S. HRG. 107–635

PENDING HEALTH LEGISLATION, INCLUDING THE HEATHER FRENCH HENRY HOMELESS VETERANS ASSISTANCE ACT

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

JULY 19, 2001

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JULY 19, 2001

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PENDING HEALTH LEGISLATION, INCLUDING THE HEATHER FRENCH HENRY HOMELESS VETERANS ASSISTANCE ACT

THURSDAY, JULY 19, 2001

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

The committee met, pursuant to notice, at 1:12 p.m., in room SR–418, Russell Senate Office Building, Hon. Paul Wellstone presiding.

Present: Senators Rockefeller, Jeffords, Wellstone, Specter, and Campbell.

Senator WELLSTONE. We are going to bring the hearing to order, and I wonder—first of all, I know that Senator Rockefeller is on his way, and my understanding is that Senator Specter is on his way as well. So they both will be here.

I wanted to ask you, Ben, whether—and I guess I want to ask Congressman Evans. What we could do is I actually—rarely do I have a statement, but I do have something that I would like to lay out. But if you are—and, Ben, the same for you. But, Lane, if you are under a time constraint, I would be just as pleased, if it would be OK with the panelists, to have you make an opening statement. You have been the leader on this legislation in the Congress, and then maybe Ben and I and whoever else comes could make brief statements, and then we would go to the panelists. Is that all right with everybody?

I would like to thank everyone who is here. We have got some great panelists, and we have got some other supporters. But I would like to just proceed with Congressman Evans, if that is all right with everyone. And thank you for your—not good work but great work for veterans, not this year but every year for a long time.

STATEMENT OF HON. LANE EVANS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. EVANS. Thank you, Mr. Chairman. Twenty years now, which is hard to believe. But I appreciate your holding the hearing today.

This is the first time, as it turns out, that I have ever testified before the Senate, as well, for some reason. So you are so friendly, I have to come back and ask for more help from time to time, and I appreciate it very much.

According to another great Minnesota Senator, Hubert Humphrey:

It was once said that the moral test of government is how that government treats those who are in the dawn of life—the children; those who are in the twilight of life—the elderly; and those who are in the shadows of life—the sick, the needy and the handicapped.

I know that Senator Humphrey, like you today, Senator, would also champion programs for homeless veterans and be fully committed to ending homelessness among our veterans. With your leadership in the Senate, I am confident that this Congress will enact significant legislation like that which you and I have introduced.

The Heather French Henry Homeless Veterans Assistance Act takes an important step forward. It states, in law, that Congress has a goal to end homelessness among veterans in a decade. I know that no Members of Congress who would oppose this goal.

As you know, our bill has received the support of the National Coalition of Homelessness Veterans, which has hundreds of provider members, and the Veterans Homeless Organizations Council, which has the representation of many of the major military and veterans organizations. In addition, many of the major mental health and homeless consumer and provider groups have written letters of support. In the House, 128 cosponsors from both sides of the aisle support this legislation.

There is no quick fix to this problem. Homeless veterans are more likely to have serious chronic mental illnesses, to have substance use disorders, to have significant chronic illnesses or disease, to lack the social networks that help most of them through their difficulties, and to lack jobs and even basic living skills. The programs that you and I want to provide through this bill work to address these problems with comprehensive solutions.

I believe we can achieve the goal of ending homelessness among our veterans by using programs that have demonstrated their effectiveness, by better coordinating the services offered by the DVA with other Federal, State, and local agencies, and by enhancing relationships with private sector entities.

I also believe that we must have the experts bringing their thoughts to the table to enrich this dialog about service to homeless veterans and about program effectiveness and needed innovations. That is why stiffer regulations from the Federal Government and a new statutory VA Advisory Committee on Homeless Veterans reporting directly to the Congress and the Secretary are needed.

Some programs provided for or funded by the VA have demonstrated their effectiveness and progress. We have proposed creating incentives for VA to provide Mental Health Intensive Community Management programs, supportive, therapeutic housing for veterans recovering from substance abuse, and more care in VA community hospitals and domiciliaries to help us meet the needs for transitional housing.

Entire major metropolitan areas lack adequate resources for homeless veterans. Here in the Nation's capital, for example, veterans have neither a VA domiciliary nor a comprehensive homeless veterans service. We want community-based organizations to have the opportunity to be even more effective by giving them a rate that is slightly higher and more predictable for the daily care of veterans.

We will also invite them to participate in programs to assist certain veterans with special needs and to provide therapeutic residences for veterans participating in compensated work therapy. I believe this bill offers these providers additional opportunities to continue their innovations on behalf of our veterans.

Mr. Chairman, earlier this year, one of my staff members visited a program in Las Vegas where she was told that the VA can "usually" find a bed for a dying homeless veteran within his or her last week of life. As a Nation, we should be outraged by this situation. I know you agree that we need to do more for our veterans.

Thank you, Paul. You have been a great friend and a solid advocate for veterans across this country. I could spend a little bit longer, but we have a bill coming up soon. I thank the Senate for allowing me to say a few words.

Senator WELLSTONE. Well, thank you. I want to say for Senator Specter and Senator Jeffords that I knew that Congressman Evans had a vote coming up and that I asked him to make an opening statement. He has really been the leader in this area, and I thought that was more than appropriate.

We have distinguished panelists. I thought maybe all of us could make a brief statement if we want to, and then we will go right to the panelists.

I want to thank Senator Rockefeller for letting us have this hearing on the Heather French Henry Homeless Veterans Assistance Act that Congressman Evans has introduced in the House and that I have introduced in the Senate. I, however, don't think the topic or the legislation is owned by two people. Everybody in this hearing today, including all members of this committee, Democrats and Republicans alike, I think care fiercely about the issue. And I think this is something we can and should get done.

I also want to mention that Secretary Principi came out to Minnesota after we originally had introduced this legislation, Lane, and I am absolutely convinced that he is very committed to this legislation and very committed to our doing better as a country.

We heard from Congressman Lane Evans, who I can't say enough about. We are going to also hear from Tom Garthwaite, who is Under Secretary of Health, and I think you have got with you Peter Dougherty, who is Director of Homeless Veterans Programs; Ron Henke, who I have mixed feelings about, who did such great work in Minnesota, who is the Director of Veterans Benefits Administration, Compensation and Pension Service; and Walter Hall, Assistant General Counsel.

In our second panel, we are going to have Linda Boone, who is executive director of the National Coalition for Homeless Veterans, who I know well, and thank you for your work; Richard Schneider, MA, Director of Veterans and State Affairs, Non Commissioned Officers Association; Daniel Shaughnessy, MSW, member, Local 495, American Federation of Government Employees; and then Jimmie Lee Coulthard. And I have got to say this for other members of the committee. He is president and CEO of the Minnesota Assistance Council for Veterans, but he has been my teacher. He has been the teacher for so many people in Minnesota, absolutely unbelievable person.

I want to thank—and I am speaking quickly because I want to let other people speak and let you speak—Heather French Henry. We should really name the legislation after her. She richly deserves it. While Miss America and now, she has just been never-ending in her commitment. You know, we could be talking about 300,000 of our Nation's veterans. And as many of you may know, Ms. Henry and her husband just had a little girl, Harper, on July 6th. So we wish her and her family well.

The legislation has the goal of ending homelessness in 10 years, and we all say we are committed to that. I think it is time to get down to work and put some pieces together that we think will make the difference.

The independent budget pointed out that we have got 275,000 veterans that are homeless on any given night. I would guess—and I think their budget goes like this: If you were to put women and children in parenthesis—which you should never do, but just for a moment look at adult men, I would bet about a third are veterans. A good many of them are Vietnam vets. A good many of them struggle from post-traumatic stress syndrome. A good many of them are struggling with substance abuse. And for all of them, we can do better.

I think we are building up a good head of steam, and I am, again, very, very excited about this hearing and hope we can—and I have no doubt that we can move this piece of legislation, with other good legislation, forward.

I now would turn to Senator Specter.

Senator SPECTER. Well, thank you very much, Mr. Chairman. I will submit an opening statement for the record.

I am glad to see activity moving ahead to tackle the problem of homelessness for veterans. I can recall the first time I saw someone sleeping on a grate in Philadelphia in 1982, shortly after a Federal judge in Philadelphia handed down a landmark decision releasing many people who had been institutionalized. And that was really the beginning of the very intense homeless problem which we have had in America. Perhaps we have always had a homeless problem, but that is when it really started to burgeon. And I can recollect in 1982 Senator Pryor and I sponsored the first appropriations, $50 million, for the homeless. At that time, we had seen quite a national effort on this important subject, and veterans ought to come first.

There is a big debt which America owes to veterans; we haven't even made an adequate down payment. So I am glad to see this important matter moving forward.

[The prepared statement of Senator Specter follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Thank you, Mr. Chairman. I join you in welcoming our witnesses to this important hearing. We have an ambitious agenda today, so my remarks will be brief. But I would like to say a few words about a couple of important items on today's agenda—namely, proposals to attack the seemingly intractable problem of homelessness; and a bill on VA nurse pay that you introduced yesterday, Mr. Chairman, and which I am pleased to have cosponsored.

Obviously, the fact that many of our citizens are homeless is a national scandal. That those who have served the country in uniform are among the homeless is worse than a scandal—it is a source of national shame. I will support legislation that aims to attack this problem; the only source of controversy—if any—will be

issues of approach. I will seek the expert views, for example, on the question of whether it would be fair—and, more importantly, whether it would be therapeutically advisable—to make cash payments to homeless persons who have histories of drug and/or alcohol abuse. But apart from such issues, I join the Senator from Minnesota in expressing outrage that this problem persists. I will work with him to solve it.

I also wish to comment briefly on S. 1188, the "VA Nurse Recruitment and Retention Enhancement Act," introduced just yesterday—with my cosponsorship—by Chairman Rockefeller. This bill would respond to many of the concerns we heard during our oversight hearing on June 14, 2001. I commend the Chairman and his staff for drafting a bill on these issues so quickly. S. 1188 would modify and improve VA's Nurse Scholarship and Debt Reduction Programs; it would mandate that Licensed Practical Nurses, and others, receive premium pay when they have to work on Saturdays; it would require VA to tackle, in a serious way, nurse to patient staff ratio issues; and it would improve nurse retirement benefits. While perfecting amendments to the bill may be in order—we are here, after all, to learn from VA how the bill might be improved—I intend to support this legislation. And I look forward to marking it up later this month.

Mr. Chairman, that concludes my opening remarks. I look forward to an informative hearing.

Senator WELLSTONE. Thank you very much, Senator Specter.

Senator Campbell?

Senator CAMPBELL. Thanks, Mr. Chairman. Thanks for convening this hearing to focus on legislation affecting homeless veterans and veterans health care issue. I don't think we would serve on this committee if we weren't all interested in it.

I was particularly pleased that the name of Heather French Henry was given to S. 739. Many of us know Heather very well, and, in fact, Memorial Day, she was here in Washington with 300,000 veterans when she was 8 months' pregnant. I think that says something about her strength of character and her commitment to helping veterans. During the year she was Miss America, she traveled endlessly making appearances for veterans. And, I think right from the beginning she made it known that she was really concerned because her dad had been a veteran and had been injured in battle. I think he raised her with a commitment to trying to help veterans. She is the first one I have known, frankly, that has ever run for Miss America that has made a priority of helping homeless veterans, and I thought that was very unusual.

But, certainly, having a quarter million homeless veterans is unacceptable. We can do better than that. We look at the news every day, and we see that we are in space now dealing with Russians on the Space Station, and we have all these marvelous things going on in the technical world. Yet in the shadows of many of the institutions that developed these marvelous things that go into space, there are veterans sleeping in cardboard boxes. And I just know that we can do better.

It seems like whenever we are in a war, there is an awful lot of publicity about how important our military is. Then, when it subsides, somehow our soldiers sort of disappear into the ranks of the nameless and faceless, and that is not good enough for you and it is not good enough for me or this committee.

So I want to commend you on that. I think, as you do, that Secretary Principi is doing a really good job. He has made also a big commitment, done a lot of traveling, made a lot of appearances, and made some personal commitments that he is going to try to make it better. And I certainly look forward to that.

When we were dealing with the veterans health care budget this year, I know that there has been $1 billion more put in than last year. But many of our veterans groups, like the VFW, the American Legion, and others, are saying that is not enough because the problems have increased. Certainly we have to revisit that, too, and I am looking forward to working with you on that issue.

Senator WELLSTONE. Absolutely.

Senator CAMPBELL. Thank you.

Senator Jeffords?

Senator JEFFORDS. Well, thank you, Mr. Chairman, certainly for holding these hearings, and I can only echo what has already been heard. And I thank the Under Secretary of Health for being with us today, also.

I have been very concerned about the plight of homeless veterans for much of my career in the Congress. In Vermont, this is a serious problem that defies the usual solutions to homelessness. In Vermont, we also suffer the same difficulties as other veterans, veterans hospitals and problem in recruitment and retention of nurses, and so I am pleased to see these issues being raised here today.

On the positive side, I would like to say that I recently visited a homeless program in Long Beach, California, which is an incredibly good program. It is the finest one I have seen. And I came away very positive after visiting there to know what can be done.

Thank you, Mr. Chairman.

Senator WELLSTONE. Dr. Garthwaite?

STATEMENT OF THOMAS L. GARTHWAITE, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY PETER H. DOUGHERTY, DIRECTOR, HOMELESS VETERANS PROGRAMS, OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS; RON HENKE, DIRECTOR, VETERANS BENEFITS ADMINISTRATION, COMPENSATION AND PENSION SERVICES, DEPARTMENT OF VETERANS AFFAIRS; AND WALTER HALL, ASSISTANT GENERAL COUNSEL, PROFESSIONAL STAFF GROUP III, DEPARTMENT OF VETERANS AFFAIRS

Dr. GARTHWAITE. Mr. Chairman and members of the committee, I am pleased to be here to present VA's views on several bills under consideration by the committee and have limited my oral remarks to Senate 739, as requested, and my full statement has been presented for the record.

VA is the only Federal agency that provides substantial hands-on assistance directly to homeless persons. Our major homeless programs constitute the largest integrated network of homeless assistance programs in the country, offering a wide variety of services and initiatives to help veterans recover from homelessness and live as self-sufficiently and independently as possible.

With additional funding made available in the fiscal year 2000 budget, we significantly expanded these programs and have initiated new program evaluation efforts, as required by the Millennium Act.

VA expects to expend $142 million on specialized programs for homeless veterans this year and is projecting a budget of $148 million for these programs in fiscal year 2002.

Using our resources and in partnership with others, VA has helped to secure more than 10,000 transitional and permanent beds for homeless veterans throughout the Nation. Programs unique to homeless veterans are integrated with extensive other VA health care and benefits services. In addition, VA relies heavily on its Federal, State, and community-based partners to assure a full range of services for homeless veterans.

I have a summary of VA's current homeless veterans assistance programs and would like to submit that for the record.

Senator WELLSTONE. It will be in the record.

Dr. GARTHWAITE. Thank you.

[The information referred to follows:]

HOMELESS VETERANS TREATMENT AND ASSISTANCE PROGRAMS

VA has developed a wide range of programs and services to address homeless veterans needs. These programs operate in partnership with community-based organizations and service providers and other federally funded programs. With the additional funding made available in the FY 2000 budget we have significantly expanded our homeless programs this year and we have initiated new program evaluation efforts as required by the Millennium Act. While many special programs have been designed to address the special needs of homeless veterans, they do not function in isolation. These programs are integrated with other VA healthcare and benefits services. In addition, VA relies heavily on its federal, state and community based partners to assure a full range of services for homeless veterans.

Secretary Principi recently announced his decision to establish a VA Advisory Council on Homelessness Among Veterans with the mission of providing advice and making recommendations on the nature and scope of programs and services within VA. The advisory committee will consist of not more than 15 members, including a Chairperson. Committee member appointments will be made from knowledgeable VA- and non-VA experts, and will include representatives from community service providers with qualifications and competence to deal effectively with care and treatment services for homeless veterans. The overall makeup of the membership will ensure that perspectives on health, benefits, education and training, and housing for homeless veterans are addressed. Close attention will be given to equitable geographic distribution and to ethnic and gender representation.

The Council is expected to meet two to four times annually. This committee will greatly assist VA in improving the effectiveness of our programs and will allow a strong voice to be heard within the Department from those who work closely with us in providing service to these veterans. We hope to have the Advisory Council members selected and the Council ready to function by the end of July.

HOMELESS VETERAN POPULATION

In 1996 the Federal Interagency Council on the Homeless (ICH) designed and the Census Bureau conducted the "National Survey of Homeless Assistance Providers and Clients." The survey was conducted in the 28 largest metropolitan areas, 24 randomly selected small and medium sized areas and 24 randomly selected groups of rural counties. Approximately 12,000 service providers were contacted and 4,200 consumers of homeless services were interviewed. Survey findings and a technical report written by the Urban Institute were released in December 1999. Survey findings related to homeless veterans were as follows:

- 33 percent of homeless males are veterans;
- 33 percent of homeless veterans report being stationed in a war zone;
- 28 percent of homeless veterans report being exposed to combat;
- 67 percent of homeless veterans reported serving 3 or more years in the military;
- 32 percent of veterans compared to 17 percent of non-veterans reported that their last episode of homelessness lasted more than 13 months; and
- 57 percent of homeless veterans reported using VA health care services at least once.

The Urban Institute issued a press release in February 2000, estimating that between 2.3 million to 3.5 million Americans may have experienced an episode of homelessness during 1996. Extrapolation from this estimate would suggest that between 322,000–491,000 veterans might have experienced homelessness during that time period.

HOMELESS VETERANS SERVED BY VA

In FY 2000, staff in VA's Health Care for Homeless Veterans (HCHV) Program had contacts with over 43,000 homeless veterans. Approximately 32,000 homeless veterans were given formal intake assessments to determine their clinical, housing and income status. Data from these intake assessments provides VA with detailed information about the demographic and clinical characteristics of the homeless veterans served by VA. We would like to share some of these findings with you today:

- Approximately 97 percent of homeless veterans contacted by program staff are men and 3 percent are women.
- The mean age of these veterans was 47.
- Approximately 49 percent of the veterans served in the military during the Vietnam Era while nearly 5 percent served during the Persian Gulf era.
- Approximately 47 percent of these veterans were African Americans and 6 percent were Hispanic.
- 60 percent of homeless veterans report part-time, irregular employment or no employment during the past 3 years; 72 percent of homeless veterans report not having worked at all during the 30 days prior to the intake assessment.
- 68 percent of homeless veterans reported living in emergency shelters or outdoors at the time of the intake assessment.

82 percent of homeless veterans were determined by HCHV clinicians to have a serious psychiatric or substance abuse problem—

44 percent had a serious psychiatric problem,

69 percent were dependent on alcohol and/or drugs,

32 percent were dually diagnosed with psychiatric and substance abuse disorders.

PROGRAMS AND SERVICES PROVIDED BY VA

VA is the only federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to veterans, VA's major homeless programs constitute the largest integrated network of homeless assistance programs in the country, offering a wide array of services and initiatives to help veterans recover from homelessness and live as self-sufficiently and independently as possible.

VA, using its resources or in partnerships with others, has helped to secure more than 10,000 transitional and permanent beds for homeless veterans throughout the nation. These include:

- beds in VA's Domiciliary Care for Homeless Veterans (DCHV) program;
- beds in VA's Compensated Work Therapy/Transitional Residence (CWT/TR) program;
- beds supported through contracts under the Health Care for Homeless Veterans (HCHV) program;
- the VA Supported Housing (VASH) program;
- the joint HUD-VA Supported Housing (HUD-VASH) program; and
- the Homeless Providers Grant and Per Diem Program.

With the new Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans Program and additional grant awards under the Grant and Per Diem Program, VA expects to help community service providers develop approximately 6,000 more transitional beds for homeless veterans over the next 4 years.

In addition to these special initiatives, VA provides a wide range of services to homeless veterans through its mainstream health care and benefit assistance programs. To increase this assistance, VA has initiated outreach efforts to connect more homeless veterans to both mainstream and homeless-specific VA programs and benefits. These programs strive to offer a continuum of services including:

- aggressive outreach to veterans living on streets and in shelters who otherwise would not seek assistance;
- clinical assessment and referral to needed medical treatment for physical and psychiatric disorders including substance abuse;
- long-term sheltered transitional assistance, case management and rehabilitation;
- linkage and referrals for employment assistance, linkage with available income supports; and assistance in obtaining housing.

HOMELESS VETERANS-SPECIFIC PROGRAMS

VA's FY 2000 budget increased funding for specialized services for homeless veterans by $50 million. Of this increase, $39.6 million was included in the medical care appropriation and the remainder is available to guarantee loans made under the Multifamily Transitional Housing for Homeless Veterans Program. VA expects to spend $142.2 million on specialized programs for homeless veterans this year and is projecting a budget of $148.1 million for these programs in FY 2002. The following provides an overview of the types of programs VA has developed to meet the multiple and varied needs of homeless veterans:

VA's Health Care for Homeless Veterans Program (HCHV) operates at 127 sites where extensive outreach, physical and psychiatric health exams, treatment, referrals, and ongoing case management are provided to homeless veterans with mental health problems, including substance abuse. As appropriate, the HCHV program places homeless veterans needing longer-term treatment into one of its 250 contract community-based facilities. During the last reporting year, this program assessed more than 32,000 veterans, with 4,800 receiving residential treatment in community-based treatment facilities. The average length of stay in community-based residential care is about 60 days and the average cost per day is approximately $38.00. VA committed $18.8 million to the expansion of the HCHV program in FY 2000 and funds were distributed in mid year. This included the activation of new sites and expansion of existing programs. When all new staff and new programs are fully operational, it is expected that 12,000 additional homeless veterans will be treated. Approximately one fourth of these veterans will be provided contract residential treatment. In FY 2000, VHA also committed an additional $3 million to establish 11 programs that are dedicated to homeless women veterans. These programs are expected to serve 1,500 homeless women veterans per year, when they are fully operational.

VA's Domiciliary Care for Homeless Veterans (DCHV) Program provides medical care and rehabilitation in a residential setting on VA medical center grounds to eligible ambulatory veterans disabled by medical or psychiatric disorders, injury or age and who do not need hospitalization or nursing home care. There are 1,781 operational beds available through the program at 35 VA medical centers in 26 states. The program provided residential treatment to some 5,500 homeless veterans in FY 2000. The domiciliaries conduct outreach and referral; admission screening and assessment; medical and psychiatric evaluation; treatment, vocational counseling and rehabilitation; and post-discharge community support.

Special Outreach and Benefits Assistance is provided through funding from VA's Veterans Health Administration to support 10 veterans' benefits counselors from the Veterans Benefits Administration (VBA) as members of VA's Health Care for Homeless Veterans Program and DCHV programs.

Acquired Property Sales for Homeless Providers Program makes available properties VA obtains through foreclosures on VA-insured mortgages. These properties are offered for sale to homeless provider organizations at a discount of 20 to 50 percent. To date, 173 properties have been sold, and 9 properties are currently leased to nonprofit organizations to provide housing for the homeless.

Drop-in Centers provide homeless veterans who sleep in shelters or on the streets at night with safe, daytime environments. Eleven centers offer therapeutic activities and programs to improve daily living skills, meals, and a place to shower and wash clothes. At these VA-run centers, veterans also participate in other VA programs that provide more extensive assistance, including a variety of therapeutic and rehabilitative activities. Drop-In Center staff also coordinates with other programs to provide veterans with long-term care services.

Compensated Work Therapy (CWT) and CWT/Transitional Residence Programs have had dramatic increases in activity during the past few years. Through its CWT/TR program, VA offers structured therapeutic work opportunities and supervised therapeutic housing for at risk and homeless veterans with physical, psychiatric and substance abuse disorders. VA contracts with private industry and the public sector for work to be done by these veterans, who learn new job skills, relearn successful work habits and regain a sense of self-esteem and self-worth. The veterans are paid for their work and, in turn, make a monthly payment toward maintenance and upkeep of the residence.

The CWT/TR program includes 53 community-based group home transitional residences with more than 400 beds. Ten program sites with 18 residences exclusively serve homeless veterans. The average length of stay is approximately six months. There currently are more than 110 individual CWT operations connected to VA medical centers nationwide. Nearly 14,000 veterans participated in the programs in FY 2000. CWT programs developed contracts with companies and agencies of gov-

ernment valued at a national total of $43.2 million. Increased competitive therapeutic work opportunities are occurring each year. At discharge from the CWT/TR program 42 percent of the veterans were placed in competitive employment and 20 percent were in training programs. VA has committed $2.3 million to the activation of new CWT programs and other therapeutic work initiatives for homeless veterans. When these programs are fully operational, it is expected that they will be able to serve an additional 1,600 veterans annually.

Intradepartmental programs also support the CWT programs for homeless veterans. VA's National Cemetery Administration and Veterans Health Administration have formed partnerships at 20 national cemeteries, where more than 120 formerly homeless veterans from the CWT program have received therapeutic work opportunities while providing VA cemeteries with a supplemental work force.

HUD–VA Supported Housing (HUD–VASH) Program, a joint program with the Department of Housing and Urban Development (HUD), provides permanent housing and ongoing treatment services to the harder-to-serve homeless mentally ill veterans and those suffering from substance abuse disorders. HUD's Section 8 Voucher Program continues to renew 1,780 vouchers for $44.5 million, designated over a ten-year period, for homeless chronically mentally ill veterans, and VA staff at 35 sites provide outreach, clinical care and case management services. Rigorous evaluation of this program indicates that this approach significantly reduces days of homelessness for veterans who suffer from serious mental illness and substance abuse disorders.

VA's Supported Housing Program is like the HUD–VASH program in that VA staff provides therapeutic support and assistance to help homeless veterans secure low-cost, long-term transitional or permanent housing and provide ongoing clinical case management services to help them remain in housing. It differs from HUD–VASH in that dedicated Section 8 housing vouchers are not available to homeless veterans in the program. As part of VA's clinical case management services, staff work with private landlords, public housing authorities and nonprofit organizations to find therapeutically appropriate housing arrangements. Veterans service organizations have been instrumental in helping VA establish these housing alternatives nationwide. In 2000, VA staff at 26 Supported Housing Program sites helped 1,800 homeless veterans find transitional or permanent housing in the community.

Comprehensive Homeless Centers place a variety of VA's homeless programs into an integrated organizational framework to promote coordination of VA resources and non-VA homeless programs. VA currently has seven comprehensive homeless centers connected to medical centers in Brooklyn, Cleveland, Dallas, Little Rock, Pittsburgh, San Francisco, and Los Angeles.

Stand Downs are 1–3 day safe havens for homeless veterans that provide a variety of services to veterans and opportunity for VA and community-based homeless providers to reach more homeless veterans. Stand downs provide homeless veterans a temporary place of safety and security where they can obtain food, shelter, clothing and a range of community and VA-specific assistance. In many locations, VA provides health screenings, referral and access to long-term treatment, benefits counseling, ID cards and linkage with other programs to meet their immediate needs. VA participated in 179 stand downs run by local coalitions in various cities during CY 2000. Surveys showed that more than 35,000 veterans and family members attended these events. More than 20,000 volunteers contributed to this effort.

VA Excess Property for Homeless Veterans Initiative provides for the distribution of federal excess personal property, such as clothing, footwear, socks, sleeping bags, blankets and other items to homeless veterans through VA domiciliaries and other outreach activities. In less than seven years, this initiative has been responsible for the distribution of more than $90 million worth of materiel and currently has more than $6 million in inventory. A CWT program providing a therapeutic work experience for formerly homeless veterans has been established at the VA Medical Center in Lyons campus of the VA New Jersey Health Care System, to receive, warehouse and ship these goods to VA homeless programs across the country.

The Homeless Providers Grant and Per Diem Program is a dynamic component of VA's homeless-specific programs. It provides grants and per them payments to assist public and nonprofit organizations to establish and operate new supportive housing and service centers for homeless veterans. Grant funds may also be used to assist organizations in purchasing vans to conduct outreach or provide transportation for homeless veterans. Since the first year of funding in FY 94, VA has awarded 243 grants to nonprofit organizations, units of state or local governments and Native American tribes in 44 states and the District of Columbia.

Total VA funding for grants has exceeded $53 million. When these projects are completed, approximately 5,000 new community-based beds will be available for homeless veterans. Nearly 3,500 unique homeless veterans were cared for through

these programs in IFY 2000 and their care was supported by VA per them payments to service providers.

VA announced a new round of grants in April 2001, and has committed $10 million for the eighth round of funding.

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans is a nationwide initiative. VA medical center and regional office directors work with other federal, state and local agencies and nonprofit organizations. They assess the needs of homeless veterans, develop action plans to meet identified needs, and develop directories that contain local community resources to be used by homeless veterans.

More than 10,000 representatives from non-VA organizations have participated in Project CHALENG initiatives, which include holding conferences at VA medical centers to raise awareness of the needs of homeless veterans, creating new partnerships in the fight against homelessness and developing new strategies for future action.

Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans is currently being implemented as authorized by P. L. 105–368. This program will allow VA to guarantee loans made by lenders to help non-VA organizations develop transitional housing for homeless veterans. VA awarded a contract to Birch and Davis Associates, Inc., and their subcontractors, Century Housing Corporation, to assist with the development of this pilot program. VA plans to guarantee 5 loans in the next two years, with a total of 15 loans guaranteed over the next 4 years. It is hoped that up to 5,000 new transitional beds for homeless veterans will be created through this program.

MAINSTREAM VA PROGRAMS ASSISTING HOMELESS VETERANS

The Veterans Benefits Administration (VBA) administers a number of compensation and pension programs: disability compensation, dependency and indemnity compensation, death compensation, death pension and disability pension. Vocational rehabilitation and counseling assist veterans with service-connected disabilities to achieve independence in daily living and to the extent possible become employable and maintain employment. In the Fiduciary or Guardianship Program, the benefits of veterans who are determined to be incapable of managing their funds are managed by fiduciary.

VBA regional offices at 57 locations have designated staffs that serve as coordinators and points of contact for homeless veterans through outreach activities. In FY 2000, VBA staff assisted over 21,000 homeless veterans and had contacts with over 6,500 community organizations.

The Readjustment Counseling Service's Vet Centers have homeless coordinators who provide outreach, psychological counseling, supportive social services and referrals to other VA and community programs. Each year approximately 140,000 veterans make more than 800,000 visits to VA's 206 Vet Centers. During the winter months, approximately 10 percent of Vet Center clients report being homeless.

A substantial number of homeless veterans are served by VHA's general inpatient and outpatient mental health programs. For the past six years VA's at its Northeast Program Evaluation Center (NEPEC), has conducted an End-of-Year Survey of hospitalized homeless veterans in VA health care facilities. On September 30, 2000, 17,023 veterans were being treated in acute medical surgical and psychiatric beds, acute substance abuse beds, psychosocial residential rehabilitation and treatment program (PRRTP) beds and domiciliary beds. A total of 4,774 veterans (28 percent) were homeless at admission. Nearly 20 percent were living on the streets or in shelters before admission and 8 percent had no residence and were temporarily residing with family or friends.

A total of 4,148 veterans were being treated in VA mental health beds. Approximately one-third of these veterans were homeless at admission and another 6 percent, while not homeless when admitted, were at high risk for homelessness if discharged on the day of the survey. The following is a break out of the type of mental health bed section veterans occupied:

- 23.7 percent of 2,692 veterans in Acute Psychiatry beds were homeless at admission.
- 41.2 percent of 226 veterans in Acute Substance Abuse beds were homeless at admission.
- 47.3 percent of 1,230 veterans in PRRTP beds were homeless at admission.

VA has also collected information on homeless veterans seen in outpatient mental health programs. In FY 2000, approximately 104,000 veterans were identified as homeless on VA encounter forms. About 50,000 homeless veterans were treated in VA's specialized programs for homeless veterans; the remainder were treated exclusively in general mental health outpatient programs.

HOMELESS VETERANS PROGRAM MONITORING AND EVALUATION

VA has the Nation's most extensive and long-standing program of monitoring and evaluating data concerning homeless individuals and the programs that serve them. In 1987, we initiated a three-fold evaluation strategy for what was then an unprecedented VA community collaborative program—the original HCMI veterans program.

Under this evaluation plan: (1) all veterans evaluated by the program were systematically assessed to assure that program resources were directed to the intended target population (now almost 30,000 under-served homeless veterans per year); (2) housing, employment, and clinical outcomes were documented for all veterans admitted to community-based residential treatment, the most expensive component of the program; and (3) a detailed outcome study documented housing and employment outcomes after program termination was initiated.

The VA study showed 30 percent to 40 percent improvement in psychiatric and substance abuse outcomes, employment rates doubled, and 64 percent exited from homelessness at the time of program completion. When these veterans were reinterviewed 7.2 months after program completion, they showed even GREATER improvement. A similar effort was mounted for the Domiciliary Care for Homeless Veterans program with similar long-term post-treatment results. These data have been published by NEPEC in leading medical journals.

After establishing the effectiveness of these standard programs with extensive follow-up studies, VA developed several enhancements to the core program in several areas. These areas include compensated work therapy (CWT), outreach to assure access to Social Security Administration (SSA) benefits, and a collaborative program with HUD that joins VA case management with HUD section 8 housing vouchers. Outcome studies demonstrated the long-term effectiveness of the CWT/TR program at reducing substance abuse and increasing employment. The Joint VA–SSA outreach effort conducted in New York City, Brooklyn, Dallas, and Los Angeles almost doubled the percentage of SSI awards made to veterans from 7.19 percent to 12.4 percent of the veterans contacted during the outreach effort.

An outcome study showed that, compared to a control group that did not receive benefits, SSA beneficiaries had improved housing and overall satisfaction with life as a result of their receipt of benefits. The outcome of the study also showed no increase in substance abuse, with the exception of tobacco use for SSA recipients. A follow-up study of the HUD–VA supported housing program shows that the benefits of this program, especially housing stability were sustained three years after program entry. This is one of the longest follow-up studies conducted on any homeless population anywhere.

All of our homeless initiatives and programs receive rigorous evaluation. VA uses a consistent set of clinical measures for the Homeless Providers Grant and Per Diem Program as with all other VA homeless veterans programs to assure that valid comparisons can be made. VA performance measures provide consistency in evaluating homeless programs.

In FY 2000, VA expanded its evaluation of homeless veterans programs to more thoroughly determine the effectiveness of these programs. Sec. 904 of the Veterans Millennium Health Care and Benefits Act (P. L. 106–117) requires VA to conduct evaluations of its homeless veterans programs. This is to include measures to show whether veterans for whom housing or employment is secured through one or more of VA's programs continue to be housed or employed after six months. The General Accounting Office (GAO) made a similar recommendation in its April 1999 Report entitled, Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness is Unclear. GAO's single recommendation to VA was to conduct . . . "a series of program evaluation studies to clarify the effectiveness of VA's core homeless programs and provide information about how to improve those programs."

Through these ongoing and new program evaluation efforts, we expect to increase our knowledge about the effectiveness of services that are provided to assist homeless veterans. Information will be used to modify and improve our programs for homeless veterans.

CONCLUSION

VA health care services and other benefits programs form the core elements for the wide range of medical, work therapy, rehabilitation, transitional housing and benefits programs that VA offers to homeless veterans. With assistance from community-based service providers and veterans service organizations, we are bringing thousands of veterans off the streets and into a continuum of care that offers them the health care and support services they need to resolve their health, housing and vocational problems.

Dr. GARTHWAITE. VA strongly supports the objectives and supports many of the provisions of the Heather French Henry Homeless Veterans Assistance Act. The full text of my statement provides an analysis of each provision of the bill. Where we are unable to support some of the provisions, it is largely because we believe they duplicate activities and programs conducted by the Department. At this time, I will comment briefly on areas where we have particular concerns.

Section 7 of the bill would require that VA designate specific veterans as "complex" for the purposes of VERA. This proposal could add more than 200,000 additional veterans into the complex reimbursement category based solely on diagnosis of the programs serving them and not on the complexity and cost of the care being provided. Placing veterans in the complex category should be based on the cost of their care, not on a designation of homelessness, a designation that is not readily verified.

Section 9 would require that we carry out a new grant program for VA facilities and grantees that would target sub-groups of homeless veterans. We believe this section is unnecessary, as VA has funded programs addressing these special populations already, and the current Homeless Provider Grants and Per Diem Program already gives weight to programs described in this section.

