BERKLEY. I have no questions of the witnesses but I want to thank you for taking time out and coming to testify.

Mr. MICHAUD. Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman. Mr. Berger, do you believe that H.R. 3051 actually begins to implement the provisions of the Dole-Shalala recommendations?

Mr. BERGER. I think that particular recommendation about support for the family is contained in the bill, yes, sir.

Mr. SALAZAR.. Let me just read you a little bit of the statement that was submitted for the record by Anna Frese, who is with the Wounded Warrior Project. She talks about her brother, Retired Army Sergeant Eric Edmundson, who was seriously injured in Iraq in October 2005 and is currently living at home receiving 24/7 care from her father, Edgar Edmundson. This is what the father experi-

enced. "Upon learning of Eric's lifelong challenges, our father resigned his position at work in order to provide Eric the full-time care that he needed. This decision did leave him and our mother with one less income, and in times of need they had to dissolve their personal and retirement savings. Just as importantly, now at 53 years old, my father is no longer covered by health insurance." So these are the kinds of issues that families face——

Mr. BERGER. Yes, sir.

Mr. SALAZAR [continuing]. Especially in rural communities where they do not have facilities close by. It seems to me that soldiers or patients who have gone through some kind of traumatic brain disorder can actually recover better and have a better quality of life by having family caregivers. Is that correct?

Mr. BERGER. That is absolutely correct, sir.

Mr. SALAZAR. Thank you. I would ask for Mr. Wilson and Ms. Ilem to comment on that as well?

Mr. WILSON. I have no comment currently. Please refer to our book, "A System Worth Saving."

Ms. ILEM. We would agree that the family caregiver issue, just as you have noted, in talking with family members you see how their lives are impacted and DAV is very supportive of doing everything we can to support the caregiver to make sure veterans have the best care possible, and in the best environment for those veterans.

Mr. SALAZAR.. Well as you know, VA does not support H.R. 3051 because they say there are current provisions and existing efforts that accomplish the goals of the caregivers training program and outreach for PTSD and TBI patients. Would you comment on that?

Mr. BERGER. Again——

Mr. SALAZAR. Are the programs that are already in place sufficient?

Mr. BERGER. I do not believe that they are, sir.

Mr. WILSON. I also disagree that they are. The Veterans Traumatic Brain Injury Family Caregiver Panel, which is in place, has not been fully effective in resolving that issue of that disconnect, of that family, or family member, or even an associate being a caregiver to that particular patient. As I stated in the testimony, maybe the two in a contiguous effort, or maybe the two actually in consortium may be able to decrease the gap there and allow for more continuous care.

Mr. SALAZAR. Ms. Ilem.

Ms. ILEM. In just briefly looking over VA's testimony, I think they indicated that they are providing their certification and training for these family caregivers through, you know, already an outside third party that is doing that. And I think in just, you know, looking at that this morning, you know, the concern would be with these very special cases of TBI and the very high-care needs of these veterans and the family members, you know, if we are really understanding and making sure that they can go the distance to provide that care as well, to make sure that they are taking care of themselves. We would like to have VA, you know, at the forefront because these are some very specific, you know, service connected injuries that are occurring, for them to be at the forefront of providing the training and certification to make sure that they

have, you know, the really overview and the quality of that care that they hold so high in esteem in VA.

Mr. SALAZAR.. Would any of you wish to comment on how you feel that this would actually save the VA some additional monies by being able to take care of these veterans at home?

Mr. BERGER. Certainly, sir, your testimony threw out some dollar figures that I think are absolutely right in line. I do not think you can put a dollar value on the care that can be given by family members who are properly trained to care for these brain-injured troops. And so I will leave it at that. I do not think you can put a price tag on it.

Mr. WILSON. In regards to TBI itself, there are other issues arising from TBI, to include blind eye injury and PTSD. If TBI is left untreated, it becomes difficult to distinguish from other disorders. For example, a lay person who does not understand the symptoms, or in denial, can attribute to the breakdown in his/her family. That is also an added issue. And after reading this particular piece of legislation, we were in agreement at the American Legion that this was something that needed to be implemented.

Mr. SALAZAR.. Ms. Ilem.

Ms. ILEM. I think without question the costs would be higher if left to the Government to provide, you know, full-time in-house care versus at home. But I think that most importantly it is the quality of life. And if the family wants to provide that care for their loved one, then they should be provided the resources they need and the support that they need to provide the best care to that veteran. But I think cost aside, the quality of care issue is probably the most important.

Mr. SALAZAR. Thank you all for your testimony. I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Mr. Salazar. Once again, I would like to thank all three of you for your testimony here this morning.

The last panel is Dr. Cross, who is the Principal Deputy Under Secretary of Health, and will be accompanied by Walter Hall and Joleen Clark. I want to thank you all, for coming here today to give your testimony on the two pieces of legislation we have, and the third piece that was added at the last moment. Without any further ado, Dr. Cross.

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

Dr. CROSS. Good morning Mr. Chairman and Members of the Subcommittee, and thank you for inviting me here today to present the administration's views on two bills under consideration, H.R. 3051, the "Heroes at Home Act of 2007," and H.R. 6153, the "Veterans Medical Personnel Recruitment and Retention Act of 2008."

VA recently received H.R. 6629, the “Veterans Health Equity Act of 2008,” and is not prepared to address the bill today but we will be happy to submit our views and cost estimates on the bill for the record. VA is still preparing cost estimates on the other two bills on today’s agenda. As soon as those become available, we will supply them for the record. Also, I want to say I am accompanied today by Mr. Walter Hall, Assistant General Counsel, and Mrs. Joleen Clark, our Chief Officer for Force Management and Consulting.

[As of January 12, 2009, the VA failed to provide the Administration views on H.R. 3051, H.R. 6153, and H.R. 6629.]

I will begin with H.R. 3051. section 2 would require VA to establish a program to train and certify family members of veterans and servicemembers with traumatic brain injury, which is also called TBI, as personal care attendants. VA supports using family members as caregivers for these veterans, but believes VA’s current home healthcare program already accomplishes this in a more efficient and effective manner than would be possible under the bill. Implementing section 2, as written, could give rise to potential conflicts concerning the veteran’s care between the family member, the caregiver, and the VA, with the veteran. This would place VA in an untenable position. We strongly urge the Congress to allow VA to continue to obtain caregiver services under the Home Healthcare Program, which uses a third party to provide for the training and payment of personal care attendants.

Subsection 3 of H.R. 3051 would require VA to conduct a comprehensive outreach to enhance the awareness of veterans and the general public about the symptoms of post traumatic stress disorder and TBI and available VA healthcare services. VA already has an extensive and expanding outreach program in place to inform veterans and the general public about PTSD and TBI, as well as the services we provide to veterans with these injuries. We, therefore, think this statutory mandate is not necessary.

Section 4 would require DoD and VA to jointly establish a demonstration project to assess the feasibility and advisability of using telehealth technology to assist cognitive functioning of Members and former Members of the Armed Forces who have sustained head trauma in order to improve the diagnosis and treatment of TBI. VA supports the goals of this provision, but cannot support this section as written because it is too prescriptive. VA and DoD should be allowed more flexibility in executing the demonstration project and would be pleased to work with the Subcommittee’s staff to develop legislative language that would enhance its value.

I turn now to H.R. 6153, the “Veterans Medical Personnel Recruitment and Retention Act of 2008.” We support many provisions that would contribute to VA’s mission, such as the expansion of VA’s education assistance program outlined in section 4. Similarly, we endorse several measures that would improve VA’s ability to provide comparable pay and benefits to nurses, physicians, and executives. Other sections of the bill need only minor adjustments, such as the authority to add nurse assistants to the list of so-called hybrid occupations. We believe this authority should apply to healthcare delivery occupations in general.

However, there are some provisions that would negatively impact patient care and VA must oppose. Subsection 2B would change the probationary period for full and part-time registered nurses from 2 years to the equivalency of 4180 hours. Part-time Title 38 employees, including RNs, do not serve probationary periods. These apply only to full-time permanent employees. We see no benefit in creating a probationary period for part-time nurses, since it would not make them the equivalent of tenured employees for purposes of discipline or discharge.

VA also opposed section 2C, which would limit temporary part-time employments of hybrid nurses, specifically licensed practical nurses, LPNs, and licensed vocational nurses, LVNs, to no more than 4180 hours. Currently, the part-time hybrid appointments may be for periods exceeding 1 year. Operationally, this change could severely limit VHA by preventing us from appointing highly qualified LPNs and LVNs who only want to work on a part-time basis.

Finally, we oppose Subsection 2M since it appears to create a windfall by extending premium paid benefits for employees performing occasional work. We also note subparagraph 2 would not be limited to registered nurses, which we understand is the intent of this provision. It would also apply to other employees. We are similarly concerned that Subsection 3B, which would amend the "Baylor Plan," could provide an unwarranted bonus structure.

Mr. Chairman, this concludes my prepared statement. I am happy to answer any questions that you or the Subcommittee may have.

[The prepared statement of Dr. Cross appears on p. 40.]

Mr. MICHAUD. Thank you very much, Dr. Cross. You noted that VA refers interested family members to home health agencies that VA contracts with. How many referrals has VA made and does VA pay for the training?

Dr. CROSS. Under our program right now, VA currently contracts with more than 4,000 home health agencies that are approved by the Centers for Medicare and Medicaid Services and/or State licensed. And many of these have expertise in training and certifying home health aides. Many of them also are found in rural settings and we can engage them there. I do not have for you the exact number of individuals within that program.

Mr. MICHAUD. Could you provide that for the Committee?

Dr. CROSS. Yes, sir.

Mr. MICHAUD. Of the referrals, how many, have completed the certifications as well.

Dr. CROSS. Yes, sir.

[The following information from VA was subsequently received:]

In situations where a veteran will require long-term or lifetime care or assistance in the requirements of daily living, VA provides counseling and training to family members and other caregivers who are capable and willing to take on this responsibility. VA is not authorized to pay these individuals and, for practical and legal reasons that were discussed in our testimony and at the hearing, we do not believe VA should be the appropriator or payer.

When it is clinically necessary and appropriate, VA has arrangements with local contractors who will provide caregiver training to family members and qualify them to be a State certified caregiver. Following State cer-

tification, the family member caregiver may become a certified, salaried employee of that contractor or another entity that provides caregiver services. The decision for referral to a contractor is made on a case-by-case basis. VA has no data on the number of individuals who elect to use this process.

Mr. MICHAUD. Does the VA provide respite care while the family caregiver is in training programs so that the family can continue to care for the needs of the veteran?

Dr. CROSS. Yes. Our respite program is more broadly construed. It can be for any number of reasons. It would not be limited to just that one reason.

Mr. MICHAUD. In your testimony you identified language on the telehealth demonstration as being too prescriptive and detailed. Can you expand on that? What type of flexibility do you need?

Dr. CROSS. We are working with DoD and the Center of Excellence already, and we want to continue doing that, and intend to do so. Some of the language in the bill relating to using telehealth for educational purposes is kind of a mixed approach, using something that we use for diagnosis and treatment for what appeared to be a more broad reaching outreach effort. And we use other modalities for that. We did not think that was a well constructed component within the bill.

Other portions of the bill relating to the reporting requirements would be substantial. We can work with your staff, sir, to try and mitigate that. I think clearly on the intent, we have the same intent.

Mr. MICHAUD. Good. Thank you. On H.R. 6153 you mention that it is hard to recruit occupations that this provision would help with. Can you give us, some of the top five occupations that you are referring to?

Dr. CROSS. I will ask Ms. Clark to comment.

Ms. CLARK. Each year we do a, what we call Successions Strategic Plan and we have the networks update their plans. And we have what we call our top ten critical occupations. And those this year are the traditional ones, nurses, physicians, pharmacists, LPNs. We do have an administrative one in there, human resources, occupational therapists, physical therapists, medical technologists. Of the physicians there is several occupations that were mentioned, actually, earlier in some of the testimony. Gastroenterologist, anesthesiologist, psychiatrist, there are a few others. And then inpatient nursing areas, we do have a few that we target and certified registered nurse anesthetists are also one of those occupations.

Mr. MICHAUD. Thank you. You mentioned in your testimony that VA is facing worsening pay compensation issues within the ranks of senior pharmacy program managers in VHA, and that special incentive pay provisions for pharmacist executives would not address the retention need for the agency in the long run. Could you explain what that need might be, number one? And number two, what are you doing to try to address that need? That is, I know actually, in VISN 1, they are looking at building a brand new community-based outpatient clinic (CBOC) in the Bangor area, but also we have a private college that is interested in working collaboratively with VA for a pharmacy program, which would be a great opportunity to work collaboratively with higher ed. If you can, ex-

plain what the needs are and what are you doing to help address those needs.

Dr. CROSS. Sir, I will comment briefly on it and ask Ms. Clark to add. In consultation with my Chief of Pharmacy for this testimony today, we are holding our own fairly well in most places for pharmacists at the staff level. Certainly it remains a concern that we have to watch closely, because it is a competitive environment. This provision was related to the executive level and we have some challenges there in terms of long lag times, absences, and difficulty in recruiting.

To follow on to your other comment, though, and what we are doing, we do a great deal of effort in recruiting and reaching out to individuals including schools. And I will ask Ms. Clark to comment on some of that.

Ms. CLARK. We are quite competitive with the pharmacists, the staff pharmacists, because we can set special salary rates depending on the area. So that is not as big a concern. We do have to be vigilant so that we stay on top of it and keep those salaries competitive. As Dr. Cross mentioned, it is our executive rank, because there is not special salary rates for those executive rank. And so to try to get people to take those positions is really hard when they can get special salary rates and make almost as much as a staff pharmacist at those levels. So it is an issue and it is a problem to try to get those salaries, something, some kind of other compensation for that level.

Mr. MICHAUD. Is it more of a problem in rural areas than?

Ms. CLARK. Well, the rural areas pretty much are just like, with setting salaries, are pretty much the same across the country. You can set them based on the local market and what the local market dictates. And if that dictates paying relocation incentives, retention incentives, because you have a hard time keeping people in that area, you can pay those things on top of the salaries. So there is mechanisms, you know, in place for the staff pharmacists or the staff level employee.

Mr. MICHAUD. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. PVA expressed concern that the development of programs to address the needs for veterans with mild or subclinical TBI have not been fully developed or implemented. Could you respond to PVA's concern?

Dr. CROSS. We have done a tremendous amount of work in regard to TBI. Let me just highlight a couple of key points. We started this program back in the mid-eighties, creating special centers for TBI which we have now modified to call polytrauma centers. There were four of them. We are getting ready to open up, we are getting ready to build a fifth one in San Antonio. That was not enough. We have expanded those to create centers at our Medical Centers, and reaching out even into our smallest parts of our program by providing levels of expertise regarding TBI at those sites. We have done something that is unique in the United States. We are screening for mild TBI and we have developed the screen in such a way as to be more sensitive than specific.

Our intent was to not miss anyone. And so we designed the program with some elements from DoD to create that screening program. We have screened thousands and thousands at this time.

And when they screen positive we put them into a special program. And what is more, we are reaching out to the ones that we have not seen yet because we are concerned that there are people who might need these services that we have not even addressed. We are calling every single veteran from Operation Iraqi Freedom and Operation Enduring Freedom who has not been to one of our facilities and contacting them by phone and saying, "Hey, how are you doing? Can we help you?"