Section 11 would require that we conduct two treatment trials in integrated mental health services delivery. We have recently decided to carry out the project contemplated by Section 11 using our Health Services Research and Development Service and our MIRECC's. We welcome the opportunity to work with committee staff to assure the study design will yield results that address your questions. We also believe this particular research study will require more than the amount of time permitted under Section 11.

Section 12 would effectively extend eligibility for outpatient dental services to certain enrolled veterans who are receiving care in an array of VA settings. We recognize the importance of dental care to restoring self-esteem and the potential of making veterans more easily employable, but cannot support this provision because it would result in a disparity in access to dental care among equally deserving veterans.

Section 13 would require VA to have mental health treatment capacity in every VA primary health care site. We strongly believe in equitable availability of mental health services, and such services are included in our basic benefits package. We are working currently to assure that all sites of care can either directly provide for care, contract for it, or refer patients to other VA facilities for mental health care. We would prefer not to have one method prescribed for all facilities across the Nation.

Another provision in Section 13 would require that we expend not less than $55 million from medical care funds for our Grants and Per Diem Program. We cannot support this provision. Of the $32 million identified this year, approximately $10 million is available for our eighth round of grants, and we expect that these funds will allow us to develop an additional 1,000 community-based beds. However, since fewer than 50 applications received in any given year satisfy scoring criteria, we believe this provision would force us to fund providers who have a low likelihood of establishing via-

ble programs. Steady and reasonable growth in the Homeless Provider Grant and Per Diem Program appears to be one of the keys to the success of this important program.

Another provision of Section 13 would require us to ensure that opioid substitution therapy is available at each VA medical center. We do not support this provision, but we do believe that the size and location of medical programs should be determined by the veterans' needs and have already established 36 opioid substitution programs in VA medical centers across the country. We are in the process of assessing the need for additional such programs and will not hesitate to establish more programs where needed.

Finally, Section 16 would establish a 3-year pilot program to provide transitional assistance grants to up to 600 homeless veterans at regional offices. This provision lacks safeguards or limitations on the receipt and use of the grant funds, despite the strong likelihood that many recipients would be suffering from mental illness or substance abuse disorders. Awarding funds to veterans without requiring them to participate in simultaneous clinical intervention or oversight would likely result in many of them not seeking the care and treatment necessary to overcome the disorders and become self-sufficient.

Mr. Chairman, certain provisions of this bill seek to address broader issues of the adequacy of VA's specialized mental health programs. In this regard, we have initiated the National Mental Health Improvement Program that will be dedicated to the development and implementation of performance and outcome measures to ensure that VA becomes a national leader in evidence-based care for the mentally ill. While we believe that VA mental health services remain strong and effective, no system is without its challenges. It is imperative that access to mental health services and best clinical practices be provided in a uniform manner across the VA health care system. To the extent that there are unacceptable levels of variance in these parameters, corrections must and will be made.

Next year's performance contracts with our network directors will include volume and variance measures for mental health services and will emphasize the expansion of substance abuse programs. The National Mental Health Improvement Program will develop measures of adequacy of access in addition to measures of quality and effectiveness. If additional resources are required to provide needed care, a plan to provide these resources will be developed and implemented.

Two months ago, I ask for an analysis of the current state-of-the-art in measuring patient need in mental health and last month asked for the specific review of the role of case mix in mental health funding under VERA be undertaken. It is my commitment and we all agree that we must assure that there is an incentive rather than a disincentive to provide needed and effective care to this very vulnerable population.

Mr. Chairman, this completes my remarks, and we will be pleased to respond to any questions you might have.

[The prepared statement of Dr. Garthwaite follows:]

PREPARED STATEMENT OF THOMAS L. GARTHWAITE, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

I am pleased to be here to present the Department's views on six different bills being considered by the Committee. They cover a wide range of subjects related to personnel matters and VA's provision of health care services to veterans. We support many provisions in the bills before the Committee, however there are some on which we recommend modifications, and others which we cannot support at this time.

S. 739

Mr. Chairman, I will begin by offering comments on S. 739, a bill entitled the Heather French Henry Homeless Veterans Assistance Act. The bill is an ambitious and comprehensive piece of legislation that seeks to improve the services and benefits furnished to homeless veterans. We strongly support the objectives of the bill and generally support many of its provisions. However, we are unable to support some of the provisions largely because they duplicate long-standing activities and programs conducted by the Department for homeless veterans or more recent initiatives begun in Fiscal Year 2000. Today I will briefly comment on each of the sections of the bill.

Section 2 articulates Congress' findings regarding the magnitude and scope of homelessness among veterans, the inadequacy of current programs to provide them needed services, the levels of funding needed to provide beds to homeless veterans, and the commitment of the Congress to end homelessness among the Nation's veterans. Other findings articulate statistical information obtained from VA's report on activities conducted under the Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) program for veterans. Section 2 also defines various terms used in the bill.

It is important to note that in light of more recent information from our CHALENG program the number of homeless veterans, as well as the number of additional beds needed for homeless veterans, are likely to be somewhat lower than the numbers cited in section 2.

Section 3 would declare a national goal of ending homelessness among veterans within a decade and encourage all governmental components, quasi-governmental departments, agencies, and private and public sector entities to work cooperatively in reaching this goal. We strongly support section 3.

Section 4 would establish a 15-member Advisory Committee on Homeless Veterans within the Department of Veterans Affairs, articulate the functions and responsibility of the committee, and establish the pay, allowances and terms for members. It would also establish various reporting requirements. We share the view that an advisory committee would be beneficial, but a statutorily-created Committee is not needed. The Secretary has already announced his intention to establish an Advisory Committee on Homeless Veterans with many of the same functions and objectives.

Section 5 would amend the McKinney-Vento Homeless Assistance Act to require that the Interagency Council on Homeless (ICH) meet at the call of its Chairperson or a majority of its members and that the ICH meet at least annually. We support this provision.

Section 6 is concerned with evaluation of our programs for homeless veterans and calls for reporting to Congress on those programs. It would require the Secretary to support the continuation of at least one Department center for evaluation to monitor the structure, process, and outcome of VA's programs for homeless veterans. It would further require the Secretary to annually provide Congress with a detailed report on the health care needs of homeless veterans including information on our Health Care for Homeless Veterans Program (HCHV) and Homeless Providers Grant and Per Diem Program. Section 6 would also require that we carry out our CHALENG assessment program on an annual basis and report to Congress on the findings and conclusions of the CHALENG report.

We support the objective of the requirement for maintenance of an evaluation center, as called for in section 6, but we believe the objective can be achieved without legislation by expanding the mission of our Northeast Program Evaluation Center (NEPEC). We currently rely on NEPEC to monitor and evaluate the services provided to homeless veterans. Its current efforts are comprehensive with respect to the health care related services that are available and furnished to homeless veterans. However, we capture limited information on outreach activities and monetary benefits administered by the Veterans Benefits Administration (VBA) in connection with homeless veterans. Recognizing that our current efforts in this area are fragmented

and incomplete, we plan to take steps to improve and strengthen the reporting of all programs and benefits to fully and effectively monitor and evaluate all of the Department's programs for homeless veterans.

We do not support the requirements of section 6 that would statutorily require additional reporting and assessment activities. We are essentially already performing these assessment activities and reporting on them. Through the NEPEC, we provide ongoing monitoring and evaluation of our health care programs for homeless veterans. NEPEC provides detailed reports on structure, process, and outcomes for all specially funded homeless veterans programs as well as evaluation support for a wide range of other mental health programs that are not exclusively targeted to homeless veterans but are utilized by homeless veterans such as the Compensated Work Therapy (CWT) Program, and the Compensated Work Therapy/ Transitional Residence (CWT/TR) Program. In addition, the CHALENG program achieves the objectives of the proposed requirements.

Section 7 would require the Secretary to designate care and services provided to certain specified veterans as "complex care" for purposes of the Veterans Equitable Resource Allocation system (VERA). Veterans receiving the following types of care would be covered: (1) veterans enrolled in the Mental Health Intensive Community Case Management program; (2) continuous care in homeless chronically mentally ill veterans programs; (3) continuous care within specialized programs provided to veterans who have been diagnosed with both serious chronic mental illness and substance abuse disorders; (4) continuous therapy combined with sheltered housing provided to veterans in specialized treatment for substance use disorders; and (5) specialized therapies provided to veterans with post-traumatic stress disorders (PTSD), including specialized outpatient PTSD programs; PTSD clinical teams; women veterans stress disorder treatment teams; and substance abuse disorder PTSD teams. Finally, section 7 would require that we ensure that funds for any new program for homeless veterans carried out through a Department health care facility are designated as special purpose program funds (not VERA funds) for the first three years of the program's operation.

We do not support section 7 of the bill. The complex reimbursement rate under the VERA system is currently reserved for reimbursing VISNs for providing the most complex and expensive care, and should not be based on diagnosis or type of disorder being treated. Section 7 directs complex reimbursement based on broad and general diagnosis and does not consider whether the care is costly. For example, VA now treats some 2,800 veterans in its Mental Health Intensive Community Case management (MHICM) Program. If a veteran in that program receives at least 41 visits per year, the VERA model will reimburse at the complex rate because that veteran is receiving costly care. Many others in the program have far fewer visits and are far less costly to treat. Section 7 of this bill would require complex reimbursement for all of 2,800 veterans in the program regardless of how many visits they have.

The proposal could add more than 200,000 additional veterans into the category of patients for whom Veterans Integrated Service Networks (VISNs) receive complex reimbursement. This would require VHA to either set aside a greater percentage of the medical care appropriation for the care of veterans identified in this section, or significantly reduce the complex reimbursement rate per veteran treated. Neither option is acceptable. The first reduces funding for the standard care of veterans, and the second dilutes the reimbursement for complex care so that there is little incentive to provide services to these veterans. In addition, this approach provides a perverse incentive for clinicians to provide more treatment than is needed in order to qualify for the complex reimbursement rate. The effect of this provision would be to reduce the availability to veterans, including many who are homeless, of care not identified in the complex reimbursement category.

Section 8 would require that per diem payments paid to grantees of our Homeless Providers Grant and Per Diem Program be calculated at the same rate that currently applies to VA per diem payments to State homes providing domiciliary care to veterans. Under current law, the homeless provider per diem rates are based on each grant recipient's costs. In short, we pay per diem that amounts to not more than 50% of the recipient's total costs up to a cap. To calculate the per diem rate for each grantee, we must document each recipient's costs. This is an extremely labor intensive and complex process.

We support simplification of program management in the manner proposed. However, since domiciliary care and care under the Homeless Providers Grant and Per Diem Program vary in types of services and intensity, we support a per diem rate of 85 percent of the domiciliary care per diem rate. That would equate more closely with the actual cost of services provided under the Homeless Providers Grant and Per Diem Program.

Section 9 would require that we carry out a new grant program for VA health care facilities and grantees of VA's Homeless Grant and Per Diem Payment Program. The new program would encourage the development of programs targeted at meeting special needs of homeless veterans, including those who are women, who are age 50 or older, who are substance abusers, who suffer from PTSD, a terminal illness, or a chronic mental illness; or who have care of minor dependents or other family members. The measure would also require a report that includes a detailed comparison of the results of the new grant program with those obtained for similar veterans in VA programs or in programs operated by grantees of VA's Homeless Providers Grant and Per Diem Program.

We appreciate the intent of this provision, but we do not support the section because it appears to be unnecessary. We currently operate and/or support successful programs that are specifically targeted at meeting the special needs of these particularly vulnerable groups of homeless veterans. We undertook several special program initiatives in 2000 that were specifically targeted at the special needs of homeless veterans, including women veterans. A study of the effectiveness of the initiative related to homeless programs for women veterans is underway. Finally, we have been successful in establishing and cultivating relations with non-profits in the community to ensure a continuum of services for homeless veterans. We are concerned that this proposal may have a disruptive effect on those relationships by requiring our community partners to compete with VA facilities for these limited grant funds.

Section 10 would require that appropriate officials of our Mental Health Service and Readjustment Counseling Service initiate a coordinated plan for joint outreach on behalf of veterans at risk of homelessness, expressly including those who are being discharged from institutions such as inpatient psychiatric care units, substance abuse treatment programs, and penal institutions. The section sets out a detailed list of items and factors to be included or provided for in the plan.

We support this provision in concept but suggest that it may be duplicative of our current outreach authority and statutory requirement to coordinate with other governmental and non-governmental agencies and organizations. However, we recognize the need for continuing to expand and improve our coordination efforts on behalf of homeless veterans and those at risk for homelessness and the concomitant need to report adequately on these efforts. We will work towards these ends.

As to the issue of coordination between VHA and Vet Centers, our Health Care for Homeless Veterans (HCHV) Programs staff, who primarily serve under mental health service lines at VA medical centers, currently collaborate with Vet Centers staff regarding the needs of homeless veterans. (Vet Centers estimate that approximately 10% of veterans served in Vet Centers are homeless.) Referrals are regularly made between VA's specialized homeless programs and Vet Centers for appropriate services for veterans who are homeless or at risk for homelessness. In addition, Vet Centers staff are invited to attend and participate in CHALENG meetings. Further, HCHV staff and Vet Centers staff already collaborate with non-VA community-based service providers and with other government sponsored programs.

Section 11 would require that we conduct two treatment trials in integrated mental health services delivery. The bill defines "integrated mental health services delivery" as "a coordinated and standardized approach to evaluation for enrollment, treatment, and follow-up with patients who have both mental health disorders (to include substance use disorders) and medical conditions between mental health and primary health care professionals." One of the treatment trials would have to use a model incorporating mental health primary care teams and the other would have to use a model using patient assignment to a mental health primary care team that is linked with the patient's medical primary care team. We would also have to compare treatment outcomes obtained from the two treatment trials with those for similar chronically mentally ill veterans who receive treatment through traditionally consultative relationships. The VA Inspector General would have to review the medical records of participants and controls for both trials to ensure that the results are accurate.

We share an interest in this area of clinical research and have decided to carry out the project contemplated by section 11 using mechanisms and special programs already in place, i.e. VA's Health Services Research and Development Service and the Department's MIRECCs program. In pursuing this endeavor, we welcome the opportunity to work with Committee staff to ensure the language of the request for research proposals satisfies the objectives of section 11. However, this particular research study (including the final analysis and report to Congress) would likely require more than the amount of time permitted under section 11. Additionally, VA program officials and evaluators will be expected to manage and report on the results of a project of this size without immediate and direct oversight from the Office

of the Inspector General (OIG). If there is a need for human subject protection review, the Office of Research and Compliance Assurance (ORCA) should conduct it and OIG involvement should consist only of their current oversight of the activities of ORCA.

Section 12 would effectively extend eligibility for outpatient dental services, treatment, and appliances to certain veterans when such services, treatment, and appliances are needed to successfully gain or regain employment, to alleviate pain, or to treat moderate, severe, or severe and complicated gingival and periodontal pathology. The new authority would extend benefits to enrolled veterans who are receiving care in an array of VA settings, and community programs supported by VA.

Although we recognize that these veterans need dental care and services, we do not support this provision because it would result in a disparity in access to needed outpatient dental care and services among equally deserving veterans. As an alternative, we will heighten and expand our current efforts to obtain dental care and services for homeless veterans through pro bono providers, dental schools and related teaching programs, and service providers receiving grants under VA's Homeless Providers Grant and Per Diem Program.

Section 13 contains several varied provisions. The first would require the Secretary to develop standards to ensure that mental health services are available to veterans in a manner similar to that in which primary care is made available to veterans by requiring every VA primary care health care facility to have mental health treatment capacity. We certainly believe in equitable availability of mental health services and we have included such services in our basic benefits package. We are also already working to assure that all sites of care can either directly provide, contract for, or refer patients to other VA facilities for mental health care.

Another provision in section 13 would require that we expend not less than $55 million from Medical Care funds for our Homeless Providers Grant and Per Diem Program. The amounts to be expended would also have to be increased for any fiscal year by the overall percentage increase in the Medical Care account for that fiscal year from the preceding fiscal year. We don't concur with this provision. We have offered grant funds each year for the past seven years. Grant fund availability has ranged from a low of $3.3 million in FY 1996 to a high of $15.3 million in FY 1998. Of the $32.4 million identified for the Grant and Per Diem Program in FY 2001, approximately $22 million is expected to be spent on per diem payments, leaving $10 million available for the eighth round of grants. We believe that making $10 million available for grants is a reasonable funding level for any given year. Grant awards of $10 million assist with the development of approximately 1,000 community-based beds. It often takes grant recipients two years or longer to complete construction or renovation and to bring the program to full operation. During the development phase, VA staff at the national, VISN and VAMC level are available to assist grant recipients with any problems they might encounter. We believe this personal attention and assistance are partially responsible for the relatively high success rate of grant program implementation. Steady and reasonable growth in the Homeless Providers Grant and Per Diem Program appears to be one of the keys to the success of this program. It is likely that the Grant and Per Diem Program will reach a spending level of $55 million in the next five years.

Moreover, a requirement to spend not less than $55 million next year and in future years may actually be counter-productive to achieving the goals of this program because it would require VA to fund programs that would otherwise not merit grant assistance based on competitive scoring criteria. Past experience has shown VA that not all grant applicants are able to propose viable projects. Indeed, less than 50 applications received in any given year satisfy scoring criteria. This is not indicative of a program weakness; rather, it reflects the requirement that we award grants under the program only to those providers that demonstrate their viability and ability to succeed in meeting their grant applications' stated purpose(s).

A third part of section 13 would require that we establish centers to provide comprehensive services to homeless veterans in at least each of the 20 largest metropolitan statistical areas. Currently, we must have eight such centers.

We support this provision, but defining what services would constitute a comprehensive homeless services program for each of the 20 largest metropolitan statistical areas is a particularly complex task, which depends on the specific demographics of, and the services available in, each particular area. We would like to work with the Congress in defining what specific programs and services are envisioned by this provision.

A fourth aspect of Section 13 would require us to ensure that opioid substitution therapy is available at each VA medical center. We don't support this provision on the basis that a determination to provide opioid substitution therapy is medical in nature (not legislative) and, as such, is dependent on the individual clinical facts

of each case. The size and location of medical programs should be determined by veterans' medical needs. However, we recognize the clinical value of this particular treatment. Indeed, we have established 36 opioid substitution programs in VA medical centers across the country and we are evaluating our substance abuse treatment needs to determine whether additional programs may be needed. If deemed to be medically necessary and appropriate, we will not hesitate to establish more programs where needed.

Finally, the last part of section 13 would extend, through December 31, 2006, both our authority to treat veterans who are suffering from serious mental illness, including veterans who are homeless and VA's authority to provide benefits and services to homeless veterans through VA's Comprehensive Homeless Centers. The authority for each of those programs will expire on December 31, 2001 and we support both extensions.

Section 14 would permit homeless veterans receiving care through vocational rehabilitation programs to participate in the Compensated Work Therapy program. It would also allow homeless veterans in VHA's Compensated Work Therapy program to receive housing through the therapeutic residence program or through grantees of VA's Homeless Providers Grant and Per Diem Program. We support both of those provisions.

Section 14 would also require that we ensure that each Regional Office assign at least one employee to oversee and coordinate homeless veterans programs in that region, and that any regional office with at least 140 employees have at least one full-time employee assigned to the above-stated functions.

We support the need for continued effective outreach to homeless veterans, but we have concerns about the proposed staffing requirements. Homeless Veterans Outreach Coordinators are already assigned at each VBA regional office. In most instances, this assignment is a collateral duty and not a full-time assignment. There are, however, some regional offices at which a full-time coordinator is assigned as necessitated by the size of the homeless veteran population and homeless support programs within its jurisdictional area. In addition, we have eight full-time homeless outreach coordinators assigned as members of our Health Care for Homeless Veterans Program and DCHV programs. We also have two offices that have a part-time employee on the homeless program. These positions are reimbursed by VHA. The staffing requirement in this measure would therefore be an unfunded mandate for which employees would have to be re-assigned from other key duties such as claims processing, rating functions, etc. In addition, we believe the veteran population and its particular needs, not the organizational structure of an office, should determine the number and type of outreach coordinators assigned.

Finally, the last part of section 14 would require disabled veterans' outreach program specialists and local veterans' employment representatives where available to also coordinate training assistance benefits provided to veterans by entities receiving financial assistance under section 738 of the McKinney-Vento Homeless Assistance Act. We support this provision.

Section 15 would require that, with a limited exception, real property of grantees under our Homeless Providers Grant and Per Diem Program meet fire and safety requirements applicable under the Life Safety Code of the NFPA.

We strongly support this requirement. The fire and safety requirements under the Life Safety Code of the National Fire Protection Association (NFPA) have been developed through consensus of experts across the country. They assure a consistent level of safety for homeless veterans living in transitional housing or receiving services in supportive service centers developed under the Grant and Per Diem Program. Entities that have received grants in recent years have been aware of VA's preference for structures to meet the fire and safety requirements under the Life Safety Code of NFPA and have developed their grant applications to cover the costs associated with meeting those requirements. There are, however, some organizations that received grant awards and their buildings do not meet the fire and safety requirements under the Life Safety Code of NFPA. It is therefore particularly valuable that this measure would permit VA to award grant assistance to these entities to enable them to upgrade their facilities to meet the Life Safety Code of NFPA.

Section 16 would establish a three-year pilot program to provide transitional assistance grants to up to 600 eligible homeless veterans at not less than three but not more than six regional offices. The sites for the pilot must include at least one regional office located in a large urban area and at least one serving primarily rural veterans. To be eligible, a veteran would have to live in the area of the regional office, be a war veteran or meet minimum service requirements, be recently released, or in the process of being released from an institution, be homeless and have less then marginal income.

Grants under the program would be limited to three months with an exception for any veteran who, while receiving such transitional assistance, has a claim pending for service-connected disability compensation or non-service-connected pension. Such veterans could continue to receive transitional assistance under this section until the earlier of (A) the date on which a decision on the claim is made by the regional office, or (B) the end of the six-month period beginning on the date of expiration of eligibility under subsection (c). The measure would also require the Department to expedite its consideration of pending claims of veterans. VA would have to pay the grants monthly and in the same amount as that which VA would be obligated to pay under chapter 15 of title 38, United States Code, if the veteran had a permanent and total non-service-connected disability. VA would have to determine the amount of the grant without regard to the income of the veteran, once it is determined the veteran meets the eligibility criteria. Finally it would require the Department to offset the amount of retroactive disability or pension benefits paid to a veteran by the amount of transitional assistance provided to the veteran for the same monthly period.

We cannot support section 16, as it appears to be at odds with the inherent interest of our attempts at rehabilitation. The provision lacks safeguards or limitations on the receipt and use of the grant funds, notwithstanding the strong likelihood that many of the grant recipients would be veterans suffering from mental illnesses and/or substance abuse disorders. Awarding funds to these veterans without also requiring them to participate in simultaneous clinical intervention or oversight would result in many of them not seeking the care and treatment necessary to overcome their disorders. This, in turn, could keep those veterans in a condition of homelessness. Simply awarding grant funds, as proposed, is not, in our view, an appropriate means for making these vulnerable veterans self-sufficient.

Section 17 would require that we conduct a technical assistance grants program to assist non-profit groups, which are experienced in providing services to homeless veterans, to apply for grants related to addressing problems of homeless veterans. The measure would authorize $750,000 to be appropriated for each of fiscal years 2001 through 2005 to carry out the program. We do not support this section as we already provide extensive information about the Homeless Providers Grant and Per Diem Program through the Internet, participation in national, state and some local conferences and one-on-one discussions between interested applicants and VA program managers.

Section 18 would authorize the Secretary to waive any requirement that a veteran purchasing a manufactured home with the assistance of a VA guaranteed loan own or purchase a lot to which the manufactured home is permanently affixed.

We do not favor this provision. Rather than address the specifics of this section of the bill, we have concluded the manufactured home loan program no longer provides a viable benefit to veterans, homeless or otherwise. Accordingly, VA recommends that the manufactured home loan program, which for all intents and purposes is dormant, be terminated.

The number of veterans obtaining manufactured housing loans has significantly declined over the years since Fiscal Year 1983 when VA guaranteed 15,725 such loans. No manufactured housing loans have been guaranteed since Fiscal Year 1996.

The cumulative foreclosure rate on VA manufactured home loans is 39.2 percent, which is significantly higher than the 5.6 percent rate for loans for conventionally-built homes. This foreclosure rate has greatly increased the cost to the taxpayers of the VA housing loan program and resulted in substantial debts being established against veterans.

Therefore, VA does not believe the manufactured home loan program has any role in the effort to assist homeless veterans.

Section 19 would increase from $20 million to $50 million the amount authorized to be appropriated for the Homeless Veterans' Reintegration Programs for Fiscal Year 2002 and Fiscal Year 2003. It would also authorize that same amount to be appropriated for purposes of this program for Fiscal Years 2004, 2005, and 2006. VA defers to the Secretary of Labor, who administers the Homeless Veterans' Reintegration Programs.

Section 20 would require the Secretary, before disposing of real property as excess, to determine that the property is not suitable for use for the provision of services to homeless veterans by the Department or by another entity under an enhanced-use lease. Although we agree with the purpose of section 20, this provision appears to be redundant with existing authorities. Under the Department's enhanced-use leasing authority, we now have the ability to lease available lands and facilities for compatible uses including those that provide services to homeless veterans. We have, in fact, recently used this authority to obtain a 120-unit "Single Room Occupancy" (SRO) housing complex in Vancouver, Washington, and a 63-unit

SRO in Roseburg, Oregon. We are examining similar initiatives nationwide. In addition, pursuant to the Stewart B. McKinney Act, the Department surveys its property holdings and provides quarterly reports to the Department of Housing and Urban Development on the availability of excess or underutilized properties for housing for the homeless. In general terms, the provisions of the McKinney Act related to surplus federal property require each Department, in deeming property under its jurisdiction to be unutilized, under-utilized, or excess, to state that the property cannot be made available for use to assist the homeless. Before ultimately disposing of such property, the McKinney Act requires the Government to again give priority of consideration to uses to assist the homeless. Given that VA has active programs in place that strive to achieve the objective reflected in section 20, establishing a duplicate requirement would only lend confusion to the process.

S. 1188

Mr. Chairman I will next present our views on S. 1188, a bill designed to improve the recruitment and retention of VA nurses. Our nurses are critical front-line components of the VA health care team. Our health care providers are our most important resource in delivering high-quality, compassionate care to our Nation's veterans. We must maintain the ability to recruit and retain well-qualified nurses in order to continue that care. Compensation, employment benefits and workplace factors affect that ability, particularly in highly competitive labor markets and for hard-to-fill specialty assignments. Thanks to the efforts of this Committee and the House Veterans' Affairs Committee, we have been able to offer generally competitive pay in most markets. We continuously monitor the recruitment and retention of health care providers, particularly nurses, and trends in private sector employment and workforce projections. As we noted in testimony before this committee last month, VA nurse staffing is generally stable overall, but there are increasing difficulties in filling positions in some locations, and filling some specialty assignments is extremely difficult. However, I am not prepared to give the Administration's views on this bill without further study. We will provide our views on this measure as soon as possible.

S. 1160

Mr. Chairman, I now turn to S. 1160, a bill that would authorize us to furnish a "service dog" to any veteran with a compensable service-connected disability who is hearing impaired or who has a spinal cord injury or dysfunction. Service dogs can assist a disabled person in his or her daily life and can assist that person during medical emergencies. They can be trained in many tasks, including, but not limited to, pulling a wheelchair, carrying a back-pack, opening and closing doors, helping with dressing and undressing, picking up things one drops, picking up the phone, and hitting a distress button on the phone. Such dogs can also notice when the disabled individual is in distress and can find help. Dogs can also assist the hearing impaired by alerting them to doorbells, ringing phones, smoke detectors, crying babies, and emergency sirens on vehicles.

We support this bill, and any new costs will be handled under existing resources within the FY 2002 President's Budget. Having said that, however if it were to become law, we would promulgate prescription criteria and guidelines for provision of such dogs to insure that we provide animals only to those veterans who can most benefit from them.

DRAFT BILL—MEANS TEST THRESHOLD

Mr. Chairman, also on the agenda is a draft bill that would establish new geographically based income thresholds for VA to use in determining a nonservice-connected veteran's priority for receiving VA care and whether the veteran must agree to pay copayments in order to receive that care. As you know, Mr. Chairman, the law now requires that most veterans enroll in our health care system in order to receive care. Enrollees are placed in an enrollment priority group that is based, in many instances, on their level of income and net worth. Although we currently provide care to veterans in all enrollment priority groups, if there were funding shortages in the future, it might be necessary to determine that those with relatively higher incomes must be disenrolled, meaning they could no longer receive VA care. Current law establishes, on a National basis, the specific income thresholds that we must use to determine the priority group of any given enrollee with no service-connected disability or other special status. We place higher income veterans in priority group 7 and lower income veterans in priority group 5. This draft bill would establish new geographically based income thresholds that VA could use for placing veterans in those priority groups.

The draft bill would use a specific statutorily based poverty index used by the Department of Housing and Urban Development that is established for Metropolitan Statistical Areas (MSA's), Primary Metropolitan Statistical Areas (PMSA's) and counties. The index defines a family as low income if family income does not exceed 80% of the median family income for the area in which the family resides. If we determined that a veteran's income was below the threshold for the specific area where the veteran lived, and his net worth was below our threshold, we would place that veteran in enrollment priority category 5. In many instances, particularly in urban areas, this new income threshold is greater then the current statutory income threshold that we use for determining whether a veteran should be placed in priority group 5. The draft bill would provide that if the new geographically based income threshold is lower then the current threshold, VA would use the old threshold as that would benefit the veteran. We in VA are very interested in examining the use of geographically based income thresholds for placing nonservice-connected veterans in different enrollment priority groups. We recognize that the cost of living in large urban areas is much greater then in many more rural parts of the country. What might be considered a reasonably high income in some locations may be totally inadequate in other higher cost locations. However, at this time we cannot support the methodology proposed in the draft bill. There are many poverty indexes that are established in various ways. However, there are serious issues about what these indexes really measure. We believe further study is needed to determine the most appropriate method for tackling this problem.

S. 1042

Mr. Chairman, I next turn to S. 1042, a bill introduced by Senator Inouye aimed at improving benefits for Filipino veteran of World War II. Entitled the "Filipino Veterans' Benefits Improvements Act of 2001" the bill contains provisions affecting both monetary and health care benefits.

While many U.S. and foreign groups have sought wartime benefits over the years, Filipino veterans are a unique group. During World War II (WWII), the Philippine Islands was a U.S. territory, and its troops fought under the U.S. command. There has been no other similar arrangement in recent American history.

The special circumstances of Filipino veterans have been recognized in law. Soon after World War II, legislation was enacted making disabled Filipino veterans and their survivors eligible for compensation—at half the rate paid to U.S. veterans and survivors. More recently, the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106–419) and the Veterans Affairs, Housing and Urban Development and Other Independent Agency Appropriations Act for FY 2001 (P.L. 106–377) increased the rate of compensation for certain Filipino veterans, and expanded access to health care and burial services.

Any expansion of benefits to Filipino veterans brings with it scrutiny and invites comparison from other Pacific Island groups and many U.S. groups who have regularly petitioned the government for veterans benefits because as civilians they were working next to and exposed to the same hazards as military members. Given the far-reaching implications of expanding benefits to Filipino veterans, I am not prepared to give the Administration's views on the bill without further study. We will provide our views on this measure as soon as possible.

[The information referred to follows:]

Hon. JOHN D. ROCKEFELLER,
Chairman, Committee on Veterans' Affairs,
U.S. Senate,
Washington, DC.

DEAR MR. CHAIRMAN:

As requested in connection with a hearing before your Committee on July 19, 2001, I am pleased to provide the views of the Department of Veterans Affairs (VA) on S. 1042, 107th Congress, the "Filipino Veterans' Benefits Improvements Act of 2001," a bill, "[t]o amend title 38, United States Code, to improve benefits for Filipino veterans of World War II." We support this bill, in part, and oppose this bill, in part, for the reasons discussed below.

Compensation and Dependency and Indemnity Compensation

Sections 2(b) and 3(a) of S. 1042 would, in the case of compensation and dependency and indemnity compensation (DIC) paid by reason of service in the New Philippine Scouts, and in the case of DIC paid by reason of service in the organized military forces of the Government of the Commonwealth of the Philippines, including organized guerilla forces, remove the $0.50 on-the-dollar limitation if the individual to whom the benefits are payable resides in the United States and is either a citizen

of the United States or an alien lawfully admitted for permanent residence in the United States.

Section 107(a) of title 38, United States Code, generally provides that service before July 1, 1946, in the organized military forces of the Government of the Commonwealth of the Philippines, including organized guerilla forces, may in some circumstances be a basis for entitlement to disability compensation, DIC, monetary burial benefits, and certain other benefits under title 38, United States Code, but that payment of such benefits will be at the rate of $0.50 for each dollar authorized. Similarly, section 107(b) of title 38, United States Code, generally provides that service in the Philippine Scouts under section 14 of the Armed Forces Voluntary Recruitment Act of 1945, i.e., service in the New Philippine Scouts, may be a basis for entitlement to disability compensation, DIC, and certain other benefits under title 38, United States Code, but that payment of such benefits will be at the rate of $0.50 for each dollar authorized.

These limitations on benefit payments to certain Filipino beneficiaries were intended to reflect the differing economic conditions in the Philippines and the United States. These limitations were not made contingent, in any respect, on the place of residence of the beneficiary, although, at the time the limitations were established, the great majority of affected individuals resided in the Philippines. Through the years, numerous Filipino veterans and their dependents and survivors have immigrated to this country, and many have become permanent residents or citizens. It became evident that the policy considerations underlying the restrictions on payment of compensation and DIC to the affected individuals are no longer relevant in the case of those who reside in the United States. VA realized that Filipino beneficiaries residing in the United States face living expenses comparable to United States veterans and imposition of limitations on the payment of these subsistence benefits to these individuals based on policy considerations applicable to Philippine residents was not only inequitable, but may result in undue hardships to this group of beneficiaries.

In 1998 and 1999, VA proposed elimination of the $0.50 on-the-dollar limitation in section 107 in the case of affected Filipino compensation and DIC beneficiaries who reside in the United States. Section 501(a) of Public Law 106–377, enacted in October 2000, added subsection (c) to section 107, providing that, in the case of disability compensation paid by reason of service in the organized military forces of the Government of the Commonwealth of the Philippines, including organized guerilla forces, the $0.50 on-the-dollar limitation would not apply if the individual to whom the benefits are payable resides in the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence. However, that statute left unchanged the $0.50 on-the-dollar limitation on the payment of DIC regardless of the recipient's place of residence.

VA continues to believe that in the case of those Filipino veterans and their dependents and survivors who reside in the United States and therefore face living expenses comparable to United States veterans and their dependents and survivors, imposition of limitations on the payment of subsistence benefits based on policy considerations applicable to Philippine residents is inequitable and may result in undue hardships to this group of beneficiaries. Thus, we believe a change in law such as that provided in Public Law 106–377 is justified in the case of compensation and DIC benefits payable to United States residents based on service in the New Philippine Scouts and DIC benefits payable to United States residents based on service in the Philippine Commonwealth Army, including organized guerilla forces. Thus, we support sections 2 and 3 of the draft bill.

We note that technical changes contemplated by section 2(a) of the draft bill have already been accomplished by Public Law 107–14, § 8(a), enacted June 5, 2001.

Sections 2 and 3 of H.R. 1042 are subject to PAYGO requirements of the Omnibus Budget Reconciliation Act of 1990 (OBRA). VA projects that 120 former members of the New Philippine Scouts residing in the United States who have established service connection and currently receive compensation benefits at half-rates would become eligible for increased compensation benefits, under section 2 of the bill. VA estimates that section 2, if enacted, would increase direct spending by $568,000 in the first year of the program, and $2.5 million cumulatively for five years. VA also estimates that approximately 438 survivors of Filipino veterans reside in the United States and would become eligible for DIC benefits at full-dollar rates in FY 2002 pursuant to section 3. VA estimates that section 3, if enacted, would increase direct spending by $2.5 million in FY 2002, and $14.8 million in FYs 2002 through 2006.

Pension

Section 4 of S. 1042 would render service in both the organized military forces of the Government of the Commonwealth of the Philippines, including organized

guerilla forces, and the New Philippine Scouts a basis for entitlement to pension under chapter 15 of title 38, United States Code. This section would allow for the payment of such benefits under chapter 15 to be made at the full-dollar rate authorized if the individual to whom the benefits are payable resides in the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence in the United States. This section would further provide for such benefits to be paid at the rate of $100 per month if the individual to whom the benefits are payable resides in the Republic of the Philippines.

The limitations on eligibility for United States veterans' benefits based on service in the Philippine military forces were established many years ago in a carefully considered determination of the United States and Philippine governments' respective responsibilities with regard to veterans of these forces. The current limitations on United States veterans' benefits for veterans of the Philippine forces stemmed from a comprehensive economic and political plan for allocating financial assistance to the Philippines. We understand that the array of benefits offered under current Philippine law for veterans of the Philippine armed forces is nearly as comprehensive as that authorized by United States law for veterans of service in our own Armed Forces. In our view, current law appropriately recognizes our two nations' shared responsibility for the well being of members of the Philippine forces, and the longstanding allocation of those responsibilities should not be disturbed. Thus, VA opposes section 4.

We also note, with regard to section 4(b) of S. 1042, that VA's pension program is a needs-based program under which the amount of benefits awarded is based on the income of the recipient. The award of a flat pension rate to individuals who reside in the Republic of the Philippines would differ markedly from any award to which an individual who resides in the United States would be entitled. Under the proposed provision, an individual who resides in the Philippines could receive benefits, while an otherwise eligible resident of the United States subject to income limitations would receive none, even though the Philippine resident's income is equal to or greater than that of the United States resident. We can perceive of no basis for this inequitable treatment.

Section 4 of S. 1042 is subject to PAYGO requirements of the OBRA. VA estimates that there are approximately 11,000 Filipino veterans residing in the United States, and approximately 34,000 Filipino veterans residing in the Philippines, who would become eligible for pension awards under section 4. VA estimates that section 4, if enacted, would increase direct spending by $59.5 million in the first year of the program, and $251 million over five years, for Filipino veterans residing in the United States, and $40.7 million in the first year of the program, and $161.4 million over five years, in additional benefit costs for Filipino veterans residing in the Philippines.

Administrative Costs of Proposed Benefits Programs for Filipino Veterans

VA has determined that implementing the benefits programs for Filipino veterans proposed under section 2, 3 and 4 of H.R. 1042 would generate approximately 44,923 new claims, and would require 91 additional FTE. Administrative costs associated with these FTE would total $5.3 million.

Health Care in the United States

Section 5 of S. 1042 would broaden eligibility for VA health care within the United States for Filipino veterans who served in the Commonwealth Army, including organized guerilla forces, and the New Philippine Scouts. Under current law, only Commonwealth Army veterans with compensable service-connected disabilities, who lawfully reside in the United States, can receive such comprehensive care. New Philippine Scouts can receive care only on a discretionary basis and only for a service-connected disability. Section 5 of the bill would make Commonwealth Army veterans, including organized guerilla forces, and New Philippine Scouts eligible for hospital, nursing home and outpatient care, in VA facilities within the United States, in the same manner as United States veterans. Section 5 would, for the first time, allow VA to provide comprehensive care to veterans of the Commonwealth Army, including organized guerilla forces, and New Philippine Scouts who have no service-connected disability. We note, however, that section 5, as drafted, would extend VA health benefits to Filipino veterans in the United States regardless of immigration status. We urge that section 5 be amended to limit eligibility to Filipino veterans who are residing in the United States and are either citizens of, or aliens lawfully admitted for permanent residence in, the United States.

VA estimates that there are approximately 11,000 nonservice-connected Filipino veterans residing in the United States and that extending eligibility as section 5 would do would result in approximately 2,300 new users of the health care system.

VA estimates the cost of this use would be approximately $11.6 million in the first year and $52.6 million over five years. The Administration supports enactment if Congress provides funding necessary for implementation and total discretionary spending does not exceed the overall levels in the President's FY 2003 budget.

Outpatient Health Care in the Philippines

Section 6 of the bill would require that VA provide comprehensive outpatient care at the Manila VA Outpatient Clinic to United States veterans of World War II, Commonwealth Army veterans, including organized guerilla forces, and New Philippine Scouts who reside in the Republic of the Philippines. However, section 6 would limit expenditures for such care to $500,000 per year. Section 6 also provides that the authority would be effective in any fiscal year only to the extent that appropriations are available. Section 6 would not change our current authority to furnish comprehensive outpatient care in the Manila Clinic to United States veterans with a service-connected disability, and the $500,000 cap would not apply to the existing authority.

VA opposes the expansion of authority contained in section 6. Last year Congress enacted legislation revising VA's authority to furnish care in the outpatient clinic in Manila, permitting the Department to furnish U.S. veterans and Old Philippine Scouts who have a service-connected disability with care for nonservice-connected disabilities. Old Philippine Scouts are considered to be U.S. veterans. Previously, the clinic was authorized to provide care only for the service-connected conditions of these veterans. Congress elected not to open the clinic to non-U.S. veterans. Congress made these changes because these veterans were already eligible for and receiving care for service-connected disabilities in a VA-operated clinic. It makes sense to treat all conditions of a patient when treating the patient for a service-connected disability. In all other foreign countries, VA is authorized only to provide reimbursement for the cost of care for veterans' service-connected disabilities.

The $500,000 per year limitation on VA's authority to provide care would necessitate that VA establish some basis for rationing the care in the clinic. The cost of caring for those who would be made eligible would far exceed that amount. Were VA to provide care on a first come first served basis, many veterans needing care would not receive it simply because they did not need the care soon enough.

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

Sincerely yours,

ANTHONY J. PRINCIPI.

S. RES. 61

The last provision I will address today is S. Res. 61. S. Res. 61 would express the Sense of the Senate that the Secretary of Veterans Affairs recognizes American Association of Physician Specialists (AAPS) board certifications for the purpose of VHA payment of special pay.

VA does not support this provision. VHA currently provides board certification special pay only to physicians who are board certified by either American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists (BOS), the certifying body of the American Osteopathic Association.

In accordance with quality assurance standards and prudent business practices, every healthcare organization must ensure appropriate credentialing of its healthcare providers. The purpose of board certification is to assure the public that a physician has completed an approved education program and an evaluation process to assess knowledge, skills, and experience required to provide quality of care. ABMS and BOS are considered to be the official certifying approval entities for MD and DO specialties. VA does not set the qualifications standards for the ever-expanding number of certifying organizations for the numerous medical professions employed in VA healthcare facilities. Nor do we seek that role, since we have neither the expertise nor the resources to do so. We recognize the certifications of the leading recognized healthcare organizations.

Today there are an estimated 165 to 180 board-certifying organizations in the United States. These vary from organizations requiring substantive credentials and comprehensive examinations to others who require few, if any, prerequisite qualifications.

As specialty certification developed during the 1960's and 1970's, many specialty boards had "grandfather" clauses permitting established practitioners in a field to become certified by that specialty. Some practitioners either were ineligible for "grandfathering" or chose not to apply. Later, specialty certification became more important for getting hospital privileges and managed care contracts, and practitioners wanted to become certified. When the window to grandfather had passed,

the only options available were to retrain, or to create a new specialty board and hope that it would succeed. In addition, there were physicians who were either ineligible to take or unable to pass the ABMS and BOS recognized boards and wanted another option. Other sources of new specialties included areas such as cosmetic surgery. Physicians who become certified by a non-ABMS or non-BOS organization are doing so with full knowledge that this certification might not be recognized by mainstream medical organizations.

ABMS started in 1933. ABMS board certification is recognized throughout the United States as the "gold standard" in board certification. This recognition is based on ABMS' rigorous criteria for approval of new specialty boards and its high standards in developing questions and criteria for qualifying examinations.

All ABMS primary board certifications require educational preparation in approved medical schools and in Accreditation Counsel for Graduate Medical Education (ACGME)-accredited residency programs. ACGME sets requirements that institutions must meet in order to sponsor graduate medical education (GME). The ABMS uses educational and physician researchers to validate examination procedures and the content of the examinations. Peer validation also provides recognition of ABMS' "gold standard" status. Of the 630,000 board-certified physicians in the United States, ABMS certifies more than 99 percent while AAPS certifies less than 1 percent.

Many of the Residency Review Boards that recommend residency program accreditation to the Accreditation Council for Graduate Medical Education use percent of physicians obtaining ABMS board certification as an important criterion for program evaluation. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) also use ABMS data as a measure of quality. The American Hospital Association, Association of American Medical Colleges, Federation of State Medical Boards, National Board of Medical Examiners, Council of Medical Specialty Societies, and the American Medical Association are associate members of ABMS. These premier medical organizations in the United States are concerned with goals, standards, and the quality of graduate medical education.

ABMS is integrated into the structures of organized medicine. While any organization can self-proclaim a specialty certification and any organization can claim to recognize and/or approve specialties, these organizations lack the validation from and acceptance by the established medical education structures of this country.

The BOS processes for specialty recognition are analogous to those of ABMS.

In order for VHA to recognize specialties through other than adherence to the American "Gold Standard", a complex review process would be needed whereby VA would itself become a specialty recognition body. This is a role VHA has historically chosen to defer to private sector, established organizations with the requisite expertise. VHA does not believe that such deference is either arbitrary or capricious. The staffing and commitment needed to maintain a genuine certification process would be onerous.

AAPS, in comparison to ABMS and BOS, has not achieved an equivalent level of recognition within the American medical community. VHA does not recognize AAPS due to its lack of endorsement and acceptance by the general medical community, the AAMC, the AHA, the ACGME, JCAHO, etc., which VHA requires and which is the basis of its recognition of ABMS and BOS.

Mr. Chairman, this concludes my testimony.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO THOMAS L. GARTHWAITE, M.D.

Question 1. I understand that a project in Florida—Volunteers of America—has a close relationship with the VBA and has been able to secure benefits for hundreds of homeless veterans. If the active involvement of a single veterans benefits counselor can help hundreds of homeless veterans, wouldn't it follow that tens of thousands of homeless veterans would receive benefits they've earned if more VBA counselors were deployed?

Answer. As stated in the testimony, we support the need for continued effective outreach to homeless veterans. We do not believe that demographics of the homeless veteran population support assigning a full-time homeless veteran coordinator at each regional office. As also noted, where such populations indicate that the need for a full-time coordinator exists, as is the situation in Florida, one is assigned. It should be noted that a homeless veteran coordinator is assigned at least as a collateral duty at each regional office. During FY 2001, VBA homeless coordinators have contacted almost 2,000 shelters and over 3,700 Federal, local and other agen-

cies/organizations to assist homeless veterans. Just under 21,000 homeless veterans contacted VBA homeless coordinators during that same period.

Question 2. Does VBA expedite claims for homeless veterans? If yes, how is this tracked? Can you provide the Committee with that information? If no, wouldn't having at least one employee in each regional office who primarily works with the homeless be a good plan?

Answer. Directives are in place for expeditious processing of all claims initiated by homeless veterans. However, results are not tracked. As stated in the testimony, we plan to take steps to improve and strengthen the reporting of all programs and benefits to fully and effectively monitor and evaluate all of the Department's programs for homeless veterans.

See response to question one concerning staffing for the homeless veteran program.

Question 3. Have there been any leases under VA's enhanced-use lease authority that have been granted to create emergency shelters or transitional housing for the homeless?

Answer. We have used this authority to obtain two leases: (1) a 120-unit "Single Room Occupancy" (SRO) housing complex in Vancouver, Washington (awarded in July 1998), and (2) a 63-unit SRO in Roseburg, Oregon (awarded August 2000).

In addition, we have two enhanced-use lease projects approaching lease execution: (1) a 96 unit SRO in Barbers Point, Honolulu Hawaii, and (2) a 59 unit SRO in Batavia New York. The enhanced-use lease authority is scheduled for May 2002.

Question 4. How does VHA justify the decrease of inpatient detoxification beds, beyond the restructuring of the health care industry in general with regard to the transition from inpatient to outpatient care, when there is clearly a need for these beds specifically for treating homeless veterans?

Answer. In the past, VA provided detoxification and short-term acute inpatient treatment in specialized substance abuse treatment units. Following an episode of acute inpatient care, veterans were provided residential services and post-acute care rehabilitation in VA domiciliaries and community-based halfway house programs under VA contract.

With the shift from inpatient to outpatient care, VA developed various approaches to providing detoxification and support services for veterans with substance abuse disorders, including homeless veterans. VA continues to provide inpatient detoxification in general medical beds for veterans who need those services. An inpatient stay for detox usually lasts for 3–5 days. Veterans with substance abuse disorders may also be admitted to a VA domiciliary or a Substance Abuse Residential Rehabilitation and Treatment Program (SARRTP) and receive outpatient substance abuse treatment. However, domiciliaries, SARRTPs, and some per them funded programs may require a period of sobriety prior to admission. Some homeless veterans remain in emergency shelters while attending VA outpatient substance abuse treatment programs.

Each VA medical center and VISN has attempted to construct a continuum of care to address the needs of veterans with substance abuse disorders. The degree of success has been dependent on VA's ability to secure adequate residential services and, at the same time, provide appropriate outpatient substance abuse treatment services.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PAUL WELLSTONE TO THOMAS L. GARTHWAITE, M.D.

Question 1. Does it make some sense for Congress to institutionalize some of VA's current or planned programs and activities, such as the Advisory Committee on Homeless Veterans or Northeastern Program Evaluation Center and its reports which may be supported by the current leadership, but which may not enjoy such support in the future?

Answer. There does not appear to be a compelling reason to institutionalize either the Advisory Committee on Homeless Veterans or the Northeast Program Evaluation Center (NEPEC).

The Advisory Committee membership includes knowledgeable VA- and non-VA experts and representatives from community service providers with qualifications and competence to deal effectively with care and treatment services for homeless veterans. This committee will greatly assist VA in improving the effectiveness of our programs and will allow a strong voice to be heard within the Department from those who work closely with us in providing these services.

The value of NEPEC is well recognized throughout VA. NEPEC has existed for fourteen years and currently monitors the performance of over 900 VA programs

with budgetary costs of over $250 million. Its monitoring and evaluation procedures are fully incorporated into the day-to-day operations of VA's specialized mental health programs. Among the programs NEPEC monitors and evaluates are the Health Care for Homeless Veterans (HCHV) Programs, the Domiciliary Care for Homeless Veterans (DCHV) Programs, and the Homeless Providers Grant and Per Diem Program. VA relies on community-based organizations to provide contracted residential treatment and per them supported housing for homeless veterans under the HCHV Program and the Grant and Per Diem Program. VA pays approximately $40 million per year for these services, and NEPEC has developed VA's only systematic reporting and evaluation of contracted program performance. The information from NEPEC's monitoring and evaluation system allows VA officials and program managers to assess the effectiveness of services and identify areas for improvement.

Question 2. Your testimony states that VA is now reimbursing care in the Mental Health Intensive Case Management (MHICM) Program at the complex care rate under the VERA methodology. Can you tell me the status of this policy? Has guidance been issued to the field and, if so, when was that guidance issued?

Answer. On May 24, 2001, the Under Secretary for Health (USH) approved an April 19, 2001, recommendation of the VHA Policy Board to establish a new Complex Care class for patients actively participating in the Mental Health Intensive Case Management Program (MHICM), with a minimum of 41 visits. Such patients would be considered as chronic mental illness (CMI) patients for future recording and reporting. The April 19 Policy Board Minutes were distributed shortly after approval by the USH and are published on the VHA web site. Because this recommendation was a policy change for the FY 2002 VERA methodology, a description of this change is in the FY 2002 VERA Book. VHA will also assure that mental health managers and MHICM staff are fully briefed on this issue during their regularly scheduled conference calls.

Question 3. My bill requires VA to change its financial incentives for treating mentally ill veterans using various VA-provided or funded programs. VA stresses its objection to this language in Section 7 of the bill. The Agency's views seem to indicate that there is some Hobbesian choice VA will have to make—that to implement the recommendation VA will have to forsake other veterans in need of care. Does VA always spend the entire complex care rate allocated for a veteran on the care of the veteran for whom it is allocated?

Answer. The Complex Care Rate is a national average price for all Complex Care patients. The actual costs for a specific Complex Care patient could be above or below the average price. There is no requirement that the amounts allocated for Complex Care patients or Basic Care patients be spent only on those patients. On the average, VHA is currently allocating to the networks 6 percent more for the care of Complex Care patients than it actually costs to treat them and 6 percent less than it costs to treat Basic Care patients. Therefore, some of the funds allocated for Complex Care patients are spent on Basic Care patients.

Question 4. If there is a remainder of high-cost funds it is used for the care of other veterans, is it not?

Answer. Because VHA is allocating 6 percent more for the care of Complex Care patients than it actually costs to treat them and 6 percent less than it costs to treat Basic Care patients, some of the funds allocated for Complex Care patients are spent on Basic Care patients.

Question 5. Doesn't the VA's own Committee on Severely Chronically Mentally Ill Veterans indicate that chronically mentally ill people are in fact currently underserved?

Answer. The Fifth Annual Report to the Under Secretary for Health submitted by the Committee on Care of Severely Chronically Mentally III Veterans, dated February 23, 2001, makes several points regarding this issue, as briefly stated below.

- Veterans with a serious mental illness (SMI) should receive a high priority due to a high preponderance of service connection and/or low-income status in their ranks.
- The number of patients with a psychosis treated as inpatients in VHA dropped from 58,000 in FY 1994 to 44,290 in FY 1998.
- In spite of a dramatic increase in the number of Community Based Outpatient Clinics (CBOCs) in VHA over the last five years, the percent of CBOCs that offer mental health has remained in the 45—60 percent range (depending upon the size of the clinic).
- The proportion of mental health visits in CBOCs dropped from 24.5 percent in FY 1998 to 20.1 percent in FY 2000.
- Many of a selected subset of the most severely impaired mentally ill who require intensive community-based case management in order to function are not receiving such care.

• The number of individual patients receiving care for substance abuse in VHA actually dropped by 11.2 percent from 1995 to the current year.

The actual number of SMI Veterans treated has increased by 8 percent since 1996. Because we have identified specific problem areas, VHA has worked with VISN planners to identify 1) local areas where mental health care should be added to CBOCs, 2) local areas where intensive community-based case management teams should be located, and 3) specific sites where opioid substitution programs should be initiated. Furthermore, VHA has begun to address financial incentives to increase mental health care by including patients receiving highly intensive outpatient care in the special (high) reimbursement group category in the VERA system (see response to Question 2, above).

VHA approved all VISN plans for mental health in CBOC development, including placement of mental health provider staff in CBOCs and innovative use of tele-mental health approaches. Each VISN is required to establish milestones in implementing their plans and report them to VACO quarterly. A similar procedure has been carried for the development of MHICM programs. As of March 31, 2002, 65 MHICM teams are operational treating 3,298 veterans. This is an increase from the 49 Teams serving 2,637 veterans that existed in the fourth quarter of FY 2000. Funds authorized by the Veterans Millennium Health Care Act (Public Law 106–117) helped establish 3 new Opioid Substitution programs and to expand 6 others. In August 2001, each VISN was requested to conduct a detailed analysis of unmet needs of veterans for opioid agonist therapy, including information on availability, cost and quality of any community opioid treatment programs. Updates on VISN plans to enhance opioid substitution services have been submitted and are under review.

Question 6. A section of the bill requires "start up" programs to receive special purpose funds for the first three years they are operated. I included this section to ensure that programs receive a fair review from VA's VISN and facility directors who are not necessarily always friendly to proposals from Congress or the Administration. It's easy to say that a program that hasn't yet been up and running is "not working" to dismiss the expense before the program even has a chance of proving itself. We have heard from some field people that this may be the case with the special programs funded under the Clinton Administration for the homeless women's programs. Are you still providing special funds for these 11 programs and can you tell me the status of each to date?

Answer. All 11 specialized homeless women veterans programs are staffed and operational and are carefully monitored and evaluated to determine their effectiveness. There will be no closure of these programs before they have a chance to demonstrate their value. This is likely to take more time than the initially expected three-year period. To date, these programs have contacted 1,000 female veterans, and 396 have entered the follow up study. While there are no special funds for these programs, VHA is fully committed to completing an evaluation of them.

In FY 2000, special funding was provided to VA medical centers to activate other programs for homeless veterans. At the beginning of FY 2001, funding for these programs was made available through general medical care funds allocated to each VISN through the VERA methodology. I have informed the VISN Directors that I expect these programs to be supported at the initial funding level for a three-year period.

Question 7. VA seems to suggest that the Homeless Providers Grant and Per Diem Programs are less intensive and provide more services than the state home domiciliary programs and thus do not merit the same per them payment. Do you believe that is generally the case? Please describe some of the differences between these two programs to justify this assertion.

Answer. Although there may be some exceptions, the community-based programs currently receiving funds under VA's Grant and Per Diem Program generally provide services that are less intensive than the services of state home domiciliary programs.

Currently there are 137 community-based programs receiving per them under the Grant and Per Diem Program. The Grant and Per Diem Program makes per them available for up to half the cost of providing these services, up to a maximum $19.00 per day. Approximately 30 percent of the programs funded have requested less than the maximum amount for FY 2001. The majority of the remaining 70 percent of the per them funded programs have submitted operating budgets that justify not exceeding the $19.00 rate. Currently the average per them amount paid by VA is $17.67. Although some programs may provide services equal to or more intensive than the services of state home programs, in general, this does not seem to be the norm.

The law that gives VA authority to award grants and per them allows and encourages community-based organizations to seek funding from a number of local and national sources. Proposals seeking funding under the Grant and Per Diem Program are rated in part by the strength of these collaborations. Organizations that are able to secure collaborative funds are most often more viable and capable. State home programs, on the other hand, are financed by VA and state governments. Additional operating funds may be gained by requesting residents to pay rent. VA does not specifically encourage state home programs to seek an alternative funding base.

VA feels that the use of alternative funding bases significantly helps to ensure the success of programs funded under Grant and Per Diem and is an important and unique distinction between community-based Grant and Per Diem Programs and state home domiciliaries.

Question 8. VA questions the need for the grant program for homeless veterans with special needs established in Section 9 of this bill. Will you describe how many programs VA currently has in place to address the special needs of older veterans who are homeless, who have minor dependents, or who have terminal illnesses? Has VA done any analysis to evaluate the outcomes of these programs versus "mainstream" programs for homeless veterans?

Answer. Section 9 of the bill identified homeless veterans with special needs as those homeless veterans who: 1) are women; 2) are 50 years of age or older; 3) are substance abusers; 4) are persons with post-traumatic stress disorder; 5) are terminally ill; 6) are chronically mentally ill; or 7) have care of minor dependents or other family members. On December 21, 2001, the President signed Public Law 107–95, the Homeless Veterans Comprehensive Assistance Act of 2001. New Section 2061 of title 38, as established by the law, authorizes VA to establish a grant program for homeless veterans with special needs. The law identifies homeless veterans with special needs as: 1) women, including women who have care of minor dependents; 2) frail elderly; 3) terminally ill; or 4) chronically mentally ill. VA is now writing regulations to govern the grant program for homeless veterans with special needs. It is expected that the final regulations will be published early in FY 2003.

Many homeless veterans fall into overlapping categories. The percentage of veterans who fall into overlapping categories is so large that all providers of services to homeless veterans must take into account their specific needs in order to develop effective programs. For example, approximately 30 percent of the homeless veteran population are 50 years of age or older. Similarly, approximately 70 percent of all homeless veterans have a substance abuse problem, and 45 percent have serious mental illnesses.

VA's DCHV Programs, its contracted, community-based residential treatment under the HCHV Program, and supported housing services available through the Grant and Per Diem Program provide the residential and support services needed by older homeless veterans. Due to older veterans' increased need for medical care, VA medical centers and grant and per them funded programs for homeless veterans work closely together to make sure that both residential services and medical treatment services are coordinated and available to homeless veterans.

The majority of homeless veterans who have responsibility for minor dependents are homeless women. Data from the National Survey of Homeless Assistance Providers and Clients (NSHAPC) indicates that there are between 2,500 and 4,500 homeless women veterans on any given day. Between 6,300 and 12,200 women veterans may experience homelessness annually. Twenty existing grant and per them funded programs have the capability to serve homeless women veterans, including homeless women veterans with children. Approximately 547 beds are or will be available. Within these 20 programs, eight primarily target homeless women veterans and have 141 beds available. In all cases, up to 25 percent of beds in VA grant-funded programs may be used to serve non-veterans. This means that children may stay with their veteran parents in grant-funded programs. VA does not pay per them for services provided to minor dependents or other family members. VA has also established 11 special outreach and case management programs for homeless women veterans. Residential services for homeless women veterans in these programs will be provided in VA domiciliaries, contracted residential treatment programs or grant and per them programs. These 11 special programs for homeless women veterans are part of a rigorous, long-term evaluation study. Thus far, these programs have seen over 1,000 homeless women veterans and have enrolled 396 veterans in the outcome study.

Terminally ill homeless veterans, like older homeless veterans, need both residential services and medical treatment. The most important aspects of care require strong collaboration between the residential service providers and the VA medical centers.

VA has conducted a comparative analysis of the outcomes of homeless veterans who have received services in VA's DCHV Program, contracted residential treatment under the HCHV Program, and supportive housing services in the Grant and Per Diem Programs. The following charts show comparative housing and employment outcomes at discharge from these homeless veterans programs:

Housing Outcomes at Discharge

	Apartment, Room or House	Another Institutional Setting	Homeless/Unknown
DCHV	59%	20%	21%
HCHV	41%	32%	27%
Grant/Per Diem	26%	26%	48%

Employment Outcomes at Discharge

	Employed or in a Vocational Rehab/Training Program	Retired or Disabled	Unemployed
DCHV	54%	17%	29%
HCHV	49%	18%	33%
Grant/Per Diem	38%	18%	44%

Question 9. VA's views also describe a "disruptive effect" you believe this would have upon VA and grant providers due to the competitive grant process. Can you tell me exactly what VA fears impact of this proposal might be?

Answer. We believed that Section 9 of the bill would encourage grant and per them programs to develop additional treatment capabilities to address the needs of the special homeless veteran groups identified (elderly, terminally ill, homeless veterans with substance abuse disorders, serious mental illnesses, etc.). We felt that the next logical step would be the development of a separate health care system for homeless veterans, a costly and duplicative effort.

VA and its community-based partners, many of whom are under contract with VA or have received grant and per them funding, have developed a full range of services for homeless veterans that include treatment, residential rehabilitation, and supportive housing services. Ongoing efforts should be focused on coordinating these services to assure that homeless veterans have access to appropriate residential services and quality health care services.

New Section 2061 of title 38, as established by Public Law 107–95, now authorizes VA to make grants available to assist with the development of programs for homeless veterans with special needs. VA is currently writing regulations to govern the special needs grant process. It is expected that the final regulations will be published early in FY 2003.

Question 10. VA has previously cited certain veterans' need for extensive dental care as an impediment to finding them gainful employment. We've tried to find a means of addressing this problem which has identified as a top-rated unmet need for homeless veterans by VA and community evaluators in VA's CHALENG reports year after year. If the VA opposes Section 12 of the bill, do you have an alternate recommendation to address this issue?

Answer. In our testimony of July 19, we proposed, as an alternative, that we would expand our efforts to obtain dental care for homeless veterans through pro bono providers, dental schools and related teaching programs, and service providers receiving grants under VA's Homeless Providers Grant and Per Diem Program. However, we realize that obtaining services through these sources may be problematic. The private sector is experiencing a shortage of dentists and an abundance of patients. We might not be able to respond to our veterans' needs in this manner. Many private sector dentists might not be willing to take on these patients. Dental schools might not be able to treat these veterans adequately or timely, and they would charge for their services.

Under a similar concept of community collaborations, VA recently earmarked $509,000 for 10 pilot dental initiatives utilizing innovative ways to provide dental care to homeless veterans enrolled in VA-sponsored rehabilitation programs. Begun in the fall of 2000, the intent of this Homeless Veterans Pilot Program Initiative program was to seek a means to provide dental to this homeless veteran population at reduced costs through community collaborations. The pilot sites are currently providing care to veterans who have demonstrated a commitment to the rehabilitation

process through their continued participation in these rehabilitation programs. Care is provided through contracts with community partners and does not interfere with other higher priority patients receiving outpatient dental care. The initiative has been a huge success thus far. Pilots have not ended and final reports have not been made, but records to date indicate that of the 731 veterans enrolled in the program, 324 have had their dental work completed. VA clinicians and homeless coordinators praise the program because they have seen progress made by these veterans as they seek gainful employment and reintegration into the community. Although complete comprehensive treatment was not provided, the treated veterans have been extremely pleased with the care they have received. The pilots have demonstrated innovative ways to provide dental care to this veteran population through community collaborations at reduced costs.

Question 11. This bill's findings cite VA's CHALENG reports. In the views that VA has submitted VA appears to be questioning its own data citing the annual fluctuations in number as evidence that they are invalid. If we cannot trust VA's data, what data source should replace it? How should VA improve this report to Congress?

Answer. The VA's Project CHALENG for Veterans has collected data on the needs of homeless veterans at the local community level since 1994. Collection of these data has been characterized by a careful, empirical process with high rates of participation by VA and community providers. VA did not intend to suggest that the estimates were invalid but that they represented local procedures that vary widely across the country, and that VA had updated information available that modified earlier estimates.

As indicated in the National Survey of Homeless Assistance Providers and Clients (NSHAPC), determining exactly how many homeless people there are is logistically impossible and prohibitively costly. Precise counts are clearly desirable, yet complexities of survey location (shelter, streets), seasonal variation, definitions of homelessness, and obtaining unduplicated counts hamper such efforts. The CHALENG reports are estimates of homeless veterans and are not considered exact counts. However, CHALENG estimates of the number of veterans who experience an episode of homelessness over the course of a year—ranging from 350,000 in FY 1998 to 294,840 in FY 2001—are consistent with homeless veteran extrapolations from NSHAPC data, which are in the range of 232,000 to 394,000.

In FY 2001, CHALENG data validation of homeless veteran estimates included examination of all numbers submitted with follow up phone calls, where needed, to verify both the accuracy of the reported numbers and the method for obtaining the estimated number. As a result of these validation efforts, VA has greater confidence in the FY 2001 CHALENG Report estimates. No other entity has consistently gathered, examined, and reported estimated numbers of homeless veterans from as many sources, i.e., local communities, as Project CHALENG.

Since 1994, CHALENG has effectively and systematically recorded and reported data from over 14,000 community agencies, VA staff, and homeless veterans on the needs of homeless veterans across 35 distinct areas encompassing housing, medical care, mental health care, and employment. This integrated survey and planning effort fosters wide-ranging, joint local VA-community planning, action strategies, and outcomes that could not be achieved through any other mechanism.

Question 12. I understand that 40% of all community-based outpatient clinics provide veterans access to mental health services. Is VA satisfied with that level? If not, what is VA's goal and what is VA's plan for achieving it?

Answer. Since 1994 VHA has been shifting the treatment of veterans with mental illness to outpatient and community-based settings. At the same time, VHA has also increased the number of access sites so that patients in geographically under served areas may receive health care from VA. The objective is to provide services at community sites that are tailored to the needs of the veterans most likely to seek access.

In August 2001, The Assistant Deputy Under Secretary for Health directed Networks to develop a plan to improve the consistency with which VHA provides mental health services in existing and proposed new Community Based Outpatient Clinics (CBOCs). All Networks used a protocol for accessing mental health needs through community-based outpatient clinics (CBOCs) based on demand, location, size of clinic, and other local factors. In evaluating the need for mental health services at CBOCs, the following issues were studied:

- population-based estimates by county,
- number of veterans needing such services,
- availability of mental health services in nearby communities and the potential for partnering to treat severely mentally ill veterans,
- travel distances from the CBOCs to existing VA mental health specialty services, and the character and severity of the specific mental disorders identified.

VHA approved all VISN mental health plans in March 2002 and has required each VISN to identify milestones in implementing their plans and report progress quarterly on achieving those milestones. In general, VHA believes that the larger the CBOC the more crucial it is that meaningful access for mental heath services be provided. Networks were informed that Mental Health services should include the capacity to provide medication management and general counseling or psychotherapy services for our highest priority patients including those who are service connected for a mental disorder. Since demand for mental health services is generally proportionate to demand for primary care services, the smaller CBOCs will need proportionately less staffing, but should still provide convenient access to mental health care.

VHA is looking at using tele-mental health to provide and support the delivery of mental health services. The introduction of tele-mental health into CBOCs offers a way to improve the access of veterans to mental health services in rural and remote settings. Currently, VHA has tele-mental health services in seven Veterans Integrated Service Networks (VISNs), and 20 Vet Centers offer tele-mental health as an outreach service. The benefits of tele-mental health are reduced waiting times, reduced patient travel, ability to offer expert crisis management advice in the primary care setting, and improved medication management.

Performance measures to monitor compliance with the mental health capacity requirements and network plans have been incorporated into the FY 2002 performance requirements for VISN Directors and monitored quarterly.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO THOMAS L. GARTHWAITE, M.D.

Question 1. Section 904 of the Veterans Millennium Health Care and Benefits Act (Public Law 106–117) directed VA to develop a plan to evaluate the effectiveness of programs to assist homeless veterans. That evaluation was to include measures showing whether veterans—for whom housing or employment has been secured with VA and other Federal agency assistance—continue to be housed or employed six months after receiving VA's remedial services.

A. Has VA developed and implemented the mandated evaluation plan? If not, why not.

B. If VA has developed the evaluation plan, how are assisted veterans doing? Does VA's evaluation indicate that they—and VA's homeless programs—have faired well? Do veterans continue to be housed or employed after 6 months? Using other evaluation criteria VA has developed, how have VA's programs faired?

Answer. VA has implemented the required evaluation plan and has recruited approximately 500 veterans to participate thus far. Because we are only now recruiting the follow-up sample, no follow-up data are available at this time from these new evaluation efforts.

However, ample long-term outcome data will be available from the study (begun in 1992) of the HUD-VA Supported Housing Program (HUDVASH) later this fall. Of the 2,165 veterans initially housed in the program, preliminary analysis shows that data were available on 2,010 of these veterans 6 months later. Of these, 1,903 (94 percent) were still housed 6-months after their initial housing placement was documented. Assuming that all the veterans on whom follow-up data were not available were not housed (an extremely conservative assumption) 87 percent of veterans retained their housing over a six-month period after their initial placement. Over the long term (one year), our data show that only four percent of veterans in this program lose their housing each 6-months. These results are attributable to the fact that veterans in HUD-VASH receive both a housing subsidy (Section 8 voucher) and a designated long-term case manager.

Other data are available to address the question of how effectively VA's programs have operated. VA's Northeast Program Evaluation Center (NEPEC) has conducted long-term outcome studies involving hundreds of participants at 12 sites in two of VA's principal homeless assistance programs, the Health Care for Homeless Veterans (HCHV) Program and the Domiciliary Care for Homeless Veterans (DCHV) Program. Since NEPEC was also responsible for collecting similar long-term outcome data on the Department of Health and Human Services' 18-site ACCESS program, it is possible to compare outcomes in VA programs with those in non-VA programs. Descriptive outcome data show that in the domains of psychiatric symptoms, alcohol and drug use, employment, increased benefits, and long-term housing outcomes, VA's performance generally equals or exceeds the performance of non-VA programs.

Question 2. Where do VA homeless programs fit in the scheme of the President's effort to provide faith-based organizations with more of a role in providing homeless services? What is VA's current involvement with the White House Office of Faith-Based and Community Initiatives? Has VA relied on faith-based organizations to provide homeless veterans with services in the past? If so, how would you rate the effectiveness among veterans?

Answer. On January 29, 2001, President Bush signed two executive orders 1establishing federal offices to promote his faith-based and community organizations initiatives. One of the orders created an Office of Faith-Based and Community Initiatives in the White House to take the lead in enhancing current efforts and promoting the government's efforts to partner with faith-based and community organizations. His second order established a Center for Faith-Based and Community Initiatives in five federal agencies. That order did not require VA to establish a new office; however, VA, like most federal agencies, was required to establish a point of contact within an existing office. While those Departments that have a separate office meet monthly with the White House Office of Faith-Based and Community Initiatives, VA does not attend those meetings.

On August 2, 2001, the Office of Public and Intergovernmental Affairs (OPIA) was assigned the oversight and coordination role for this function and Peter H. Dougherty, Director, Office of Homeless Veterans Programs, serves as our Department's point of contact. That office and the entire VA have a long tradition of working closely with faith-based and community organizations. The task force held several meetings in September/October 2001, and sought to compile a survey to establish baseline information on VA's level of involvement with and attitudes toward faith-based and community-based organizations.