Mr. MILLER. I think PVA is still saying the milder subclinical issue has not been addressed.

Dr. CROSS. Well, perhaps there is always more to be done. And I value my colleagues in PVA's opinion. I take that very seriously. I would be happy to have an engagement to go over what we are doing currently because we have been pretty fast moving on this, and there is a lot that has been done in the past year or two.

Mr. MILLER. Thank you, great idea. I think that, just sitting down and having a conversation with them may clear up some misconception. Also, on H.R. 6153, their concerns were expressed that hiring and promotion processes under Title 38 hybrid is facing extraordinary delays because of boarding the process. My question is, are the concerns valid? Are there really problems with the boarding process?

Dr. CROSS. Frankly, there are some concerns that I have about how long it takes to bring someone on once we identify an individual that is interested in the job. I should give you just a couple of numbers and I will ask Ms. Clark to comment on the process a little bit. But we have had some success. We have expanded the number of nurse anesthetists. We added in net several thousand additional nurses to the VA last year. I have the most recent statistics yesterday. And Ms. Clark, can you comment?

Ms. CLARK. Yes, I will just add on to that. This year in 2008, we are projected in VHA to hire over 40,000 new employees, which is approximately a 49 percent increase in hiring over last year, over 2007. So it is like 13,000 more that are being hired just because of the increase in services that we are now adding. So that does add an extra burden. With that, we do realize that it takes too long. We have added different steps in the process with credentialing because we think it is important to have all our staff credentialed and make sure they are credentialed properly. So it has added some timeframe.

We went through what we call process redesign to look at all the steps and see where things can be cut out, and we are working actively. Last year we started it. This year we are going full force with it again. We have even included a performance metric within all of our network directors performance plan that after somebody is identified they have to be brought on, or not brought on, but be offered the position within 30 days. You know, usually they have to give a notice to their employer but they can start effectively then if they wanted to, actually, after that 30-day timeframe. And it has been very successful in some areas. Some areas are still struggling. But they all are improving their timeframes.

Mr. MICHAUD. Thank you. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. Dr. Cross, I just wanted to, just a couple things on H.R. 3051. You, in your testimony, you

identified the language of the telehealth demonstration as being too prescriptive and detailed. I wonder if you could maybe expand on the point and explain what flexibilities that you think are needed?

Dr. CROSS. I think if you could just leave it up to us to design a demonstration project, working with our colleagues in DoD we could come to a very workable, practical approach to this. In fact, the truth is we are already doing much of this in terms of collaboration. There has never been, in my experience, I have been in the military 20, 25 years before coming to the VA, I have never seen as much interaction and collaboration between these two organizations as exists now. We are in meetings with them at some level virtually every single day. So we can work this through. And I think sometimes the people on the ground can put this together better than anyone else.

Mr. HARE. Well let me just say that, you know, last spring we heard of internal VA emails identifying 12,000 annual suicide attempts, an estimated suicide rate of 6,570 per year across our veterans population. And these statistics to me show that current efforts are not enough to help with the hundreds of thousands of returning Iraq and Afghanistan veterans. So I would really urge the VA to not be complacent with current activities and to implement a comprehensive strategy and share best practices with non-VA healthcare practitioners. I think this bill goes a long way. And I commend my colleague for introducing the bill. And I would I would like to see, you know, and I agree with what Mr. Miller said earlier, that the working together between the VA and the VSOs to come up with something that is actually going to work here. And as you know, I am very troubled by the numbers of that as I know you are. And whatever we can do that will help, whether it is, you know, and again, I think this bill goes a long toward doing just that. But I would really like to see a collaborative effort here on behalf of the VA and the VSOs to come up with something that A will work. And when you design this demonstration project, I was just wondering if I could go back to that for a second. When you say, how long is that going to take, do you think, to be able to design that project and before we—

Dr. CROSS. The demonstration on telehealth?

Mr. HARE. Yes.

Dr. CROSS. And the cognitive assessment? I met with my staff on this, the experts. I did not actually get a timeframe. I would have to get back to you with an answer to be accurate.

[The following information from VA was subsequently received:]

Question: What is the projected timeframe for developing the joint DoD and VA demonstration project to assess the feasibility and advisability of using telehealth technology to assess cognitive functioning of Members and former Members of the Armed Forces who have sustained head trauma, in order to improve diagnosis and treatment of traumatic brain injury?

Response: A timeframe has not yet been established. However, the DoD and VA have made significant progress in the area of interoperability since the National Defense Authorization Act designated DoD as the lead agency and VA as the collaborating agency in this initiative. The two departments have developed an in-depth interoperability plan for the demonstration project that includes verification of an existing evidence-based and validated telehealth application to assess cognitive function. In developing the timeframe, DoD and VA will need to allow sufficient time for both departments to develop the project's clinical scope, arrange technology support, de-

termine location and necessary personnel, and consider legal and regulatory issues before the actual demonstration project is underway.

Mr. HARE. Thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Salazar.

Mr. SALAZAR. I do appreciate your having this hearing today, first of all. Dr. Cross, you state that whether the caregiver compensation is for caregivers as a VA employee versus the benefit, that raises significant legal issues relating to liability, taxation, the VA relationship and responsibilities to the veteran, and the caregiver, can you explain that and expand on that a little bit?

Dr. CROSS. Well, I will do my best but I think my counsel, Mr. Hall, will probably do a better job than I can so I will turn it over to him.

Mr. SALAZAR. And before you answer that, can you also address the issue of, how this bill adheres to what the Dole-Shalala recommendations were. And, are you saying that they were just spitting in the wind when they made these recommendations because you were already doing all of this? Or could you expand on that a little bit as well?

Dr. CROSS. Let me, I wanted to have a chance to respond to that. Because we support the intent of this. And in fact, that bill, you know, those provisions have been out and under discussion for some time now. And so, yes, we have already been acting on many of these things. Outreach for PTSD and TBI, we have, I listed just in the written testimony several paragraphs of our measures that we have instituted. The suicide prevention hotline, Mr. Hare's comment about suicide, tremendously important issue for us. The clinical guidelines, we are publishing them, working with DoD every day to refine them and develop them further. We call in the Institute of Medicine to help us with TBI and PTSD issues. Telehealth, we have got tens of thousands of patients now receiving support from telehealth. So, yes, we are taking these very seriously. We did not wait for today to start on this. And that is why we phrased our comments the way we did. But our intent is very much consistent with what you have here. And I will ask Mr. Hall to expand on the fine points of that distinction.

Mr. SALAZAR. Let me just follow-up on it. So in other words what you are saying is, we do not need the legislation to address the issues. We are already doing everything Dole-Shalala recommended, is that correct?

Dr. CROSS. Well, the training for family members was not one of those. We think that there are significant issues that have to be addressed there and the way that the bill was phrased to provide the support directly was problematic for us. And we wanted to continue using what we have found to be the more effective, efficient working well mechanism using these healthcare agencies across the United States.

Mr. SALAZAR. Well, are you currently providing compensation for family members, not only the training part of it, but family members when they have to quit their jobs to take care of someone who has PTSD or traumatic brain injury?

Dr. CROSS. I will ask Walt to correct me if I am off base here but the home health agencies that we contract with can hire the family member and do so.

Mr. SALAZAR. Okay.

Mr. HALL. Yes, sir. That is what in fact is going on now, is that we contract with the home healthcare provider who then hires the family member, provides them the training, then supervises the care that they give to the veteran. That puts them in the position of being responsible for assuring the quality, assuring the liability coverage of the caregiver, the family member, in case, and making sure that the quality of the care that they are getting meets the standards that are required.

The way the legislation is phrased it says that VA will compensate the caregiver. It does not say exactly what the status of the employee, or the caregiver, will be. Will they be VA employees? Will they be responsible to VA? Will VA be responsible for them as far as things like insurance liability, liability for care, if the care that they are not giving somehow, the care that they give somehow injures the veteran? What is the liability? If it is a VA employee then of course the VA is responsible for that liability regardless of the relationship between the caregiver and the veteran. It is just a, it raises a number of issues like that. If it is compensation, is it compensation to the veteran? Or is it compensation to the caregiver? Do they become a VA beneficiary, for example, like somebody receiving compensation and pension would be receiving? If, and then that raises the case of VA's responsibility for overseeing that care. What is the quality of that care? Are they doing the job that the veteran needs? If they are not what is VA's recourse? Do we terminate the compensation, and what is the mechanism for doing that? It just raises a lot of—

Mr. SALAZAR. So then what you are saying, you do not really have any oversight over the caregivers that you currently have? I mean, that is what I heard you say, is it not? Because of the liability issue?

Mr. HALL. No.

Dr. CROSS. First of all, of course, as I pointed out in the written testimony I think, we look for those home healthcare agencies that are approved by the Centers for Medicare and Medicaid Services and State licensed.

Mr. SALAZAR. Okay. But they assume the liability in case something goes wrong?

Dr. CROSS. Correct.

Mr. SALAZAR. And you have oversight over those caregivers?

Mr. HALL. Yes, sir. They are responsible under the contract that we have with them to provide care to a certain standard.

Mr. SALAZAR. And what is your recourse if they do not?

Mr. HALL. Then we are able to, under the, we have recourse under the contract, either to demand damages or payment from them, or to terminate the contract.

Mr. SALAZAR. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Mr. Salazar. I just have one follow up question, Dr. Cross. Actually, the three of us and Ranking Member Miller, had the chance to go to Iraq and visit with the troops, and talk to the individuals over there about healthcare. One of the issues that, I actually asked several of the generals we met with is, what they are doing personally to help, destigmatize PTSD, or traumatic brain injury. We got, the normal

response that we get. But the interesting thing is, at one facility after we went out and did our photo shoot out front, someone with lesser command came up to me and very discreetly said, you know, "We need more help." They are not getting the help that they need to, to the soldiers.

You mentioned that you are working with the DoD on a daily basis. What are you doing to help with that destigmatization? For instance, a couple of days ago when I was in Indiana, we had a veteran who called a Congressman, as well as the press, and said he was going to kill himself during our meeting at the CBOC. We were able to take care of that. But, there is a big problem out there. Are you working with other groups? What actually came to my attention when you look at a lot of our athletes, which are looked at as heroes as well, when you look at the concussion that athletes have, which is mild TBI, are you working with the other organizations such as, sports, to see what they can do to help destigmatize issues such as TBI or PTSD?

Dr. CROSS. Thank you for that question, sir. The stigma is very real. We recognize that. We do not deny that. And we take it very seriously. Let me tell you three or four of the things that we are doing in conjunction with your experience in Iraq.

I do not think many people necessarily who are experiencing depression are anxious to go sit in a waiting room that says psychiatry or mental healthcare. We recognize that so we created a nationwide initiative which we have already executed to insert our mental healthcare, a portion of it into primary care clinics, where the patients have already been and are already usually comfortable. We start the process right there, make the diagnosis, make the first contact, break the ice, so to speak, right in that setting. Then we are doing education. If you go out on the metro here in Washington, or watch some of the buses going by, you will see a sign. It says, it is a 1-800 number, "Call it for help." It is from the VA. If you call that number and press 1 as it tells you, it takes you to our facility at Canandaigua, New York. And when you, and you can call them anonymously you do not have to give them a name, but they will encourage you to do that. And that is our suicide prevention hotline in which we have had like, I think 50,000 or 60,000 calls since we have opened it. Now, many of those were not veterans. Many of them were people just calling for information. But some of them were significantly asking for help and we have done many rescues.

Our Vet Centers are a key tool that we have, where you have combat veterans talking to combat veterans. Combat veterans on our staff, and they have a totally different record system and create a real sense for that individual of privacy and confidentiality, and a lack of bureaucracy, perhaps, that would be different from a large hospital. So those are several of the things that we are doing.

We recognize that issue. We think it is very important, and that is why we are putting these programs, and have already put those programs in place.

Mr. MICHAUD. I know it is out of your jurisdiction, but actually I was reading an article somewhere where they had, I think, the Dallas Cowboy Cheerleaders overseas to bring morale to the troops. During your discussions, I am just wondering whether it might be

worthwhile with your discussion with DoD whether or not you do have these athletes who will admit that they have mental health problems and could really help with destigmatization of this issue.

Dr. CROSS. Sir, even while we are speaking right now there is a conference going on, I believe, back at my headquarters and the tape, it is not an athlete but it is a movie star. They are doing a press release with a videotape of Gary Sinise. I think that was Lieutenant Dan. And talking about the issues of, you know, how we are encouraging folks to come in and get help. John Elway was also involved with us on some public releases that we have done. He has been very helpful, and others as well. And I hesitate because I might leave somebody out, but a number of them have been very helpful.

Mr. MICHAUD. Okay. Well, thank you very much. Lastly, I know you are going to provide written testimony on Congresswoman Shea-Porter's, legislation. She already made clear—well, the Secretary did—that they are not going to get a hospital, but it appears that there is a problem with her veterans getting service. If you are opposed to her legislation if there is a way that we can look at addressing her concerns, you know, as well it would be very helpful.

[As of January 12, 2009, the VA failed to provide the administration views on H.R. 3051, H.R. 6153, and H.R. 6629.]

Dr. CROSS. Of course, sir, and we will do that.

Mr. MICHAUD. Okay. Well, once again I want to thank you Dr. Cross for your testimony, but also for your ongoing support for taking care of our veterans. You have always been a gentleman and I really appreciate working with you and your staff as well. If there are no other questions, we will adjourn the hearing. Thank you very much.

[Whereupon, at 11:31 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, VSOs, the VA and other interested parties to provide their views on and discuss legislation that have been introduced within the Subcommittee's jurisdiction in a clear and orderly process.

I do not necessarily agree or disagree with the bills before us today, but I believe that this is an important part of the legislative process that will encourage frank discussions and new ideas.

We have three bills before us today.

I look forward to hearing the views of our witnesses on these bills before us. I also ask that witnesses submit their views for the record on H.R. 6629.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman, for holding this legislative hearing.

Today, we will hear testimony on three legislative proposals—

H.R. 3051, which would require VA to establish a program to train, certify and compensate family members of veterans and servicemembers with Traumatic Brain Injury (TBI) as personal care attendants;

H.R. 6153, the Veterans' Medical Personnel Recruitment and Retention Act of 2008; and

H.R. 6629, which would require that veterans in the 48 contiguous states have access to full service medical care through at least one VA hospital in the state, or through a contract with other health providers in the state.

Providing the highest quality of care for our wounded warriors suffering with a TBI, the recruitment and retention of the very best VA healthcare providers, and access to care for every veteran regardless of where they live are issues that our Subcommittee has been focusing on throughout the year.

VA has recently developed and implemented many new programs and policies to address the needs of veterans with TBI, help recruit and retain its corps of healthcare professionals and enhance access to care. I want to commend the Department for their ongoing efforts. However, during this critical time, we must continue to look at where gaps in services still exist and what more can be done to ensure that our veterans receive the highest quality healthcare services.

I want to thank all of our witnesses for being here today. I look forward to a productive discussion and the opportunity to fully examine the legislative proposals before us. I am hopeful that this debate will help guide our actions on developing legislation that will best serve our Nation's veterans.