A Task Force was appointed and an internal survey was conducted of all VA field facilities. The survey showed that nearly all responses (95%) thought that faith-based and community-based organizations were providing high quality services to veterans.

VA's Homeless Service Providers Grant and Per Diem Program has a significant investment in faith-based service providers. An estimated $3.6 million in per them payments are expected to be made to faith-based service providers this fiscal year. More than one-third (35.8%) of per them only grants were awarded to faith-based organizations, more than one in five (21.5%) of all brick and mortar grants and nearly one-quarter (24.1%) of all grants for transportation and outreach were awarded to faith-based groups.

VA is looking to attract both high quality, competent faith-based and community-based organizations to insure that underserved areas and populations are not left without adequate services. While we extensively monitor each faith and community-based service provider, we are in the process of reviewing the rates of effectiveness based upon the type of organization.

Question 3. Senator Wellstone's legislation (S. 739) would create a grant program to address the special needs of homeless veterans who are women. What has been VA's experience with female homeless veterans? Do you believe there is a large population of homeless veteran women? How—if at all—does VA address the special needs of homeless women veterans?

Answer. VA's HCHV program has consistently found that about three percent of homeless veterans are female. This is somewhat less than the five percent of female veterans in the general population and indicates that female veterans have less risk of homelessness than male veterans. This relationship is also observed among non-veteran women, for whom the risk of homelessness is also lower than among non-veteran men.

Analysis of data from the National Survey of Homeless Assistance Providers and Clients (NSHAPC) shows that in the general homeless population, 3.7 percent of veterans are female, yielding the following estimates of the numbers of homeless female veterans.

Month	All Veterans	Female Veterans
October-November:		
One day estimate	79,580	2,467
Annual estimate	232,300	6,272
February:		
One day estimate	146,510	4,542
Annual estimate	394,450	12,228

VA has funded 20 Grant and Per Diem Programs with 547 beds that have indicated they will provide supported housing services to homeless women veterans.

Eight of these Grant and Per Diem Programs primarily targeted homeless women veterans for services, and these programs are developing 141 supportive housing beds. In addition, 11 specialized outreach and case management programs for homeless female veterans have been established and are being evaluated. Thus far these programs have seen over 1,000 homeless female veterans and have enrolled 396 veterans in the outcome study.

4. 1 would assume that—as part of its treatment regimen—VA assures that homeless veterans receive any pension or compensation benefits to which they might be entitled. Is monetary assistance available to homeless veterans who are not eligible for compensation and pension? Should it be?

Answer. The only other monetary benefits administered by VBA to which homeless veterans not eligible for compensation or pension may be entitled to is education assistance. However, there is eligibility criteria associated with this program also and many homeless veterans may not qualify. Several States and counties offer monetary benefits to veterans and VBA's homeless veteran coordinators are familiar with these benefits and provide basic information and referrals to homeless veterans.

Question 5. Senator Wellstone's bill proposes to provide cash benefits—in the form of VA pension—to newly discharged mental health patients and prisoners—to assist them, I presume, in avoiding homelessness. What is your assessment of this idea.

Answer. VA did not support this provision of Section 16 of S. 739. That position remains unchanged. However, we understand that the SVAC has deleted this provision from the proposed bill.

Question 6. Senator Wellstone's legislation would designate one member of each regional office to handle claims and issues involving homeless veterans. Doesn't VBA expedite claims adjudication for so-called "hardship" cases? Are homeless veterans classified as "hardship" cases for purposes of expedited claims treatment? Is there a problem with the length of time it takes to adjudicate the claims of homeless veterans?

Answer. Directives are in place for expeditious processing of all claims initiated by homeless veterans (VBA Circular 20–91–9). To some extent, processing time for these claims could be adversely impacted with the current pending workload.

Question 7. This committee had a hearing on June 14th on the topic of projected nurse shortages. We learned that a number of issues are on VA nurses' minds—for example, stagnant salaries and mandatory overtime. Are these problems unique to VA? Are the solutions proposed in S. 1188 sufficient to resolve them?

Answer. Competitive salaries and mandatory overtime are serious issues for the profession of nursing across our nation. VA faces the same challenges as our private sector counterparts in dealing with these and other recruitment and retention issues for nurses. VHA invests significant effort to successfully maintain comparable pay in each locale for all nursing roles. The locality pay survey allows VHA to review competing salary rates and adjust rates accordingly for each employment market. Mandatory overtime is a result of workforce shortage and limited options for staffing in emergent situations. In some markets where healthcare facilities are experiencing severe shortages, the need to mandate overtime occurs more frequently.

VA believes that the provisions contained in Public Law 107–135 are helping the Department address these and other challenges impacting our ability to recruit and retain nurses. Because the employee scholarship programs are now permanent, nurses can plan with confidence and work toward attaining baccalaureate and advanced degrees. Because the student loan forgiveness program is now a permanent authority and the VHA policy is in place, the Department has a powerful new tool to attract and retain new nurses. The enhancements to retirement benefits for nurses will help make VA the most attractive Federal employer. We will continue to explore strategies to strengthen VHA nurse recruitment and retention, including those from the Nursing Workforce Workgroup's report, *A Call to Action,* and the interim results of the VA Commission on Nursing.

Question 8. The nurse-recruiting program of Abington Memorial Hospital in Philadelphia was the topic of a story in the *Philadelphia Inquirer* on July 19, 2001. Let me quote from the paper:

> Rebecca Phipps has a full ride to Abington Memorial Hospital's Dixon School of Nursing in Willow Grove and is all but guaranteed a job upon graduation with plenty of perks, including child care benefits, flexible scheduling, and a starting salary of about $41,000 with a sign on bonus of at least $3000. It's like winning the sweepstakes, said the 32-year-old mother of three, a waitress in Conshohocken.

A. Can VA compete with this? Does VA provide starting salaries of $41,000? Does it provide "sign on bonuses?" Flexible scheduling? Child care benefits?

B. Should VA try to compete with this? Does S. 1188—coupled with programs VA already has in place—get VA to the point where it can compete with this?

Answer. VA is able to offer comparable starting salaries, along with sign-on bonuses, to new graduates. In addition, VA offers an attractive benefits package and, in many locations, on-site or close-by childcare centers. For those employees who qualify, VA also offers childcare assistance according to financial need.

VA also can offer scholarship and tuition assistance to current employees who pursue degrees in nursing and other critical health care occupations. VA also offers employees student loan repayment assistance—a significant recruitment tool. Where patient care needs permit, VA can offer flexible scheduling to accommodate individual preferences.

Starting rates for nurses are determined according to their qualifications, and so nurses often start at rates higher than step 1. The average salary for Nurse 1 in VA is $59,261. The 2002 minimum starting rate at the Philadelphia VA Medical Center is $42,133. Recruitment bonuses are offered for hard-to-fill specialties like OR nurse.

Thus, while VA is generally able to offer competitive recruitment packages, the provisions of Public Law 107–135 only enhance VA's ability to compete.

Question 9. In my post-hearing questions to you following the Committee's hearing on June 14, 2001, I asked you about the collaboration between VA and nursing schools—as compared to the collaboration that exists between VA and the Nation's medical schools. In your response, you stated that "VA's nursing affiliations are somewhat different than its medical school affiliations, in that VA nurses are not as strongly aligned in paid teaching and faculty roles and the preponderance of nursing affiliations are not funded." What steps is VA taking to more closely align itself with nursing schools? If VA nurses do not play paid teaching and faculty roles, should they? What authority does VA have—and what authority, if any, does it need—to develop stronger affiliations with nursing schools?

Answer. For more than 40 years, VA has conducted active affiliation agreements with multiple nursing schools. VA nurses have provided effective mentoring and preceptor support to students. Much like our VA physician affiliation arrangements, VA currently supports affiliations with nursing schools through adjunct faculty appointments. However, the vast majority of VA physicians with medical school faculty appointments are part time VA employees providing patient care, research and teaching at VA facilities. VA professional nurses that have adjunct faculty appointments with schools of nursing participate in didactic teaching and other academic activities while on authorized absence from VA. The nursing schools and VA both compete for experienced and highly qualified nurse professionals. Our goals are to increase nursing recruitment by hiring new graduates of colleges of nursing and enhancing collaborative arrangements between VA and nursing schools with strong academic and research programs. Using existing authority for strengthening our alignment with our nursing affiliates will assist in meeting the goal of recruiting and advancing nursing practice in VA.

Question 10. In those same post-hearing questions, I asked you about going into high-schools and recruiting students who might be interested in nursing by offering scholarships in exchange for service—an idea which is similar to that done by the military services recruiting for ROTC. You responded that VA has authority for such programs. But you did not state whether VA actively uses that authority. Does it? Do you think such a program would be a good idea? If not, why not? If so, why don't you implement it since you have the authority to do so?

Answer. A number of successful outreach programs are being implemented by VA medical centers to interest youth and teens in nursing or healthcare careers. Some examples of these programs include:

• VAMC Seattle has a partnership with middle and high schools, parents and teachers to develop and nurture students to become VAMC employees. Twenty students have been trained and work part time at the facility. (*http://www.puget-sound.med.va.gov/nurse/* click Partners). The facility also provides scholarships to local students.

• VAMC Charleston, SC, has a partnership with Charleston County Public Schools that involves approximately 100 elementary, middle, and high school students in health career planning.

• VAMC San Antonio has a partnership with Health Career High School through which students come to the facility for work experiences in a variety of clinical areas.

• VAM&ROC Fargo, ND, is involved in "Expanding Your Horizons." This is a program sponsored by North Dakota State University that encourages junior high age women to enroll in math and science courses while at the same time acquainting them with career options such as nursing and medicine. The facility also hosts a

Volunteer Summer Youth Program and a Job Shadowing Program for local high school students.

• VAMC Syracuse participates in "New Visions" a program in which local high school students in their senior year who are interested in health care careers spend a portion of each day at the facility in volunteer and shadowing experiences.

• The VA Southern Nevada Healthcare System has "adopted" an elementary school and meets with students regarding health information and healthcare careers.

• VAMC Tucson has a partnership with the Fred G. Acosta Job Corps Center to provide clinical instruction to students for entry-level positions along with counseling to consider careers in nursing.

Outreach programs are valuable ways of introducing individuals of all ages to nursing/healthcare careers and to VA as an employer. In addition, VA is requesting additional funds for FY 2004 in order to expand the VALOR program to foster partnerships and internships with nursing students, many of who choose VA as their post-graduate employer.

Question 11. I have heard from veterans in Pennsylvania—particularly in Philadelphia—that the single, national income threshold for determining priority status for VA health care is unfair. I am inclined to agree since I know it costs far more to live in, for example, Philadelphia than in, for example, Altoona, PA. Committee staff has developed draft legislation that would attempt to fix this problem by adjusting that threshold to take into account these cost-of-living differences across the country. Has VA been able to examine this draft bill? What do you think of it? What would be the effect of moving veterans currently categorized as "Priority 7" into "Priority Group 5"?

Answer. VA has reviewed the draft bill, which is based on the proposal of the Paralyzed Veterans of America (PVA) to use the HUD income eligibility levels to adjust the VA means test thresholds geographically. The proposal would adjust the current VA means test threshold upward in areas where the HUD income level is higher. For any location where the HUD income level is lower than the current VA threshold, it would stay the same. The advantages of this proposal are that the income levels are readily available from HUD and are updated annually; the income levels are calculated for 336 metropolitan areas and 2,409 non-metropolitan areas; and it would improve access to health care for those veterans who reside in high-cost-of-living areas. A disadvantage is that using the HUD definition would significantly increase the number of veterans that would be eligible for VA health care without making co-payments because the threshold levels would be raised in most locations, thus moving veterans currently categorized as Priority 7 to Priority 5. The estimated cost in lost revenues to VA has not yet been determined.

VA is very interested in examining the use of geographically based income thresholds for placing nonservice-connected veterans in different enrollment priority groups. However, there are many poverty indexes established in various ways, and there are serious issues about what these indexes really measure. We believe further study is needed to determine the most appropriate method for tackling this problem. Therefore, at this time, we cannot support the Committee's proposal.

Question 12. As I understand it, if the cost-of-living at a particular locale is high, and this proposed piece of legislation is enacted, some veterans who now have no priority for VA care—so-called "Priority 7" patients—would be reclassified as "Priority 5" patients. Am I correct? Would this mean that these patients would be protected against potential "disenrollment" actions in the future? Would it also mean that they would be freed from some—or all—copayment requirements?

Answer. Under the Committee's proposal, some veterans currently classified as Priority 7 enrollees would be reclassified as Priority 5 enrollees and would, therefore, not be required to make co-payments. The proposal also provides that veterans who meet the current means test threshold will still be eligible under the adjusted means test inasmuch as the current $23,688 minimum income level would be maintained. If this proposal were enacted, current Priority 7 veterans moved into Priority 5 would probably be protected from "disenrollment" solely on the basis of the income threshold. However, the proposal does not explicitly protect against future "disenrollment" actions under the authority given the Secretary to operate an annual system of enrollment to the extent appropriations and resources are made available (38 U.S.C. 1705; 1710(a)(4)).

Question 13. Do you have any idea how many existing VA patients would be moved from Priority 7 to Priority 5 if this draft bill were to be enacted? What would be the effect of such reclassifications on the VA hospitals' fiscal situations? If veterans are freed from having to make copayments—copayments that are retained by the hospital—would this legislation jeopardize a hospital's funding stream? If so, how could we mitigate that negative consequence?

Answer. We estimate that in FY 2000, approximately 200,000 (or 35 percent) of the Priority 7 patients would have been moved to Priority 5 status under the requirements of the proposal. Assuming the constancy of the 35 percent rate, we further estimate that approximately 230,000 of our current Priority 7 patients would move to Priority 5 status. These figures, however, are based on income information obtained from the 1992 VA National Survey of Veterans and should be considered rough estimates only.

If this legislation were enacted, VA hospitals would lose co-payment revenues from those veterans who changed from Priority 7 to Priority 5. However, Networks would gain additional funding under VERA for these additional Priority 5 veterans, but it is difficult to determine if the additional funding to any particular network would compensate for the loss of co-payments (see also our response to question 14). Without knowing the exact impact on any one Network, it is also difficult to determine the best method to mitigate any negative consequences, since different approaches may be warranted to meet the differing needs of the individual Networks. However, in general, the overall effects could be mitigated through increased appropriations or by reducing the number of patients served and/or the services provided.

Question 14. Am I advised correctly that—if this draft were to be enacted—VA hospitals would lose copayment revenues, but VA health care networks would gain additional revenues under VA's "VERA" allocation scheme? If that is so, why is that so? Would such added funds to the networks be directed to the hospitals that have lost copayment receipts? Or would they be allocated to all hospitals within a particular service network?

Answer. If this legislation were enacted, VA hospitals would lose co-payment revenues from those veterans who changed from Priority 7 to Priority 5. Networks would gain additional funding under VERA for these additional Priority 5 veterans because the VERA Basic Care component currently provides workload and funding credit for Category A (Priority 1–7a) veterans. However, VERA is a zero sum allocation system, and the increase in funding to high cost of living networks would be offset by a decrease in funding to low cost of living networks. This is because the increase in Basic Care workload would reduce the allocated amount available for each veteran.

The funding for additional Priority 5 veterans would be directed to networks that lost co-payment receipts, but it is difficult to determine if the funding a network would gain under VERA would compensate for the loss of co-payments. Under the VHA allocation process, the networks would then determine how these additional funds would be allocated to the hospitals within their networks.

Senator WELLSTONE. Thank you very much, Dr. Garthwaite. I think what we will try to do, because I don't want to run out of time—should we try to do about 7 minutes for each of us? Does that make sense? I am trying to figure out the best way of—let me try it this way. This might be the best use of time. I appreciate a lot of your support for the bill, and let me go over some of the concerns you raise and give you kind of my response and then have you respond to the response, if that is OK.

On the question of creating this advisory committee, which we want to make permanent, the VA believes that this might not be necessary because Secretary Principi plans to establish one under his own authority. And just so you know my position, my position is that this legislation only strengthens his hands, and I think he is a great Secretary, but we have different Secretaries, so why not make it permanent. If we think there should be a focus, it seems to me it should be there. And I have no doubt about his commitment, but it seems to me we never know who is going to be Secretary. Therefore, we ought to make this consistent with a focus now on homeless issues. We ought to make this a part of the VA.

On the question of veterans' receiving continuous care, the complex care, your position is that some of these categories have already been redesignated as complex care and that otherwise adding these new categories will cost more money and it will take away

from other veterans programs. I am just summarizing what I heard.

We certainly want to make sure that we work with you so that the cost of really assisting—really assisting—homeless veterans is appropriately estimated, but it seems to me you are in a way making it a zero-sum game. And if the VA needs more resources to do the job the right way, then the VA should get more resources. I don't like to see this sort of like all of a sudden we are going to do better by way of mental health or substance abuse, but then we are going to be taking away from other veterans. And that gets back to in part Senator Campbell's point about the budget. I mean, I think of the billion, I think most of that will be taken up in medical inflation. That is, I think, some of the concern that people have.

So it seems to me you have given us a Hobson's choice, and so maybe you could respond to those first—that may be the 5 minutes that I have left. I have about four others, but if you could respond to those first two questions.

Dr. GARTHWAITE. Well, let me pick up on the last one first, if I could. For us in a way it is a bit of a zero-sum game. We have, you know, an overall budget and many competing demands. But the concern I have is that tinkering with the VERA model has a lot of unintended implications. The seriously chronically mentally ill, many of whom are homeless, are already in the complex category because they have already met the treatment guidelines or the diagnostic guidelines that put them in there. So a significant number of the most expensive to treat complex patients are already being reimbursed at the high rate.

So I think that the combination of recognizing that fact and the performance measurements we are putting in for substance abuse and mental health will drive the system in the right direction to facilitate seeing more patients with this diagnosis and these problems.

Senator WELLSTONE. Now, my understanding is that right now we have got about only 20 percent of the veterans who need the help who are actually served by what you are doing. Is that correct? In complex care, 20 percent of veterans who are struggling with a mental health issue, 20 percent of veterans, many of whom are out there. Is that correct?

Dr. GARTHWAITE. Right. But of the total population of veterans being treated, we simply found mathematically in the VERA model it doesn't give you better distribution of funds to have 60 categories of illness versus a couple. It introduces a lot of confusion and a lot of gaming, but it doesn't necessarily change how the dollars are distributed to the networks.

So that all you end up doing if you keep subdividing and have special classes of veterans is you will change behaviors often in ways that aren't anticipated and in our experience that are somewhat perverse.

We have found it is much more effective to demand performance outcomes that are directly related to the care. So we can set performance measures—the number of homeless veterans contacted, for instance—as a way of driving the behavior to improve outreach.

Senator WELLSTONE. Well, Tom, one of the things that I would just like to get a commitment from you on, I mean, one of the things that I hear from our medical centers is that they are not—you know, VERA Is complicated and they are not getting all of the financial help that they think they need to provide the services. Maybe we just need to sort of get a commitment from you that we will be able to work closely together on this.

Dr. GARTHWAITE. Sure. I believe we have the exact same intent, and the question is how do you set up a system that gives you the intended results. And it is not easy. In the private sector, fee-for-service versus managed care, both of them have their weaknesses. So there is not a perfect way of giving out money that doesn't give you things that you may not really be desiring.

I think that the combination of performance measures, which we are in the process of implementing in mental health, and continued complex funding for those most seriously mentally ill, which we have had in from the beginning, will drive our efforts, along with the grants that Pete can discuss.

Senator WELLSTONE. I am going to have my other questions put to you, if that is OK, in writing. But since the light is yellow and I want to keep in the timeframe, I do want to say—because there are about eight other questions, but here the real question is you are going to be leaving the VA soon, and I want to recognize your service for veterans and thank you for the good work and wish you well in your future endeavors and tell you that I hope that the next Under Secretary for Health, whoever he or she may be, will share your values and, you know, we will be able to work with as well. So whoever—there are a number of other questions that I will just submit in writing, but I think maybe before we run out of time, I just want to thank you on behalf of the committee.

Dr. GARTHWAITE. I appreciate it. It has been a great honor and pleasure to serve in the Veterans Health Administration in VA, and it is the hardest job I have ever had, the last 6 years here in Washington, but the most rewarding. So thank you.

Senator WELLSTONE. Senator Specter?

Senator SPECTER. Thank you, Mr. Chairman.

Dr. Garthwaite, the Millennium Act provided for authorization for Homeless Veterans Reintegration Program for $15 million in fiscal year 2001, $20 million in fiscal year 2002. The funding came through the—can you hear me all right, Dr. Garthwaite?

Dr. GARTHWAITE. Yes.

Senator SPECTER. The funding came through the Labor, Health and Human Services, and Education Subcommittee, which I chaired, and in 2001 we appropriated $17,500,000. Can you tell this committee what was done with that money and how effective it was in tackling this important problem?

Dr. GARTHWAITE. Can I ask Pete Dougherty to respond to that?

Mr. DOUGHERTY. Mr. Chairman, of course, that program is administered by the Department——

Senator SPECTER. Excuse me. I am not the chairman.

Mr. DOUGHERTY. I am sorry——

Senator SPECTER. You are not as sorry as I am. [Laughter.]

May I ask that my time be extended due to the delay from that outburst? I am not asking that the room be cleared, just that my time be extended.

Mr. DOUGHERTY. Senator Specter, if I could, that program is administered by the Department of Labor's VETS office. I think our official position in the statement is we don't talk about that program, but I can tell you as a practical matter that that program works very closely with the Department of Veterans Affairs programs. They have a requirement for their grant recipients to come to the Department of Veterans Affairs and to make their program known to us because, obviously, getting back into the job market is a very important factor to be considered.

Senator SPECTER. That brings me to my next question. Earlier this year, OMB Director Mitch Daniels, on one of the Sunday morning talk shows, pointed out that there were some 50 programs for the homeless, as he put it, sprawling across eight departments. Dr. Garthwaite, might it be more sensible to take a look at some consolidation here before we enact any additional legislation? Here, we have an appropriation coming under the Labor Department to fund programmatic legislation passed by this committee. I am just wondering if we might not adjourn this hearing and reconvene it in the Labor Committee, where Senator Wellstone could be acting chairman.

But to return to my original question, aren't we just chasing our tails here with so many programs in so many departments without really being able to answer a basic question as to how effectively the money is being used? Why do I have to go to the Labor Department instead of the Veterans Affairs Department to find out about homeless programs for veterans? Wouldn't it be a better idea be to put all of this on ice until we find out what is going on in all these uncoordinated efforts?

Dr. GARTHWAITE. Well, I would suggest that there is pretty good evidence that more needs to be done. The question you raise, though—is it a coordinated effort?—is a very valid one. I know just in health care——

Senator SPECTER. Well, how do we know that more needs to be done if we can't really assess what has been and is being done?

Dr. GARTHWAITE. Well, we certainly believe that there are 300,000 homeless veterans, and we know we don't touch anywhere near that many, maybe only as few as 50,000 in a year's time. That leaves a significant number of veterans homeless and not in contact or being addressed or at least attempted to address by our programs.

Senator SPECTER. I recently signed a letter to the President requesting that the Interagency Council on Homelessness be invigorated. The Council is a collection of VA, HHS, Labor, HUD, and Department of Education officials. Are you personally familiar with the Interagency Council, Dr. Garthwaite?

Dr. GARTHWAITE. I was aware that it existed. I am not aware of its vigor at the present moment.

Senator SPECTER. I can't understand——

Dr. GARTHWAITE. I say, I was aware that it existed, but I wasn't aware of how vigorously it was operating at the present time.

Senator SPECTER. Well, were you aware of anything it had done? Never mind the degree of vigor. Anything?

Dr. GARTHWAITE. I know they meet and try to coordinate programs, but I don't know much more than that.

Senator SPECTER. Do you want to defer to Mr. Dougherty? He seems anxious to intervene here.

Mr. DOUGHERTY. Senator Specter——

Senator SPECTER. Mr. Henke, aren't you going to object to not having speaking parts?

Mr. HENKE. No, sir. [Laughter.]

Mr. DOUGHERTY. Senator, the Interagency Council, to the best of our knowledge, hasn't met since last fall. There have been no meetings since last fall. I think we would strongly support the coordination effort that needs to occur at the Federal level with programs.

Senator SPECTER. Well, Dr. Garthwaite, let me make this request to you: Would you please submit to this committee an evaluation as to what is being done for homeless veterans among these many, many departments. Services to homeless veterans are a primary responsibility of the Veterans Administration. It seems to me this committee ought to be able to come to the Veterans Administration and say, What is going on?

And I would also like some authentication of your figure of 300,000 homeless veterans. How do you know that is the figure? How do you know there aren't more than that? I would like to know how you get there. Also, I would like to know what your basis is for saying that only 50,000 are being taken care of. I would like some hard facts so we know what is going on, and I would like some hard facts as to what these other programs are doing.

This committee has put out a request that the Interagency Council start to function, but I would ask that the VA take an active role within the executive branch in seeing to it that we get some action. How long do you think it would take you to give the committee a report on these requests?

Dr. GARTHWAITE. Well, certainly on the facts of the matter, I think that that shouldn't take too long, within a couple weeks.

Senator SPECTER. Fifteen days?

Dr. GARTHWAITE. Yes, we can do that.

Senator SPECTER. How about the balance of the request?

Dr. GARTHWAITE. I think we can certainly make some attempts at taking a leadership role in understanding—or in trying to get coordination of the programs in a short period of time.

Senator SPECTER. Should we get you a more powerful microphone, Dr. Garthwaite, or would you speak into it? I can't hear you.

Dr. GARTHWAITE. I am sorry. What I would say is that we can I think relatively quickly move to reinvigorate the task force and get an assessment of all the departments.

Senator SPECTER. Can you do that within 30 days? I don't want to take up any more time. The red light is on. I know there are many others who want to question you.

Dr. GARTHWAITE. I think to get some commitment across a variety of departments about leadership and coordination will take a little longer than that, to be honest.

Senator SPECTER. Forty-five days?

Dr. GARTHWAITE. Probably a couple months, at least.

Senator SPECTER. Give me a date.

Dr. GARTHWAITE. I think it will take us a couple of months if we have to work across departments.

Senator SPECTER. Sixty days. Thank you.

[The information referred to follows:]

The best recent estimate of the number of homeless veterans is based on the National Survey of Homeless Assistance Providers and Clients (NSHAPC) conducted by the Census Bureau for the Interagency Council on the Homeless in November and February of 1996. The study found that 23% of all homeless adults were veterans. Applying this percentage to the estimates of the number of homeless adults presented by the NSHAPC yields the following estimates:

Month	All Homeless	Veterans
October–November:		
One day estimate	346,000	79,580
Annual estimate	1,010,000	232,300
February:		
One day estimate	637,000	146,510
Annual estimate	1,715,000	394,450

It should be noted that the data analysis for the NSHAPC Study was completed by the Urban Institute. Ten years prior to the NSHAPC Study, in 1986, the Urban Institute completed a landmark study of homelessness in America. Results from the earlier study provided a one-day estimate of approximately 250,000 homeless veterans, which was approximately one-third of the estimated adult homeless population at that time. Extrapolation from the earlier data suggested that the annual estimates of veterans who experienced episodes of homelessness was 2 or 3 times higher than the one day estimates. Therefore, the previous annual estimate was 500,000 to 750,000 homeless veterans.

Comparing the results of the earlier Urban Institute Study with the NSHAPC Study suggests a decline in the number of homeless veterans. However, it should be noted that survey methodologies for the two studies were not identical.

VA plans to contract with the Urban Institute for further analysis of the NSHAPC Study data on homeless veterans.

Approximately 40,000 veterans receive VA treatment from specialized homeless prog rams each year with at least 100,000 receiving VA treatment services from any VA health care program each year.

Please find attached a copy of the report from the Congressional Research Service that provides information on funding of Federal department and agency programs to assist homeless people including veterans.

VA is not in a position to evaluate the activities of the various Federal departments and agencies in addressing the issue of homelessness among veterans. VA will discuss your interest in such an evaluation at the next meeting of the Interagency Council on the Homeless.

Senator WELLSTONE. Let me go along with Senator Campbell. Although, Senator Specter, some of the answers to some of your questions, all of which were important, I think you are going to—some of the other panelists I think will speak to some of what is going on or not going on, where coordination is, where they aren't, where programs interrelate, where they don't. We have got some people that are down in the trenches that can speak to some of that, I think, and probably in an almost better way than the people in Washington can. We will hear from some other panelists on that.

Senator SPECTER. I would be anxious to hear that. I am going to have to excuse myself. We have an Appropriations Committee markup, and it may even be more important to keep the funds rolling than to keep the words rolling.

Senator WELLSTONE. Right. But given your intense interest in this area, I will make sure that we get everything to you.

Senator SPECTER. Thank you very much.

Senator WELLSTONE. Absolutely.

Senator Campbell?

Senator CAMPBELL. Mr. Chairman, thank you. I am also going to have to leave shortly because we are having a VA markup in just 10 minutes. I had a couple of quick questions. But, Mr. Chairman, with your permission, there is someone in the audience I would like to introduce, if I could.

Senator WELLSTONE. Absolutely.

Senator CAMPBELL. You know, time fades our memories about locations and dates and events and so on. It has been 46 years since World War II ended, and most Americans, I think the young ones, in fact, don't know much about the history of the battles of the South Pacific. But those of us who are a little bit older remember very well, from what our dads told us when we were youngsters and reading. I would like to acknowledge some people in the audience that were our wartime allies. In fact, some of them were imprisoned with our Americans in prison camps in World War II in the South Pacific, some were on the Bataan death march with Americans, and some of their friends, lost their lives in that. They are people that I have always considered to be great warriors in the battle for democracy. They are the members of the Filipino Veterans Association, who are all in the back. If they could stand up just for a moment? Would you stand up for a minute, all the folks in the back?

[Applause.]

Senator CAMPBELL. I don't think, Mr. Chairman, that we have ever really acknowledged the price that they paid because when General MacArthur left, they were still there and fighting the resistance. When he came back, they were still there, or the ones who hadn't been found out and summarily imprisoned or killed. So I think we have a great debt of gratitude. I am sure they are here to hear about Senator Inouye's bill.

Let me just ask a couple of quick questions, and I don't know, Mr. Chairman, maybe you can answer them rather than our witnesses. But in reading S. 739, which, by the way, I support the concept and appreciate your leadership on it, I was concerned about a section regarding the grant assistance pilot program that would give cash payments to veterans. How would we determine—I mean, how would we document them if they are homeless, and, in fact, how would we monitor where the money goes? Will they be victimized on the streets, or if someone were addicted to alcohol or drugs, would it be used for that instead of some productive end? And wouldn't it be better if we focused attention on the needs of the veterans through some program that dealt with their mental health, their substance abuse, employment services and so on rather than grants?

Senator WELLSTONE. The VA itself has raised some concerns about Section 16, and we can certainly start with Dr. Garthwaite. I also will tell you that, Senator Campbell, as we go back to the legislation, this is an area where, while I don't agree with the VA on some of these issues, I think they are right in raising these con-

cerns, and you are, too, and I think it is something we can work together on.

We are going to have to figure out some innovative ways of doing this. I think we are going to also hear from some of the panelists on this as well. But while we have got Dr. Garthwaite here, why don't we—

Dr. GARTHWAITE. I think our major concern was that if we didn't insist that part of the payment included some therapeutic intervention, that the reasons they are homeless in the first place might not be being addressed. It might be that it was a quick assessment and they are confident and they just need to get over a financial hump, in which case it might be relatively easy. Or it might be they need fairly long and intensive therapy for alcohol or drug abuse or for mental illness.

And so we believe there really should be a mental health evaluation and then appropriate treatment in conjunction with this rather than just a payment, which might just continue to actually feed the problem as opposed to helping.

Senator CAMPBELL. That was my concern, too, but certainly this is a good vehicle to start with, and I look forward to helping you with it. I will have to excuse myself also for the markup.

Senator WELLSTONE. Thank you, Senator Campbell.

Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman.

First, let me commend the Filipino veterans. The New England 43rd Division, which was led by my next-door neighbor, General Wing, was critical in the liberation of the Philippines, and so I just want to give my praise and thanks to you all. That is a great part of my memories.

Dr. Garthwaite, in Vermont, as in most rural areas, we have unique challenges in meeting the needs of homeless veterans. We have very little public transportation. We have very little transitional housing. In Vermont, we have no VA shelters for short-term homelessness. Years ago, Secretary Brown provided the local facilities with the authority to contract out local community resources serving homeless. They could arrange to pay these organizations to take care of veterans on a per capita basis.

My State of Vermont is having some considerable success at doing this now, but only at the expense of other programs in the VAMC's budget. In fact, they are concerned that with the advent of the care line system, the White River Junction administrator will lose his flexibility to do this. Are you considering any way to take care of this problem?

Dr. GARTHWAITE. I understand the competition for dollars and the challenges that we have in getting the dollars in the right places and meeting all the competing health care needs, but I don't know that care line management should in any way interfere with this. In fact, some of our networks that have gone to mental health care line management have the most comprehensive and aggressive mental health outreach programs of any. I would probably point you to VISN 10 where they have really done it well. For essentially the whole State of Ohio, they have a comprehensive way that they identify the population that needs help and then design services to get to them, regardless of whether they live next to a medical cen-

ter or not. Some of that is contracted with local providers and some of it is building programs of our own.

So I don't see that they are inherently in conflict, but I think that we should make sure that, regardless of whether it is a care line structure or the more traditional facility-based organization, that the end result is that homeless veterans are getting the care they need, whether we provide it directly by VA providers or contract.

Senator JEFFORDS. Our homeless veteran coordinators at the facility level are in most cases temporary positions. How can we assure that we deliver top-quality care over the long term if the very coordinators of such are not in permanent jobs?

Dr. GARTHWAITE. I am not sure—I mean, I guess because some of these are done under pilot programs and grants, they are hired initially as temporary in most cases where they are meeting the legitimate need of veterans, and certainly in this case, a high-priority need of veterans, those in our special programs such as mental health. Many of those pilot programs get converted over to permanent as we identify the resources and identify the value of the program.

If it is truly a pilot program to learn how to do and how to do it well and what the need is, then sometimes the people are hired in temporary positions because really it is temporary funding. But the goal is, if it is working, then to fold it into our day-to-day operations and make it permanent.

Senator JEFFORDS. Well, thank you. I just wanted to raise that question.

Dr. GARTHWAITE. Very good question.

Senator WELLSTONE. Thank you.

Chairman Rockefeller is here.

Chairman ROCKEFELLER. I am in an embarrassing position. I delivered a magnificent colloquy—no. Is colloquy singular or plural—soliloquy, that was it, last time about how members don't show up. And I have just shown up, and I am going to leave because Senator Wellstone and I worked out that it was important for him to chair this hearing because of his passion on this issue. Not that I lack that, but just that, you know, you get Senator Wellstone on a subject, you are going to have a good hearing. And so this hearing is his, as it ought to be.

The thing that I am about to go to has to do with people who lose jobs to overseas places, and so they are dumped and they are 45, 48 years old, and they become chaff to the country. And the country purports to have a policy called trade adjustment assistance. But the policy in effect doesn't in any way change their lives for the better. They lose their health insurance. They can't possibly get trained to do anything of significance because we don't invest in it.

And it strikes me, in fact, as almost a direct parallel to America's capacity to take people who have worked all their lives or who have served all their lives and served their country for portions of their lives or all of their lives, and then cast them away.

I watched, Senator Wellstone, just by coincidence, that movie, "Born on the 4th of July" about 4 or 5 days ago. It is one of the great movies of American history, but I think it describes in es-

sence—it ends with whoever the star is, Richard Gere or whoever it is—Tom Cruise, yes, and he says, "I think I'm beginning to come home." And he is going into a convention. And all I could think of is: Why is that home? Because it may have been with a political party with which he felt more affiliation. I don't know that. But he didn't have a job. He was still very messed up, could just as easily have been homeless but for the fact that he had a family which chose not to allow that to happen. He, in effect, became homeless by going off to live in Mexico for what is an undesignated period of time, which I took to be a rather long period of time, in which case it was an enormous deterioration of life, no motivation, reinforcement, in fact, on the negative fashion from others who had suffered, you know, the mildest way of putting it would be PTSD, but who had basically been ruined, disillusioned, cut in half, in quarters, and returned to American soil.

And I suspect that Paul Wellstone, although I know he has seen that movie, doesn't need to because I think we are talking about the same thing here. And you really raise the question how does that happen in America, and how does that happen after we in Congress have been talking about it for so many years and the percentage doesn't change and the situation doesn't change.

I presume it got a little bit better during the up economic years, but I don't think so, maybe by a couple of percentage points, but that was probably about it. And then you have something called the Department of Veterans Affairs and, you know, the VA has that etched carving above its wall at its entrance point, and somehow these folks have managed to elude the systemic care or attention which other people in a more conventional sense and a much better sense get. And then you say how does that happen, and the answer is because we are all—many of us have not fought in wars, many of us have fought in wars. Many of us have experienced different kinds of lives.

But there are always certain things that we are always able to count on, and so it raises the question when people are brought up in a way in which they can count on certain things in life which stabilize their life, you know, what is their willingness to go out and take a completely misunderstood and deteriorating—in self-esteem, health, and every other way—human being who may be only part of a human being physically, and only part of a human being psychologically, but a full human being in the sense that God intended the word. And we can't deal with it, we don't deal with it.

You know, Paul Wellstone and I have given, I think—and I am over my time, and I apologize, Senator Wellstone. But he and I both believe in Government, and we understand that most of America thinks that most of what goes wrong goes wrong in this city. But we don't share that point of view, and, in fact, our point of view is rather different, and that is that what goes on in this city is only about two-thirds of the speed that it ought to be going on. And when it comes to homeless veterans, when it comes to homeless people, when it comes to broken people, when it comes to the children of returned Persian Gulf War veterans who are deformed, or whether it comes to atomic veterans who are still waiting for things which were meant to have been promised, but the Government says, I am sorry, we don't have any more money, well, there

are reasons for that, because we have done things to cause that to happen, to let there be no more money. Or we are so overwhelmed or because we in our party, Senator Wellstone, have boasted about the fact that Government is smaller in personnel, is no bigger than it was during the time of President Kennedy, and then we think that is a really great thing. Well, in the meantime, problems have gotten 35 times more difficult, so you are asking fewer people or as many people to do many more things. And, of course, there are always predictable losers, and this hearing is about the ultimately predictable loser in this, through no fault of theirs, that is for sure.

If I had gone through in a real life form, what Tom Cruise as a warrior in that war went through, the way he went into it, the way he came out of it, I would be looking to one place. I would be looking to Government. And I don't think there is any other place he has any moral responsibility to look to than to Government. And if he served his country, it is case closed.

Let me just say that, Senator Wellstone, and I know you don't disagree with anything I say.

Senator WELLSTONE. No.

Chairman ROCKEFELLER. I just wanted to put that on the record.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Good morning. I'm very pleased to open the hearing today and welcome our witnesses.

Homelessness is a tremendous problem in this country, one which, unfortunately, plagues veterans more than any other segment of our population. I am astounded by the fact that roughly one-third of the homeless population in this country—about 300,000 people—are veterans. This truly is a national disgrace.

Over the last 10 or 15 years, VA has done much for homeless veterans and has undertaken many measures to help combat this problem. However, there is still more that can and should be done. Today's hearing will allow us all the opportunity to hear what VA and community-based service providers are doing successfully, as well as to find out what more is needed.

Unfortunately, I have a prior commitment this afternoon. I am therefore turning over the gavel to my good friend, Senator Wellstone. He is a leader on the issue of homelessness, so I know we are in good hands. I will, of course, review everyone's testimony—on the Heather French Henry bill and on the other legislation listed on our agenda—in advance of the Committee's markup now scheduled for July 31. Thank you for your appearance here today.

Senator WELLSTONE. I don't disagree with anything you said. I just couldn't say it as well. Thank you. I could build on it, but I don't want to.

While you are here, Mr. Chairman, could I just summarize with Secretary Garthwaite and say this: My understanding from what you have said today in terms of where the Veterans Administration is, is you do not disagree with these words that have just been uttered. You do not disagree that this is a moral outrage, that we should be doing much better. You agree with the concept conceptually. You are in agreement with the bill. There are some provisions of the bill you strongly support. There are some provisions of the bill where you think we need to work together. There are a couple of provisions where you don't agree. Is that accurate? But overall we are taking the same journey, correct?

Dr. GARTHWAITE. Absolutely.

Senator WELLSTONE. And this isn't going to be symbolic of politics where we talk about it and don't do anything. You are in agreement we are taking the same journey and we are going to get something done here. Is that correct?

Dr. GARTHWAITE. Absolutely. Same goal.

Senator WELLSTONE. OK. I thank all of you.

We are going to go to the next panel: Linda Boone, executive director of National Coalition for Homeless Veterans; Jimmie Lee Coulthard, president and CEO of Minnesota Assistance Council for Veterans; Richard Schneider, director of Veterans and State Affairs, Non Commissioned Officers Association of the United States of America, and chairman of the Veterans Organizations Homeless Council; and Daniel Shaughnessy, member, Local 495, American Federation of Government Employees, who is an addiction therapist.

If you all are OK with this, we will just go in the order that I called you up. That means we will start with you, Linda.

STATEMENT OF LINDA BOONE, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS, WASHINGTON, DC

Ms. BOONE. Mr. Chairman, the National Coalition for Homeless Veterans is very supportive of the intent of S. 739, the Heather French Henry Homeless Veterans Assistance Act, as the companion to the House bill H.R. 936, introduced by Representative Lane Evans, to provide for a wide range of services to homeless veterans and to begin focus on issues of prevention.

In our written testimony, we provide discussion points around contents of the bill that we have strong opinions about. In this oral testimony, I will focus on the priority issues we have within the bill.

The VA Homeless Providers Grant and Per Diem Program currently is assigned funding internally within the VA as approximately $35 million. The grant piece provides funding for the bricks and mortar for new programs, and the per diem piece provides for a daily payment of up to 50 percent for a maximum of $19 per day to provide services to the veterans housed under the grant piece.

NCHV supports a new flat fee formulate based on the State home domiciliary rate because it is a good comparison model for types of services provided. Additionally, we recommend a permanent authorization allowing existing programs to have access to the per diem to allow for program expansion that does not require the bricks and mortar piece.

NCHV believes the Grant and Per Diem Program should be at $120 million funding level and a budget line item. The $120 million would add approximately 9,000 beds with the increased per diem rate to a total of approximately 14,000 beds.

NCHV also feels that there needs to be a future vision of how to turn these transitional beds into a mix of transitional and long-term, permanent supported housing. The current grant program has employment as an expected outcome for all the veterans transitioning through the program. However, many veterans are not able to work or live without continued supportive services on a daily basis. Some of these veterans need alternatives to inde-

pendent living, and the CBO system, the community-based organization system, has the experience and the programs in place that could support the future needs of these veterans.

It is very clear that it takes a network of partnerships to be able to provide a full range of services to homeless veterans. No one entity can provide this complex set of requirements without developing relationships with others in the community. Community-based non-profit organizations are most often the coordinator of services because they house the veterans during their transition. These community-based organizations must orchestrate a complex set of funding and service delivery streams with multiple agencies in which each one plays a key critical role.

The veteran CBO system faces a capacity gap around managing this complexity in order to respond successfully to the distribution system for funds and then, if awarded funds, the resources to pay for the management and financial reporting system to properly service these funds.

We urge this committee to consider getting capacity-building services into the hands of the CBO homeless veteran provider group. While NCHV has been doing this, it has been done in a limited way without the benefit of Federal funds. We ask you to consider authorizing an allocation of $750,000 each year through 2007 to NCHV to build the capacity of the veteran service provider network.

The Homeless Veterans Reintegration Program managed through the Department of Labor VETS is virtually the only program that focuses on employment of veterans who are homeless. Helping veterans get and keep a job can be the most essential element in their recovery and reintegration for those that work is a realistic outcome.

HVRP programs work with veterans who have special needs and are shunned by other programs and services, veterans who have the very bottom, including those who have legal issues and those who are HIV-positive, those with severe PTSD and those with substance abuse. These veterans require more time-consuming, specialized, intensive assessment, referrals, and counseling than is possible in other programs that work with veterans seeking employment. NCHV recommends an investment of $50 million per year in HVRP to assist veterans in becoming self-sustaining and responsible taxpaying citizens. Fifty million dollars is only $100 for each of the over 500,000 veterans that is estimated are homeless during a year.

NCHV Board believes that ending homelessness among veterans is not a mission impossible, but a mission possible in the next few years, and we look forward to your continued support.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Boone follows:]

PREPARED STATEMENT OF LINDA BOONE, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS, WASHINGTON, DC

Chairman Rockefeller and Committee members:

The National Coalition for Homeless Veterans (NCHV) is committed to assisting the men and women who have served our Nation well to have decent shelter, adequate nutrition, and acute medical care when needed. NCHV is committed to doing all we can to help ensure that the organizations, agencies, and groups who assist

veterans with these most fundamental human needs receive the resources adequate to provide these services to perform this task. Our veterans served us faithfully, often heroically. Each of us can do no less than to do our part to ensure that these men and women are treated with dignity and respect.

NCHV believes that there is no generic and separate group of people who are "homeless veterans" as a permanent characteristic. Rather, NCHV takes the position that there are veterans who have problems that have become so acute that a veteran becomes homeless for a time. In a great many cases these problems and difficulties are directly traceable to that individual's experience in military service or his or her return to civilian society.

The specific sequences of events that led to these American veterans being in the state of homelessness are as varied as there are veterans who find themselves in this condition.

It is clear that the present way of organizing the delivery of vitally needed services has failed to assist the veterans who are so overwhelmed by their problems and difficulties that they find themselves homeless for at least part of the year.

The National Coalition for Homeless Veterans (NCHV) is very supportive of the intent of S. 739, "Heather French Henry Homeless Veterans Assistance Act" introduced by Senator Wellstone, as the companion to the House bill H.R.936 introduced by Representative Lane Evans, to provide for a wide range of services to homeless veterans and to begin focus on issues of prevention.

The following are discussion points around contents of the bill that we have strong opinions about. We have indicated the three priority issues we have within the bill.

CHALENG DATA (SECTION 2)

First start with the data. Congress recognized the need for the VA to play a leadership role within communities they serve by passing legislation (PL102–405) requiring the VA to assess and coordinate the needs of homeless veterans living within the area served by the medical center or regional office. Since that legislation passed the VA has made progress towards implementing community meetings, Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Veterans, in approximately 90% of their locations. There are many local CHALENG processes that are meeting the full intent of the law passed by Congress and are providing valuable coordination of services to homeless veterans. However, not all medical centers have implemented this law or have minimally met the intent by surveying providers without a controlled assessment process.

NCHV is surprised that in the Fifth Annual Progress Report, published August 29, 1999 for the 1998 fiscal year, childcare came as the number two item of the unmet needs for homeless veterans. NCHV members are concerned that this conflicting data with their front line experience with homeless veterans distorts the entire validity of the CHALENG process and will misdirect the VA in their resource allocation for services to homeless veterans.

NCHV wants Congress to impress upon the VA the critical need for the VA to take a tangible leadership role to assess and coordinate services in communities for homeless veterans in a consistent and complete manner throughout the VA.

The Urban Institute produced a report for the Interagency Council On the Homeless, for the survey that was conducted in 1996 titled "Homelessness: Programs and the People They Serve" released in December 1999 that has become the report that is used as the baseline in demographic data for homelessness in America. That report found 23% of all homeless individuals are veterans.

In February 2001 the Urban Institute released census information on the homeless population that was done in conjunction with the 1996 survey. Their conclusion is that at least 2.3 million people, or nearly 1% of US population are likely to experience homelessness at least once during a year. This would equate veterans experiencing homelessness to be 529,000 during a year.

Further they found that there is a high seasonal variation in homelessness, with 842,000 individuals (193,660 veterans) being homeless during an average February week and in October 444,000 (102,120 veterans) individuals.

This conflicts with the CHALENG data that we find suspect based on the inconsistent process of data gathering and reporting.

ADVISORY COMMITTEE (SECTION 4)

NCHV is very pleased that Secretary Principi has started to implement this piece without a Congressional mandate. We believe it is essential to have a formal mandated process in place that would provide an unfiltered and unrestricted channel of

information to the VA Secretary concerning the issues affecting homeless veterans when future Secretaries are confirmed.

EVALUATION (SECTION 6)

Currently Northeast Program Evaluation Center (NEPEC) is the only source of information reporting on homeless veterans used within the VA. It does not collect information from organizations outside the VA that serve homeless veterans. So currently there is no real data that can quantify the continuum of care services to homeless veterans nationwide or even by VISN.

(a) NCHV wants Congress intent language that states VA is to contract with outside group to do evaluation.

(b) Advisory Committee or community-based organizations (CBOs) need to specify what information is needed and information is to be made public.

Explicit information about programs such as CWT–TR, and domiciliary care needs to be spelled out in bill language so a comparison will be done between CBO and VA run programs in the study. NCHV's belief is that VA provided housing is much more costly than that provided by CBOs. We also believe that the VA should be providing needed health care not managing transitional housing for homeless veterans.

VERA (SECTION 7)

The proposal in this bill would mandate that homeless veterans be designated as complex care patients and therefore the medical center would receive a higher allocation and an incentive to treat their complex needs.

Currently in many facilities homeless veterans are seen as cash flow losers. The VA model provides for increased revenue by the degree of difficulty for providing services to veterans. By designating homeless veterans as complex care patients it will assure the resources are available to treat these veterans with higher needs.

Part (4) of this section addresses the need for housing coupled with treatment. Here again NCHV would like the emphasis to be on housing provided by CBOs not the VA.

NCHV clearly wants VA contracts and collaborations with CBOs but we also want the VA in the health care business not in CBO business.

PER DIEM PIECE OF HOMELESS PROVIDERS GRANT AND PER DIEM PROGRAM (SECTION 8)

This section deals only with the rate of per diem. Section 14 deals with total authorization/appropriation for Homeless Providers Grant & Per Diem Program.

This provision removes the match requirement from the per diem formula and makes the payment per bed a flat fee. It also makes the fee the same as the state home domiciliary formula.

NCHV supports this new formula based on the state home domiciliary rate because it is a good comparison model for types of services provided and compensation for those services. In addition removing the match requirement lightens the paperwork burden on the grantees and the VA. The current match requirement does not allow for in kind services to count towards the match, only hard dollars are allowed which can often create unnecessary hurdles for CBOs.

SPECIAL NEEDS GRANTS (SECTION 9)

NCHV believes the $5million called for in these special grants should be used for CBOs not to provide incentives for the VA to treat homeless veterans with special needs, which is already part of their mandate. Here again the VA would be given authority to create housing programs and NCHV feels strongly that VHA should not be in the housing business.

The study called for in this section NCHV feels should be done by outside contractor and part of the funds should be used to provide for long-term follow up to effectively gather results data.

COORDINATION OF OUTREACH (SECTION 10)

This section addresses prevention of homelessness among veterans that has long been ignored. It we are to reach the goal of ending homelessness among veterans some resources need to be focused on prevention efforts.

NCHV would like Congress to set this as a priority for the Department of Veterans Affairs.

PROGRAMMATIC EXPANSIONS (SECTION 13) PRIORITY ISSUE

Approximately 5000 transitional housing beds will be available funded through the Homeless Providers Grant and Per Diem program for veterans of which 2,076 are currently activated. The need for increased funding for beds through this program has never diminished since its inception. There is an un-addressed need for housing that is safe, clean, sober and has responsible staff to ensure that it stays that way, and that supportive services are regularly provided as to be sufficient to help veterans fully recover as much independence and autonomy as possible.

The Homeless Providers Grant and Per Diem Program currently is assigned funding internally within the VA at approximately $35 million. The "grant" piece provides funding for the "bricks and mortar" for new programs and the "per diem" piece provides for a daily payment of up to 50% for a maximum of $19 per day to provide services to the veterans housed under the "grant" piece. The grantees are required to obtain matching funds to the complete the 50% not funded through the VA.

NCHV supports a new flat fee formula based on the state home domiciliary rate because it is a good comparison model for types of services provided and compensation for those services. In addition we recommend removing the match requirement that would lighten the paperwork burden on the grantees and the VA. The current match requirement does not allow for in kind services to count towards the match, only hard dollars are allowed which can often create unnecessary hurdles for CBOs. Additionally we recommend a permanent authorization to allow existing programs to have access to the "per diem" piece to allow for program expansion that does not require "bricks and mortar".

NCHV believes the Homeless Providers Grant & Per Diem should be at $120 million funding level and a budget line item. The current level of funded beds is 5000 for an investment of about $35 million. If funding stays at the $35 million level there would be a need to cut 1000 beds when the new per diem increase became effective.

$43 million needed to remain at same 5000 bed level with increased per diem rate

$50 million would add 813 beds with increased per diem rate to total 5813 beds

$100 million would add approximately 6600 beds with increased per diem rate to total 11,628 beds

$120 million would add approximately 9000 beds with increased per diem rate to total 13,953 beds

The demand for this grant program far exceeds its current funding level. Every year programs get turned down usually because of lack of funding.

Grant applications rejected:

2000–64
1999–42
1998–67
1997–62
1996–57
1995–67
1994–67

NCHV also feels there needs to be a future vision of how to turn these transitional beds into a mix of transitional and long term permanent supported housing. The current grant program has employment as an expected outcome for all veterans transitioning through the program. However many veteran are not able to work or live without continued supportive services on a daily basis. Some of these veterans need alternatives to independent living and the CBO system has the experience and programs in place that could support the future needs of these veterans.

NCHV is concerned that there is a tendency to provide the authority to the VA to create housing programs and other competitive services that CBOs are currently providing. We believe that the VA should provide the medical services and the CBOs can provide the other supportive services within the continuum of care for homeless veterans.

Comprehensive Homeless Services Program

NCHV is concerned that this section of the bill once again gives the authority to the VA to create housing programs and other competitive services that CBOs are currently providing. We believe that the VA should provide the medical services and the CBOs can provide the other supportive services within the continuum of care for homeless veterans.

Opioid

NCHV member organizations do not support this alternative addiction program. This is an extremely costly program to make available at all medical centers.

VARIOUS AUTHORITIES (SECTION 14)

(c) NCHV would like to see an alternative in the staffing requirement at VBA dedicated to addressing the needs of homeless veterans. Instead of strictly a VBA employee make it possible for VBA to contract with local CBOs who may have more experienced staff in dealing with the unique problems of homeless veterans.

TRANSITIONAL ASSISTANCE GRANTS PILOT PROGRAM (SECTION 16)

This is an ill-advised proposition in NCHV member organizations' opinion. Giving money to veterans in transition would constitute a give away that all were entitled to. Even with a payee representative we feel there would be significant abuses.

Additionally this program would be hard and costly to implement through VBA. In the FY2002 budget documents it already predicts that the timeline for processing claims will extend by an additional 100 days. Adding this program to VBA will not be to any veteran's advantage.

An alternative would be to provide NCHV with annual funds that could be disbursed to CBOs so there was a screening process that was quick compared to DVA.

TECHNICAL ASSISTANCE (SECTION 17) PRIORITY ISSUE

It is very clear that it takes a network of partnerships to be able to provide a full range of services to homeless veterans. No one entity can provide this complex set of requirements without developing relationships with others in the community.

Community-based nonprofit organizations are most often the coordinator of services because they house the veterans during their transition. These community-based organizations must orchestrate a complex set of funding and service delivery streams with multiple agencies in which each one plays a key critical role.

There are a wide variety of Federal, state and private funds that veteran service providers are eligible for in the course of serving homeless veterans. The challenge is in accessing them. Many veteran specific providers lose several years before being able to position themselves to successfully compete and receive ANY federal, state or local agency funds.

The current prevailing public policy of devolution increases likelihood that Federal dollars are ultimately allocated through a ranking process subject to local viewpoints. At the local level the common perception is that veterans are taken care of by the VA. Some are, yet most are not. These perceptions can be a barrier to homeless veterans service providers' access to funds. It is a reality that must be reckoned with in order to compete successfully.

When a local group is forced into priority recommendations that choose between needy men, women, and/or their children, it is a challenge to argue for displacing the funding for women and children in favor of a man (who's a veteran the "VA is taking care of" anyway!). Sometimes a homeless veteran has his family still together, and obviously some homeless veterans are women, but these conditions are the exceptions.

Consistently at around $1 billion annually, the biggest piece of funding currently on the table is available from targeted HUD funds through the Super NOFA for Supportive Housing Programs (SHP). Historically only 3% of these grants are awarded to veteran specific programs. Three percent, when a quarter of the homeless are veterans. Any other help HUD grants give to veterans is purely by chance, and we have no information on whether the rest of the money reaches veterans.

The distribution system for these McKinney Act funds follow a devolution policy that organizes priorities for allocation of formula share dollars at a local level within a continuum of care. The Continuum of Care prescribes a planning process built on a community-by-community model. Within each community, a planning process takes place in which advocates and service providers describe the problem, access the current resources available, and decide what needs to be done using the "targeted" McKinney programs, which total $1.2 billion annually. Overall federal funding to assist the poor is about $215 billion annually and is not synchronized with targeted homeless assistance funds. So, these funds need to be accessed differently.

Until such time as a homeless veteran provider is able to convince the organizations that make up the local continuum of care that it is in THEIR best interest to juggle their dollars in a way to allow a veteran provider to the table, a veteran specific program typically gets ranked out of the money (if it even got ranked in the continuum at all). Veteran service providers report it takes several years of analysis,

networking, program/funding design, and negotiations to be able to show that giving a high priority to a relatively small piece of HUD Supportive Housing Programs dollars for a veteran provider is in the community's best interest. A veteran provider can access support service money and a clinical care system (the Department of Veterans Affairs) available for veterans only. This leverages resources that can off-load the community care system of the veterans currently occupying beds and free up capacity that then becomes available for women, children and other special needs population. At one level, this is the market economy operating at its best but it is complicated, to say the least.

The veteran community-based organization system faces a capacity gap around managing this complexity in order to respond successfully to the distribution system for accessing funds and then if awarded the resources to pay for management and financial reporting systems to properly service those funds.

The point here is to underscore the complexities involved in successfully responding to the streams of funding available and necessary to combine together adequate budgets in a sufficiently broad geographic area to put on a reasonable array of services for homeless veterans. Most community-based organizations throughout the country struggle to respond to this system of distribution of federal funds.

SOME SOLUTIONS

In 1990, seven homeless veteran service providers established the National Coalition for Homeless Veterans (NCHV) to educate America's people about the extraordinarily high percentage of veterans among the homeless. These seven providers are considered to be true original warriors for the cause. All former military men, they were concerned that people did not understand the unique reasons why veterans become homeless and the fact that these men and women who defended America's freedom were being dramatically under-served in a time of personal crisis. In the years since its founding, NCHV's membership has grown to 245 in 44 states and the District of Columbia.

I urge this committee to consider finding ways to get capacity building services into the hands of the community-based care provider group attempting to serve veterans. It is squarely within the mission of NCHV to help formulate this capacity. While NCHV has been doing this, it's been done in a limited way without the benefit of any federal funds. I ask you to consider authorizing an allocation $750,000 FY 2002 and each year thereafter through FY2007 to the National Coalition for Homeless Veterans to build capacity of the veteran service provider network. The goal would be to significantly increase access to the federal, state and private funding streams and to enhance the efficiency of utilization for those currently accessing these streams.

EMPLOYMENT (SECTION 19) PRIORITY ISSUE

Work is the key to helping homeless veterans rejoin American society. As important as quality clinical care, other supportive services, and transitional housing may be, the fact remains that helping veterans get and keep a job can be the most essential element in their recovery and reintegration for those that work is a realistic outcome.

The Homeless Veteran Reintegration Program (HVRP) managed through the US Department of Labor, Veterans Employment and Training Service is virtually the only program that focuses on employment of veterans who are homeless. Since other resources that should be available to our member organizations to fund activities that result in gainful employment are not generally available, HVRP takes on an importance far beyond the very small dollar amounts involved.

The Homeless Veteran Reintegration Program is a job placement program begun in 1989 to provide grants to community-based organizations that employ flexible and innovative approaches to assist homeless, unemployed veterans reenter the workforce. Local programs offer employment and job-readiness services to place these veterans directly into paying jobs. HVRP provides the key element often missing from most homeless programming—job placement.

Through HVRP funds veterans gain access to civilian assistance, ex-military benefits and entitlements, education and training opportunities, legal assistance, whatever is needed to begin the rebuilding process towards employment.

HVRP programs work with veterans who have special needs and are shunned by other programs and services, veterans who have hit the very bottom, including those with long histories of substance abuse, severe PTSD, serious social problems, those who have legal issues, and those who are HIV positive. These veterans require more time consuming, specialized, intensive assessment, referrals, and counseling than is possible in other programs that work with other veterans seeking employment.

This program has suffered since its inception because it is small and an easy target for elimination or reduced appropriations. Even DOL rarely asks for the full appropriation for HVRP in the budget they submit to OMB. Our coalition has spent the majority of its advocacy efforts in the past five years in keeping this program alive because it has been so vital in ending homelessness among veterans.

HVRP is an extraordinarily cost efficient program, with a cost per placement of about $1,500 per veteran entering employment. Based on years of experience of our member organizations NCHV strongly believes that helping homeless veterans to get and keep a job is the key to reducing homelessness among veterans. NCHV recommends an investment of $50 million per year in HVRP to assists veterans in becoming self-sustaining and responsible tax paying citizens.

$50 million is only $100 for each of the over 500,000 veterans that is estimated are homeless at some point during the year.

NCHV looks forward to working with this committee and the staff on solutions that will lead to the end of homelessness among veterans.

NCHV's Board believes that ending homelessness among veterans is not a mission impossible but a mission possible in the next few years and look forward to your continued support.

Mr. Chairman, thank you for this opportunity.

Senator WELLSTONE. Thank you, Ms. Boone, for your excellent testimony. Excellent.

Jimmie Lee Coulthard, welcome.

STATEMENT OF JIMMIE L. COULTHARD, PRESIDENT AND CEO, MINNESOTA ASSISTANCE COUNCIL FOR VETERANS, MINNEAPOLIS, MN

Mr. COULTHARD. Thank you, Mr. Chairman.

There is a solution. The tremendous fact for every one of us is that we have discovered a common solution. We have a way out of which we can absolutely agree, and upon which we can join in brotherly and harmonious action. This is the great news this book carries to those who suffer from alcoholism.

That is from page 17 of the Big Book of Alcoholics Anonymous.

Senate bill 729, the Heather French Henry Homeless Veterans Assistance Act, also is common ground and a common solution upon which we can agree and join in harmonious action. This harmonious action is to have a national goal to end homelessness among veterans and to achieve that goal in 10 years.

Thirty-plus years ago, each of has varied and opposite views and goals on most of the current issues of the time. The Vietnam war and serving in the military means something profound to most of us today and still has the emotions of that time in our hearts today. There were few voices of middle ground. It seemed to me you were for or against one side or the other. It seemed none escaped judgments from the other. Passion reigned in each camp. That passion is here today from both sides in a collective effort in support of ending a national shame by setting the goal of ending homelessness among veterans by taking certain action steps provided by the Heather French Henry Homeless Veterans Assistance Act.

I have thoughts and ideas on each of these actions, and I will be brief in the outline.

This goal, this bill, and action will require committed leadership from each of you. The saying "Lead or get out of the way" is very relevant in this situation. Secretary Principi, please hear and know that our last Secretary of Veterans Affairs did not do either, and the VA and veterans have paid a high price and lost ground for his inaction and lack of leadership.

This bill, this goal must not become a political casualty from any party. There must be a willingness to come into each other's camp. This hearing speaks well of your hopes and intentions. It speaks well for those who have the courage and hope to extend the invitation to work together on this goal. Passion, courage, honor, and a willingness to do the right thing for others will carry us far. But it will require more.

This national goal to end homelessness among veterans must be accepted by Veterans Affairs and the Veterans Affairs medical centers as a priority, and the care needs to be reimbursed as complex care. The VA is a health care provider and needs to keep its resources in this arena. One VA at all VA medical centers and VA regional offices must accept this goal and act as a complete partner in the community.

HUD must stop the continuum of care discrimination against veterans and provide funds that are realistic. More than 3 percent of their funds is the best they have done in the past. HUD is in the housing business and needs to step up to the plate and face the lack of concern they have around providing appropriate dollars for veterans experiencing homelessness. HUD should only be in housing.

The Department of Labor employment programs such as the Homeless Veterans Reintegration Project need to be funded at much higher levels and in more areas. This is an excellent use of money directed toward employment, and this money will be returned in new employment taxes. Fifty million dollars is needed in the very near future for this effort.

These agencies should stick to what they are best suited to provide and work with community providers to utilize their resources.

It must be accepted by the Veteran Service Organizations and become more of a solution and provide leadership as well as money to local providers. These organizations could welcome these veterans into their ranks.

The Advisory Committee on Homeless Veterans, I just cite one example, the great example, the Veterans Service Organizations could take a look at what the Disabled American Veterans Association has done nationally, and I know that all the Veteran Service Organizations could do more.

Advocates for homeless veterans, there is no better organization than the National Coalition for Homeless Veterans and Linda Boone.

I see my time is running out, and I just want to say that this evaluation, this idea of working with HUD, the Department of Labor, Health and Human Services, and VA, this interagency, they absolutely have to work together, what Senator Specter was talking about. It is so frustrating to have to do these grants on each one of these agencies' time lines when I personally think that it would not take much effort for them to get together. They are all working toward helping end homelessness among veterans. They could all use the same evaluation tool. They could all use the same outcomes. They could work together and really help providers such as Minnesota Assistance Council for Veterans do our mission. We all want to get there, but it sure doesn't seem like we are working in a coordinated effort to get there. I will stop right there.

[The prepared statement of Mr. Coulthard follows:]

PREPARED STATEMENT OF JIMMIE L. COULTHARD, PRESIDENT AND CEO, MINNESOTA ASSISTANCE COUNCIL FOR VETERANS, MINNEAPOLIS, MN

Strategic Profile

WHY MINNESOTA ASSISTANCE COUNCIL FOR VETERANS EXISTS

Homelessness and its consequences are leading causes of personal and family suffering and community problems resulting in major health and social costs. We exist to directly help veterans and their families affected by homelessness and to serve, inform, educate and train others to carry our message of hope; and to set a national standard for caring and excellence working with veterans who are threatened by or are experiencing homelessness.

WHERE WE'RE GOING

Vision

To be an enthusiastic proactive champion and national leader; creating and supporting alliances and partnerships that assists veterans who are threatened by or are experiencing homelessness.

OUR MISSION IS

To provide/coordinate preventive, transitional & permanent housing and supportive services for veterans who are experiencing homelessness or who are in danger of becoming homeless and who are motivated towards positive change.

WE DO THIS BY

Providing food and housing, coordinating employment, school and work hardening, in a structured program that is affordable. Our program environment is chemically/intoxication free, clean, and free of discrimination, harassment and violence.

WE'LL GET THERE BY . . .

Focusing on these organizational goals

- To have a measurable positive impact on veterans' lives and our communities by providing/coordinating appropriate services and resources.
- Continually improve our quality of teamwork and our dedication to meeting the needs of veterans by self and outside assessment.
- Using innovation and collaboration to develop/coordinate new services that meet veteran' needs.
- Daily attention to the stewardship of our human, financial and physical resources.

LIVING OUR VALUES

We believe . . .

- In promoting the respect and dignity of veterans in need and of our employees through caring and teamwork
- That homelessness is a multi-dimensional circumstance requiring a multidisciplinary holistic approach for recovery
- The philosophy of Alcoholic Anonymous provides the context for action and foundation for multi-dimensional, holistic recovery
- In valuing our history
- In being leaders, and requiring professional behavior and integrity from all staff and board members
- Innovation, collaboration, and continuing education are essential in meeting these veterans needs—thus assuring our success
- That our veteran staff, who have experienced homelessness, are essential to our success

STRENGTHENING OUR CORE COMPETENCY

Our core competency is our ability to use knowledge gained through experience, continuous learning, as well as, community collaborations and realizing the need for a multi-disciplinary, holistic approach working with these veterans and their families.

REMEMBERING, "TO THINE OWN SELF BE TRUE" ORGANIZATIONALLY

We value military service, compassion, accountability, justice, dignity, respect, commitment, tradition, and community. We value and believe people have the ability to change with quality education, treatment that requires self-responsibility, commitment and persistence. We believe in a safe, sustainable living environment. We believe our relationships carry an honorable debt to those who finance this undertaking.

Chairman Rockefeller and Committee members; thank you for this opportunity.

"THERE IS A SOLUTION"

"The tremendous fact for every one of us is that we have discovered a common solution. We have a way out of which we can absolutely agree, and upon which we can join in brotherly and harmonious action. This is the great news this book carries to those who suffer from alcoholism." P.17 from the Big Book of Alcoholics Anonymous.

Senate File 730, the "Heather French Henry Homeless Veterans Assistance Act" also is common ground and a common solution upon which we can agree and join in "Harmonious Action". This harmonious action is to have a national goal to end homelessness among veterans and to achieve that goal in ten years.

30 plus years ago each of us had varied and opposite views and goals on most of the current issues at the time. The Vietnam War and serving in the military means something profound to most Americans today and still has the emotions of that time in our hearts today. There were few voices of middle ground. It seemed to me you were for or against one side or the other. It seemed none escaped judgment from the other. Passion reined in each camp then. That passion is here today from both sides in a collective effort in support of ending a national shame by setting the goal of ending homelessness among veterans by taking certain action steps provided by the "Heather French Henry Homeless veterans Assistance Act".

I have thoughts and ideas on each of these actions and I'll be brief in this outline.

This bill/goal and action will require committed leadership from each of you. The saying "Lead or get out of the way" is very relevant in this situation. Secretary Principi, please hear and know that our last Secretary of Veterans Affairs would not do either and the VA and veterans have paid a high price and lost ground for his inaction and lack of leadership.

This bill, this goal must not become a political causality from any party. There must be a willingness to come into each other's camp. This hearing speaks well of your hopes and intentions. It speaks well for those who have the courage and hope to extend the invitation to work together on this goal. Passion, courage, honor and a willingness to do the right thing for others will carry us far. It will require more.

- National Goal to End Homelessness Among Veterans
  1. Must be accepted by Veterans Affairs and the VA Medical Centers as a priority and the care needs to reimbursed as complex care. The VA is a health care provider and needs to keep its resources in this arena. One VA at all VAMC/VARO must accept this goal and act as complete partners in the community.
  2. Housing Urban Development (HUD) must stop the continuum of care discrimination against veterans and provide funds that are realistic. More than 3% is the best they have done in the past. HUD is in the housing business and needs to step up to the plate and face the lack of concern they have around providing appropriate dollars for veterans experiencing homelessness. HUD should only be in housing.
  3. The DOL the employment programs such as the Homeless Veterans Reintegration Project need to be funded at much higher levels and in more areas. This is an excellent use of money directed towards employment and this money will be returned in new employment taxes. $ 50 million is needed in the very near future for this effort.
  4. These agencies should stick to what they are best suited to provide and work with community providers to utilize their resources.
  5. Must be accepted by the Veteran Service Organizations and become more of the solution and provide leadership as well as money to local providers. These organizations could welcome these veterans into their ranks.
- Advisory Committee On Homeless Veterans
  1. Veterans Service Organizations look close at the Disabled American Veterans and what they are doing nationally for homeless veterans. They can all do more.
  2. Advocates for homeless Veterans: There is no better organization than the National Coalition for Homeless Veterans when information on any scale is needed. They have the total picture of what is taking place in America today

on the problem. They will provide accurate and currant needs assessments and responses around the role of providers and their needs. They are the heart and soul of the providers who serve the veterans in need. They have the pulse of the nation on this plight.

- Evaluation of Homeless Programs

1. Create an evaluation and reporting tool that satisfies all agencies: VA, DOL, HUD and HHS and give this tool to all providers along with training when making a grant. This way we truly can measure across the full spectrum of providers and not be spending so much time on varied reports that say the same thing in different ways and in different time frames.

2. The federal agencies ought to be more user friendly. There should be one application process/timeline for all of these agencies for VA-HUD-DOL-HHS for this goal. Each agency can have their own components they need and a standard report driven from required outcomes and using a standard database developed for this effort.