Thank you Mr. Chairman, I yield back.

Prepared Statement of Hon. Phil Hare

First, I would like to thank Chairman Michaud and Ranking Member Miller for holding this hearing. The three bills before us today address important issues, all of which have huge impacts on the welfare of our Nation's veterans.

Second, I would like to thank the sponsors of these bills, the three members that are testifying before us today.

Mr. Salazar is a fellow Committee Member and I know from sitting next to him over the past 2 years, that he is a tireless advocate for veterans, especially the many

rural veterans that live in his large district in Colorado. His bill addresses family caregivers for veterans suffering from TBI, and also telehealth services. These are crucial matters and are directly in line with Mr. Salazar's passion for improving the lives of veterans and their families.

Ms. Johnson is also a big supporter of veterans. For 15 years she worked at the Dallas VA Medical Center as a medical and psychiatric nurse. Appropriately, her bill aims to help VA recruit and retain more nurses and other healthcare professionals.

Ms. Shea-Porter and I came into Congress at the same time, and I know without a doubt, that there is nobody more dedicated to serving our veterans than she is. It is a paradox then that her home state, the great State of New Hampshire, does not have a VA medical center. Her bill attempts to resolve this injustice.

Third, I would like to thank all our witnesses for testifying today, including Dr. Cross of the VA and each representative of the three VSOs present. I would also like to congratulate the Disabled American Veterans for recently electing Raymond E. Dempsey, a fellow Illinoisan, as National Commander. Speaking on behalf of the great state of Illinois, I take great pride in knowing that such a well-respected organization is under the leadership of Mr. Dempsey.

Mr. Chairman, thank you again for holding this important hearing.

**Prepared Statement of Hon. Eddie Bernice Johnson,
a Representative in Congress from the State of Texas**

Thank you, Mr. Chairman, and Members of the Subcommittee, for the opportunity to testify today on issues related to veterans.

Millions of veterans nationwide receive treatment in the VA healthcare system. A significant number of these veterans have returned from war—including the wars in Afghanistan and Iraq—with serious injuries, including traumatic brain injury. Quite understandably, a large number of troops are also suffering from psychiatric disorders, such as post-traumatic stress disorder.

It is our duty to ensure that our veterans, who have so courageously served our country, receive the medical support they deserve. The VA system must be able to successfully compete for the best healthcare providers in the United States. Today, I speak in support of the Veterans' Medical Personnel Recruitment Act of 2008, because it gives the VA the tools to recruit and retain the very best medical and professional employees.

This legislation will raise salaries for nurses, physicians, dentists, senior executives and pharmacist executives. It will streamline pay systems, making them easier to understand and to implement. It will provide incentives to retired employees to return to the VA system by removing annuity and salary offsets, thereby encouraging the qualified workers most familiar with the VA system to return to work. The legislation will also increase education benefits for new VA hires and current staff.

I worked as a medical and psychiatric nurse at the Dallas VA Medical Center for 15 years, and I can attest to the unparalleled role nurses play in all medical facilities. Nurses are often the medical professionals with whom patients have the most contact, and they are repeatedly cited by patients as the medical professionals they trust the most. There is a nursing shortage in our country, and if we want the VA to attract the very best nurses, we must provide the proper incentives.

Standardizing the definition of "emergency" will facilitate more consistent and equitable use of emergency mandatory overtime. By clarifying VA regulations regarding work schedules, overtime and emergency duty the Veterans' Medical Personnel Recruitment and Retention Act will offer nurses more schedule flexibility and provide for the VA to become a more employee-friendly place to work. The legislation will also make it easier for the VA to hire and retain part-time nurses and to allow full-time nurses to transition to part-time work schedules.

The Veterans' Medical Personnel Recruitment and Retention Act will strengthen the VA system, helping to make the VA the healthcare employer of choice. Our veterans, who have so courageously served our country, deserve its passage and implementation.

Mr. Chairman, this concludes my testimony I will be happy to answer any questions that you may have.

**Prepared Statement of Hon. John T. Salazar,
a Representative in Congress from the State of Colorado**

Thank you Mr. Chairman.

First I would like to thank Dr. Jim Schraa, a Neuropsychologist at Craig Hospital, and Anna Frese, with the Wounded Warrior Project, who submitted testimony for the record.

On July 17, 2007 I introduced H.R. 3051 the Heroes at Home Act.

The purpose of this bill is to improve the diagnosis and treatment of traumatic brain injury in current and former Members of the Armed Forces.

The program will be located in VA healthcare centers across the Nation.

This is especially important to rural districts like mine where making healthcare accessible is a constant challenge.

H.R. 3051 addresses the need for access to care by expanding both DoD and VA telehealth and telemental health programs.

Ultimately this bill will ease the burden on our veterans suffering from TBI and the families who care for them.

Our Committee has heard testimony from many veterans, Veteran Serving Organizations and the VA on the mounting cases of TBI, PTSD and other invisible wounds of war.

Many agree that veterans are often worse off with these unseen injuries than those with visible physical injuries.

Unlike other injuries that can heal, brain injuries are often permanent and disabling.

In addition, TBI can sometimes take years to develop and diagnose.

Even when discovered the road to recovery is long and is borne by the families of our brave men and women in uniform.

We have also heard of the link between TBI and other mental conditions such as epilepsy.

A DoD study after Vietnam found that 15 percent of soldiers with a penetrating TBI developed epilepsy soon after their injury.

H.R. 3051 creates a program to train the family members of TBI patients to become their personal care attendants.

Participants going through the program would become certified and receive compensation from the VA so that they can focus their energy on caring for their loved ones.

By taking place at home with family, the healing process is made more comfortable for our veterans.

The cost to the VA for having someone cared for at home is less than having them at a medical facility and allows the VA to allocate the resources they have to serve more veterans.

We have soldiers in Iraq and Afghanistan spending longer periods of time in harms way and away from their families.

With that in mind we need to ensure that there are programs in place to care for them when they return home.

A program that provides quality care for our veterans and a financial benefit for their families seems appropriate for the difficult economic times our country is facing.

Most importantly, this bill will help us all reach our goal of ensuring our veterans the best care possible.

Mr. Chairman, I thank you and the Members of this Subcommittee for the opportunity to introduce legislation that improves the lives of our veterans suffering with TBI.

**Prepared Statement of Hon. Carol Shea-Porter,
a Representative in Congress from the State of New Hampshire**

Mr. Chairman.

Thank you for the opportunity to speak to your Subcommittee about a critical inequity facing New Hampshire's veterans—the lack of full service, in state healthcare.

New Hampshire has not had a full service veterans' hospital since 2001. New Hampshire is the only state without a full-service VA hospital or comparable facility. Veterans in Alaska and Hawaii receive care at military hospitals on base. While New Hampshire may be a small state, it has a veteran population of over 130,000. Unlike many New England states whose veterans populations are declining, New Hampshire's veterans population is projected to grow over the next 10 years.

Because New Hampshire does not have a full service veterans' hospital, our veterans are forced to travel out of state for medical care. Veterans traveling from the most northern parts of the state can travel for 3 hours to Manchester and then may be forced to travel another hour to Boston, if referred there for care.

This routinely happens. In 2007, 704 of our veterans were transferred out-of-state for Acute Care. Three hundred forty-six of those veterans were sent to Boston.

I have been calling for the VA to either restore the Manchester facility to full-service hospital care or allow NH vets to receive care locally since I came to Congress. I have been working with both the VA and my colleagues to realize that goal. Chairman Filner visited the Manchester Veterans facility earlier this year and held a series of events including a roundtable during which we heard about the serious burdens placed on the New Hampshire veterans and their families because we do not have a full-service hospital.

Despite these efforts, the administration refuses to either provide local access to care or restore full service VA hospital care to New Hampshire. I met with Secretary Peake at the Manchester Veterans Administration Medical Center in June to express my interest in working with him to either restore the facility to a full-service hospital or provide local access. Unfortunately, after our meeting Secretary Peake told the local press that there would be no full-service hospital in Manchester.

The Administration's failure to act is unacceptable. New Hampshire's veterans deserve the best possible care and the current system is not delivering that. This is why I introduced H.R. 6629, the Veterans Health Equity Act of 2008.

This legislation will ensure that veterans have access to at least one full-service hospital, or that they can receive care, the same care they would get in a VA hospital, in the state. This would mean that the VA would have to do one of two things, either restore the Manchester facility to a full-service hospital, or partner with more local health providers to make sure our Veterans can receive the care they need, in New Hampshire.

The men and women in our local VA facility have done a herculean job of caring for our vets despite the limits to access imposed on New Hampshire vets. The Administration has very recently shown some willingness to allow radiation therapy to be provided locally. But this is not enough.

Our veterans—regardless of whether they need radiation therapy, mental health services, acute care or anything else—need and deserve the care their counterparts in every other state receive. It is unconscionable that we deny them this full service care and instead offer them ad hoc services.

Mr. Chairman, I appreciate your leadership in providing the best possible healthcare for our Nation's veterans. I am sure you and the other Members of your Subcommittee appreciate the challenges created by the lack of full service hospital care in New Hampshire. I look forward to working with you and the Subcommittee to address these challenges.

Thank you again for giving me the opportunity to testify on this important issue. I look forward to answering any questions you may have.

**Prepared Statement of Joy J. Ilem,
Assistant National Legislative Director, Disabled American Veterans**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this legislative hearing of the Committee on Veterans' Affairs Subcommittee on Health. 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 two bills primarily focused on healthcare services for injured military servicemembers and veterans, and personnel issues affecting healthcare employees of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA). We appreciate the opportunity to provide our views on these measures to the Subcommittee.

H.R. 3051—the Heroes at Home Act of 2007

In general, this bill seeks to improve the diagnosis and treatment of traumatic brain injury (TBI) and raise awareness about post-traumatic stress disorder (PTSD) among current military servicemembers and veterans; provide support to families of severely injured veterans; and, expand telehealth and telemental health programs of the Department of Defense (DoD) and VA.

Section 2 of the bill would require VA, in collaboration with the Secretary of Defense, to develop a program of training and certification of family caregivers and other personal care attendants of veterans and still-active members of the Armed Forces with TBI, at every VA medical center. The curricula developed would incorporate the standards and protocols of national brain injury care specialist organizations and, to the degree possible, would require use of, and would expand the curricula developed under, the John Warner National Defense Authorization Act for Fiscal Year 2007 (Public Law 109-364). Certification received by family caregivers or others would qualify them to be compensated for personal care services rendered to the injured veteran or servicemember. Training would be provided at no cost to the veteran or caregiver, but would be borne by VA or reimbursed through TRICARE.

Section 3 of the bill would require VA to conduct comprehensive outreach to enhance awareness among veterans and the general public about the symptoms of PTSD and TBI and the services provided by the VA. It would further require VA to make information available to non-VA practitioners on best practices in treatment of TBI and PTSD.

Section 4 of the bill addresses telehealth and telemental health services of DoD and VA, and would require the Secretaries to jointly establish a demonstration program to assess the feasibility of using telehealth technologies to evaluate cognitive functioning among servicemembers who have sustained head trauma. In addition, the bill would require an assessment of telehealth tools to obtain information regarding the nature and symptoms of brain injury, the use of technology to rehabilitate those with TBI, and the usefulness of applying such technology to dissemination of educational material to veterans and servicemembers. The funds for the demonstration would be drawn from the DoD-VA healthcare Sharing Incentive Fund and the results of the demonstration would be reported in the administration's joint report to Congress on sharing initiatives between the two Departments. Another study the bill would require is an ongoing review of telehealth and telemental health services, to include the number of servicemembers and veterans who have used such services and the extent to which the National Guard and Reserve components of the armed forces use them, in addition to identifying improvements for such programs. The report would also require best practices of civilian mental health providers assisting veterans and former servicemembers and demonstrate the feasibility and advisability of partnering with civilian mental health facilities to provide telehealth and telemental health programs.

While modern protective gear and battlefield medicine have greatly improved from previous conflicts, the intensity of polytrauma injuries, including TBI, presents great challenges to DoD and VA in meeting servicemembers and veterans acute, rehabilitative and long-term care health needs. As you well understand, Mr. Chairman, the most severe of these injuries may require a lifetime of care. The family members of military polytrauma casualties typically appear at the bedside of their loved one and remain with them throughout their acute treatment and extensive rehabilitative periods. A survey conducted on behalf of the President's Commission on Care for America's Returning Wounded Warriors (Commission) found that ". . . 33 percent of active duty, 22 percent of reserve component, and 37 percent of retired/separated servicemembers [who were injured] report that a family member or close friend relocated for extended periods of time to be with them while they were in the hospital."^[1]

Family members of severely injured veterans often shoulder a great and lifelong burden as home and institutional caregivers, giving up or severely restricting their own employment and educational advancement and negatively impacting social interactions that are taken for granted in the normal course of life. The Commission's survey also found that "21 percent of active duty, 15 percent of reserve component, and 24 percent of retired/separated servicemembers [who were injured] say friends or family gave up a job to be with them or act as their caregiver."^[2] Not surprisingly, family caregivers often suffer severe financial and personal hardships as a consequence of providing care to a severely disabled veteran. Yet, in their absence, an even greater burden of direct care would fall on DoD and VA, at significantly higher financial cost to the Government and a reduced quality of life for severely wounded war veterans.

DAV testified before the Senate Committee on Veterans' Affairs earlier this year in support of S. 2921, a bill that would require VA to develop a pilot program to train and certify family caregivers of traumatically brain injured veterans. We are

^[1]The President's Commission on Care for America's Returning Wounded Warriors. *Final Report: Serve, Support, Simplify*. July 2007: 9.

^[2]Ibid.

very enthusiastic about bolstering the financial support for these vulnerable families and believe that this is also an idea that will improve the quality of care our veterans receive. We agree with the intent of H.R. 3051 that this common-sense program could be started without being a pilot—since family caregivers of severely injured veterans are already shouldering a great deal of the care these veterans receive. This program would allow these family members to have up-to-date and consistent training and to receive compensation that recognizes their services and will better ensure the stability of the family at an extremely difficult and vulnerable time. The needs of these veterans and their families are urgent. However, we believe that initially, the training and certification process may need to be limited to sites that have these capabilities in place—most likely in the polytrauma centers and other units within the Defense and Veterans Brain Injury Network. We ask the Subcommittee to consider this aspect of the bill and modify it accordingly to ensure the training provided is of high quality and focused on the particular needs of these families.

Similar to the provision for a training and certification program in S. 2921, section 2 of the Heroes at Home Act would address veterans with traumatic brain injuries but would also be beneficial for other catastrophically injured veterans with long-term personal assistance needs, such as veterans with spinal cord injuries or severe physical trauma without brain injury. Indeed, an educational proposal to assist family caregivers of all veterans with catastrophic injuries who would be taking on personal assistance duties was originally recommended by the Commission on Care for America's Returning Wounded Warriors. If successful, we would like to see this provision related to training caregivers expanded to other catastrophically disabled veterans requiring caregiver assistance.