- Changes in Veterans Equitable Resource Allocation Methodology

1. Complex Care designation for this group of veterans using documented indicators of care needed and received. So many of these veterans have so many varied health care needs that it appears this designation of a Complex Care is correct. Keeping this money only for these population's providers is a must and will allow their needs to be met. The health care needs will become more complex as these veterans age.

- Programmatic Expansions

1. Comprehensive Homeless Service Programs are a must and they need to be in the community run by community organizations. They must include though:

Vets Centers
VA Outreach Teams
VAMC
VARO
State Department of Veterans Affairs
County Veteran Service officers
State Veterans Homes
Private Non Profits
For profit Fee for Service Providers
HUD-DOL-HHS
In Minnesota CF&L Economic Security

VISN # 13 needs to have a Comprehensive Homeless Center and it is the St Cloud VAMC that seems to be the appropriate setting due to the Domiciliary and other residential programs for veterans experiencing homelessness. They can access dental care while receiving residential treatment for CD and upon completion can enter the Dom and the vocational rehabilitation IT/CWT Programs. Only after these programs cannot be expanded and they are operating at full capacity should other duplicating services be considered at other sites.

- Use Of Real Property (Enhanced-Use Lease) in Minnesota

1. 218 Units of Permanent Housing on Minneapolis VA Campus
2. 120 Units of Transitional/Permanent on St. Cloud VA Campus
3. Go to HUD and get this funding now directly from them for these two projects and other similar project in the works across this nation. They are not spending anything close (3% of their money) in proportion of the need for veterans who are homeless.
4. Assist with time lines for these leases.

Three things this legislation could provide is:

1. Complex care designation for most homeless veterans.
2. Funding Homeless Veteran Reintegration Project at $ 50 Million dollars per year.
3. HUD stepping up to the plate with adequate funding for veteran specific programs.

This will require leadership to move in this direction and stamina to stay the course with this legislation.

I do think there is a solution to this problem. I do think the goal can be meet. I commit our organization to meet the goal for the veterans experiencing homelessness in Minnesota and in this nation.

Mister Chairman thank you for this opportunity.

Senator WELLSTONE. Jimmie Lee, we have a whole section of the bill that deals with this interagency—I was going to say this to Senator Specter. I will get it to him—that deals with insisting on,

you know, that this Interagency Council on Homeless actually meets, that we get the cooperation and coordination. We have to do that. We have to do that.

Mr. Schneider?

STATEMENT OF RICHARD C. SCHNEIDER, DIRECTOR OF VETERANS AND STATE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA, AND CHAIRMAN, VETERANS ORGANIZATIONS HOMELESS COUNCIL, ALEXANDRIA, VA

Mr. SCHNEIDER. Thank you very much, Mr. Chairman, and thank you very much for bringing to us a bill to end homelessness in a decade. That is really admirable.

We need to do a couple things, and we have outlined in our statement—and it is for the record. I would just add that in my speaking today, I represent the Veterans Organizations Homeless Council. I also this past week, in addressing the issue here today, got the full endorsement of the National Military and Veterans Alliance, and they are all on board on this. And in typing this up, I missed one organization, and I would like to add it for the record now, the Military Order of World Wars.

You know, veterans don't want their dead and their wounded left on any battlefield, and these organizations don't want them left on the streets of America, and you know that, Mr. Chairman. Our comments in the testimony provide insights that we believe are beneficial to the legislation, but I want to add comments that I think are most appropriate.

One is that you put in this legislation a section entitled "Prevention," and, by God, we need to focus more on prevention. We need to put a tasking for the Interagency Council to look at prevention as part of the job. And I would say this: DOD needs to be a player on the Interagency Council because we have, as you define in this legislation, too many at-risk veterans coming out of the military, and they are not tagged, they are not identified, people don't know where they are going, and you don't see them until they show up in a shelter or they show up in a courthouse or they show up in the jail. And so we would like to see the Interagency Council become more responsive.

I think I would probably take exception with a couple of the remarks that were made today. One is the Interagency Council hasn't met since last year, but we had a whole change of Government. We had a change in administration. We had appointments to the Cabinet, and we have literally been in the state of transition. It is time to remind the Interagency Council that they have responsibilities and commission them to go back to the work that they have.

But it is bigger than the Interagency Council, and I want you to send this word, sir, if you would, from the Congress of the United States. We don't expect Cabinet officers to sit at the table and decide what is going on with homelessness. We expect the committee working underneath them to meet and to discuss and to make recommendations to the Interagency Council. And I am going to tell you, regretfully, I am not aware that that committee has not met since November of last year, approximately. That committee ought

to be meeting at least quarterly, if not bi-monthly, and they ought to be identifying the things.

You know, the mandate in the legislation says the Interagency Council will meet at the call of the chairman or when requested by the members. Well, by God, if there is a housing program, HUD ought to be asking for the meeting to be held, and it shouldn't be just once annually. And I think we need to re-emphasize that to them.

I would also like to go back to part of the legislation where you address the CHALENG groups. One of the great things that VA has done at its medical centers across the world was to take public law that was implemented and establish a program to develop community partners, to end the cycle of homelessness, and to establish the local and regional contacts. Well, I will tell you what. VA did a great job in doing that, but they screwed up in one area, and the screw-up is identified in the testimony, and the screw-up is they started consolidating resources because streamlining is good, you don't have to have as many reports, you don't have to have as many people.

You take Maryland, three hospitals, different ends of the State, the committee, one report, they are not identifying nor are they working with the organizations to develop a comprehensive program. We need to take this Congress and say in legislation that every medical center should have its own independent CHALENG group to work with community providers.

We need to expand the legislation to say that the big outpatient clinics, such as located at Orlando, FL, has a CHALENG group to work with the veterans in that area. They cannot be treated from a group 85 miles distant. It just doesn't work.

We agree with the Grant and Per Diem Program. We agree that the money needs to be increased. And I will tell you, when you talk internal money within VA, you are talking about money that comes through VERA and other things.

I disagree with Tom Garthwaite today. I disagree that all veterans at 20 percent are the only ones that should be complex veterans. I will tell you, I have seen homeless veterans in hospitals, and as soon as he walks in the door, they want to get rid of him as quick as possible. And nobody has ever said, you know, are you a complex veteran? Hell, he wouldn't know what a complex veteran was.

We need to talk with these people. We need to identify them, and we need to tag them, and it ought to be directed that they do more for these people. And by doing more for them, identifying them as complex, we can take the Grant and Per Diem Program from $35 million to $50 million or more, as Linda has said.

I want to—I see the red light. I am sorry. I have got two barrels. I would like to march.

I would like to share with you another comment that Under Secretary for Health Garthwaite made and I disagree with, and that was he said we have so many requests coming in for Grant and Per Diem money that are so badly prepared. Well, dammit, he is absolutely right. They are coming in. They are being turned down. And some are being awarded every year. But 50, on average, are turned down every year. And he says, well, we have it on the Internet and

they can look on the Internet. Sir, I suggest that the Congress needs to have that technical assistance that you speak of to go out to these people who are failing in their grant applications because somebody didn't consider this dimension or that, which resulted in no points being awarded.

We need to do that. We need the technical assistance. And I will tell you what. Nationally, I have great respect for one organization dealing with homeless veterans, and that is this organization that is represented at the table with me today, National Coalition for Homeless Veterans.

I will end with just two thoughts. We have got to do more. It is going to cost more. We expect the leadership in the Senate and in the House to fight for those dollars. If we don't start taking this seriously, 10 years from now we are going to be saying, gee, we still have the problem, sorry we didn't have the money. Well, dammit, it is going to be a pain in the butt when we have our next war and people say I don't want you to go in the service because I don't want to see you living out here on the street.

We need to uphold the truths and the values that our people had when they went out for this Nation. They raised their hand and they said that they would defend and support the Constitution of the United States. They came back different because of that war experience, and I want to tell you something, 5 years ago, when they started emptying out the VA PTSD inpatient units, when they started closing down the bloody bed spaces, they did a disservice to every person who served in combat, because it is those combat veterans out there on the street that need those services in mental health and others. And, by God, it is time we started putting the money where the need is and we start integrating these people back into the program.

I think and I strongly believe and my member organization strongly believes we can end homelessness of veterans in a decade. We can take them off the streets. We can put them back to work. But we need the money. And I will agree again with Linda Boone when she said earlier today HVRP needs to go from $12 to $50 million a year. That is the program that is putting them back to work. I mean, hell, after you take the drink out of them, after you take the drug out of them, after you get their heads screwed on right, after you get them prepared to work, let's have the programs out there to ensure that they can work. HVRP works. And you know what, sir? They become taxpayers and they support this Government, this Nation. We need to take care of our veterans.

If I sound like I am just a little bit passionate about that, I am sorry, but I am mad as hell.

Thank you.

[Applause.]

Senator WELLSTONE. I don't know whether I am supposed to applaud or not, but I am. [Laughter.]

[The prepared statement of Mr. Schneider follows:]

PREPARED STATEMENT OF RICHARD C. SCHNEIDER, DIRECTOR OF VETERANS AND STATE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA, AND CHAIRMAN, VETERANS ORGANIZATIONS HOMELESS COUNCIL, ALEXANDRIA, VA

INTRODUCTION

Mr. Chairman and distinguished Members of the Subcommittee, the Non Commissioned Officers Association of the USA (NCOA) is most grateful for the opportunity to present its perspective on S. 739, The Heather French Henry Homeless Veterans Assistance Act. NCOA membership is exclusive in its representation of enlisted personnel of Active, Reserve, and Guard Service Components, the USCG, military retirees and veterans. The significant ratio of enlisted personnel to military officers who have served in the Armed Forces quickly translates to the majority of homeless veterans being formerly enlisted Soldiers, Sailors, Marines, Airmen, and members of the Coast Guard. NCOA has a deep concern on the issue of homelessness and recognizes that today's homeless veterans are not only former comrades-in-arms from years gone past but also the sons and daughters of America that answered the clarion call to duty.

Today's homeless veterans just a few short years ago were those disciplined warriors that this Nation hailed as the best educated, motivated and trained military force in the world.

NCOA is a member organization of the Veterans Organization Homeless Council (VOHC) and as the association's representative, I also hold the position of Chairman, VOHC. The testimony presented today is further supported by the member organizations of the VOHC listed below:

American Veterans of WWII, Korea and Vietnam
The American Legion
Blinded Veterans Association
Disabled American Veterans
Jewish War Veterans of the USA, Inc.
Marine Corps League
Military Order of the Purple Heart of the USA, Inc.
Non Commissioned Officers Association of the USA
Paralyzed Veterans of America
Veterans of Foreign Wars
Vietnam Veterans of America, Inc.

Likewise, the member organizations of the National Military and Veterans Alliance (NMVA) through this statement strongly support Senate 739. The member organizations of the NMVA include:

Air Force Sergeants Association
America Retirees Association
American Military Retirees Association
American Military Society
American WWII Orphans Network
Catholic War Veterans
Class Act Group
Gold Star Wives of America
Korean War Veterans Association
Legion of Valor
Military Order of the Purple Heart
National Association for
Uniformed Services
National Gulf War Resource Center
Naval Enlisted Reserve Association
Naval Reserve Association
Non Commissioned Officers Association
The Retired Enlisted Association
Society of Medical Consultants
Society of Military Widows
Tragedy Assistance Program for Survivors
Uniformed Services Disabled Retirees
Veterans of Foreign Wars
Vietnam Veterans of America
Women in Search of Equity

BACKGROUND

Mr. Chairman, and members of the Veterans Committee, let me begin with the statement that the proposed S. 739 Heather French Henry Homeless Veterans Assistance Act has the potential to significantly reduce the homelessness of former members of the United States Armed Forces. I would point out that the organizations endorsing the Senate legislation are also supportive of H.R. 936, the companion House Bill introduced by Representative Lane Evans. This Statement quickly summarized would state that to end veteran homelessness requires a dedicated decade to provide the continuum of care services that would move the veteran from the street to employment. That summary statement would also place greater emphasis in the area of prevention programs to of homeless. We must stop the flow of veterans to the streets of America.

RECOMMENDATIONS

1. CHALENG Data (Section 2 (a)(2) and (7))

Congress was correct in the need for the Department of Veterans Affairs (VA) to have a leadership role to assess and coordinate the needs of homeless veterans served by local Medical Centers and Regional Offices. Great progress has been made through the Community Homelessness Assessment, Local Education Networking Groups (CHALENG) for veterans.

VA has taken CHALENG seriously but significant holes exist in the program. VA in its streamlining process has garnered efficiencies through the consolidation of effort to the detriment of CHALENG. Considered a consolidated management process such as a single CHALENG group that represents Baltimore MC, Ft. Howard MC, and Perry Point MC in Maryland. Three distinctly different settings blended together with a resultant "vanilla" program that at best served the needs of the institution. The issue of assessing LOCAL needs, developing effective community partners, and implementing local programs was in our judgment unquestionably lost in the consolidated process. The data from that CHALENG report also becomes questionable and suspect when compared to other reports such as that issued by the Urban Institute on the homeless veteran population.

1. The effectiveness of designing a plan at one facility (removed by distance) from other state VA facilities excludes community partners from being integrated into a real partnership, questions the statewide assessments made, and undermines the validity of programs established for the state. Ending veteran homelessness must be an aggressive cooperative local effort with united teams serving needs in their local population.

Recommendations:

(a) That Congress direct that every VA Medical Center and Regional Office establish a LOCAL CHALENG program that complies with the mandated actions required by P.L. 102–405.

(b) That Congress mandate a CHALENG program be established at all large Community Outpatient Clinics such as that complex located in Orlando, Florida. In this instance, Orlando is supported by the Tampa VAMC some 86 miles or 1½ hours distant. A CHALENG report should be developed at and by representatives of the Orlando Community Outpatient Clinic. That action would solidify a large base of community providers, have the potential to involve a significant number of veterans who utilize the medical clinic, and provide an effective CHALENG community partnership. These same parameters exist at other locations where large outpatient clinics are established.

(c) That Congress direct all facilities to submit a local CHALENG report, without any area consolidation, developed in concert with community partners and that these reports be used to:

1. Develop a local comprehensive care plan,
2. Identify met and unmet needs
3. Compare and Match data with HUD generated Continuum of Care efforts
4. Identify the Number of Homeless Veterans in the local area for which concerted programming can be achieved.

2. ADVISORY COMMITTEE (Section 4)

Strongly concur that a VA Advisory Committee on Homeless Veterans be appointed by the Secretary. Pleased to note that the incumbent Secretary of Veterans Affairs has already begun to implement this recommendation.

Recommendation:

Although implementation of the Advisory Committee requirement has begun recommend nonetheless that the formal requirement for the committee be codified in law.

3. MEETINGS OF INTERAGENCY COUNCIL ON THE HOMELESS (Section 5)

Strongly support the recommendation that the "Cabinet Level" Council meet at the call of its Chairperson or a majority of its members, but not less often than annually.

However, below the "Cabinet Level" Council is the Interagency "Staff working group" comprised of directed agency representatives that coordinate and review programs, policies, and make recommendations to their respective Agency Council Members. This is the action level working group and interestingly has no mandate for frequency of meetings. They meet at the call of their Chairman. The last such meeting of the action officers is believed to have been in the November 2000 time frame.

Recommendation:

That the Chairman, Interagency Council on the Homeless require quarterly meetings of the Interagency Working Group with copies of meeting documentation provided to all Council Members. This requirement would ensure the viability of both the Council and working group.

4. EVALUATION OF HOMELESS PROGRAMS (Section 6)

There is need for Evaluation of Homeless Programs to ensure the effective use of resources. Currently, the Northeast Program Evaluation Center collects VA information and provides the only known source data on homeless veterans for VA leadership. Clearly, an evaluation of homeless veterans must consider that data related to the continuum of care services provided to homeless veterans.

It is the collective opinion of the Veterans Organization Homeless Council that an advisory group comprised of VA staff, CBO, Community based providers, representative of the Secretary's Homeless Advisory Council, and a contract vendor design an evaluation tool(s) for the national homeless veteran program.

The Veterans Organization Homeless Council (VOHC) recommends that quality standards be established for homeless veterans' programs. A greater emphasis on program outcomes is necessary to assure that veterans' grant programs operated by the Departments of Veterans' Affairs, Labor, and Housing and Urban Development are efficient and effective.

Effective "best practices" program model(s) should be created and considered for replication as deemed appropriate for veterans' homeless assistance programs. A "revolving door" program model will neither critically address the homeless veterans' problem or end veteran homelessness.

VOHC representatives have considered a number of program thoughts that would seek through evaluation to increase the efficiency of homeless programs and add incentives to further stimulate effective program models. The following thoughts resulted from one member organization's brainstorming session:

Determine what constitutes a successful program model and what services need to be provided to homeless veterans,

Develop an industry "standard of excellence",

Develop a concurrent program review, i.e., who currently meets established standards and develop a paradigm to meet such standards,

Convert current grant program to a contract program.

Reward programs meeting the established industry standards,

Data collection (demographic analysis of homeless veteran population),

Allow programs not meeting industry standards a reasonable period to adjust programs and services,

Encourage existing local grant programs to consolidate energy, efforts and resources,

Encourage a greater degree of coordination and cooperation among Federal agencies responsible for homeless veterans' assistance programs,

Define initiatives that place a greater emphasis on the prevention of homelessness.

5. CHANGES IN VETERANS EQUITABLE RESOURCE ALLOCATION METHODOLOGY (Section 7)

Recommendation: Implement VERA recommendation NOW.

There is no doubt that many homeless veterans have significant substance abuse, dual substance abuse issues, mental health, and post traumatic stress disorders.

Further, that these mental and substance abuse problems directly relate to a veteran's current or future homeless status.

The reduction in Veterans Health Administration's resident veteran substance abuse, mental health and PTSD programs has saved the United States Government significant dollars when shifted from an inpatient to an outpatient process. Regrettably, the cost savings did little for America's veterans.

It is VOHC's opinion that the real expense has been borne first by America's veterans whose lives slipped from mildly productive to veteran homelessness and secondly by their families, both spouses and children, whose lives and life styles were further sacrificed in the cost savings bargain.

Recommendation:

That Congress request a study to determine the value of inpatient mental health, substance abuse and PTSD residential treatment programs as a "prevention alternative" program to help stop the migration of veterans from becoming victims of their illnesses and deteriorating into the vicious cycle of homelessness. Resident programs offered a controlled environment that works efficiently for veterans.

6. COORDINATION OF OUTREACH SERVICES FOR VETERANS AT RISK OF HOMELESSNESS (Section 10)

The essence of prevention programs to stop veteran homelessness is the identification of at risk veterans coupled with intervention techniques and program resources that can effectively help the veteran.

Recommendation:

The Department of Defense must be a part of the transition team with the Department of Veterans Affairs in a prevention program for "at risk" military personnel separating from their service component. Included in the "at risk" category are personnel separated for the convenience of the Government; on a fast track for qualitative reasons (administratively separated under honorable conditions); disability severance actions; or other circumstances that will have an immediate impact on their transition from service, continued health care, or opportunity to secure gainful employment.

7. PROGRAMMATIC EXPANSIONS (Section 13)

The Homeless Providers Grant and Per Diem program is internally funded at $35 Million and provides transitional housing beds for homeless veterans in a safe and controlled environment.

Grant and Per Diem are two separate elements of the program with grants providing the facility in new housing programs. The Per Diem program allows a daily payment of up to 50 percent for a maximum $19.00 per day to provide services to veterans housed in "Grant" provided facilities. Grantees must provide matching funds for the 50 percent not funded through the Department of Veterans Affairs.

The requirement for homeless housing and support services continues to grow every year. The current fiscal resource of $35 Million for the Grant and Per Diem Program provides approximately 5,000 beds, which will decrease by fiscal necessity to 4,000 beds when the new per them increase is implemented. A budget increase to $43 Million would sustain the annual 5,000 bed increase or status quo but not meet the program requirement for housing and services to end veteran homelessness in a decade.

The lack of funding in the Grant and Per Diem Program has resulted in the disapproval of 426 grant applications in the past seven years. Approximately 60 valid applications of reasonable merit were denied each year because funds were not available. The ability to move veterans off the streets is obviously limited by the bed and services available to accommodate their journey to employment and independence.

Recommendation(s):

The Homeless providers Grant and Per Diem Program needs to be a separate budget line item funded at $120 Million to add approximately 9,000 beds and with the increased per them rate to total nearly 14,000 beds.

Currently, the Grant and Per Diem program requires the community-based provider to use both elements. Recommend that established housing programs have access to the Per Diem element for program expansion that does not require facility enhancement or expansion.

That Community Based Providers be authorized a new flat fee formula based on the state home domiciliary rate. That authorization for this rate would eliminate the 50 percent per them match requirement.

Failing the above Per Diem Match recommendation allow the community based provider to match the VA 50 percent per them authorization with consideration of "in kind services or a workload credit."

8. EXTENSION OF HOMELESS VETERANS REINTEGRATION PROGRAM (HVRP) (Section 19)

Gainful employment is the key to ending homelessness. HVRP managed through the United States Department of Labor, Veterans Employment Training Services is the most significant program nationally focusing on the employment of homeless veterans. Local HVRP initiatives offer employment and job-readiness services that place veterans into paying jobs. Job placement into opportunities above minimum wage provides the income and motivation necessary to break the cycle of homelessness.

Recommendation(s):

(1) That Congress invest $50 Million per year in the Homeless Veteran Reintegration Program that in turn will move homeless veterans to self-sufficient tax-paying citizens.

(2) HVRP has unlimited potential to provide gainful employment opportunities for "at risk" veterans across America and should be developed as a preventative initiative to stop homelessness.

9. ASSISTANCE FOR GRANT APPLICATIONS (Section 17)

Strongly endorse the recommendation in S–719 that the Secretary of Veteran: Affairs carry out a program of technical assistance through grants to nonprofit base(community groups to provide community based providers to assist them in grant application processes relating to homeless veterans.

Recommendation:

That Technical Assistance Grants be made to established nonprofit organization: recognized nationally for their program efforts in direct support of homeless veterans.

CONCLUSION

Mr. Chairman and members of the Senate Veterans Committee I again thank you for you leadership and caring for America's veterans.

I would be remiss if I did not further extend to you the appreciation and respect of the Non Commissioned Officers Association, The Veterans Organization Homeless Council, and the National Military and Veterans Alliance for naming S. 739 as the Heather French Henry Homeless Veterans Assistance Act. Heather French Henry, as the reigning Miss America 2000, choose homeless veterans as her platform and for the thirteen months of her reign proceeded to create a national awareness of homeless veterans. Ms Henry's motivation and action on behalf of these American Veterans were noble. You commend the right person, Heather French Henry as America's Homeless Veteran Advocate by naming this United States Senate Legislative Act in honor of her service to America.

We are confident that you will continue to press this legislative agenda until it is enacted. Your leadership to secure this legislation must also be coupled with the tenacity to secure the needed fiscal appropriation to make the stated national goal to end homelessness among veterans a reality.

Your efforts are appreciated.

Thank you.

Senator WELLSTONE. I—well, I am just trying to—let me thank you for your testimony, Mr. Schneider. And before going to Mr. Shaughnessy, who I think has a very powerful perspective to present, just two quick things—I can say it in 30 seconds—occur to me. One is I do think that with your conclusion about being mad as hell, the indignation, I do think that, you know, we are going to continue to bump up against, oh, if we do this, we don't have the money to do that, we don't have the money. And then, of course, the question is: Well, what about the cost of the people that are homeless, you know, who served the country? And I really think we are going to have to really turn up the heat. We are going to have to put a lot of pressure on. You know, you said it here. I

think we are going to have to do a lot of organizing in the veterans community, and I hope we can get the support to get this done.

The other thing I wanted to say to you, Mr. Schneider, is that I suspect—you know, not knowing you well but just listening to what you said and almost more the way you said it, we may very well come from different backgrounds, and I want to tell you that for me I would have to say—and, again, I guess I could thank Jimmie Lee, among others, but you would be at the top, Jimmie Lee. I was in the war against the Vietnam war, for example. I mean, I adamantly opposed the war. When I came here to the Senate, I knew hardly anything about veterans. I knew so little. And I just couldn't believe, just through our office from calls and people we began to try to help, you know, that—I just couldn't—I felt like I was a fairly well educated citizen, but I just did not have any understanding of the number of veterans who fell between the cracks, who weren't getting any help at all. I had no understanding of it at all. No understanding of it at all.

And I would say—and, you know, you can't say this unless you mean it sincerely. I would say of the work that I have done as a Senator, or tried to do—I hope to the best of my ability—the most rewarding, the work that I am most emotional about has been with the veterans. And you were the one who captured it in what you said, so I just wanted to say that to you.

Mr. Shaughnessy?

STATEMENT OF DANIEL SHAUGHNESSY, MEMBER, LOCAL 495, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO, AND ADDICTION THERAPIST, TUCSON VA MEDICAL CENTER, SOUTHERN ARIZONA VA HEALTH CARE SYSTEM, TUCSON, AZ

Mr. SHAUGHNESSY. Thank you. Senator Wellstone, my name is Danny Shaughnessy, and I am a 60-percent service-connected disabled veteran of the United States Marine Corps. I served in Beirut in 1982 and 1983, and I have a master's degree in social work. I work as an addiction therapist at the Tucson VA. I am a steward of Local 495 of the American Federation of Government Employees.

I was a homeless veteran and alcoholic. I lived on the streets of Southern California and Tucson, Arizona, for a little over 9 months.

S. 739 will help get homeless veterans the care and the treatment that they need, and AFGE supports the passage of this legislation.

In the Marines, I was a functional drunk. I was a hard-drinking, hard-fighting, and hard-charging Marine. After I was discharged from the service in 1986, I worked but my drinking got in the way. During this time, I lost my apartment, my family, and everything I owned. I became one of those people on the streets that children are taught not to look at.

During the time I lived in a shelter, my self-esteem was lower than the curbs I stumbled across. I began to think this is not how my family brought me up to be. As a 25-year-old homeless veteran, I began to wonder if my life was over.

I turned to the VA is 1987, and I had to wait nearly 2 weeks for an inpatient substance abuse bed to open up. I was placed in a homeless shelter and waited and waited.

We need more inpatient detoxification beds or detox beds for treating homeless veterans. A few years ago, our facility had six acute medical detox beds. Now we have three. Detox is the first stage in substance abuse treatment. These beds are essential. For many veterans, delirium tremens, commonly known as DTs, can cause a heart attack or even worse.

Last week, I served as the intake coordinator for our substance abuse treatment program. Nineteen homeless veterans called for those three detox beds that we have. What do we do with the extra homeless veterans?

We stuck them in pretreatment purgatory. Pretreatment is not state-of-the-art care. We only do it because our beds have been cut.

Since I wrote this testimony, the number of homeless veterans in pretreatment were up to 13. They are living in the shelters, on the streets, and in the desert until a detox or treatment bed opens up.

Some 60 percent will drop off the pretreatment list. Many will relapse and many will die.

I hate what happens to veterans because we don't have a treatment bed or a detox bed. Some 10 to 15 veterans have died waiting for a detox bed in the summer heat of Arizona since I have been doing this.

Beds for intensive substance abuse treatment are also vital to help homeless veterans begin a new life. At our VA, we have used an effective, intensive residential treatment program—we used to have, excuse me. Homeless veterans receive 28 days of around-the-clock support, intensive treatment, and the medical care needed. This treatment saved my life.

Two months ago, all 20 of our hospital's substance abuse beds were eliminated. The VA management has made this space into being an outpatient care team. We have not opened up any new rehab beds in our hospital. Instead, the VA contracted for 10 beds in the community. Homeless veterans are being warehoused at this contract facility. The loss of inpatient substance abuse treatment programs is devastating.

Senator Wellstone, your bill will help rebuild and expand the homeless programs that helped others and me. I am, however, concerned that the VA may still try to treat substance abuse on an outpatient basis. I have seen inpatient services shrink to the point that the sheer numbers of homeless veterans that need a bed overwhelm the direct care staff because we do not have beds available for these veterans.

I cannot emphasize enough how the lack of substance treatment beds is affecting our ability to end homelessness. In the military, I was taught we don't leave our wounded behind. Homeless veterans who are mentally ill and addicted to drugs and alcohol are still wounded. It is immoral for us to leave them behind and deny them the inpatient care that they deserve.

Thank you for the opportunity to speak.

[The prepared statement of Mr. Shaughnessy follows:]

PREPARED STATEMENT OF DANIEL SHAUGHNESSY, MEMBER, LOCAL 495, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO, AND ADDICTION THERAPIST, TUCSON VA MEDICAL CENTER, SOUTHERN ARIZONA VA HEALTH CARE SYSTEM, TUCSON, AZ

Chairman Rockefeller, Ranking Member Specter and Senator Wellstone: my name is Daniel Shaughnessy. I am a 60 percent service-connected disabled veteran of the United States Marine Corps. I served in Beirut in 1982–83. I have a Masters in Social Work and work as an Addiction Therapist at the Tucson Arizona Veterans' Affairs Medical Center (VAMC). I am proud to be a member of Local 495 of the American Federation of Government Employees, AFL–CIO.

I also was a homeless veteran with an alcohol addiction who lived on the streets in Southern California and Tucson, Arizona for nine months.

Thank you for the opportunity to testify today about S. 739, the Heather French Henry Homeless Veterans Assistance Act. This legislation will help get homeless veterans the care and treatment they need by pushing VA to expand and improve vital programs. AFGE supports passage of this legislation. My struggles as a homeless veteran, successful treatment at the Tucson VAMC and years of experience as a social worker specializing in substance abuse treatment for homeless veterans suggest some key ways in which this important bill can be even stronger.

When I was honorably discharged from the Corps in 1986 I, like so many homeless veterans, did not take a traditional path from the service to school and then to work. I had a much more difficult route to follow—addiction and homelessness. When I was in the Corps I was a functional drunk. My addiction did not prevent me from serving; I was a hard-drinking, hard-fighting and hard-charging Marine. I was even able to work for a few months after I was discharged from the service, but my drinking got in the way and I quit my job before I was fired. During this time, I lost my apartment and everything. I was drinking, was very angry, and my family was afraid of me. I began to live on the streets. I became one of "those people" that children are taught not to look at.

I hid from my problems and society by drinking. My addiction was not a conscious decision. During the time I lived in a shelter I worked as a day laborer. With the small amount of money I made I could buy alcohol but never get ahead. My self-esteem was lower than the curbs that I stumbled across. I began to think, "This is not how my family brought me up." This realization came while I was sitting on a lifeguard tower on an empty beach at midnight. As a 25-year-old homeless veteran I began to wonder if my life was over.

I struggled with my addiction for another two months until I walked through the gate of the Tucson VAMC Center in 1987. The first person that I met was Sandy Eggleston, a social worker in the homeless program. She assessed the situation and referred me to the VA's substance abuse treatment program. I had to wait nearly two weeks until an inpatient bed opened up. During this time I was placed in a homeless shelter and waited and waited. After day labor I would go back to the VA to check in with Sandy and that helped me stay sober. Sandy is now our union's Local President.

The lack of inpatient detoxification or "detox" beds is a major barrier to treating homeless veterans. In Tucson, roughly 75 percent of veterans in our substance abuse program are homeless.

A few years ago our facility had six acute medical detoxification beds. Now we have three. Now veterans who want to become sober must wait twice as long. Detox is the first stage in substance abuse treatment. These beds are essential for veterans coming off severe alcohol addiction or who are already medically compromised patients. For many veterans, delirium tremens, commonly referred to as DTs, can be severe enough to cause a heart attack. Detoxification beds are needed to prevent renal failure and other medical complications during the detox phase of treatment.

Last week, I served as the intake coordinator for our substance abuse program. I received calls from 19 homeless veterans who wanted to get in those three detox beds. The lack of in-patient detox beds is widespread across the country.

Our staff has devised a creative but woefully inadequate way to deal with the limited number of beds for detox. We register veterans for "pretreatment." In effect, we are telling veterans to go back to the shelter but come back every day for an hour of care until a bed opens up. "Pretreatment" is not state-of-the-art care; we only do it because our beds have been cut. Currently my facility has 11 homeless veterans who want to get sober in "pretreatment." They are living in shelters, on the streets and in the desert until a bed opens up to provide them with detox or treatment.

On average, some 60 percent will drop off the "pretreatment" list because they are tired of waiting. Many will go back to drugs or alcohol, some will try to go elsewhere for treatment, and some will die of drug and alcohol related incidents.

One of the saddest things for me since I made the commitment to help fellow veterans is watching homeless veterans die from the disease of addiction and our failure to provide them with inpatient treatment. Some 10 to 15 veterans have died waiting for a detox bed in the summer heat of the Arizona desert. One veteran who was waiting for a bed was the 112th homeless veteran I had known who died from substance abuse. This veteran touched my life in such a deep way that I stopped counting the deaths of veterans who are waiting for a detox bed or treatment.

When our facility was planning to eliminate all detox beds for cocaine and heroin addicts, a compromise, although unsatisfactory, was reached. We now have six specialized beds on the locked psychiatric unit. Most detox beds are not on locked wards and I believe that this creates an unnecessary deterrent for homeless veterans to seek treatment.

Post-detox inpatient beds for intensive substance abuse treatment in VA facilities are essential to ensuring that homeless veterans begin real recovery.

After detoxification, the next stage in substance abuse treatment at our facility is the partial residential rehabilitation treatment program (PRRTP). In layman's terms this is like a halfway house but it is in the VA's medical facility. This program is a subacute care unit where homeless veterans receive 28 days of round-the-clock support, intensive treatment, and needed medical care. Addiction research shows that better outcomes are achieved with longer intensive treatment after detox. This part of the treatment was pivotal for me.

Two months ago all 20 of our facility's residential rehabilitation beds were eliminated. The beds, which had been used to provide inpatient care for recovering homeless veterans, are being pushed aside to make room for a new primary care team. Instead of opening up new residential rehabilitation beds in our facility, the VA has contracted for ten beds in the community. Homeless veterans are just housed at the facility overnight and eat their meals there on the weekends; during the week they eat at our facility.

Since our facility used to have 20 beds and has only contracted for ten I believe we have failed to maintain our capacity to treat homeless veterans with addictions. Moreover, as an addiction therapist, I believe that shunting homeless veterans back and forth between the medical center for treatment and these contracted beds is not as therapeutic as when the veterans receive treatment in a residential program in the hospital. The loss of an inpatient intensive substance abuse program is significant. Tragically, it is common throughout the country.

In order for homeless veterans to reenter society they must have supportive residential programs.

S. 739 will help rebuild and expand the homeless programs that helped others and me. It requires VA to develop new domiciliary programs in the ten largest metropolitan service areas without existing programs. AFGE supports this effort. Homeless veterans who have been through DVA's substance abuse treatment programs need further intensive treatment and rehabilitation in a residential setting.

The Tucson VAMC does not have a domiciliary. When I went through treatment the VA contracted with a halfway house from me to stay in for 60 days. Four years ago, because of flat-line budgets, our facility cut the length of stay to 31 days.

In addition to opening new domiciliary care facilities I urge that the legislation require VA to evaluate the length of stay and outcomes achieved in both VA operated facilities and VA contracted residential transition facilities.

LESSONS LEARNED

The support that I received during inpatient detox, intensive rehabilitation and transitional residential care allowed me to stay sober. However, many homeless veterans I began treatment with and have subsequently treated as a social worker are unable to cope with the long waiting periods to get into detox and treatment. In fact, the wait to get into treatment is anywhere from 2 weeks to 1 month at our hospital at this time.

The changes to the funding formula for VA facilities proposed in this legislation are key to providing medical directors and their supervisors with greater incentives to care for homeless veterans. S. 739 requires that VA expand its mental illness programs; this is a vital step toward ending homelessness. I am, however, concerned that VA may still try to treat substance abuse on an outpatient basis.

I was able to have my treatment in a VA in-patient program and was able to take advantage of VA's halfway house contracts, and regularly attended the VA sponsored aftercare program. Through the assistance of VA staff I was able to be in a position to seek compensation for service connected disabilities that occurred while I was in the Marines. After receiving my service connection rating I was eligible for the VA's vocational rehabilitation program and completed a baccalaureate and mas-

ter's degree in social work. While completing my baccalaureate I started a nonprofit organization for homeless veterans. The focus of the program was to help homeless veterans with mental illness and substance abuse problems.

The loss of VA in-patient services for homeless veterans that have psychiatric and substance abuse problems was one of the main reasons that I took the job at the VA and left the program I started. I truly believe that I made a difference in many veterans' lives while working in the community setting but it was time to make a difference from inside the VA. I have seen inpatient services shrink to the point that the sheer numbers of homeless veterans that need a bed overwhelms the staff because we do not have treatment beds available for these veterans. I cannot emphasize enough how the lack of substance abuse treatment beds is affecting our ability to end homelessness.

In the military I was taught that we don't leave our wounded behind. Homeless veterans who are mentally ill and addicted to drugs and alcohol still carry the wounds of war with them. It is wrong of us to leave them behind and deny them inpatient care.

Thank you for the opportunity to testify.

Senator WELLSTONE. Thank you. That is very, very powerful.

I might just go with this just because we finished with you, Mr. Shaughnessy. I might just respond briefly to what you said.

Part of the issue is whether or not the substance abuse is designated as a part of what we are calling complex care. Is that correct? And right now it is not?

Mr. SHAUGHNESSY. Well, it is on a sunset—it is not the sunset criteria concerning complex care. Basically what it is, sir, you have to reinvest that care every year. They have to have a certain amount of bed days every single year to get that complex care money every year.

Senator WELLSTONE. But the report you are giving, I mean, people don't even get to the point—Jimmie Lee, the discussions I have had with him, he has talked about where is the housing, right? We don't have the housing. But people don't even get to that point or even to the point of being able to, you know, get the skills development and get back out in the labor market and work until they first are able to deal with addiction, correct? And, of course, what you are saying, it is not there, both in terms—we don't have the delivery of the services.

Mr. SHAUGHNESSY. It is gone.

Senator WELLSTONE. What?

Mr. SHAUGHNESSY. For all intents and purposes, it is gone, you know, and it is leaving all over the country.

Senator WELLSTONE. By the way, just as an aside, I hope you don't think—I want to focus on this hearing. One of the pieces of legislation that I believe we are going to pass—we are going to mark it up in committee probably next week now or the following week—deals with mental health services, which basically says it has to be treated in all insurance plans the same way as any physical illness. I would have liked to have had substance abuse in that bill, but we are going to work on doing that as well. I just think it is crazy that we—you know, in other words, what I am saying, with these health plans what happens is they say diabetes, heart condition, all the rest, you know, this is the coverage. Then when it comes to, you know, somebody who is struggling in the way you were so honest to talk about yourself, it is like detox two or three times a year, 2 days at a time, that is it, no more coverage, period—which is crazy. I mean, it is actually just blatant discrimination, and, of course, the consequences are so harsh.

Let me start out with Ms. Boone. I want to ask questions of each of you, if I can. You testified that there is an unaddressed—I am going to quote—"need for housing that is safe, clean, sober, and has responsible staff," and that your organization strongly supports the flat fee—I want to get this on the record—formula for the Homeless Providers Grant and Per Diem Program based on the State home domiciliary rate.

VA supports simplifying the program but believes that the homeless grant providers should be only 85 percent of the State home rate.

Again, for the record, your view of this recommendation?

Ms. BOONE. Well, we see it as that the type of care that our community-based organizations are providing through the Grant and Per Diem Program mirror what the State domiciliary homes are doing, so that should be a fair rate. And right now the rate is like $22 a day. So that is what—we support that.

Senator WELLSTONE. And without it, you just don't get the resources to do the job?

Ms. BOONE. Right. I mean, the Grant and Per Diem Program is a critical, critical piece in a community that wants to serve homeless veterans. That is sort of like the seed money, and then they are able to go out and get other grants, usually HUD grants or State grants, and combining those is really able to serve—put together a real comprehensive, you know, care plan for veterans in a community. So the VA Grant and Per Diem Program, we just can't emphasize enough how critical it is that that money is available for some of those startup groups because they can't—most of the homeless veteran groups that have been established in the last 5 to 10 years can't compete with the organizations that have been around for 100 years for the HUD continuum of care money as entryway. So this VA Grant and Per Diem is very, very critical and they need that.

Senator WELLSTONE. Mr. Schneider talked about this, as I remember. I think he was the one—this whole issue of technical assistance.

Mr. SCHNEIDER. Right.

Senator WELLSTONE. Either one of you, actually. The VA testified that Section 17 of the bill, which is the assistance for grant applications, is unnecessary and there is already extensive information available for private providers to access the Federal assistance. What is, for any of you, I guess, for any of you, what is your perspective on the adequacy of VA's current offerings in terms of assistance and capacity building for the private providers?

Mr. COULTHARD. I guess I would like to respond to that, Senator Wellstone. Right now we have got an application in, and I read the application, the guy that put it together for us, and I am embarrassed by it myself. And if it gets funded, it will be funded because they know the need is there and we are probably good providers. The application is terrible. I was embarrassed by it.

But one of the things that happens to us with all these applications is that HUD has a time line, followed by the 78-page document. The VA has a time line. Theirs is not much smaller. Each one of these agencies has different time lines, wanting to know the same type of information, and to get—it is there if you have the

capacity to find it on the Internet, if you know how to do that kind of thing, if you know how to write grants, then it is probably there.

Our HVRP grant that we did, I never found our technical performance goals until we got our second grant. I couldn't find it anywhere. I asked for it. I did all kinds of things. It was probably there all along. I was just asking the wrong people, and the people I did ask weren't providing it to us. Once we had it, we put it in place.

But I do think that there are all kinds of providers that are submitting poor applications that are good providers and they are getting turned down, just like was said, because they couldn't hit the mark with their application. And yet they are providing—that is kind of the harsh thing about it. Most of these providers, I think, are trying to provide services without the dollars. All they are trying to do is get some dollars so they can become a little bit better, and you are really kind of penalized unless you can write a good grant. And I think that we all want to write good grants. We just need somebody that we really know we can turn to, like the National Coalition, and get that information today and say this is how you do it and get that kind of training.

I am kind of shocked that they don't really combine all their grants. I mean, it is the same veterans that we are all trying to look at, but they don't combine their grant process. They don't combine the reporting systems. They could all have their own section, you know, the VA, Department of Labor, HUD. They could all have it. They could all approve it and give us one application and then just give us the software to report back to them. Give us the training on it that would go right with the grant.

Ms. BOONE. It is my understanding that the VA does not have authority to provide technical assistance. They don't have the authorization to do that. That is what I have been told. So some provision is needed to be able to authorize them to be able to do that.

Senator WELLSTONE. It is in the bill. That is in the bill, and we talked about that.

Ms. BOONE. That is right. Exactly.

Senator WELLSTONE. I want to keep that in there.

Ms. BOONE. And HUD, who has the most of the homeless money and the housing money and supportive services money chose not to provide technical assistance specifically for homeless veteran providers. We applied a couple of different years. They recently gave a grant to a provider that has nothing to do with homelessness among veterans, knows nothing about veterans, but they gave them a grant to provide technical assistance to homeless veteran providers. And they have been struggling because they were paying them actually to learn about homeless veterans so they can turn around and do some technical assistance. So we oppose that process.

Homeless veteran providers, most of them that are serving 100 percent homeless veterans have been established in just the last few years. The National Coalition for Homeless Veterans has been in business since 1990, and some of the providers started before that. But the majority of providers that serve specifically homeless veterans have become established after 1990. They don't have this expertise or the staff to compete with the organizations like Salvation Army, Volunteers of America, Goodwill, who have been around

for a hundred years and have the staff and the experience and the community connections. So it is really critical that this nucleus group that is serving homeless veterans learn how to do that better in terms of providing their information.

The other issue is because advocates and Congress have been very good to veterans, increasing the two pots of money that homeless veteran providers can access, more groups that veterans are not their primary clientele have been coming to the table and submitting grants and getting that money and taking away from other providers that their clientele is 100 percent veterans. Is that good or bad? Well, it depends on the community, you know, and if veterans are getting served.

But what is happening is that the veteran providers that went in business to serve homeless veterans are losing out because they can't be competitive, and that is the issue.

Senator WELLSTONE. Dick, you had commented on it, too, earlier.

Mr. SCHNEIDER. Yes. I see it as both. I have spoken in the same venue, but what I see is the lack of education and fundraising and grant writing that exists in a community-based organization that is providing homeless care. You have people that are working 18 hours a day taking care of homeless veterans, taking care of the business of the client. They don't have the time and the energy to put together a 78-page document to come in for a grant. And when grant applications come in and are discredited because they are not complete, they didn't score high enough, it is really the absence of understanding, of knowing how to do it. And our recommendation is get an organization that is recognized in homelessness, wherever that organization is, as long as it is a national type organization, get that organization and allow them to give the technical assistance. Look at grant applications that have been denied and help those organizations develop the opportunity to complete a grant that would be acceptable.

Senator WELLSTONE. Let me ask, because we are going to run out of time in about 5 minutes, a question that starts with Jimmie Lee, but I would actually like each of you to respond to it.

We have talked about some of the features in the legislation, and we have talked about the money issue, which I think we are going to come up against that because I am convinced that—I have said it to Secretary Principi. I said, you know, as good a heart as you have and as committed as you are, the worst thing that could happen is if you have a budget that is so inadequate that people say, well, God, you know, we came out here and we believed in them, and nothing really happened, because I am telling you, of that $1 billion, I think $900 million is medical inflation. And then we don't even get to the whole issue of substance abuse of homeless veterans. We don't get to the issue of Millennium, of aging veterans, of home-based care. We don't get to the issue of hepatitis C, and we don't get to any of that.

But above and beyond that, the question that I wanted to ask you, Jimmie Lee, and the rest of you is: Do you think that there is any kind of culture change that needs to be made at the VA or, for that matter, the Federal Government when it comes to addressing veterans' homelessness? Because you are down in the trenches.

Mr. COULTHARD. No, I don't. But I can only speak about the VA that I work in, the VISN I work in. Most of the people have bent over backward to really help us do what we are doing. But yet I agree with what I hear down there with Danny. I do not agree with what has happened in our VISN with care for chemical dependency treatment. I don't believe that it needs to be inpatient, but I do know that it needs to be residential. And so there is that disagreement that I see that is happening inside of it. Ron and Pete and everybody that I know around here have really bent over backward to try to help us become successful.

But I think that, you know, I go back to my statement about Secretary Principi, lead us out of this, because the last Secretary, Togo West, didn't ask for the adequate budget when he was even given the opportunity. And I think you brought forward a request for more money for the VA that they weren't even asking for. And that just boggles my mind that they aren't asking for the full measure and fighting for it and asking for the dollars that they need for this.

Senator WELLSTONE. Well, each of you, it occurs to me, it could be that question, or really I just would like of the three of you, if we are going to—if you could respond to that question, or it could be just if we want this to be more than—I mean, the one thing I just don't want this to be is symbolic politics, have a hearing, 10 years we are going to end it, and then, you know, 10 years from now—what do you think we need to do to really just get the country to focus on this, get the Congress to focus on this? You all are such advocates. This is your passion. It is your indignation. What is your best recommendation you can give me as to what we need to do?

Ms. BOONE. From our opinion, the Interagency Council is a good place to start. But that has to come from the President. The passion has to come from the top, and this country has to really set a goal.

Years ago, we set a Federal plan to implement—you know, to end homelessness within 10 years. Parts of that plan have never been implemented. So I think that, you know, as a Nation as a whole, we need to get refocused. Is this an acceptable living condition for our citizens? And if it is not, then we need to have a passion to do that.

For veterans, I think that there are good people at the VA that are doing great things, and I think that the rest of the country thinks that the VA takes care of all veterans for all things. And so there is that, you know, sloughing off, we will just send them to the VA.

The VA is not delivering consistent service at all VA hospitals or regional offices for benefits. There is not consistent—you have pockets of good things happening, and then you have some that are really inadequate. And I think that the VA needs to be more consistent and step up to that.

But the Secretary of the VA needs to make sure that everyone knows, the other Cabinet members know, that homeless veterans are everybody's responsibility from all those Cabinet levels, and that needs to start with the President and down to the Interagency.

Mr. SHAUGHNESSY. Senator Wellstone, in 1987, after I got sober, I went down to the library and learned how to run a non-profit agency, and I started one for homeless veterans. And actually it is still running real strong today, actually. And I knew that I made a difference from outside the VA system. So that is when I took the job inside the VA to see if I could make a difference from the inside, the way that people think about homeless veterans.

Instead of people thinking about them as being basically a pain the butt to deal with because they don't smell very nice or they don't look very nice or their dental care is awful, I thought that make a difference inside and educating people inside about what homelessness is all about, that it would make a difference.

I personally haven't seen a tremendous difference in that since I have been working in the VA about the past 5 years. However, people are starting to become more cognizant of the problem itself in there. I think that people don't want to look at it because it is an ugly thing to look at for a lot of people. It is easier to overlook the homeless people and to step over them, especially the substance-abusing one, than it is to deal with them because it takes effort to deal with them. And I think that is what it is. It is a little bit a lack of effort, maybe, and a lack of wanting to deal with the problem because it is a hell of a problem to tackle.

Senator WELLSTONE. I have got to believe—and I want to let Dick have the last word. I have got to believe, Dan, that when someone is struggling with substance abuse and they come in and there is a long wait, that has got to be lethal. You know, that is the moment when that person is going to come in, and then there is this long wait and they don't get the care, and then they are gone. Is that not true?

Mr. SHAUGHNESSY. Over 60 percent of the people basically on our waiting list drop off. That is 60 percent—because when they come in, they are ready right then. That is the point that it is to get them, when they are ready. And, you know, sometimes we have to put people—the people that are lucky enough to get into detox, sometimes they have to go back and wait in a shelter until a bed opens up in the intensive treatment program, and that is not good continuity of care. And once you get them in the door, that is the best time to keep them because then you can do a full range of services. And that is when you start building people's self-esteem and they can get better.

The VA has great programs. I mean, I used the vocational rehabilitation program for my bachelor's degree and my master's degree. That is an unbelievable program that not a lot of people know about. But we haven't seen a veterans benefits officer at our VA in probably 8 years. So basically what happens is who helps the vets is I am doing a lot of the work that I don't, you know, know as well as other people. However, I do try to send them to the DAV and the VFW and the American Legion and the Military Order of Purple Heart, Paralyzed Veterans of America. They all do a great job at trying to get these people disability payments that they rightly deserve for being wounded in the service or whatever.

I had a gentleman come in the other day that was 100-percent service-connected for post-traumatic stress disorder. He was a Marine combat veteran in Vietnam, did two tours. We had to send him

back to the street because we don't do heroin detoxes. So it is a difficult thing.

So attitudes have to change. Are they going to? I don't know. Sometimes I am a little bit doubtful. But, fortunately, seeing how passionate you are about this actually gives me a little more hope.

Thank you.

Senator WELLSTONE. Thank you.

I would like you to finish up for us.

Mr. SCHNEIDER. Thank you very much, sir. I am just overwhelmed by my colleague, I really am. In listening to what has been said, I remember a gentleman last year that stood up and put his hand up in the air and said, "Help is on the way." "Help is on the way." He made that commitment to the armed forces. He made that commitment to the veterans. And I believe that the help that is necessary for homeless veterans and motivation, the national motivation needs to come from the top. It needs to come from Pennsylvania Avenue.

I think we have awfully dedicated people within VA. I think we have people who are going the extra mile. But they are limited by dollars, and they are also limited by policies that have taken beds and inpatient care units out of hospitals that are making those six out of ten leave the VA and walk away. And, you know, there are probably some people that are saying, gee, they didn't come back, they really didn't want to be cured. They never knew the motivation or the attitude that you have got to get them when they are ready. And they rejected them when they were ready, and they left. And they may have died on the streets or they may have left and died elsewhere. But they were ready and they came and they had their hand out, and they were told to come back at a more convenient time, we are not ready to do that today.

I think it comes down from the top. It comes down to motivating the Interagency Council, the Cabinet officers. It comes down to the dollars and to the appropriations that will be made.

You know, we never would have put anybody on the moon if we didn't fund the program. We will not end homelessness unless we take the dollars, put them into the programs, and begin the migration of people from the streets into the shelters, through the care that is needed, to employment readiness, and then employment. Employment takes a person off the street, and it is not flipping hamburgers. Employment with credible jobs takes them off the streets.

Senator WELLSTONE. Sure. Absolutely.

Mr. SCHNEIDER. Mr. Wellstone, I would just like to end with this comment. Thank you for your leadership and, to end with, thank you also that when you started today you said you named this for Heather French. Heather French, Miss America 2000, created more public awareness and the national attention on homelessness than anybody in the past 10 years. You have named your legislation, as it was named in the House, for an individual who deserves singularly the honor of being the veterans' advocate, and I applaud you for it.

Thank you.

Senator WELLSTONE. Well, I would like to thank—I want to get back to the panelists. I want to say to the Filipino veterans who

have been sitting through this long hearing that we thank you for coming. Congressman Filner, who is a great advocate for you, has certainly been in touch with me, and I would be remiss if I didn't mention his advocacy. I want you to know he has really spoken very strongly for you, and I appreciate your being here.

I would like to thank other Senators who were here. They had other committee—you know, it has been my honor to get to chair this, but they all are very committed to this area, and they had other markups to go to and other committee hearings. But I feel like I got—I am so glad I got to hear from you. Thank you. What you said was very powerful, and I believe it will make a difference. I believe that.

Thank you so much. Thank you, everyone.

The hearing is adjourned.

[Applause.]

[Whereupon, at 3 p.m., the committee was adjourned.]

APPENDIX

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

Mr. Chairman, thank you for holding today's hearing which focuses on how we can better address the needs of our nation's homeless veterans. I would like to welcome Veterans Affairs Under Secretary for Health Dr. Thomas Garthwaite and his colleagues from the Department. I would also like to welcome the representatives of organizations which assist homeless veterans.

As we all know, veterans comprise about one-third of the adult homeless population in the United States on any day. These veterans typically face multiple challenges in their daily lives, including mental and physical disorders, substance abuse problems, and limited work and social skills.

Homelessness among veterans is a complex issue which presents many questions as to how our government can be more effective in assisting homeless veterans to realize their full potential. I believe that today's hearing will help to identify ways to improve the effectiveness of existing programs and activities.

Today's agenda also includes health legislation pending before the Committee. In particular, I am pleased that the agenda includes S. 1042, the Filipino Veterans' Benefits Improvements Act of 2001. Introduced by Senator Inouye, the bill would improve benefits for Filipino veterans of World War II who served in the United States Armed Forces. I am a cosponsor of S. 1042 since it recognizes the contributions of Filipino World War II veterans and corrects an injustice by providing them with the veterans' benefits they deserve.

I welcome the opportunity to receive oral testimony from today's witnesses on the veterans homeless legislation and review the written testimony on health legislation pending before the Committee.

Mr. Chairman, I look forward to working with you and the other members of the Committee on legislation to address the needs of our nation's veterans.

Thank you.

PREPARED STATEMENT OF HON. TIM HUTCHINSON, U.S. SENATOR FROM ARKANSAS

Mr. Chairman, Senator Specter, I would like to express my appreciation for including S.Res. 61 as part of this important hearing. Last March I introduced this legislation that would express the sense of the Senate that the Department of Veterans Affairs should recognize board certifications from the American Association of Physician Specialists for purpose of special pay by the Veterans Health Administration. This legislation is aimed to at ensuring that our veterans receive the best health care available.

Since 1997, the AAPS has worked with the Congress and the VA, providing all documents requested by the Under Secretary for Health, in an effort to have their board credentials recognized. However, the VA thus far has not been responsive to these efforts.

I believe that it is critical that our veterans have access to the highest quality health care. Because the Veterans Health Administration only recognizes the certifications of two organizations for special pay, it discourages many fine physicians from working with the VA. My legislation would signal the Senate's belief that are veterans should receive the highest quality health care from our nation's finest doctors.

In addition, I would like to include for the record a statement from the AAPS. I look forward to hearing the comments of the administration, and hope that in the near future that S.Res. 61 can be approved by this Committee.

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

Mr. Chairman and Members of the Committee:

I introduced the Filipino Veterans' Benefits Improvement Act of 2001 to provide our country the opportunity to right a wrong committed decades ago by providing Philippine-born veterans of World War II who served in the United States Armed Forces their hard-earned, due compensation.

The Philippines became a United States possession in 1898, when it was ceded from Spain following the Spanish-American War. In 1934, the Congress enacted the Philippine Independence Act (Public Law 73–127), which provided a 10-year time frame for the independence of the Philippines. Between 1934 and final independence in 1946, the United States retained certain powers over the Philippines, including the right to call all military forces organized by the newly-formed Commonwealth government into the service of the United States Armed Forces.

On July 26, 1941, President Roosevelt issued an Executive Order calling members of the Philippine Commonwealth Army into the service of the United States Armed Forces of the Far East. Under this order, Filipinos were entitled to full veterans' benefits. More than 100,000 Filipinos volunteered for the Philippine Commonwealth Army and fought alongside the United States Armed Forces.

Shortly after Japan's surrender, Congress enacted the Armed Forces Voluntary Recruitment Act of 1945 for the purpose of sending American troops to occupy enemy lands, and to oversee military installations at various overseas locations. A provision included in the Recruitment Act called for the enlistment of Philippine citizens to constitute a new body of scouts. The New Scouts were authorized to receive pay and allowances for services performed throughout the Western Pacific. Although hostilities had ceased, wartime service of the New Philippine Scouts continued as a matter of law until the end of 1946.

Despite all of their sacrifices, on February 18, 1946, Congress betrayed these veterans by enacting the Rescission Act of 1946 and declaring the service performed by the Philippine Commonwealth Army veterans as not "active service," thus denying many benefits to which these veterans were entitled.

On May 27, 1946, the Congress enacted the Second Supplemental Surplus Appropriation Rescission Act, which included a provision to limit veterans' benefits to Filipinos. This provision duplicated the language that had eliminated veterans' benefits under the First Rescission Act, and placed similar restrictions on veterans of the New Philippine Scouts. Thus, the Filipino veterans that fought in the service of the United States during World War II have been precluded from receiving most veterans' benefits that had been available to them before 1946, and that are available to all other veterans of our armed forces regardless of race, national origin, or citizenship status.

The Congress tried to rectify the wrong committed against the Filipino veterans of World War II by amending the Nationality Act of 1940 to grant the veterans the privilege of becoming United States citizens for having served in the United States Armed Forces of the Far East.

The law expired at the end of 1946, but not before the United States had withdrawn its sole naturalization examiner from the Philippines for a nine-month period. This effectively denied Filipino veterans the opportunity to become citizens during this nine-month window. Forty-five years later, under the Immigration Act of 1990, certain Filipino veterans who had served during World War II became eligible for United States citizenship. Between November, 1990, and February, 1995, approximately 24,000 veterans took advantage of this opportunity and became United States citizens.

Although progress had been made, we must, as a nation, correct fully the injustice caused by the Rescission Acts by providing equal treatment for the service and sacrifice made by these brave men. The Filipino Veterans' Benefits Improvement Act of 2001 works to compensate the veterans by providing a number of needed benefits: Dependency and Indemnity Compensation to surviving widows of service-connected veterans living in the United States that were mistakenly excluded from benefits provided under the Fiscal Year 2001 Veterans Affairs, Housing and Urban Development, and Independent Agencies Appropriations Bill; a payment increase to New Scouts and survivors residing in the United States from 50 percent to the full dollar amount for service-connected disability compensation; authorization of non-service connected disability pensions for veterans residing in the United States in the same manner as United States veterans; authorization of non-service connected disability pensions for veterans residing in the Philippines, but at a rate of $100 per month, which matches the amount of the veterans' pension received by them from the Philippine government; access to veterans hospitals for non-service connected disabled

veterans in the same manner as United States veterans; and $500,000 per year to the Outpatient Clinic in Manila.

Heroes should never be forgotten or ignored, so let us not turn our backs on those who sacrificed so much. Many of the Filipinos who fought so hard for our nation have been honored with American citizenship, but let us now work to repay all of these brave men for their sacrifices by providing them the veterans' benefits they have earned.

PREPARED STATEMENT OF BOB FILNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

I appreciate the opportunity to present written testimony to the Senate Committee on Veterans Affairs in support of S. 1042, legislation to restore long overdue benefits to Filipino World War II veterans. Congressman Benjamin Gilman and I have introduced similar legislation in the House of Representatives.

Over fifty years ago, the brave Filipino soldiers of World War II, drafted into our Armed Forces by President Franklin D. Roosevelt, exhibiting great courage in the epic battles of Bataan and Corregidor were unceremoniously deprived of all veterans benefits due to them by Congress in the Rescissions Act of 1946.

Particularly unfortunate was the language of this Rescissions Act which said that service in the Philippine forces was not to be considered active military service for the purposes of veterans benefits. This language took away the honor and respect due these veterans who served under the direct command of General Douglas MacArthur. It shocked the thousands of Filipinos who, along with the Americans with whom they fought side-by-side, suffered brutality during the Bataan Death March and as prisoners of war.

President Harry S. Truman, when he signed the bill that included various other appropriations matters, as well as the rescission of Filipino veterans benefits, stated that a great injustice was being done. "Filipino Army veterans are nationals of the United States. They fought with gallantry and courage under the most difficult conditions during the recent conflict. Their officers were commissioned by us. Their official organization, the Army of the Philippine Commonwealth, was taken into the Armed Forces of the United States by Executive Order of President Roosevelt. That order has never been revoked or amended. I consider it a moral obligation of the United States to look after the welfare of the Filipino Army veteran." That was President Truman in 1946. That moral obligation remains with us today.

For more than fifty years, a wrong has existed that must be righted. I urge you to think of morality, of dignity, of honor. There is scarcely a Filipino family today, in either the United States or in the Philippines, that does not include a World War II veteran or a son or daughter of a veteran. Fifty years of injustice burn in the veterans' hearts. Now in their 70s and 80s, their last wish is the restoration of the honor and dignity due them.

It is time that our nation adequately recognize their contributions to the successful outcome of World War II, recognize the injustice visited upon them, and act to correct this injustice. To those who ask if we can afford to redeem this debt, I answer: "We can't afford not to." The historical record remains blotted until we recognize these veterans.

I urge you to work with your colleagues, both in the Senate and in the House of Representatives, to pass legislation that demonstrates our deep respect for the Filipino Veterans of World War II.

PREPARED STATEMENT OF BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr Chairman, I want to thank you and the members of the Senate Committee on Veterans Affairs for holding this hearing this morning and agreeing to have a panel to discuss the issue of benefits for Filipino veterans of World War II. I would also like to express my gratitude to you for inviting me to testify on this panel.

As many of you may know, I have long been an advocate of Filipino veterans in the Congress. For the past several Congresses, I have introduced legislation to amend title 38, of the US Code, in order to provide that persons considered to be members of the Philippine Commonwealth Army veterans and members of the special Philippine Scouts—by reason of service with the armed forces during World War II—should be eligible for full veterans benefits.

On July 26, 1941, President Roosevelt issued a military order, pursuant to the Philippines Independence Act of 1934, calling members of the Philippine Common-

wealth Army into the service of the United States forces of the far east, under the command of Lt. General Douglas MacArthur.

For almost four years, over one hundred thousand Filipinos, of the Philippine Commonwealth Army fought alongside the allies to reclaim the Philippine Islands from Japan. Regrettably, in return, Congress enacted the Rescission Act of 1946. This measure limited veterans eligibility for service-connected disabilities and death compensation and also denied the members of the Philippine Commonwealth Army the honor of being recognized as veterans of the United States armed forces.

A second group, the special Philippine Scouts called "New Scouts" who enlisted in the U.S. armed forces after October 6, 1945, primarily to perform occupation duty in the Pacific, were similarly excluded from benefits.

These members of the Philippine Commonwealth Army and the special Philippine Scouts served just as courageously as their American counterparts during the Pacific war. Their contributions helped to disrupt the initial Japanese offensive's timetable in 1942, at a point when the Japanese were expanding unchecked through the western Pacific.

This delay in the Japanese plans helped to buy valuable time for the scattered allied forces to regroup, reorganize and prepare for checking the Japanese advance in the battles of the Coral Sea and Midway. Many have forgotten how dark those days before the victory at Midway really were.

These actions also earned the Filipino solders the wrath of their Japanese captors. As a result, many of them joined their American counterparts in the Bataan death march, and suffered inhumane treatment which redefined the limits of human depravity.

During the next two years, Filipino Scout units, operating from mobile isolated bases in the rural interior of the Philippine Islands, conducted an ongoing campaign of guerilla warfare, tying down precious Japanese resources and manpower.

In 1944, Filipino forces provided valuable assistance in the liberation of the Philippine Islands which in turn became an important base for taking the war to the Japanese homeland. Without the assistance of Filipino units and guerrilla forces, the liberation of the Philippine Islands would have taken much longer and been far costlier than it actually was.

In a letter to Congress dated May 16, 1946, President Harry S. Truman wrote: "The Philippine Army veterans are nationals of the United States and will continue in that status after July 4, 1946. They fought under the American flag and under the direction of our military leaders. They fought with gallantry and courage under the most difficult conditions during the recent conflict. They were commissioned by us, their official organization, the army of its Philippine Commonwealth was taken into the armed forces of the United States on July 26, 1941. That order has never been revoked and amended. I consider it a moral obligation of the United States to look after the welfare of the Filipino veterans."

I believe it is time to correct this injustice and to provide the members of the Philippine Commonwealth Army and the special Philippine Scouts with the benefits and the services that they valiantly earned during their service in World War II.

Mr. Chairman, I realize that the current fiscal climate may preclude the awarding of full benefits. The Filipino Government is cognizant of this as well. However, it is my hope that this hearing, and any future one that we may hold in the House, will allow us to reach some type of workable solution which provides the recognition and compensation that these veterans so valiantly earned.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF PHYSICIAN SPECIALISTS, INC.

The American Association of Physician Specialists, Inc. (AAPS) is a national organization, which represents thousands of physicians in many specialties and types of practices throughout the United States and is registered to do business in the State of Georgia as a not-for-profit corporation. The AAPS was organized in 1950 and incorporated in 1952 to provide a clinically recognized mechanism for specialty certification of physicians with advanced training. Unlike other medical associations, the AAPS accepts both osteopathic (DO) and allopathic (MD) physicians as full members.

AAPS coordinates the administrative and testing activities of twelve autonomous yet affiliated Boards of Certification providing physician specialty certification/recertification and serves as the administrative home for these boards. The twelve autonomous Boards of Certification focus on activities related to clinical excellence through certification and re-certification.

Boards of Certification recognized by the AAPS, although independent bodies, must meet rigorous standards for specialty certification established by the Association's Certification Standards Committee and approved by the House of Delegates of AAPS. Each board has its own by-laws and separate eligibility requirements for certification.

The AAPS-affiliated Boards of Certification are delineated into the following twelve medical specialty areas:

- Anesthesiology
- Dermatology
- Emergency Medicine
- Family Practice
- Geriatric Medicine
- Internal Medicine
- Neurology/Psychiatry
- Obstetrics and Gynecology
- Orthopedic Surgery
- Plastic & Reconstructive Surgery
- Radiology/Radiation Oncology
- Surgery

AAPS is extremely cognizant of the importance of maintaining the highest level of standards possible for all exams, an ongoing process that must constantly be evaluated and reevaluated. For that reason AAPS contracts with an independent testing/psychometric firm that assists the organization in technical aspects of examination objectives.

Once a physician becomes certified by an AAPS-affiliated Board of Certification, re-certification is a mandatory requirement. Diplomates must complete the re-certification process every ten (10) years to maintain their certification. Beginning in 2002, those certified must re-certify every eight (8) years in order to maintain the certification. These boards of certification offer both written and oral examinations in January and July in Atlanta, Georgia.

In 1997, the VHA issued a directive that no non-American Board of Medical Specialties (ABMS) certified physician could be hired. They added the Bureau of Osteopathic Specialists in 1998. The AAPS had protested this directive since it was published, and, in January of 2001, the VA General Counsel advised the VA to rescind the directive because it was illegally published, as the Under Secretary for Health at the VA rather than the Secretary signed it. Only the Secretary has the power to issue such directives. Now that AAPS physicians are, once again, employable at VA hospitals, AAPS is asking that they be recognized for certification pay. In the VA system and in the military, if a physician is board certified, he/she receives more pay for the certification if the certification is recognized.

Since 1998, AAPS has communicated and met with representatives of the Department of Veterans' Affairs on several occasions. When requests for information have been forthcoming from the Department, AAPS has provided the requested materials in a timely fashion, including a 750-plus page Role Delineation Study/Practice Analysis with supporting documentation. AAPS has demonstrated the equivalency of its eligibility requirements for certification with those of the American Board of Medical Specialties (ABMS) and the Bureau of Osteopathic Specialists (BOS) of the American Osteopathic Association (AOA) through a side-by-side Comparative Analysis.

As recently as June 2001, representatives of the AAPS met with the Chief of Staff to Secretary Principi and, subsequently, provided additional information on the accreditation of AAPS to present continuing medical education by the Accreditation Council for Continuing Medical Education (ACCME), an organization with rigorous standards and requirements. The ACCME is comprised of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association for Hospital Medical Education, the Council of Medical Specialty Societies, the Federation of State Medical Boards and the Association of American Medical Colleges.

At this juncture, it is AAPS' sincere hope and desire to continue to work with the Department of Veterans' Affairs, via an open and substantive dialogue, in order to ensure the best possible quality of care for our nation's veterans population. AAPS feels very strongly that S. Res. 61 is the right step in this direction so far as certification credentials, quality of care, specialty pay, and the creation of a level playing field.

PREPARED STATEMENT OF ERIC LACHICA, EXECUTIVE DIRECTOR, AMERICAN COALITION FOR FILIPINO VETERANS

Good afternoon, Mr. Chairman and members of the Veterans Affairs Committee.

My name is Eric Lachica, the executive director of the American Coalition for Filipino Veterans. Our nonprofit organization advocates for the interests of Filipino American veterans of World War II and is based in Washington, D.C.

Our national coalition has more than 4,000 members and leaders representing more than 200 affiliated community-based organizations. During the past five years,

we have campaigned for full recognition, justice and equal treatment of 12,000 of our elderly Filipino American veterans who reside in America. Furthermore, we have worked towards obtaining equitable benefits for Filipino veterans who reside in the Philippines who loyally served under the U.S. flag.

I am also a son of an 80-year-old Filipino American veteran who was honorably discharged in 1946 from the U.S. Armed Forces in the Far East. My father now lives in Temple City, California.

Mr. Chairman, with your permission, I would like to briefly introduce to the Committee, the president of our coalition, Mr. Patrick Ganio Sr., a veteran who fought in the battles of Bataan and Corregidor. He is a recipient of a Purple Heart, and a former teacher who now lives in the District. He is joined today by two dozen Washington area veterans of our coalition. Mr. Ganio's statement to the committee is attached.

In addition, I would like to mention the hardy veteran leaders who drove 300 miles to be here today. They are from the American Legion Douglas MacArthur Post in New York City and from the American Legion Alejo Santos Post in Philadelphia-Cherry Hill area.

Our out-of-state members are being hosted by the local Veterans of Foreign Wars MacArthur Post in Fort Washington, Maryland and by the community organizations affiliated with the National Federation of Filipino American Associations, also known as "NaFFAA."

PARTIAL RECOGNITION

Mr. Chairman, these veterans with us today all fought for freedom and democracy as U.S. soldiers half a century ago. Today, they are still fighting for full recognition as American veterans.

In the 105th and 106th congress, we and our allies won several partial victories beginning with the July 1996 House-Senate Concurrent Resolutions (HCR 191–SCR 64) that "honored and recognized the contributions" of Filipino WWII veterans.

Then, in 1997, we had a historic Senate VA Committee hearing on our "Equity bill," S. 623 that was introduced by our unwavering champion in the Senate, the Honorable Daniel Inouye, and co-sponsor Senator Daniel Akaka, a member of this committee.

In 1998, the House VA committee conducted a 4-hour-long hearing solely devoted to Filipino veterans' benefits and "The Filipino Veterans Equity Act," H. R. 836. Our campaign then achieved 208 cosponsors—ten votes shy of the majority in the House.

In 1999, we won the "Special Veterans Benefits" under Public Law 106–169, Title VIII that allowed lonely and poor Filipino American veterans to take 75 percent of their monthly Supplemental Security Income (now about $397) upon relocating to the Philippines. The humanitarian law permitted them to rejoin their families and to live in dignity.