Section 3 of H.R. 3051 would require that VA conduct outreach activities targeted at increasing recognition of symptoms and public awareness that resources are available within VA to treat traumatic brain injury and PTSD. Veterans may not be the first to recognize the changes in their own behavior consequent to their exposure to concussive and traumatic events. Indeed, even with the high rates of prevalence expected for both TBI and PTSD, some veterans will not recognize their own symptoms until weeks or months after repatriation, if ever.^[3] Often, a family member notices changes in a veteran's behavior and mood; thus, informing the general public is also an important element of this bill. DAV believes that there must be a systematic means of educating veterans and their families about these problems and how to find support. We acknowledge that some veterans are receiving care for war-related disabilities outside of the VA and military systems, so we appreciate the requirement in the bill that VA would disseminate best practices on both mild-to-moderate TBI and PTSD to non-VA providers.

Mr. Chairman, DAV also supports, but with some concern, section 4 of this bill to improve and expand telehealth and telemental health in VA and DoD. DAV certainly agrees that it is a challenge for VA and DoD to place resources everywhere veterans want and need to receive care. Tele-medicine has played a vital role in filling gaps in care in a number of communities—particularly in rural and frontier communities that lack access to a full continuum of care, and in some cases even basic healthcare services. We support efforts to assess new web-based diagnostic tools for the prevalent cognitive conditions that are emerging among our returning veterans. However, this section also contains a provision that would require VA and DoD to study ways that civilian providers might be used to enhance telehealth services offered to injured veterans and servicemembers. DAV has long held the position that contracting for healthcare outside VA should be attempted judiciously so as not to undermine VA's high-quality and specialized health and rehabilitative programs, and only when community-based care is coordinated and of high quality. Thus, we ask the Subcommittee to carefully consider the results of the required study in this bill before advancing any legislative mandate for VA or DoD to significantly expand tele-medicine into the private sector. Any such expansion should include coordination through the VA Office of Rural Health and would also need to be attended by new resources outside VA's Medical Care appropriation to garner full DAV support.

While we support this bill, we would ask the Subcommittee to also consider the needs of veterans with less severe traumatic brain injuries. Mild-to-moderate brain injuries are prevalent among the Iraq and Afghanistan deployments—possibly as many as 320,000 veterans may be affected, yet of those reporting a probable TBI, 57 percent had not been evaluated by a clinician for that injury according to the recent RAND report. Key findings of the study also noted that about half of those

^[3]*Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Ed's: Tanielian, T; Jaycox, L. RAND Center for Military Health Policy Research: 2008

who need treatment for PTSD, depression or probable TBI seek care for those conditions, and only slightly more than half who receive treatment get minimally adequate care.^[4] The DoD and VA must be at the forefront of efforts to improve the diagnosis, treatment, management and surveillance of all brain injuries to ensure high-quality and consistent care is obtained for all servicemembers and veterans who suffer from concussive blasts in Iraq and Afghanistan. This bill would acknowledge the enormous debt the Nation owes, not only to injured veterans, but to their family caregivers, whose lives may be forever altered. However, we ask the Subcommittee to also consider expanding this measure to include the broader slate of initiatives DAV supports for family caregivers. DAV supports legislation to provide comprehensive supportive services, including financial support, health and home-maker services, respite, education and training and other necessary relief to immediate family member caregivers of veterans severely injured, wounded or ill from military service.

With these cautionary notes, DAV believes the ideas in the bill are worthy and if implemented carefully, could provide relief and support for sick and disabled veterans, particularly those with invisible wounds of war, including TBI and PTSD, and would provide welcome relief to family caregivers of the severely disabled. With exceptions noted, most of the proposals are consistent with recommendations of the Fiscal Year 2009 Independent Budget. Thus, DAV supports this bill and urges the Subcommittee to work toward its enactment.

H.R. 6153—Veterans’ Medical Personnel Recruitment and Retention Act of 2008

Along with our partners in the Independent Budget, DAV has called for improvements in VA policies and procedures used to recruit and retain highly qualified VA clinical staff. Also for the past several years our organizations have expressed concerns that VA needs new authority to achieve and sustain this goal, to be competitive with private sector providers and become a preferred employer of physicians, nurses, dentists and other personnel needed to care for enrolled veterans. With increasing numbers of veterans turning to VA for their healthcare and—particularly at a time of ongoing military engagements in Iraq and Afghanistan—VA needs the best and the brightest to meet the increasingly complex medical needs of an aging veteran population, veterans severely disabled during wartime service, and enrollees suffering from chronic disease. This bill, aimed at providing meaningful financial and professional incentives to encourage VA clinicians to pursue full careers in the VA healthcare system appears to be timely and appropriate given all of the challenges VA faces to maintain its effectiveness as a provider of comprehensive healthcare services.

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 Office of Management and Budget (OMB) and to both House and Senate Committees on Veterans’ Affairs. 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 healthcare occupational fields under sections 7401 and 7403, title 38, United State Code, without offsetting their retirement annuities for which they would remain eligible 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 comparability pay adjustments and market pay provisions in chapter 74, title 38, United States Code. Finally, it would provide additional policy clarifications on nurse compensation caps, special compensation for nurse executives; locality salary systems for VA nurses; part-time nurse compensation rules; weekend premium rules, as well as clarified direction on the use and disclosures of wage surveys in nurse locality compensation 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 reversing VA’s

^[4]Ibid.

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 1964, from discrimination or any adverse action based on their refusal to work required overtime. Under this section, the VA Secretary would be provided an emergency exigency power in certain circumstances to require a nurse to work overtime, but the section defines the term “emergency” within narrow grounds. Section 3 also clarifies language on weekend duty and other alternative work schedules for VA nurses, and would provide a number of associated technical and conforming amendments.

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

Mr. Chairman, while DAV has no national resolution adopted by our membership that addresses these specific matters, *The Independent Budget for Fiscal Year 2009*, sponsored by DAV, Veterans of Foreign Wars of the United States (VFW), American Veterans (AMVETS) and Paralyzed Veterans of America (PVA), conveys a series of recommendations that are fully consistent with this bill. Therefore, DAV would have no objection to its enactment.

Mr. Chairman and Members of the Subcommittee, as you may know, our DAV advocacy campaign, *Stand Up For Veterans*, is well underway. Its purpose is to generate greater public awareness and support for strengthening Federal policies to provide greater healthcare assistance to veterans disabled in the ongoing wars in Iraq and Afghanistan, as well as to sick and disabled veterans from prior eras and conflicts. In this effort, our campaign has focused on TBI, post-deployment mental health challenges (including PTSD), women veterans’ health, family caregiver support, and reforms in budgeting that will bring sufficient, timely and predictable funding to VA healthcare. DAV has been pleased by Congressional responsiveness to many of the proposals emanating from our campaign that we have shared and discussed with Members of this Subcommittee and others in Congress. We appreciate that responsiveness and encourage the Congress to complete a significant package of veterans’ health legislation before adjournment.

Mr. Chairman, this concludes my statement on these two bills, and I would be happy to answer questions on these issues from you or other Members of the Subcommittee.

SUPPLEMENTAL STATEMENT

H.R. 6629, the Veterans Health Equity Act of 2008

This measure would seek to ensure availability of at least one full-service hospital of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA), or comparable services through contract, in each of the 48 contiguous States.

Congresswoman Shea-Porter provided an opening statement for the Subcommittee at the September 9th hearing explaining the reasons for the introduction of this measure (H.R. 6629). Ms. Shea-Porter noted that New Hampshire was the only State that did not have access to a VA full-service medical center and that the most ill veterans in her state routinely had to drive or be transported to Boston for more comprehensive healthcare services. She stated that she was particularly concerned that the sickest and generally very elderly veterans with complex and chronic health problems were subjected to having to first report to the VA’s Manchester facility—which could be up to a 3 hour drive—and then having to continue on for another hour to get to the Boston VA Medical Center (VAMC) or other VA provider sites. Finally, the Congresswoman noted that it may not be fiscally responsible, given the veterans’ population in her state, to have VA provide a full continuum of hospital services and that contracting for such services may be the best option. Her main concern was that sick and disabled veterans in New Hampshire are having to make unnecessarily long trips to Boston area VAMCs to get the care they need for complex health conditions.

Convenient access to comprehensive VA healthcare services remains a problem for many of our Nation’s sick and disabled veterans. While VA must contract or use fee basis to provide care to some veterans, it maintains high quality care and cost

effectiveness by providing health services within the system. According to VA, the Manchester VAMC of New Hampshire provides urgent care, mental health and primary care services, ambulatory surgery, a variety of specialized clinical services, hospital based home care and inpatient long-term care. In addition, community-based outpatient clinics (CBOCs) are located in Somersworth, Tilton, Portsmouth and Conway.

In light of the escalating costs of healthcare in the private sector, to its credit, VA has done a remarkable job of providing high quality care and holding down costs by effectively managing in-house health programs and services for veterans. However, outside care coordination is poorly managed by VA. When it must send veterans outside the system for care, those veterans lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health records, and bar code medication administration program (BCMA). The proposal in H.R. 6629 to use broad-based contracting for necessary hospital services in the New Hampshire area concerns us because these unique internal VA features noted above culminate in the highest quality care available, public or private. Loss of these safeguards, which are generally not available in private sector systems, equate to diminished oversight and coordination of care, and, ultimately, may result in lower quality of care for those who deserve it most. However, we agree that VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA's policies in determining the appropriate locations and settings for providing VA healthcare services.

In general, current law places limits on VA's ability to contract for private healthcare services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban.

DAV believes that VA contract care for eligible veterans should be used judiciously and only in these authorized circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans. VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with complex health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new VA healthcare programs only exacerbates the problems currently encountered.

Nevertheless, after considerable deliberation, and in good faith to be responsive to those who have come forward with legislative proposals such as H.R. 6629, to offer alternatives to VA healthcare, we have asked VA to consider developing a series of tailored demonstration projects and pilot programs to provide VA-coordinated care (or VA-coordinated care through local, state, or other Federal agencies) in a selected group of communities that are experiencing access challenges, and to provide to the Committees on Veterans' Affairs reports of the results of those programs, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of veterans in VA healthcare. To the greatest extent practicable, VA should coordinate these demonstration pilots with interested health professions' academic affiliates. We suggest the principles of our recommendations from the "Contract Care Coordination" section of the FY 2009 Independent Budget be used to guide VA's approaches in this effort. Also, any such demonstration pilot projects should be funded outside the Veterans Equitable Resource Allocation (VERA) system, and their expenditures should be monitored in comparison with VA's historic costs for care.

Veterans service organization representatives from the local areas involved, and other experts need a seat at the table to help VA consider important program and policy decisions, such as those described here, that would have positive effects on veterans who live in these areas. VA must work to improve access for veterans that are challenged by long commutes and other obstacles in getting reasonable access to a full continuum of healthcare services at VA facilities and explore practical solutions when developing policies in determining the appropriate location and setting for providing VA healthcare services.

As a final note, we believe VA must fully support the right of all enrolled veterans to have reasonable access to healthcare and we insist that funding for alternative care approaches and outreach be specifically appropriated for this purpose, and not

be the cause of reductions in highly specialized VA medical programs within the healthcare system.

Prepared Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on these two important pieces of legislation.

H.R. 3051, Heroes at Home Act of 2007

This bill seeks to improve the diagnosis and treatment of traumatic brain injury in members and former members of the Armed Forces; to review and expand telehealth and telemental health programs of the Department of Defense (DoD) and the Department of Veterans Affairs (VA), and for other purposes.

Section 2 of HR 3051 requests the Secretary of VA establish a program on training and certification of family caregivers of veterans and members of the active duty Armed Forces with Traumatic Brain Injury (TBI), as personal care attendant. Pursuant to section 744(a)(2) of Public Law 109-364, a Veterans' Traumatic Brain Injury Family Caregiver Panel was established in 2007.

The 15 member panel was created by the DoD to operate under the Department of Health as a Subcommittee to advise and specifically provide DoD and VA with independent advice and recommendations on the development of training curricula to be utilized by the above mentioned family members on techniques, strategies, and skills for care and assistance for such individuals with TBI. The panel has convened on occasions, to include a recent townhall meeting, to discuss matters related to the development of a this curriculum and to hear from the public about the issue.

The American Legion asserts that the advice of this Subcommittee into the provisions of this piece of legislation is vital, and that its absence may deprive such a bill of an effective stance and approach to treatment and care of TBI. The American Legion, in its continued efforts to increase access and quality of care to all eligible and potentially eligible veterans, supports this proposal, as it would help to accomplish this ongoing challenge.

H.R. 6153, Veterans' Medical Personnel Recruitment and Retention Act of 2008

This bill seeks to amend Title 38 of the United States Code to enhance the capacity of VA to recruit and retain nurses and other critical health-care professionals, in addition to addressing other issues. The American Legion applauds this proposal to amend the methods of hiring and retaining additional medical personnel of various disciplines to adequately equip VA Medical facilities to ensure the adequacy and quality of treatment and care.

The American Legion supports the proposal request in section 2(j), which seeks to amend 7451(c)(2), to allow critical fields such as nurse anesthesiologists, to exceed rate limitations on authorized competitive pay. Although VA has various antidotal programs in place, to include recruitment, relocation, and retention incentives for these hard-to-fill positions, there remains a shortage of such nurses and specialty medical physicians.

The overall response to the question of shortage indicated that salaries and delays in appointments were key causative factors. The American Legion, during its VA Medical Center site visits to 49 facilities in 2008 encountered various recruitment issues, including such delays in the appointment of nursing assistants. Management attributed these delays to a three to 4 month hiring process. By the time management completed the hiring process, applicants have accepted a position in the private sector.

In their site visits the American Legion representatives ascertained other areas with difficulty recruiting; these included mental health positions, specifically psychologists and psychiatrists; Dermatology; Gastroenterology; Orthopedics; and, Anesthesia. A study published in the New England Journal of Medicine ascertained there were shorter inpatient stays and lower complication rates in hospitals with higher staffing levels, while there were longer inpatient stays and increased urinary infections, gastrointestinal bleeding, pneumonia and shock or cardiac arrest in hospitals with lower staffing levels. Thus planning and adequate staffing up front can

help curtail long term care costs and unnecessary complications to the veteran patients down the road.

We hereby urge Congress to act on this piece of legislation by incorporating it into the VA system to prevent the Healthcare system from being included in the casualties of the projected shortage of medical professionals through the year 2020.

Mr. Chairman and Members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on the abovementioned matters and issues of similarity. Thank you.

**Prepared Statement of Thomas J. Berger, Ph.D., Senior Analyst for
Veterans' Benefits and Mental Health Issues, Vietnam Veterans of America**

Mr. Chairman, Ranking Member Miller, Distinguished Members of this Subcommittee, and guests, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on H.R. 3051, the "Heroes at Home Act of 2007," that is designed to improve the diagnosis and treatment of TBI (traumatic brain injury) for servicemembers and veterans, and to review and expand the telehealth and telemental health programs DoD and VA. With your permission, I shall keep my remarks brief and to the point.

First, VVA thanks you, Mr. Chairman and Mr. Miller as well as distinguished Members of this Subcommittee for your active concern in regard to Traumatic Brain Injury (TBI) and related mental health problems of our troops and veterans, and for your leadership in holding this hearing today.

In general, Vietnam Veterans of America supports the intent of H.R. 3051. However, medical experts say that traumatic brain injuries are the "signature wound" of the Iraq war in particular, a by-product of the explosions caused by I.E.D. roadside blasts and suicide bombers. TBIs have become so commonplace that they, in fact, form the basis for today's hearing.

Although TBI may share some symptoms with post traumatic stress disorder, it is markedly different than PTSD, which is triggered by extreme anxiety, and permanently resets the brain's fight-or-flight mechanism. Battlefield medics and corpsmen can often miss traumatic brain injuries, and many troops don't know the symptoms or won't discuss their problems for fear of being sent home stigmatized with mental illness. The same is true for those who return to the U.S. for garrison duty or exit their term of military service and become veterans.

Certain TBI symptoms, such as seizures, can be treated with medications, but the most devastating effects—depression, agitation and social withdrawal—are difficult to treat with medication, especially when there is loss of brain tissue. In troops with documented TBI, the loss of brain functions is often compounded by other serious medical conditions that affect physical coordination and memory functions. These patients need a combination of psychological and physical treatment that is difficult to coordinate in a traditional medical setting, even when properly diagnosed at an early date. And we must remember that both concussive and contusive brain injuries are never just isolated injuries. Over time without proper diagnoses, care and treatment, TBI can affect nearly everything about the survivor including one's cognitive, motor, auditory, olfactory and visual skills, perhaps ultimately resulting in behavioral modifications, not a mental illness.

As more and more troops return home damaged from the war, their families must contend with not only the physical desolation of their loved ones, but come to grips with the new emotional reality of their lives which have changed drastically and not necessarily for the better. Take for example, a 35-year old soldier or Marine who returns home with what is diagnosed with traumatic brain injury (TBI). His/her impairment affects the future of the entire family. His or her spouse and children have to deal with his/her ability to concentrate, the mood swings, the depression, the anxiety, even the loss of employment. As you can well imagine, the economic and emotional instability of a family can be as terrifying and as real as focusing or simply waking in the middle of the night and crying because of nightmares. In cases of severely brain-damaged casualties, spouses, parents and siblings may be forced to give up careers, forsake wages, and reconstruct homes to care for their wounded relatives, rather than to consign them to the anonymous care of a nursing home or assisted living facility.

Families say that they also struggle with military and VA medical systems that were unprepared for these wounded. In some cases new equipment and specially trained staff needed for the most catastrophic cases are not available or have not kept pace with the advances in battlefield medicine that kept these servicemembers

live and brought them home safely. In addition, there are issues about the intensity and drain of needed family support that will be hard to sustain, as well as significant issues regarding the complexity of the medical and other specialized needs that need to be addressed. Of all the war's medically challenging injuries, brain injuries require the most personal involvement and cost over time.

TBI also presents a most puzzling challenge, especially in mild to moderate cases. Symptoms can be hidden or delayed, diagnosis is difficult, and evidence-based treatments are as of yet largely undetermined. Very few medical facilities are capable of providing even the most basic level of care for brain-injured patients, forcing most to seek treatment miles from home, if they can find it at all, and we must remember that over forty percent of our troops deployed in Iraq and Afghanistan come from rural America.

As you are well aware, one of the recommendations of the Dole-Shalala Commission was to "significantly strengthen support for families." This will not be an easy task, but VVA believes H.R. 3051 to be a key step in achieving this recommendation and providing a mechanism for empowering the families of brain-injured servicemembers **IF** the VA can develop effective implementation strategies for certification, competency evaluations, and meaningful outcome measurements to carry it out. As they say, "the devil remains in the details".

I thank you again for the opportunity to offer VVA's views on this proposed legislation, and I shall be glad to answer any questions you might have.

**Prepared Statement of Gerald M. Cross, M.D., FAAFP,
Principal Deputy Under Secretary for Health,
Veterans Health Administration, U.S. Department of Veterans Affairs**

Good morning Mr. Chairman and Members of the Subcommittee. Thank you for inviting me here today to present the administration's views on two bills, H.R. 3051, the "Heroes at Home Act of 2007," and H.R. 6153, the "Veterans' Medical Personnel Recruitment and Retention Act of 2008." I am accompanied by Mr. Walter A. Hall, Assistant General Counsel, and Ms. Joleen Clark, Chief Officer, Workforce Management and Consulting, Veterans Health Administration.

H.R. 3051. "Heroes at Home Act of 2007"

H.R. 3051 includes several provisions intended to enhance care and services to veterans and particularly new OEF/OIF veterans suffering from traumatic brain injury. section 2 of H.R. 3051 would require VA to establish a program to train and certify family members of veterans and servicemembers with traumatic brain injury (TBI) as personal care attendants. VA would be responsible for developing curricula for training family caregiver personal care attendants and for determining the eligibility of family members to participate in the program. A family caregiver who is certified as a personal care attendant would be eligible for compensation from VA for care provided to a veteran or servicemember.

Mr. Chairman, VA does not support section 2 because VA already has a program in place that accomplishes the goals of that section in a far more efficient and effective manner. To keep VA from being in the position of having to directly oversee the quality of care provided by individual caregivers, including family members, VA uses a third-party to obtain needed caregiver services. Implementing the bill, as written, would not only be impractical but also inadvisable. The resulting arrangement could well give rise to potential conflicts concerning the veteran's care between the family member-caregiver and the veteran, placing VA in an untenable position. We strongly urge the Congress to let us continue to obtain caregiver services as we currently do under our Home healthcare Program.

This bill provides that certified family caregivers shall be eligible for compensation but it does not state the nature of such compensation – is it payment for services provided so that the caregivers are VA employees or is it a benefit and, if so, is it to the veteran/servicemember or to the caregiver? Whether the compensation is for employment or is a benefit raises significant legal issues relating to liability, taxation and VA's relationship and responsibilities to both the patient and the caregiver. We also note the bill would make VA responsible for compensating caregivers of both veterans and active duty members of the Armed Forces. That responsibility to pay compensation may be that only relationship VA has with active duty members.

Under our program, VA currently contracts with more than 4,000 home health agencies that are approved by the Centers for Medicare and Medicaid Services (CMS) and/or are state licensed. Many of these agencies have expertise in training and certifying home health aides, including family members. Many operate in rural communities. VA refers interested family members to these agencies and, after their training, these family caregivers become paid employees of the agencies. VA provides remuneration pursuant to agreements with the home health agencies, thus compensating family caregivers indirectly. Importantly, VA also ensures that these home health agencies meet and maintain training and certification requirements specific to caregivers of TBI patients. For the reasons we have discussed, this model is preferable to that which would be required by section 2.

Subsection 3(a) of H. R. 3051 would require VA to conduct comprehensive outreach to enhance the awareness of veterans and the general public about the symptoms of post traumatic stress disorder (PTSD) and TBI and available VA health and other services. Mr. Chairman given the extensive and expanding outreach program that we already have in place to inform veterans and the general public about PTSD and TBI and the services we provide to veterans with these symptoms and injuries, this statutory mandate is not necessary. Let me take a moment to describe just some of the exciting new efforts underway to reach out to returning veterans.

VA is making intensive outreach efforts to veterans as they leave active duty. Upon return from deployment, every eligible veteran receives a letter from the Secretary of Veterans Affairs informing him or her of the availability of VA services near his or her home. VA is currently sending out follow-up letters to all of those returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans who have not come to VA for care, to reinforce the point that care is available through the Department. As of January 2008, more than 796,000 letters had been mailed. On April 24 of this year, the Secretary announced the creation of a "Combat Veteran Call Center" to begin contacting the nearly 570,000 recent combat veterans who have not used VA healthcare services to ensure they know about VA's medical services and other benefits.

In addition, the Vet Center program reaches out to returning veterans in their communities. Informing combat veterans and family members about the availability of readjustment counseling services is one of the primary missions of the Vet Center program. In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning servicemembers at military demobilization and National Guard and Reserve sites. The Vet Center program also provides access to other VHA and Veterans Benefits Administration (VBA) programs. To augment this effort, the Vet Center program recruited and hired 100 OEF/OIF veterans to provide the bulk of this outreach to their fellow veterans. Outreach provided by fellow combat veterans promotes a peer relationship that helps veterans with PTSD and other readjustment problems overcome any perceived stigma that may be associated with asking for professional assistance. Vet Center staff also participate with VAMC representatives in all onsite and call center Post-Deployment Health Reassessment events across the country, and provide outreach throughout the local community at events that feature veterans and family members. This is essential for making effective contact with veterans who have already returned to their home communities and are resuming normal family and work life.

VA is preparing a series of public service announcements to inform veterans about various VA services. As a first action, VA has released a series of posters and other public service announcements on VA's Suicide Prevention Hotline. Additionally, VA is using non-traditional approaches to disseminate outreach information, including presentations about mental health issues that are played on the Music Television Channel (MTV) and targeted at young OEF/OIF veterans and their families. VA is also developing a comprehensive nation-wide TBI awareness educational campaign that targets active duty servicemembers and veterans, media and the general public, Congress, Veterans Service Organizations, State VA Offices, and a variety of other key stakeholder groups. Some primary messages included in this campaign are identification of the symptoms of mild/moderate TBI, how to access VA screenings and treatment, and the benefits and advantages of receiving care from VA versus that of the private sector. Lastly, VA's National Center for PTSD website, www.ncptsd.va.gov, posts regularly updated Fact Sheets and other information on PTSD available for the general public.

Mr. Chairman, VA also believes that Subsection 3(b), which would require VA to share best practices developed for the treatment of PTSD and TBI with non-VA health practitioners, is redundant of activities already in place and therefore unnecessary. VA's reports and other documentation on best practices are generally a matter of public record. Moreover, VA participates in healthcare conferences where best

practices are exchanged and works continually with national organizations to share medical information. The following are a few examples of VA's sharing of best practices:

- VA's Clinical Practice Guidelines, including topics such as PTSD, depression, and substance use disorder treatment are publically available on the Internet.
- Local VA medical centers and Mental Illness Research Education and Care Centers (MIRECCs) are collaborating with the States in educating practitioners on issues of military culture and best practices for treatment of returning veterans.
- VA is involved in national meetings, such as the August 2008 "Conference and Policy Academy on Returning Veterans and their Families", which was a collaboration among the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Defense, and VA. The meeting was designed to help the states and communities develop effective plans and best practices for helping returning veterans and their families. VA staff made presentations on VA care during the Conference phase and provided consultative support to State teams during the Policy Academy.
- VA's National Center for PTSD has a web based curriculum "PTSD 101" providing education on best practices in PTSD assessment and treatment available to non-VA practitioners on VA's National Center for PTSD website (www.ncpted.va.gov.)
- The clinical experience and advances in rehabilitation methodologies at the Polytrauma Rehabilitation Centers (PRC) have been shared with the DoD/VA Senior Oversight Committee (SOC), which functions as the main conduit by which lessons learned are distributed within DoD and VA.
- VA and the Defense Center of Excellence for Psychological Health and TBI are collaboratively developing Clinical Practice Guidelines for mild TBI, which will be published and available to the public in late 2008.
- In June of this year, VA's Office of Rehabilitation Research and Development, in collaboration with DoD, sponsored a State-of-the-Art Conference on Approaches to TBI: Screening, Treatment, Management, and Rehabilitation.

Section 4 would require DoD and VA to jointly establish a demonstration project to assess the feasibility and advisability of using telehealth technology to assess cognitive functioning of members and former members of the Armed Forces who have sustained head trauma, in order to improve the diagnosis and treatment of TBI. In selecting sites, priority would be given to locations providing services in rural areas. This section would require, among other things, that the demonstration project address the use of telehealth technology to assess the feasibility of obtaining information regarding the nature of any brain injury incurred by a servicemember or veteran and any symptom of TBI in such individuals. Mr. Chairman, VA supports the goals of this provision but cannot support the section as written.

Section 4, as written, is too prescriptive and detailed. VA and DoD should be allowed more flexibility in executing the demonstration project. The technology is evolving and new ideas for utilizing the telehealth networks are emerging. DoD and VA should be given every opportunity to discover the possibilities of maximizing the technology rather than focusing on the enumerated requirements currently specified in section 4. We would be pleased to work with Subcommittee staff to develop legislative language that would make the project more tenable and productive.

VA is continuing to develop cost estimates for H.R. 3051 and will have the results for the Subcommittee as soon as possible.

H.R. 6153. "Veterans' Medical Personnel Recruitment and Retention Act of 2008"

H.R. 6153 contains several provisions intended to enhance VA's ability to recruit and retain nurses and other health-care professionals. Many of these provisions would be helpful, and we can support them. However, several of the provisions would not be helpful or are otherwise flawed.

Authority to Extend Hybrid Status to Additional Occupations

Subsection 2(a) of the bill would amend section 7401(3) to add “nurse assistants” to the list of so called hybrid occupations for which the Secretary is authorized to appoint and to determine qualifications and rates of pay under title 38. In addition, it would authorize the Secretary to extend hybrid status to “such other classes of healthcare occupations as the Secretary considers necessary for the recruitment and retention needs of the Department” subject to a requirement to provide 45 days’ advance notice to the Veterans’ Affairs Committees and OMB. Before providing such notice, VA would be required to solicit comments from labor organizations representing employees in such occupations.

VA favors such a provision. Nursing Assistants are critical to the Veterans Health Administration’s (VHA) ability to provide care for a growing population of older veterans, who are high-acuity patients and/or frail elderly requiring 24-hour nursing care.

Turnover data, 10.5 percent for 2006 and 11.1 percent for 2007, illustrate the great difficulty VA experiences in retaining this occupation. It is increasingly critical for VHA to be able to quickly and easily employ these nurse extenders. The same holds true for other hard-to-recruit healthcare occupations. This bill would give the Secretary the ability to react quickly when it is determined that these authorities would be useful in helping in recruiting and retaining a critical occupation without seeking additional legislative authority. However, the bill language should be modified to specifically apply to occupations that clearly involve the delivery of healthcare. In addition, because this authority involves the conversion of title 5 occupations to title 38 hybrid, the 45-day notice requirement should be modified to add OPM. Thus, we recommend modifying subsection 2(a) of the bill to read:

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

(1) **IN GENERAL.**-Paragraph (3) of section 7401 of title 38, United States Code, is amended by striking “and blind rehabilitation outpatient specialists.” and inserting in its place the following: “blind rehabilitation outpatient specialists, and such other classes of healthcare occupations as the Secretary considers necessary for the recruitment and retention needs of the Department who:

- (A) are employed in the administration (other than administrative, clerical, and physical plant maintenance and protective services employees);
- (B) are paid under the General Schedule pursuant to section 5332 of title 5;
- (C) are determined by the Secretary to be providing either direct patient care services or services incident to direct patient care services; and
- (D) would not otherwise be available to provide medical care and treatment for veterans.

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

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

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

Probationary Periods for Part-Time Nurses

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

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

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

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

Reemployed Annuitant Offset Waiver

Subsection 2(d) generally provides that annuitants may be temporarily reemployed in a title 38 position without being subject to having their salary offset by the amount of their annuity.