As of today in the Philippines, more than 2,000 veterans are receiving the special benefit from the Social Security Administration and thus saving the U.S. taxpayers 25 percent in SSI payments or about $3 Million per year—in addition to Medicaid savings.

Last year with your committee's support, we won service-connected compensation at the full-dollar rate under P.L. 106–377 for our 950 U.S.-based Filipino veterans with war related injuries. Moreover, the VA burial benefits of P.L. 106–419 made our non-service-connected veterans eligible for a burial in national cemeteries and for a funeral expense allowance of $300, a headstone, a U.S. flag and a Presidential Memorial Certificate.

Our equity campaign has progressed this far because of the step-by-step strategy and coalition-building approach of our leaders in major cities. The political support from our key allies in the American Legion, V.F.W., Vietnam Veterans of America, Asian American advocacy groups, and Filipino American community organizations was crucial.

EQUITABLE BENEFITS

With this background, we are here this afternoon to urge your committee to support the bipartisan and equitable bill, the "Filipino Veterans Benefits Improvement Act," S. 1402 that was introduced last month on Flag Day by Senator Inouye after consultations with Rep. Benjamin Gilman (R-NY) and Rep. Bob Filner (D-CA).

Mr. Chairman, S. 1042 primarily seeks to provide eligibility for VA health care and permanent disability pension benefits to Filipino American veterans of World War II.

Your staff requested me to limit my testimony today to the VA medical care component of S. 1042 and I will do so. However, on behalf of our members' interest,

I will later submit additional testimony within the ten-day submission period for the disability pension benefit.

The historical facts and legislation that I cite are contained in the Department of Veterans Affairs research and options paper prepared for President Clinton. It was released to the public on January 9, 2001 and was entitled, "A Study of Services and Benefits for Filipino Veterans," hereinafter referred to "USDVA Study." The July 22, 1998 transcript of the "Benefits for Filipino Veterans" hearing issued by the House Committee on Veterans' Affairs is another reference, hereinafter referred to "1998 Hearing."

Based on the findings of the USDVA Study and the 1998 Hearing, there are seven compelling reasons why your VA committee should support S. 1042.

FIRST, Filipino veterans were U.S. nationals when they were "called into service" by President Roosevelt in his military order of July 26, 1941. Under the G.I. Bill of Rights, "VA officials considered that Filipino military service met the statutory definition of U.S. veteran until Congress passed Public Law 79–301 and 79–391 in 1946," the USDVA Study stated.

SECOND, Succeeding Administrations and Congresses have wrestled over the past five decades to remedy the dilemma faced by Filipino veterans. President Truman stated his objections to the so-called "Rescission Acts" of 1946:

> "The Philippine Army veterans are nationals of the United States and will continue in that status until July 4, 1946. They fought under the American flag and under the direction of our military leaders. They fought with gallantry and courage under the most difficult conditions . . . They were commissioned by us. Their official organization, the army of the Philippine Commonwealth was taken into the Armed Forces of the United States on July 26, 1941. That order has never been revoked nor amended. I consider it a moral obligation of the United States to look after the welfare of the Filipino veterans."

THIRD, Under the Immigration and Naturalization Act of 1990, an estimated 28,000 elderly Filipino veterans became naturalized American citizens and 13,849 are U.S. residents by virtue of their loyal and well-documented military service in the U.S. Army Sen. Inouye recently said, "Many of the Filipinos who have fought so hard for us have been honored with American citizenship, but let us now work to repay all of these brave men for their sacrifices by providing them the full veteran' benefits."

FOURTH, There is a congressional precedent to solve this dilemma: "Public Law 94–491 enacted in October 1976 . . . extended VA health care benefits to veterans of World War I or II who served in the Armed Forces of either Czechoslovakia or Poland. . . . in armed conflict against enemies of the United States and [who] have been U.S. citizens for 10 years or more" (USDVA Study, p. 2). Why not include} the Filipino American veterans?

FIFTH, The USDVA Study estimated that providing VA health care to the U.S. population of non-service-connected Filipino veterans and New Scouts would cost $12.1 Million in discretionary spending (under Option G, p.28). On the issue of "budget offsets," if S. 1042 were made into law, Filipino American veterans would have to choose between their Medicaid doctors and the VA clinic's. To the American taxpayers, the ultimate cost will still remain the same.

SIXTH, Providing VA health care to an estimated 8,000 Filipino American veterans and to 33,000 Filipino WWII veterans who reside in the Philippines for their service and non-service-connected disabilities at the Manila Outpatient Clinic with an annual budget of $500,000 may be sufficient to begin with. This assistance would foster better U.S relations with the Republic of the Philippines, a strategic ally.

In May 2000, Mr. Ganio and I visited the Manila USDVA Outpatient Clinic and met with the Medical Director and the Clinic Coordinator. We were surprised to learn that they could see 15 more patients per day above their 45 daily average without increasing their medical staffing level and overhead costs. We then asked why our Filipino Americans veterans who reside in or visit the Philippines could not be seen on space-available and non-priority basis. We were told it was because of VA policies based on laws that excluded these veterans.

As an added option, the VA Committee should consider the USDVA Study Option K that would restore the grant-in-aid program to assist the Philippine government in meeting the health care needs of Filipino veterans with the same annual funding discontinued in 1996.

SEVENTH, According to a recent VA policy interpretation of P.L. 106–419 on burial expense assistance, non-service-connected veterans of the Philippine Commonwealth Army and Recognized Guerillas who are U.S. permanent residents would now be treated like any other American veteran if they died in the U.S. This means a poor and disabled Filipino American veteran would now be recognized as a U.S. veteran after his death. He later could be buried in a VA national cemetery. How-

ever, while he lives, he is denied enrollment as a patient at VA hospital—a dishonorable situation indeed.

FULL RECOGNITION

Mr. Chairman, S. 1042 will correct this inequity. What this bill would do is to simply permit our 12,899 Filipino American veterans who reside in the U.S. to get a "VA Universal Access ID Card" and enroll in VA facilities in the U.S. and in the Philippines.

Indeed in California, Hawaii, Washington, New York and other states, our veterans feel the shame of being treated as second-class citizens when they are turned away at their VA centers. When in fact, their military service should have earned them the full honor in carrying the red, white and blue VA card and the chance to qualify for a permanent disability pension.

Mr. Chairman and members of the committee. On behalf of my father who was turned away years ago at the VA hospital in Los Angeles and our members who have truly been patient, I urge you to pass S. 1042. Our veterans deserve full recognition. Equity now.

PREPARED STATEMENT OF PATRICK G. GANIO, SR., NATIONAL PRESIDENT, AMERICAN COALITION FOR FILIPINO VETERANS

Mr. Chairman: My name is Patrick G. Ganio, Sr., a WWII veteran survivor of Bataan and Corregidor, a former POW, and the National President of the American Coalition for Filipino Veterans based in Washington, DC. It is my distinct honor and a privilege to address the honorable members of this Committee on the subject of healthcare to Filipino WWII Veterans both for service connected and non-service connected disability condition. For this, I wish to thank the distinguished members of the committee and the Honorable Chairman.

There is no denying of the fact how history and events have brought the United States and the Philippines together. As American nationals, the organized military forces of the Commonwealth of the Philippines were called and ordered by President Roosevelt to serve in the United State Army Forces in the Far East under General Douglas MacArthur in the period of the second world war. Our Filipino and American forces fought and laid their lives together in defense of our freedom and democracy. The great war made no distinction between Americans and Filipinos.

When victory was won and the war was over, their distinction turned out distinct in the administration of veterans benefits under the Veterans Affairs Benefit Program, a glaring disparity of right, privileges, and compensation benefits created by the passage of the Supplemental Surplus Appropriations Rescission Acts of 1946 codified as Sec. 107, Title 38 of the US Code. Since then our issue on our veterans benefits claim is raised on discrimination and unfair treatment. We have fought in defense of this government and country we love so well in the last war but it is ironic that we continued fighting for justice and equity from the same government and country we defended.

At this point in time in over 55 years today before this honorable committee after the passage of the Rescission Acts, I consider it one last chance for us and one last look we seek from this Committee, this Congress, and this Administration into the validity of our search for justice from this government and country we fought and defended to enact the appropriate corrective legislation to correct the inequity done to us in seeking for full veterans benefits equal with other class of American veterans under the same situation.

It is a fact that as US nationals owing allegiance to the United States, we served. We fought and laid our lives in defense of the American flag as called and ordered by President Roosevelt for federal service in the Armed Forces of the United States during the period of war. The order of the President was a constitutional contract for Federal service in the armed forces of the United States in the great war where tens of thousands of lives were lost, an undisputable fact that validates our military service.

But not withstanding the constitutional validity of the President's Military Order, the 79th Congress deliberately passed the Supplemental Surplus Appropriations Acts of 1946 to expressly deem our military service as not active service in the US Military or Naval Forces of the United States. We were singly excepted from all other class of servicemen for purposes of right, privilege, or benefits under the laws of the United States. The legislative history of the Rescission Acts is rent with the intent to disqualify Filipinos from the full benefits of the GI Bill of Rights by reason of their large number that required a Federal obligation of $3-B compensation benefits on the basis of equal footing with all other American veterans.

Over 55 years since the passage of the Rescission Acts to date we have raised the issue of unfair treatment and injustice to our claim for veterans benefits we validly deserve for the service we rendered in the defense of this government and this country we love so well. Where the intent of Congress in passing the Servicemen's Readjustment Act better known as the GI Bill of Rights on June 22, 1944 providing for a range of compensation benefits to all men and women bravely and courageously fighting under the American flag without regard to race, color, or nationality, Congress reversed itself in squarely discriminating against Filipinos from their right to full veterans benefits.

Mr. Chairman, in spite of our long pursuit for fair treatment of which this honorable committee, this Congress, and this Administration are aware of the legal technicalities brought down on us to bear the painful struggle for justice from the same government and country we fought for, I am profoundly grateful to the opportunity given me to make our last ditch to be heard. I wish to acknowledge the support to our cause you have consistently given us, and, the support of all our allies in this Congress, the Administration, and from our Community.

And in the long road we tread to justice, I would like to acknowledge the small victories we won for the benefits of our veterans. Equally and gratefully as well, I would like to recognize the consistent support of all who understand our issues and plight and from whose support we found strength and encouragement in our continuing struggle. Whatever we have won from the Immigration Reform Act of 1990; the Special Veterans Benefits of PL 106–169 under the Social Security Program; the Burial Benefits under PL 106–417; and the DIC and Service Connected Compensation Benefits under PL 106–377 as VA-HUD Federal Budget Appropriations Act of 2001; all of these, we know, are moves to resolve our claims issue closer to full "equity."

The American Coalition for Filipino Veterans of over 4000 members across the country including Hawaii, strongly urge the Honorable Chairman and members of this Committee to support and endorse into law Senator Inouye's Senate Bill, S 1042 providing for the much needed healthcare and an equitable pension benefits to Filipino Veterans living in the Philippines with access to the VA Healthcare facilities here and in the Philippines. Our veterans are on the fast track of aging and time for them is of the essence. I earnestly appeal to this Honorable Committee to approve this bill as one more step closer to the fulfillment of America's obligation and commitment to justice to Filipino veterans.

Thank you.

PREPARED STATEMENT OF JACQUELINE GARRICK, ACSW, CSW, CTS, DEPUTY DIRECTOR, HEALTH CARE, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to comment on these key issues that face the nation's veterans. Homelessness, nursing shortages, services, priority access to care, and quality assurance deserves special attention. The bills and draft legislation under consideration have been reviewed by The American Legion and we offer the following comments and recommendations.

S. 739 PROVISIONS TO IMPROVE PROGRAMS FOR HOMELESS VETERANS

The American Legion recommends that a quality standard be established for homeless veterans' programs. A greater emphasis on program outcomes is necessary to assure that the veterans' grant programs operated by the Departments of Veterans Affairs (VA), Labor (DoL), and Housing and Urban Development (HUD) are efficient and effective. Over the past ten years, in spite of millions of dollars being spent on homeless veterans' programs, the homeless veterans' population has increased by approximately 75,000 veterans. To get ahead of the current problem, 10,000 additional transitional housing beds are required. The proposed Heather French Homeless Assistance Act will primarily address needed medical services, but will not address the larger systemic issue of program results and the necessary expansion of VA beds.

An effective "best practices" program model must be created and replicated across the country and be appropriate to veterans' homeless assistance programs. Using the current "revolving door" program model will never critically address the homeless veterans' problem.

Some ideas generated to create an effective program model include:

1. Determine what constitutes a successful program model and what services need to be provided to homeless veterans,

2. Develop an industry "standard of excellence",
3. Develop a concurrent program review, i.e., who currently meets established standards and develop a paradigm to meet such standards,
4. Convert current grant program to a contract program,
5. Reward programs meeting the established industry standards,
6. Data collection (demographic analysis of homeless veteran population),
7. Allow programs not meeting industry standards a reasonable period to adjust programs and services,
8. Encourage existing grant programs to consolidate energy, efforts and resources,
9. Encourage a greater degree of coordination and cooperation among Federal agencies responsible for homeless veterans' assistance programs, and
10. Place a greater emphasis on the prevention of homelessness.

DRAFT LEGISLATION TO IMPROVE RECRUITMENT AND RETENTION OF VA NURSES

The American Legion appreciates the opportunity to provide the Committee comments on the critical issue of the nursing shortage and its potential effect on VA health care. Clearly, sufficient and high quality nursing care is one of the most important and necessary components of VA's healthcare delivery system. It is the backbone of direct patient care. Quality nursing care is synonymous with quality patient care. One aspect of ensuring quality nursing care is ensuring that there is sufficient coverage for the range (amount) and complexity of veteran care. This is essential if VA is to meet its obligations and keep the promise of quality medical care for veterans.

Articles in nursing publications state the nurse shortage is evident by rising nursing vacancy rates. It has resulted in closed beds, canceled non-urgent surgeries, and the diversion of patients from emergency rooms. It is caused by, among other things, the diminishing supply of new talent entering the profession coupled with a growing demand for health care services. Surveys and studies report an alarming picture for the future of nursing. The preliminary results of the latest National Sample Survey of Registered Nurses showed a 5.4 percent increase in the total RN population, but it was the lowest increase in the previous national surveys, which date back to 1977.[1] The latest numbers from the American Association of Colleges of Nursing indicate that enrollments in five year baccalaureate nursing schools dropped 16.6 percent during the past five years. Furthermore, the supply of nurses, reported as insufficient, will slow even further. In addition, the registered nurse (RN) workforce is getting older and as those RNs retire, the supply of working RNs is projected to be 20 percent below requirements.[2] Thus, this is not just a cyclical nursing shortage, but a significant issue that will impact the delivery of health care for some time.

Overall, VA nurse staffing was relatively stable in 2000. The turnover rate was 9.5 percent, while the percentage of new nurses brought on board was 9 percent. VA's turnover rate of 9.5 percent compared very favorably to the US turnover rate of 15 percent. Nevertheless, VA is still experiencing nursing shortages. This often involves positions with special qualifications that vary by region. However, The American Legion also has seen several long term care programs, for example, the nursing homes in Tuskeegee, AL; Augusta, GA; and Amarillo, TX, that are not at capacity due to nursing coverage. Furthermore, the Legion has seen voids, such as 40 RN vacancies in Richmond, VA, such significant vacancies at VAMC Albuquerque that the medical center's ability to meet its mission has been compromised. Inpatient beds have been closed since May 2000, and elective surgeries delayed because the facility must limit its operations to ensure quality care and maintain a safe patient environment. Referral facilities have looked elsewhere because the VAMC can not accommodate their workload. Actions have been taken. The facility has advertised widely. Salary surveys have been conducted and salaries increased on several occasions. Recruiting bonuses have been established. Yet despite these efforts, a significant number of vacancies exist with no apparent light at the end of the tunnel. There are simply not enough nurses in the geographic area to fill the void, and the situation has been compounded by a reduction in the number of slots at the university's nursing school. The facility has stemmed the net loss of personnel, but it has not substantially increased the number of nurses on board to offset the previous losses.

The American Legion commends Congress for its action in passing PL 106–419, which revitalized VA salaries in a number of disciplines including nursing. While

[1] The Registered Nurse Population. National Sample Survey of Registered Nurses—March 200. Preliminary Findings—February 2001. NurseWeek www.nurseweek.com/nursingshortage/rnsurvey.asp

[2] Critical Condition by Mary Elizabeth Hopkins. NurseWeek. March 12, 2001.

VA must remain competitive in its benefits package, salaries are only one component of the equation of retention and recruitment. A study by the Center for Health Economics and Policy at the University of Texas Health Science Center in San Antonio Texas identified three key factors that affect the retention of nurses. They were: work environment practices that may contribute to stress and burnout, the aging of the RN workforce combined with the shrinking applicant pool for nursing schools, and the availability of other career choices that making nursing less attractive. Other factors cited most frequently for leaving nursing included lack of time with patients, concern with personal safety in the healthcare setting, better hours outside of nursing, and relocating. Of note, 63 percent of those surveyed said that RN staffing is inadequate and that current working conditions jeopardize their ability to deliver safe patient care.[3]

Other surveys and studies reinforce and expound these themes and factors. A 5-country study revealed that nurses in countries with different health systems reported similar problems in their work environment. Less than half of the nurses surveyed said that the administration listens and responds to their concerns. Less than 38 percent said that there is enough staff to get the job done. Nurses also commented that staffing shortages force many RNs to perform non-nursing duties.

Health care institutions are struggling with and searching for solutions. "Experts" say that improving the work place and polishing the image of nursing are among the steps that must be taken. Within VHA, the National Association of Government Employees (NAGE) has been on record in Congressional testimony saying that VA must embrace staffing practices that are favorable to employee and family needs, such as hiring staff for permanent tours instead of rotating shifts and providing for alternative work schedules.

NAGE noted that rewards and recognition for employees in the field is "non-existent".

NAGE further advocate that VA must increase its educational resources to allow VA nurses to pursue BSN or masters degrees.

Currently, VA has two Task Forces looking at the issues affecting nurse recruitment and retention.

It is clear that nursing faces significant challenges imposed by an aging workforce, the increasing medical care demands of an aging population and a declining interest in the profession prompted by more preferable career alternatives and a perceived lack of appreciation and respect for the profession.

VA has talent among its clinical staff that can help address the issues of teachers for nursing programs. VA must draw upon its models of collaborative efforts to maximize this effort.

VA is a leader in the fields of the electronic medical record and patient safety initiatives. VA must ensure that such efforts are widely recognized because this will enhance VA's ability to attract those looking to be part of the cutting edge of nursing practice. VA must also continue to explore ways to enhance the work environment.

Nurse morale is deeply affected by the amount of non-nursing functions imposed on nurses. VA must ensure that there is sufficient clinical and ancillary support to maximally use the nursing skills of nurse providers.

VA needs the ability to aggregate data that will clearly define its position, relative to its nurse coverage. This would include the number of vacant positions and the associated consequence of those vacancies—bed closures, delayed delivery of care.

VA Chiefs of Nurses have said that the most effective recruitment tool is to capture student nurses while they are in training or as they graduate. In the private sector states have considered legislation providing starting bonuses, and private sector facilities have established programs for new nurses that involve preceptorships, mentoring and financial incentives to stay. The VA must not only stay abreast of these initiatives, but VA must be placed in a position to excel in these initiatives. Ironically, the VA can not be the leader in the pay scale. We expect the best, but we do not allow the system to be the best, at least in salary.

The American Legion is appreciative of the many contributions of nurses, in particular, VA nursing personnel. Every effort must be made to recognize, reward and maximize these contributions to Americans veterans because [nurses and] veterans deserve nothing less.

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[3] Veterans Health System Journal, March 2001. Article about the report, *In Their Own Words: Career Fulfillment of Texas RNs.*

S. 1160 AUTHORIZE VA TO PROVIDE CERTAIN HEARING IMPAIRED VETERANS, SCI, AND BLIND VETERANS WITH SERVICE DOGS

The American Legion is aware of the vital services these animals offer in assisting disabled veterans. The companionship and aide service dogs offer is well documented in the private sector. This level of care goes a long way to improve the quality of life for the disability community overall and veterans should be no different. VA should make every effort to assess and provide veterans requesting service dogs with that option.

DRAFT LEGISLATION TO CHANGE MEANS TEST FOR ENROLLMENT IN PRIORITY GROUPS 5 OR 7

The means test has been a widely discussed and long debated issue since its inception. The American Legion recognizes its necessity in determining care for those who are not service-connected disabled and are not indigent. However, The American Legion believes that determining eligibility based on an economic criterion can be skewed depending upon where in the country a veteran lives. There is no doubt that the cost of living in some cities is higher than in others and that there are variances from rural, to suburban and to urban neighborhoods. The American Legion fully supports VA developing a geographically adjusted means test according to the United States Bureau of Labor cost-of-living index by state as of January 1 of the preceding year, but not to reduce the threshold below the currently established limit.

S. 1042 VA SHALL PROVIDE HOSPITAL AND NURSING HOME CARE TO FILIPINO VETERANS AND FOR TREATMENT AT THE MANILA VA OUTPATIENT CLINIC

The American Legion has long recognized the invaluable service to this nation provided by the Philippine Scouts who are still residing in the Republic of the Philippines. The American Legion supports S. 1042 to allow Filipino veterans to have equal access to VA health care and benefits.

S. 61 RECOGNITION OF BOARD CERTIFICATIONS FROM THE AMERICAN ASSOCIATION OF PHYSICIANS SPECIALISTS

The American Legion is aware of the standards for certification from the American Association of Physician Specialists and recognizes this certification to be of equivalent value to the certification from the American Board of Osteopathic.

Mr. Chairman, The American Legion, as always is grateful for your leadership on these key issues and appreciates the opportunity to provide this statement and remains available to answer any questions.

PREPARED STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association (APA) is a national medical specialty society, founded in 1844, whose over 40,000 psychiatric physician members specialize in the diagnosis and treatment of mental and emotional illness and substance use disorders. As a major medical association, the care and treatment of our nation's veterans is a significant concern of ours. We feel compelled to be advocates for these heroes that stood in the forefront to protect our freedoms and way of life. It is our turn to look after their needs.

An estimated 250,000 veterans, or roughly one-third of the adult homeless population, are veterans. Many of these veterans served in Vietnam. In fact, the number of homeless Vietnam era veterans is greater than the number of service persons who died during the Vietnam War. About 45% of these homeless veterans suffer from mental illness and slightly more than 70% suffer from alcohol or drug abuse problems. The VA offers an array of programs to help homeless veterans live as self-sufficiently and as independently as possible and provides the largest integrated network of homeless treatment and assistance services in the country.

HOMELESS VETERANS MENTAL ILLNESS

With the large number of homeless veterans, it follows that these veterans typically suffer the same mental illnesses as found in the general homeless populations. These illnesses include schizophrenia, schizo-affective disorder, bipolar disorder, and major depression. All these illnesses differ in their causes, course, and treatment. Frequently, those in need of protection and services the most are the chronically mentally ill individuals who suffer from the cognitive and social deficits of their illnesses. As a result of their illnesses, these individuals are left to fend for themselves

in the community. As noted in a federal task force report, their symptoms may differ dramatically. Symptoms may range from exhaustion and severe depression to displaying delusional or suspicious behavior. They may be withdrawn from any human contact or become possibly hostile and dangerously aggressive. Symptoms that, by officials not trained to diagnose mental illnesses, may be interpreted to be criminal in nature.

These symptoms often occur because homeless individuals are not receiving the necessary psychotropic medications or have resisted treatment. Or, there may have been a breakdown within the familial and social network, the mental health and criminal justice systems, or societal polices ranging from housing availability to legal definitions of dangerousness to self.

HOUSING

Most individuals with severe mental illnesses can live in their communities with the appropriate supportive housing options. However, all too often, the suggested solution is temporary shelter residencies. Although temporary shelters may be necessary as an emergency resource, they do not offer solutions to a mentally ill person's problem. Temporary shelters even offered as solutions for the mentally ill implies that society has accepted the notion that mentally ill individuals should be permitted to refuse treatment and live on the streets.

However, based on both clinical observation and research data, the reality is quite the opposite. Life on the streets is generally characterized by dysphoria and extreme deprivation. Studies suggest that the mentally ill often reject the housing opportunities presented to them because of expectations placed upon them to enter into unrealistic or inappropriate treatments or placements.

The lack of low cost housing is one example for the high number of homeless mentally ill. Single-room-occupancy hotels have sharply declined over the years and for the most part are no longer an option for the homeless mentally ill. Without this housing option and with no other suggested options to fill the void, mentally ill individuals are left with few choices.

The APA Task Force on Homelessness advocates the following:

• The care, treatment, and rehabilitation of chronically mentally ill individuals must be made the highest priority in public mental health and receive the first priority for public funding;

• Comprehensive and coordinated community-based mental health systems to engage homeless mentally ill individuals and help them to accept treatment and suitable living arrangements, while serving this mentally ill population immediately;

• A full complement of research efforts to identify subgroups of the homeless mentally ill population, assess their service needs, study alternative clinical interventions, and evaluate those outcomes;

• Professionals serving the mentally ill must be provided to the appropriate training to assess both functional strengths and dangerous degrees of disability;

• Residential and treatment standards for homeless mentally ill individuals should measure up fully to the standards of care needed for severely disabled individuals and that they should be capable of being monitored; and

• The provision of housing opportunities, the provision of psychotropic medications, and the provision of structure, in varying amounts, are each important and interrelated matters in serving the homeless mentally ill.

PRESIDENT BUSH'S VETERANS HEALTH CARE TASK FORCE

APA commends the President for convening a Veterans Health Care Task Force composed of officials and clinicians from the Department of Veterans' Affairs (VA) and Department of Defense (DOD), leaders of veterans and military service organizations, and leaders in health care quality to make recommendations for improvements in the VA. The VA will focus its attention on treating disabled and low-income veterans. The APA hopes the task force will address the workplace shortages of psychiatrists and psychiatric nurses in looking at quality of care. The APA also believes the task force should look at quality of care issues in formularies.

ADVISORY COMMITTEE ON HOMELESS VETERANS

The APA supports the language in Heather French Henry Homeless Veterans Assistance Act (S. 739) that calls for the establishment of an Advisory committee on Homeless Veterans.

ACCESS TO MENTAL HEALTH SERVICES

The APA applauds the language in S. 739 that provides veterans access to mental health services that are on par to primary care. The APA supports the Secretary of Veterans Affairs efforts to develop standards that ensure mental health services are available to veterans similar to the manner in which primary care is available to veterans who require services by ensuring that each primary care health care facility of the Department has a mental health treatment capacity.

TREATMENT TRIALS IN INTEGRATED MENTAL HEALTH SERVICES DELIVERY

The APA supports the language in S. 739 that allows the Secretary of Veterans Affairs to carry out two treatment trials in integrated mental health services delivery.

VA HOMELESS PROGRAMS

Mental Illness Research, Education and Clinical Centers

An important VA program, Mental Illness Research, Education and Clinical Centers (MIRECCs), began in October 1997 with establishment of three new Centers. These Centers bring together research, education and clinical care to provide advanced scientific knowledge on evaluation and treatment of mental illness. MIRECCs demonstrate that coordinating research and training of healthcare personnel in an environment that provides care and values the synergism of bringing all three elements together results in improved models of clinical services for individuals suffering from mental illness. Further, they generate new knowledge about the causes and treatments of mental disorders.

MIRECCs were designed to deal with mental health problems that impact America's veterans. These include schizophrenia, post-traumatic stress disorders (PTSD), and dementia. In addition, MIRECCs focus on complex disorders including serious psychiatric issues complicated by homelessness, substance abuse and alcoholism. The funding of additional MIRECCs, which would provide research for these complex medical disorders, is vital.

Alcohol and other substance use disorders continue to be a major national healthcare problem. Numerous studies show that rates of alcohol and other substance abuse are high among veterans within VA healthcare system. To its credit, VHA made significant progress during the past three years in screening all primary care patients for alcohol misuse. Which has resulted in identifying additional patients in need of specialized treatment services.

The APA recommends the VHA should increase funding for Mental Illness Research Education and Clinical Care Centers (MIRECCs). Two new MIRECCS should be funded in FY 2002. Congress should incrementally augment funding for seriously mentally ill veterans by $100 million each year from FY 2002 through FY 2004.

VHA should reinvest savings from closing inpatient mental health programs to develop an outpatient continuum of care that includes case management, psychosocial rehabilitation, housing alternatives, and other support services for severely and chronically mentally ill veterans.

Again, we thank the Committee for the opportunity to deliver this statement on homelessness programs in the VA. Please do not hesitate to call on the APA as a resource, should there be any way in which we might be able to assist in working with you to provide the best health care possible to the veteran community.

PREPARED STATEMENT OF DAVID A. PENDLETON, MINORITY FLOOR LEADER, HAWAI'I HOUSE OF REPRESENTATIVES

My name is David A. Pendleton. I am a state elected official of Filipino ancestry, and I am writing in strong support of Filipino veterans of World War II. More specifically, I urge the U.S. Senate Committee on Veterans' Affairs to take steps to assure equity for Filipino veterans by passing Senate Bill 1042, the "Filipino Veterans Benefit Improvement Act of 2001," introduced by Senator Daniel Inouye.

Distinguished members of this Committee, my interest in Filipino veterans' issues derives partly from the fact that my late Filipino grandfather served in the United States Navy, He was enthusiastically patriotic. He was proud to be an American, proud of the fact that he was a citizen of a Nation committed to high ideals—liberty, justice, and equality before the law. I never mastered the details of World War II military history, but I grasped the themes, the major events, and acquired a sense of the times from my grandfather's account. His position—as I now reflect upon what he said—regarding the treatment of Philippine veterans was that some mis-

understandings occurred, some unfairness took place, and some representations were made which were not lived up to.

Philippine veterans fought for the United States in the Pacific Theater during World War II. During that time, various U.S. officials assured these Filipinos, who risked their lives for America, that their service would result in equal military benefits. Unfortunately, whatever hopes these Filipino veterans had about equal treatment were dashed by the Federal Rescission Act of 1946.

The Rescission Act was preceded by President Franklin D. Roosevelt's Executive Order of 1941 and continued in Public Law 89–640, which passed the U.S. Congress in 1966. The policy had the effect of taking into consideration the currency exchange rate when paying benefits. The U.S. has veterans in many countries, but only when it comes to veterans in the Philippines does it take into account currency exchange rates.

This is but one example of the apparent lack of equity with respect to our Filipino veterans.

During World War II, many non-American soldiers were involved in this great conflict, fighting against the powers of conquest, namely, Japan and Nazi Germany. Among the military forces which opposed Japanese and German expansionism were allied troops from other countries. These troops, not unlike the Filipino veterans, fought in conjunction with American forces against a common enemy, They were subsequently afforded the right to naturalization. Beginning in 1943, naturalization officers were dispatched to foreign countries where they accepted applications for naturalization, performed naturalization ceremonies, and swore into American citizenship thousands of veterans from other countries.

In contrast, the great majority of Filipino soldiers who had fought under the command of American officers were not afforded similar liberal naturalization policies. In fact, the United States withdrew its naturalization officer from the Philippines for nine months and then permitted the law to lapse in 1946, resulting in severely limiting the number of Filipino veterans able to exercise their rights in a timely fashion.

Members of the committee, it is clear that Filipinos who fought for the United States during WWII, have been discriminated against and that promises made to them have not been kept.

Accordingly, I urge Congress to pass S. 1042, This bill would make veterans of the Philippine Commonwealth Army, recognized guerillas, and New Philippine Scouts eligible to receive medical benefits and monthly disability pensions from the U.S. Department of Veterans Affairs.

Permit me to close by reminding us all of the purpose and goal of the Department of Veterans Affairs: "to care for him who shall have borne the battle. . . ." The United States Congress has an opportunity to effectuate genuine equity for Filipino veterans. Let us today begin the arduous but necessary task of crafting legislation, which will lead to equity for Filipino veterans, Let us care for those who have borne the battle.

Thank you for this opportunity to submit testimony on this issue.

PREPARED STATEMENT OF THE PARALYZED VETERANS OF AMERICA

Chairman Rockefeller, Ranking Member Specter, members of the Committee, the Paralyzed Veterans of America (PVA) is pleased to present our views for the record regarding health-related legislation pending before the Committee.

S. 739, THE "HEATHER FRENCH HENRY HOMELESS VETERANS ASSISTANCE ACT."

PVA supports S. 739, the "Heather French Henry Homeless Veterans Assistance Act" introduced by Senator Wellstone. There continues to be a problem with homelessness among our Nation's veterans. The Independent Budget, which is co-authored by PVA, has estimated that more than 275,000 veterans are homeless on any given night. Furthermore, more than half a million veterans experience a period of homelessness throughout the course of a year.

Additional estimates show that one out of every three homeless males who is sleeping in a doorway, alley, or box in our cities and rural communities has put on a uniform and served this Nation. The Department of Veterans Affairs (VA) reports that most homeless veterans are male; only two percent are female. More than 67 percent of these homeless veterans served in the Armed forces for at least three years.

Another major problem that the VA faces is that of homeless veterans with mental illness and substance abuse disorders. The VA estimates that about 45 percent of homeless veterans suffer from mental illness, and 50 percent have substance

abuse problems. One of the most common illnesses among these individuals is Post-Traumatic Stress Disorder (PTSD). In the past five years, spending on the VA's mental health programs has declined by nearly 10 percent. We recently testified before the House Veterans' Affairs Subcommittee on Benefits that the decline in the VA's mental health capacity has increased the number of veterans with no place to go; thus, the rate of homelessness among veterans with mental illness continues to increase.

Support from various government agencies including the VA, the Department of Labor, and the Department of Housing and Urban Development is essential in overcoming the problems our homeless veterans face. The Homeless Veterans Reintegration Program (HVRP) of the Department of Labor has been the leading program for the employment of homeless veterans. Within the VA, physical and mental health care is vital to gain and hold employment. Mental health and substance abuse programs are key to preparing many homeless veterans for the workforce. PVA requests that each VA medical center report its current capacity in order to provide the VA with an idea of the direction we must go to improve.

PVA supports the establishment of the Advisory Committee on Homeless Veterans within the VA. The interaction between the agencies represented on the committee should allow for multiple solutions to be developed and implemented. A critical task of this advisory committee is identifying barriers under existing laws and policies to effective coordination by the VA with other Federal agencies and with State and local agencies addressing homeless populations. Once the difficulties between the federal agencies are overcome, then a unified, focused effort can be made among these agencies to turn these problems around.

PVA also recognizes the need to assist homeless veterans with special needs. We must not let our women veterans, veterans over 50 years of age, veterans who have to care for minor dependents or other family members, or veterans who suffer from substance abuse, PTSD, terminal illness, or chronic mental illness be left behind.

The grant program for medical centers that would allow these centers to support those veterans with special needs is a vital part of meeting the national goal of overcoming homelessness among veterans within a decade.

An important way to accomplish the national goal for overcoming veterans' homelessness is the implementation of outreach programs. It is no secret that non-homeless veterans filing claims face many difficulties because they are not fully aware of the benefits and services they are entitled to. That being said, if these individuals do not have easy access to everything they need to know, then you can only imagine how difficult it is for homeless veterans who have no link to information. Our homeless veterans need to know what benefits they are entitled as well as what local VA facilities they have access to. We urge the VA to focus on outreach if it intends to be successful in overcoming the plight of homelessness.

PVA believes that S. 739 represents a comprehensive approach to dealing with the problem of homelessness among our veterans, and we urge its serious consideration, and passage.

S. 1188, THE "DEPARTMENT OF VETERANS AFFAIRS NURSE RECRUITMENT AND RETENTION ENHANCEMENT ACT OF 2001."

PVA supports S. 1188, the "Department of Veterans Affairs Nurse Recruitment and Retention Enhancement Act of 2001." There is no single cause of the looming nursing crisis, and there is no simple solution. By requiring the VA to produce a policy on staffing standards and report on the use of overtime by the nursing staff, by providing Saturday premium pay and improving existing scholarship and debt reduction programs by providing additional flexibility to recipients this measure is a forward-looking attempt to begin solving this crisis. PVA asks the Committee to pay special attention to the retention and recruitment of specialized services nurses. PVA members rely upon the professionalism of these nurses who man the VA's Spinal Cord Injury Centers.

S. 1160

PVA enthusiastically supports S. 1160, a bill that would provide the VA with the authority to provide service dogs to disabled veterans. We urge the Committee to make these dogs available to all veterans who need them.

The Journal of the American