VA instead favors a Government-wide policy on waivers of this offset. Under current law, VA must obtain a waiver for individuals on a case-by-case basis, or obtain delegated waiver authority from the Office of Personnel Management (OPM). VA has done this for some critical occupations. The Administration has submitted a bill, which VA favors, to provide agencies with the authority to grant offset waivers to facilitate the temporary part-time reemployment of annuitants, which has been introduced as H.R. 3579/S. 2003. With many VA employees at or near retirement eligibility the potential for significant losses of mission-critical leaders and technical experts is a significant threat to VA's capability to deliver high quality healthcare to our Nation's veterans. VA access to retired title 38 healthcare providers, without financial penalty, would enhance our ability to meet these challenges and maintain the continuity of quality patient care, including support in times of disaster. As explained by OPM, 3579/S. 2003 "would allow Federal agencies to rehire recently retired employees to assist with short-term projects, fill critical skill gaps and train the next generation of Federal employees."

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

Subsection 2(e) would amend section 7404(a) to add a provision setting the basic pay of non-physician/dentist section 7306 employees at not less than the lowest rate of basic pay for the Senior Executive Service (SES). This amendment would be effective the first pay period that is 180 days after enactment.

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

Equity in pay for executive level managers and consultants is essential to attracting and retaining candidates for key positions. The pay schedule for 38 USC § 7306 appointees is now capped at the pay rate for Level V of the Executive Schedule (currently \$139,600). Locality pay is paid up to the rate for Level III (currently \$158,500). Individuals appointed under 38 USC § 7306 serve in executive level positions that are equivalent in scope and responsibility to positions in the SES. By comparison, employees in the SES receive a significantly higher rate of basic pay. The maximum SES pay limitation is the rate for Level II (currently \$172,200) when OPM has certified that an agency meets all regulatory criteria for certified performance appraisal systems, including the employing agency makes meaningful distinctions based on performance.

We estimate the costs of this provision to be \$225,290 in FY 2009 and \$2,466,862 over a 10-year period.

We recommend modifying this proposal to state that the basic pay of non-physician/dentist section 7306 employees be set at the rates of pay for SES employees under section 5382 of title 5. This modification would allow VA executive pay to track the full range of SES pay. The SES pay system conditions pay up to EL II on OPM certification that an agency's SES rating system meets all regulatory criteria for certified performance appraisal systems. In this regard we note that VHA

uses the same rating system for its section 7306 executives as it uses for its SES members. OPM has certified VA's SES performance appraisal system in the past, and it is currently certified by OPM through calendar year 2009. For consistency, we also recommend that the bill be modified to require that the Secretary make the same certification for the rating system covering section 7306 employees. Thus, we suggest that subsection 2(e)(3) be modified to read as follows:

“(3) Positions to which an Executive order applies under paragraph

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

Comparability Pay Program for section 7306 Appointees

Subsection 2(f) would amend section 7410 to add a new subsection to establish “comparability pay” for non-physician/dentist section 7306 employees of not more than \$100,000 per employee in order to achieve annual pay levels comparable to the private sector. Similar to provisions for RN Executive Pay in section 7452(g), it would provide that “comparability pay” would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

VA supports the concept of comparability pay for its non-physician/dentist executives. However, at this time we cannot support this proposal because it is a potentially precedent-setting departure from the unitary approach to government-wide SES pay. The Department is evaluating alternative proposals that may be more appropriate in addressing the comparability pay issues of these executives.

We estimate the cost of this provision to be \$1,165,500 for FY 2009 and \$12,761,900 over a 10-year period.

Special Incentive Pay for Department Pharmacist Executives

Subsection 2(g) would further amend section 7410 to authorize recruitment and retention special incentive pay for pharmacist executives of up to \$40,000. VA's determination of whether to provide and the amount of such incentive pay would be based on: grade and step, scope and complexity of the position, personal qualifications, characteristics of the labor market concerned, and such other factors as the Secretary considers appropriate. As with RN Executive Pay and comparability pay added by subsection (l), it would provide that “comparability pay” would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

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

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

Physician/Dentist Pay

Section 2(h) concerns physician/dentist pay. VA supports this provision.

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

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

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

RN and CRNA Pay

Subsections 2(i) and 2(j), relate to RN and Certified Registered Nurse Anesthetist (CRNA) Pay.

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

It is important for pay caps to be both fiscally responsible and sufficient to promote employee recruitment and retention. These proposals are not consistent with these principles. We note the alternative GS-15 cap would be meaningless inasmuch as it already is lower than the existing cap that is set at EL V, with a difference of about \$15,000. Moreover, it is unclear whether this alternative cap would be at the GS-15 rate before locality pay or after locality pay. The CRNA cap would leave CRNA pay rates completely uncapped, which would allow rates to potentially exceed those of physicians and dentists, the title Executive Schedule (Levels I-V), or the VA 7306 Schedule.

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

Subsection 2(k) would make amendments to the RN locality pay system (LPS). These provisions are not helpful and unnecessary. No costs are associated with this provision.

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

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

Subsection 2(I) would increase the maximum payable for nurse executive special pay to \$100,000. This provision would make the amount of nurse executive pay con-

sistent with the Executive Comparability Pay in subsection 2(f). For the same reason we oppose subsection 2(f), we do not support this proposal. We estimate the cost of this provision to be \$316,250 for FY 2009 and \$3,710,053 over a 10-year period.

The caption for subsection 2(m) suggests it provides for eligibility of part-time nurses for certain nurse premium pay. However, many of the substantive amendments are not limited to part-time nurses, or to all registered nurses.

VA opposes subsection 2(m) as seriously flawed, unnecessary, and costly.

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

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

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

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

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

(a)(1) Subject to subsections (b), (c), and (d), when the Secretary determines it to be necessary in order to obtain or retain the services of persons described in paragraph (2), the Secretary may increase the minimum rates of basic pay authorized under applicable statutes and regulations, and may make corresponding increases in all rates of the pay range for each grade. Any increase in such rates of basic pay—

* * * *

(c) An increased minimum rate established under subsection (a) may not exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent, and no rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.

Subsection 3(a)(1) would add new section 7459, imposing restrictions on nurse overtime. section 7459 generally would prohibit mandatory overtime for nurses (RNs, LPNs, LVNs, nursing assistants, and any other nurse position designated by the Secretary). It would permit mandatory overtime by nurses under certain conditions: an emergency that could not have been reasonably anticipated; the emergency is non-recurring and not due to inattention or lack of reasonable contingency planning; VA exhausted all good faith, reasonable attempts to obtain voluntary workers; the affected nurses have critical skills and expertise; and the patient work requires continuity of care through completion of a case, treatment, or procedure. VA could not penalize nurses for refusing to work prohibited mandatory overtime. Section 7459 provides that nurses may work overtime hours on a voluntary basis.

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

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

Subsection 3(b)(2)(A), in eliminating the requirement that service be on a "tour of duty" appears to make the Baylor 1,248 hourly rate divisor apply to all service on the weekend instead of just non-overtime hours. It is not appropriate for non-Baylor weekend work hours, and VA opposes this provision.

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

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

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

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

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

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

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

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

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

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you and the Members of the Subcommittee might have.

Statement of Raymond C. Kelly, National Legislative Director, American Veterans (AMVETS)

Chairman Michaud, Ranking Member Miller, thank you for holding this important hearing today. AMVETS is pleased to provide our views on H.R. 3051, the Heroes at Home Act of 2007, and H.R. 6153, the Veterans Medical Personnel Recruitment and Retention Act of 2008.

H.R. 3051 will establish two separate programs. First it will provide training and certification of family caregivers for veterans and members of the Armed Forces with Traumatic Brain Injury (TBI). Once a family member has been deemed eligible for the certification they also become eligible for compensation for the care they provide. H.R. 3051 will also establish a DoD–VA demonstration project to test the feasibility of using telehealthcare to care for servicemembers and veterans who have or could have TBI.

TBI is the signature wound of the current conflicts in Iraq and Afghanistan. Identifying, treating, and caring for servicemembers who have TBI ranks at the top of AMVETS’ priorities; therefore, AMVETS fully supports H.R. 3051, which will provide training and certification for family members of servicemembers who are affected by the unique nature of TBI. Family members are a natural choice for caring for patients who need daily in-home care. Because of the desire to help, family members will become caregivers. Providing them with the proper training and certification will give them the confidence they need to fully care for their loved one and reduce VA’s need to provide additional home healthcare.

H.R. 3051 will also broaden the use of telehealth and telemental health services. VA is a national leader in the development and use of telehealth programs. Nearly 200,000 veterans have been seen this year by specialists from the convenience of their local CBOC. Evaluating, diagnosing and treating mental health conditions related to TBI through telehealth will improve the lives of our servicemembers who have sustained head injuries. AMVETS supports the provision that will establish the telehealth and telemental health demonstration project. It is critical that VA and DoD make every effort to make receiving treatment for our servicemembers and veterans as convenient and as effective as possible, and the use of telehealth will ensure that veterans in remote locations or veterans who may have trouble traveling any distance will receive the attention and care they need and deserve.

H.R. 6153, the "Veterans' Medical Personnel Recruitment and Retention Act of 2008" would give the Department of Veterans Affairs an enhanced ability to recruit and retain nurses and other critical healthcare professionals at VA facilities. The Veterans Health Administration (VHA) is the largest direct provider of healthcare services in the Nation and adequate staffing is necessary to provide the care our veterans deserve. It is for this reason that AMVETS wholly supports H.R. 6153.

Critical shortages of healthcare professionals, such as registered nurses (RN), registered nurse anesthetists, physical and occupational therapists, speech pathologists, pharmacists, and physicians make it difficult to fill positions in the best of circumstances. Add to this the difference between VA compensation and private sector salaries and it becomes evident why the VA is understaffed.

One recruitment and retention tool in H.R. 6153 would be to increase pay for critical jobs. Currently VA medical professionals' salaries are not in line with what other facilities can pay. This has resulted in understaffed hospitals. By increasing the limitation on special pay for nurse executives from \$25,000 to \$100,000, for example, the VA has a tool to recruit new professionals as well as provide retention incentives for those already employed by VA facilities.

Another recruitment tool provided for in H.R. 6153 is limits on mandatory overtime and more flexible work schedules. It also improved education assistance programs and loan repayment plans. Combined with increased pay for certain positions, these tools would expand VA's ability to recruit and retain employees which would translate into improved care for our Nations' veterans. AMVETS wholly supports H.R. 6153.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions regarding our opinion on these matters.

**Statement of Susan H. Conners, President/Chief Executive Officer,
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, strongly supports The Heroes at Home Act of 2007 (H.R. 3051) and urges the United States House Committee on Veterans' Affairs to approve this important legislation in a timely manner.

The Heroes at Home Act of 2007 (H.R. 3051) would significantly improve support for family caregivers of returning servicemembers with traumatic brain injury (TBI). This important bill proactively acknowledges the reality that a brain injury impacts the entire family, not just the individual.

Importantly, this legislation acknowledges the critical role played by family caregivers in facilitating recovery from brain injury and addresses the pressing need to increase support for these caregivers through programs providing access to training, certification and financial compensation for their work as personal care attendants.

Family care is the most important source of assistance for people with chronic or disabling conditions, including people with brain injury. Yet, research has found that all too often, the traumatic brain injury of a spouse or close relative places extreme stress on family caregivers, frequently resulting in adverse physical and emotional outcomes for the caregivers themselves. Unfortunately, despite these documented physical hardships and psychological stress, family caregivers receive little support.

Specifically, stress reaction is known to occur in situations where the demands of the environment exceed an individual's resources. One critical component that has been found to be related to caregiver burden is whether or not the caregiver perceives the effects of the injury to exceed the caregiver's resources to manage the situation. In other words, perceived stress has consistently predicted negative outcomes for the caregiver.¹ A lack of financial resources and social supports are some of the common perceived stresses impacting family caregivers of loved ones with TBI.

One longitudinal study found that 47 percent of family caregivers of individuals with TBI had altered or given up their jobs at 1 year postinjury, and 33 percent at 2 years postinjury, decreases in both employment and financial status were reported over a 2-year time period postinjury¹¹. Particularly in light of the fact that

¹Chwalisz, Kathleen. "Perceived Stress and Caregiver Burden after Brain Injury: A Theoretical Integration." *Rehabilitation Psychology*, Vol. 37, No. 3, 1992. pp 189-203.

¹¹Hall KM, Karzmark P, Stevens M, Englander J, O'Hare P, Wright J. *Arch Phys Med Rehabil*. 1994 Aug;75 (8): 876-84.

caregivers often report severe financial strain and frequently must give up their jobs in order to take care of their loved one with TBI, increased financial support and access to respite care for family caregivers of returning servicemembers with TBI is vital and long overdue.

Again, the Brain Injury Association of America enthusiastically endorses The Heroes at Home Act of 2007 (H.R. 3051) and strongly encourages the Committee to approve this legislation.

Sincerely,

Susan H. Connors
President/Chief Executive Officer

**Statement of Hon. Paul W. Hodes,
a Representative in Congress from the State of New Hampshire**

I strongly support my colleague Carol Shea-Porter's bill, H.R. 6629, the Veterans Health Equity Act. Her bill would ensure that New Hampshire's veterans have access to the healthcare they have earned. I thank Chairman Michaud for holding this important hearing that highlights the lack of adequate access to healthcare for New Hampshire's veterans.

New Hampshire is the only state in the continental United States that does not have a full service Veterans Affairs Medical Center (VAMC). In my district alone, there are over 66,000 veterans, making up 13 percent of the population. New Hampshire's many veterans deserve the same access to healthcare services as veterans in other states across the country.

Seven years ago, the Manchester VAMC suspended various inpatient and outpatient services and was downgraded from a full-service VAMC. Now, veterans in New Hampshire must travel to surrounding states like Maine, Vermont or Massachusetts to receive VA healthcare services.

This travel causes both physical and financial hardships for our wounded veterans. Without a full service VAMC in state, New Hampshire's veterans are forced to drive across state lines, traveling farther and paying more at the pump with record gas prices to access the healthcare they earned.

Recently, the Secretary of Veterans Affairs James Peake visited New Hampshire and announced that the VAMC in Manchester will not return to a full service VAMC. I was extremely disappointed in Secretary Peake's shortsighted remarks. More wounded warriors are returning home from the Wars in Iraq and Afghanistan as veterans with physical and mental wounds, with Post Traumatic Stress Disorder and Traumatic Brain Injury, stretching our veteran's healthcare system.

With so many soldiers fighting abroad, we should not be turning our backs on veterans at home when they need it most. New Hampshire is the only state in the continental U.S. without a full service VA. With record high gas prices, we shouldn't ask Granite State veterans to drive long distances just to get the care they have earned. I strongly support H.R. 6629, the Veterans Health Equity Act, which would ensure that veterans across the country will receive the same access to healthcare that they deserve, no matter which state they live in.

**Statement of Barbara Cohoon, Deputy Director, Government Relations,
National Military Family Association, Inc.**

Chairman Michaud and Distinguished Members of this Subcommittee, the National Military Family Association (NMFA) would like to thank you for the opportunity to present written testimony for the record on 'Heroes at Home Act of 2007.' We thank you for your focus on the many elements necessary to ensure quality healthcare and mental healthcare for our wounded/ill/injured servicemembers, veterans, and the families who care for them; and, recognizing the important role caregivers play in the care of their loved one.

NMFA will discuss several issues of importance to wounded/ill/injured servicemembers, veterans, and their families in the following subject areas:

- I. Wounded Servicemembers Have Wounded Families
- II. Who Are the Families of Wounded Servicemembers?
- III. Caregivers
- IV. Mental Health

Wounded Servicemembers Have Wounded Families

NMFA asserts that behind every wounded servicemember and veteran is a wounded family. Spouses, children, parents, and siblings of servicemembers injured defending our country experience many uncertainties. Fear of the unknown and what lies ahead in future weeks, months, and even years, weighs heavily on their minds.

Transitions can be especially problematic for wounded/ill/injured servicemembers, veterans, and their families. The Department of Defense (DoD) and the Department of Veterans Affairs (VA) healthcare systems, along with State agency involvement, should alleviate, not heighten these concerns. It is NMFA's belief the government must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded servicemember must also consider the needs of the spouse, children, parents of single servicemembers, siblings, and especially the caregivers. According to the VA, 'informal' caregivers are people such as a spouse or significant other or partner, family member, neighbor or friend who generously gives their time and energy to provide whatever assistance is needed to the veteran."

Who are the families of Wounded Servicemembers

In the past, the VA and the DoD have generally focused their benefit packages for a servicemember's family on his/her spouse and children. Now, however, it is not unusual to see the parents and siblings of a single servicemember presented as part of the servicemember's family unit. In the active duty, National Guard, and Reserves almost 50 percent are single. Having a wounded servicemember is new territory for family units. Whether the servicemember is married or single, their families will be affected in some way by the injury. As more single servicemembers are wounded, more parents and siblings must take on the role of helping their son, daughter, sibling through the recovery process. Family members are an integral part of the healthcare team. Their presence has been shown to improve their quality of life and aid in a speedy recovery.

NMFA recently gathered information about issues affecting our wounded servicemembers, veterans, and their families through our Healing Adventure Operation Purple Camp in August and a focus group held this March at Camp Lejeune. They said following the injury, families find themselves having to redefine their roles. They must learn how to parent and become a spouse/lover with an injury. Spouses talked about the stress their new role as caregiver has placed on them and their families. Often overwhelmed and feeling as if they have no place to turn to for help.

Caregivers

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded servicemembers and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DoD and VA healthcare providers because they tend to the needs of the servicemembers and the veterans on a regular basis. And, their daily involvement saves DoD, VA, and State agency healthcare dollars in the long run.

Caregivers of the severely wounded, ill, and injured servicemembers who are now veterans have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. This will require the VA to train them through a standardized, certified program, and appropriately compensate them for the care they provide. NMFA is pleased with the 'Heroes at Home Act of 2007' legislation that will provide for the training, certification, and compensation for injured servicemembers or veterans with TBI. TBI has become the signature wound of this current conflict; however, the legislation should be flexible and allow for the expansion of training, certification, and compensation to encompass other injuries. Often, our wounded servicemembers and veterans present with more than one type of injury. This legislation places VA in an active role in recognizing caregivers' important contributions and enabling them to become better caregivers to their loved ones. It is a win-win for everyone involved.

The VA currently has eight caregiver assistance pilot programs to expand and improve healthcare education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. These pilot programs are important, but there is a strong need for 24-hour in-home respite care, 24-hour supervision, emotional support for caregivers living in rural areas, and coping skills to manage both the veteran's and caregiver's stress. These pilot programs, if found

successful, should be implemented by the VA as soon as possible and fully funded by Congress. However, one program missing is the need for adequate child care. Veterans can be single parents or the caregiver may have non-school aged children of their own. Each needs the availability of child care in order to attend their medical appointments, especially mental health appointments. NMFA encourages the VA to create a drop-in child care for medical appointments on their premises or partner with other organizations to provide this valuable service.

Mental Health

Families' needs for a full spectrum of mental health services—from preventative care and stress reduction techniques, to individual or family counseling, to medical mental health services—will continue to grow. It is important to note if DoD has not been effective in the prevention and treatment of mental health issues, the residual will spill over into the VA healthcare system. The need for mental health services will remain high for some time even after military operations scale down and servicemembers and their families transition to veteran status. The VA must be ready. They must partner with DoD and State agencies in order to address mental health issues early on in the process and provide transitional mental health programs. They must maintain robust rehabilitation and reintegration programs for veterans and their families that will require VA's attention over the long-term.

NMFA is especially concerned with the scarcity of services available to the families as they leave the military following the end of their activation or enlistment. They may be eligible for a variety of health insurance programs, such as TRICARE Reserve Select, TRICARE, or VA. Many will choose to locate in rural areas where there may be no mental health providers available. We ask you to address the distance issues families face in linking with mental health resources and obtaining appropriate care. Isolated veterans and their families do not have the benefit of the safety net of services and programs provided by MTFs, VA facilities, CBOCs, and Vet Centers. NMFA recommends the use of alternative treatment methods, such as telemental health. The 'Heroes at Home Act of 2007' provision for telemental health will provide an additional benefit to this population. Another solution is modifying licensing requirements in order to remove geographical practice barriers that prevent mental health providers from participating in telemental health services outside of a VA facility.

NMFA appreciates the 'Heroes at Home Act of 2007' inclusion of an outreach and public awareness provision. The VA must educate their healthcare and mental health professionals, along with veterans' families of the effects of mild Traumatic Brain Injury (TBI) in order to help accurately diagnose and treat the veteran's condition. Veterans' families are on the "sharp end of the spear" and are more likely to pick up on changes contributed to either condition and relay this information to VA providers. VA mental and healthcare providers must be able to deal with polytrauma—Post-Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. NMFA appreciates Congress establishing the National Center of Excellence and the Defense Center of Excellence. Now, it is very important for DoD and VA to partner in researching TBI and PTSD. We believe the VA needs to educate their civilian healthcare providers on how to identify signs and symptoms of mild TBI and PTSD. And, as the VA incorporates Project Hero, they must educate civilian network mental health providers about our military culture.

NMFA strongly suggests standardized training, certification, and compensation for caregivers of injured servicemembers or veterans with TBI.

NMFA recommends the use of alternative treatment methods, such as telemental health; and, the modification of licensing requirements to remove geographical practice barriers that prevent mental health providers from participating in telemental health services outside of a VA facility.

The VA must educate their healthcare and mental health professionals, along with veterans' families of the effects of mild Traumatic Brain Injury (TBI) and Post-traumatic Stress Disorder (PTSD) to help accurately diagnose and treat the servicemember's condition. The VA needs to encourage more education for civilian healthcare providers on how to identify signs and symptoms of mild TBI and PTSD. NMFA recommends spouses and parents of returning servicemembers and veterans need programs providing education on identifying mental health, substance abuse, suicide, and traumatic brain injury.

NMFA recommends Congress require Vet Centers and the VA to develop a holistic approach to veteran care by including their families in providing mental health counseling and programs.

NMFA would like to thank you again for the opportunity to present testimony for the record on the 'Heroes at Home Act of 2007' for servicemembers, veterans, and their families. Military families support the Nation's military missions. The least their country can do is make sure servicemembers, veterans, and their families have consistent access to high quality mental healthcare in the DoD, VA, and within network civilian healthcare systems utilizing alternative treatment methods, such as telemental health. Wounded servicemembers and veterans have wounded families. The caregiver must be supported by the VA by providing training, certification, and compensation for the care of their loved one. The system should provide coordination of care DoD, VA, and State agencies working together to create a seamless transition. We ask Congress to assist in meeting that responsibility.

Statement of Paralyzed Veterans of America

Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) is pleased to present our views concerning H.R. 6153, the "Veterans Medical Personnel Recruitment and Retention Act of 2008," and H.R. 3051, the "Heroes at Home Act of 2007," which will improve the diagnosis and treatment of Traumatic Brain Injury (TBI) for members and former members of the Armed Forces.

H.R. 6153, THE "VETERANS MEDICAL PERSONNEL RECRUITMENT AND RETENTION ACT OF 2008"

PVA's primary concern, and the basic reason for our existence, is the health and welfare of our members and our fellow veterans. The thousands of Department of Veterans Affairs (VA) healthcare professionals and all of those individuals necessary to support their efforts are at the core of VA's primary mission. These individuals serve on the frontline every day, caring for America's wounded veterans from Iraq and Afghanistan and seeing to the complex medical needs of our countries older veterans from previous wars. PVA believes that VA's most important asset is the people it employs to care for those who have served our Nation.

Mr. Chairman, when PVA testified on May 22, 2008 concerning the human resources challenges facing the Department of Veterans Affairs, we applauded the Subcommittee for its timely and well placed interest in the issues concerning VA healthcare personnel. PVA continues to believe that Congress must assist VA efforts to recruit and retain its corps of healthcare professionals as the demand for healthcare increases both because of the ongoing Global War on Terrorism and the aging of the veteran population from previous wars. The current serious national short fall in the supply of physicians, nurses, pharmacists, therapists and psychologists threatens VA staffing as competition for experienced medical personnel and newly licensed professionals continues to increase. H.R. 6153 is a step in the right direction.

The United States is currently in the tenth year of a critical nursing shortage which is expected to continue through 2020. The shortage of registered bed-side nurses and registered nurse specialists is having an impact on all aspects of acute and long-term care. America's nursing shortage has created nurse recruitment and retention challenges for medical-care employers nationwide and is making access to quality care difficult for consumers.

The gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our Nation. According to VA, it employs more than 64,000 nursing professionals, and has one of the largest nursing staffs of any healthcare system in the world. Of that 64,000, VA has 43,000 registered nurses, 12,000 licensed practical nurses, and 9,000 nursing assistants. VA also says that approximately 4,300 nurses retire or leave each year. VA must be able to recruit the best nurses, and retain a cadre of experienced, competent nurses. Providing high quality nursing care to the Nation's veterans is integral to the healthcare mission of VA.

During PVA's previous testimony, we asked for the Subcommittee's consideration of specialty pay for nurses providing care in VA's specialized service programs such as: spinal cord injury/disease (SCI/D), blind rehabilitation, mental health and brain injury. PVA is disappointed that the Subcommittee chose not to include such specific language in H.R. 6153.

Mr. Chairman, veterans who suffer spinal cord injury and disease require a cadre of specialty trained registered nurses to meet their complex initial rehabilitation and life-long sustaining medical care needs. PVA's data reveals a critical shortage of registered nurses who are providing care in VA's SCI/D center system of care. The complex medical and acuity needs of these veterans, makes care for them ex-

tremely difficult and demanding. These difficult care conditions become barriers to quality registered nurse recruitment and retention. Many of VA's SCI/D nurses are often placed on light duty status because of injuries they sustain in their daily tasks. When this happens it becomes a significant problem because it places additional patient care responsibility on those SCI/D nurses not on light duty. PVA believes SCI/D specialty pay is absolutely necessary if nurse shortages are to be overcome in this VA critical care area. We strongly encourage your committee to include a Title 38 specialty pay provision that will assist VA's efforts to recruit and retain nurses in these specialized areas.

PVA is concerned about the VA's current ability to maintain appropriate and adequate levels of physician staffing at a time when the Nation faces a pending shortage of physicians. Recent analysis by the Association of American Medical Colleges (AAMC) indicates the United States will face a serious doctor shortage in the next few decades. The AAMC goes on to say that currently, "744,000 doctors practice medicine in the United States, but 250,000—one in three—are over the age of 55 and are likely to retire during the next 20 years." The subsequent increasing demand for doctors, as many enter retirement, will increase challenges to VA's recruitment and retention efforts. PVA believes H.R. 6153 will allow VA to be more competitive in recruiting doctors for the VA system.

Mr. Chairman, the Veterans Health Administration has made great strides over the last decade to improve the quality of care it provides to our Nation's veterans. Despite these gains, VA now finds itself in a precarious situation if it expects to retain its position as a vastly improved healthcare system. As stated earlier, H.R. 6153 is only a first step in meeting the challenges associated with maintaining a highly qualified medical care workforce for VA. Competition to hire medical care professionals, during a national period of low supply, is making it more-and-more difficult for VA to successfully recruit and retain qualified personnel. This Subcommittee and VA must be vigilant in developing programs that will provide professional healthcare workers to care for our veterans.

H.R. 3051, "THE HEROES AT HOME ACT OF 2007"

Traumatic Brain Injuries (TBI) have become an important topic as a result of the wars in Afghanistan and Iraq. In fact, *The Independent Budget*, co-authored by PVA, AMVETS, Disabled American Veterans (DAV) and the Veterans of Foreign Wars (VFW), identified treatment for veterans with TBI as a critical issue for 2008 and beyond. PVA welcomes the Subcommittee's action on H.R. 3051.

TBI, Spinal Cord Injury, and other serious injuries account for almost 20 percent of the combat casualties sustained by U.S. soldiers, airman and Marines in OEF/OIF. Explosive blast pressure waves from improvised explosive devices (IEDs) violently shake or compress the brain within the closed skull and cause devastating and often permanent damage to brain tissues. There has been universal recognition that veterans with severe TBI will need a lifetime of intensive services to care for their injuries. However, PVA is concerned that, at all levels, development of programs to address the needs of veterans with mild, subclinical TBI have not been fully developed or implemented.

DoD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these IED detonations. Veterans suffering from this milder form of TBI may not be readily detected; however, symptoms can include chronic headaches, irritability, disinhibition, sleep disorders, confusion, executive functioning and memory problems, and depression, among other symptoms. With tens of thousands of IED detonations now recorded in Iraq alone, it is believed that many OEF/OIF servicemembers have suffered mild, but pathologically significant, brain injuries (including multiple concussions) that have gone undiagnosed and largely untreated thus far. TBI and its associated symptoms may be detected later only if proper screening is conducted.

PVA is concerned about emerging literature that strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DoD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic Post Traumatic Stress Disorder (PTSD) or other conditions. And TBI and PTSD can be coexisting conditions. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. We believe VA should conduct more research into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include older veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. Their medical and social histories could be of enormous value to VA researchers interested in the likely

long-term progression of these new injuries. Likewise, such knowledge of historic experience could help both the DoD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild TBI in combat veterans of the future. This is where PVA sees great potential for the demonstration project of Telehealth and Telemental programs proposed in H.R. 3051. We would caution the Subcommittee, however, to ensure that this program is a supplement to regular VA programs and not used as one more way for VA to move veterans' healthcare further away from VA facilities.

Individuals suffering from mild brain injury often present complex, difficult-to-assess complaints and conditions that can masquerade as other diagnoses. This complexity requires an integrated, personalized recovery plan coordinated by a cadre of specialists with expertise in TBI to diagnose and manage their medical, psychological, and psychosocial needs.

Although VA has initiated new programs and services to address the needs of severe TBI patients, gaps in services still exist. The VA's Office of the Inspector General (OIG) issued a report in July of 2006, titled "Health Status of and Services for Operation Enduring Freedom/ Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The report assessed healthcare and other services provided for veterans and active duty patients with TBI, and then examined their status approximately 1 year following completion of rehabilitation.

The report found that better coordination of care between DoD and VA healthcare services was needed to enable veterans to make a smooth transition. According to the report, the goal of achieving optimal function of each individual requires further interagency agreements and coordination between the DoD and VA. PVA believes the true measure of success will be the extent to which those most severely injured veterans are eventually able to recover, reenter their communities, or at minimum, achieve stability of function at home or in the least restrictive, age-appropriate continuing care facilities provided by VA to meet their needs and preferences.

PVA strongly supports the provisions of H.R. 3051 which provide training and certification for family caregiver personal attendants at no cost to the family. Providing the ability for family members to care for their loved ones injured in conflict will assist in keeping the families strong while properly caring for the veteran. Though PVA remains concerned about whether VA has addressed the long-term emotional and behavioral problems that are often associated with TBI, and the devastating impact on both the veteran and his or her family, we believe this program may help address these concerns. As noted in the July 2006 OIG report, "these problems exact a huge toll on patients, family members, and healthcare providers." The following excerpt from the report is especially telling:

In the case of mild TBI, the [veteran's] denial of problems which can accompany damage to certain areas of the brain often leads to difficulties receiving services. With more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

The OIG recommendations included improving case management for TBI patients to ensure lifelong coordination of care; improving collaborative policies between the DoD and VA; starting new initiatives to support families caring for TBI patients, including providing access to VA or contract caregivers; and recommending that rehabilitation for TBI patients be initiated by the DoD when clinically indicated. We fully concur with the OIG's recommendations and recognize that supporting these patients for a lifetime of care and service will be a continuing challenge for VA.

VA now requires a case manager be assigned to each OEF/OIF veteran enrolled in VA healthcare. The case manager's duty is to communicate and coordinate all VA benefits and services. Also, VA has created liaison and social work positions in DoD facilities to assist injured servicemembers with their transitions to veteran status and to provide advice and assistance to them and their families in accessing VA services. PVA commends VA for its efforts to improve the knowledge and skills of VA clinicians through educational initiatives defining the unique experience and needs of this newest generation of combat veterans. We also acknowledge VA's dedication and commitment to meeting the needs of veterans with TBI through high quality services at its polytrauma-TBI lead centers, for ongoing research into this debilitating injury, and for establishing effective services with academic and military affiliates to fill gaps in service when and where they are found. However, we are concerned about media reports from veteran patients with TBI and their family members who claim that VA TBI care is not up to par in certain locations, prompting them to seek rehabilitation services from private facilities. VA must ensure that its TBI network provides excellent care to all veterans irrespective of their degree of impairment. VHA's current continuing education programs should be enhanced

to ensure that all VA providers are knowledgeable about the spectrum of clinical presentation and treatment of veterans with combat-related TBI.

We encourage VA and Congress to ensure that severely wounded TBI veterans are receiving the best treatment and rehabilitation care available and that the needs of their family caregivers be met with innovative and effective programs.

Mr. Chairman, this concludes our remarks. PVA will be happy to respond to any questions you or Members of the Subcommittee may have.

**Statement of James C. Schraa, Psy.D., Neuropsychologist, Licensed
Psychologist, State of Colorado, Craig Hospital, Englewood, CO**

Severe traumatic brain injury is a family injury in the sense that it converts the loved ones of the brain injured servicemembers into caregivers and personal care attendants. After acute rehabilitation, the family members must substitute their judgment, planning and memory functions for the cognitive abilities and emotional control that their loved one has lost. Positive outcomes following severe traumatic brain injury are strongly associated with ongoing family support and involvement. Unfortunately, providing care giving and a safe structure for the severely brain injured is associated with the experience of high levels of stress and very high divorce rates. The civilian literature also establishes that brain injury substantially increases the frequency of bankruptcy.

The vast majority of Americans would agree that supporting our troops includes helping families to successfully cope with the behavioral and adjustment challenges that persist following severe traumatic brain injury. Americans want their military servicemembers with severe brain injuries to have as much quality of life as possible. This is clearly associated with keeping them with their families and in their own communities. The Medicare cost literature amply documents that maintaining patients in the community is also cost effective. The most expensive cases in terms of long-term medical costs are the chronically institutionalized disabled. Thus, Representative Salazar's Bill, H.R. 3051 not only reflects the loyalty we feel to our fellow citizen soldiers, but also represents a cost-effective approach to reduce healthcare costs (references available on request). It should also be noted that divorce involving patients with severe brain injuries results in increased long-term costs to government agencies for establishing and managing guardianships and conservatorships.

The literature on urban versus rural health-related quality of life establishes that the rural veteran population experiences lower physical and mental quality of life. Numerous studies have established that members of the National Guard and Reserve experience higher rates of emotionally based symptoms and problems related to alcoholism. Fewer supports in rural communities contribute to poorer coping in all at-risk groups including soldiers with traumatic brain injury. Rural VA clinics and Veteran Centers in rural communities constitute tremendous improvements for veterans but they usually do not include specialty care. Therefore, in all states with dispersed rural populations, initiatives to improve telemedicine are needed. Rural veterans with moderate to severe traumatic brain injuries will clearly be in need of ongoing consultation for the foreseeable future. Given the difficulties that this group of brain injured veterans has with driving and transportation, telemedicine outreach projects to increase their access to services should be supported.

I have had the experience of working with patients with severe traumatic brain injuries and spinal cord injuries for 26 years at Craig Hospital. Our experience is that supporting and maintaining families in the community is the most cost effective approach to long-term care, and the approach that affords the highest quality of life. There is literature from the Workers' Compensation Reinsurance industry which establishes that maintaining brain injured patients with their families in the community is the most cost effective treatment approach. Therefore, I strongly recommend that you consider passing H.R. 3051. H.R. 3051 is superior to S. 2921 because it will help keep more families with a brain injured servicemember intact, and prevent the institutionalization of more soldiers with severe brain injury than the provisions of S. 2921

Respectfully submitted,

James C. Schraa, Psy.D.
Neuropsychologist
Licensed Psychologist, State of Colorado
Craig Hospital, Englewood, CO

**Statement of Christopher Needham, Senior Legislative Associate, National
Legislative Service, Veterans of Foreign Wars of the United States**

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to provide testimony for this legislative hearing. The 2.3 million men and women of the Veterans of Foreign Wars of the U.S. appreciate the voice you give them at these important hearings.

H.R. 3051, the Heroes at Home Act

The VFW strongly supports the *Heroes at Home Act*. This legislation would dramatically improve the delivery of healthcare for those veterans suffering from traumatic brain injury. We thank Representative Salazar and the original cosponsors of this legislation for its introduction, and we urge its passage.

We especially appreciate section 2 of the legislation. It would create a family caregiver program to train families or friends of veterans suffering from the effects of severe traumatic brain injuries.

The newest generation of war veterans is presenting VA with many new healthcare challenges. Advances in technology and battlefield medicine are allowing many hundreds of men and women to survive injuries that previously would have been fatal. This, however, is coming at a price; many of them are grievously wounded and suffering from complex and intertwined ailments that are stretching VA's ability to adapt. Once the worst of their ailments are addressed, a great number of these men and women are returning home to their immediate families. In some cases, this is a spouse and in other cases—especially given the relatively young age of many of these men and women—to their parents.

The impact on these families is daunting. Their loved ones have complex physical and emotional difficulties and they must battle the bureaucracy of VA and DoD to ensure that everything the veteran is due comes to him or her. These families often have to put their lives on hold, delaying work, their education, relationships and other aspects of their life because of their veteran's illnesses and conditions, and the demands their intensive care require. With the complexity of the overlapping bureaucracies, some veterans fall through the cracks and do not receive the pays or compensation they need to cover their care. Further, in cases where parents—as opposed to spouses—are providing care, they may not be eligible for the full range of services and benefits the two departments provide.

Section 2 would go a long way toward fixing these problems, training and certifying family and friends to serve as caregivers, which would make them eligible for compensation for their time and service.

Section 3 would require the Secretary to conduct outreach to educate veterans and the public about PTSD and TBI, as well as to provide information about the range of services VA can provide for their treatment. Additionally, it would require VA to release information about the best practices it develops so that healthcare practitioners can learn from VA's experiences when dealing with these conditions for all Americans in the civilian world. Both are worthy provisions.

Section 4 of the bill would expand telehealth and telemental health options through a pilot program that primarily focuses on rural areas. It would determine the feasibility of using these technologies to assess the cognitive function of service men and women and veterans, as well as to help with rehabilitation. This is a good goal and a creative approach to solving the difficulties some veterans experience when trying to access their care. Should the program work, it would be of great benefit to many thousands of veterans suffering from these conditions.

H.R. 6153, the Veterans' Medical Personnel Recruitment and Retention Act

The VFW is happy to offer our support to this legislation, which would improve VA's ability to recruit and retain nurses and other healthcare practitioners. This is a continuing challenge for VA and one that is shared by all healthcare facilities. With the nursing shortage around the country, it is critical that VA have the tools and flexibilities it needs to adapt and be competitive in the marketplace as the workplace of choice for high quality healthcare providers.

This bill would improve pays for various healthcare specialties, including specific targeting for nurse executives and part-time nurses. It also revises rules relating to overtime and weekend duty and work schedules, which could help ease the burden many nurses face. Additionally, it reinstates the health professional educational

assistance scholarship program, which is an excellent recruitment benefit that would make VA more attractive to various healthcare providers.

We believe that its passage would improve VA's abilities to recruit and retain high-quality healthcare providers. This can only serve to better the care VA provides to this Nation's veterans. For this reason, we support this bill.

H.R. 6629

We understand that this bill was introduced to address a specific problem in New Hampshire. New Hampshire is the only one of the contiguous 48 states that lacks a full-service veterans hospital. As a result, veterans seeking certain types of basic care are forced to travel to hospitals in other states, whether in White River Junction, Vermont or near Boston, Mass.

This bill would require VA to either run a full-service hospital in each of the 48 contiguous states or it would require VA to fully contract out for all healthcare services. It is the latter part that causes us to have some qualms with the bill.

First, we believe that New Hampshire veterans deserve better. Many face long drives for basic care. In 2007, for example, over 700 veterans were transferred out-of-state for acute care. If they live in the northern part of the state, this could mean a travel time of 4 hours one-way just for basic services that the Manchester VA should otherwise be able to provide. Only recently has the Secretary announced that Manchester will begin offering radiation therapy, meaning that veterans who needed this for the treatment of cancer had to travel hours for care. Clearly, this is unacceptable.

We believe, however, that the mechanism of this bill could create some further inequities. Should the contracting provisions be in force, a veteran living across the border from the White River Junction VA Medical Center in Lebanon, NH would be entitled to contract care for any service they would need. Presumably, they could call up their private physician and have an appointment in a matter of hours or days. The same veteran, should they live five miles to the west in Vermont, would be required to wait in line for their turn at the White River Junction Medical Center. That is not fair.

We have supported contracted care in limited cases, namely where VA is otherwise unable to provide care—particularly in the case of specialized services. This legislation, though, could lead to wide-spread contracting, which we oppose.

VA already has the authority to provide fee-basis care, and it uses it with great success in many areas, especially in some remote parts of the west. We would urge the Committee to use its oversight authority to ensure that VA is doing the right thing for New Hampshire's veterans. If VA does not believe that the Manchester Medical Center requires full services, then we need the Committee to ensure that veterans who need these specific services receive contracted care when they would otherwise have to travel these long distances. We need to adapt the lessons VA has learned from other areas to New Hampshire, even if most people have not previously considered New Hampshire to be a large state or one that would require significant travel.

This concludes my statement. I would be happy to answer any questions you may have.

Statement of Anna Frese, Family Outreach Coordinator for Brain Injury, Wounded Warrior Project

The men and women of the Armed Forces have been providing an example of service, to their country, for over 200 years. Many families have watched and supported their loved one as they head off to fulfill the missions assigned to them. Unfortunately, in the process of fulfilling those missions, not all loved ones return home as they left. The need has presented itself, to assist in supporting the service of the family member, whose chosen mission is to care for and provide a quality of life to their loved one that has been seriously injured while in service to their country.

I thank the Committee for allowing me the opportunity to respectfully submit this testimony for the record and I strongly support this direly needed legislation. My name is Anna Frese and I currently am working with the Wounded Warrior Project (WWP) as a Family Outreach Coordinator for Brain Injury. My understanding for the urgent need of H.R. 3051 does not just come from working with the Wounded Warrior Project, but also what I witness daily as sister of Retired Army Sergeant Eric Edmundson, who was seriously injured in Iraq in October of 2005, and is currently living at home receiving 24/7 total care from our father, Edgar Edmundson.

Our family made the decision to bring Eric home and care for him. This decision was made knowing that it was what Eric would want. As our father says, “My son went to war, he honored himself, he honored his family, and he honored his Nation. He went to war, did his duty and got injured. As a parent, Eric, in my eyes is not a handicapped person, he is not a 100 percent disabled Veteran; Eric in my eyes is a 28 year old husband, a father and a young man with a whole life ahead of him. I as a parent need to honor him, and see to it that his needs are met.”

It is important for Eric’s young family that Eric be home, and be an active part in daily life. Eric is not only dealing with medical or rehab issues, he needs to be home to help deal with everyday issues so that he is meeting his responsibilities and being included, involved and helping to keep his small family intact. Anyone can be trained to take care of medical needs, but when you are 28 years old, a husband and father with responsibilities and a desire to get your life back—it goes a lot deeper than pills and therapy. You need to be around people that know you, understand you, and are willing and able to be there for you.

Our father sees it as his duty to ensure not only that Eric’s short term goals are met but that a focus remains on his long term goals as well. He focuses on helping Eric in maintaining a high morale and self-esteem which is paramount in the achievement of reaching his goals. Some long term goals to getting his life back include his hobbies of hunting and fishing—and our family sees that there is no reason that he can’t have those as a regular part of his life.

The decision to bring Eric home came with sacrifice and changes on many levels. Ours is just one of many families that have adapted to the “new normal” with changes in family infrastructure, in relationships with friends and extended family, in finances, in hopes, plans and goals for the future. Upon learning of Eric’s lifelong challenges, our father resigned his position at work, in order to provide Eric the full-time care that was needed. This decision did leave him and our mother with one less income, and in times of need they had to dissolve their personal and retirement savings. Just as importantly, now at 53 years old my father is no longer covered by health insurance.

The financial and emotional stress of not having the ability to maintain ones physical health is not only reflected in our family, but again in many of the families caring for their severely injured Veteran. By the Committee supporting H.R. 3051, family caregivers will have the option of receiving training by the VA, certifying them to receive compensation for the care they are providing their Veteran. This compensation will possibly allow some to better manage their own lives and health, so that they will be there for their loved one in the future.

One constant statement that I hear not only from my father, but other family caregivers who have made the same decision as ours, is that they are grateful. They are grateful to have the opportunity to spend time and enjoy the life of their loved one. So many Servicemember and Veterans have persevered through immeasurable odds, and families see it as their time to persevere and provide as much joy and quality of life as possible.

The family caregivers of these returning wounded warriors appreciate the concern, and acknowledge the recommendations that are trying to provide for the many others caring for their loved one. These warriors need someone at their side who knows them, understands them, and someone who is willing to be there for them and speak for them, in order for him to fully recover—or recover as much as possible. Families just wish it to be known they are committed to being by their Veterans side no matter what; the need is just too urgent. This legislation will allow family caregivers to follow through on that commitment.

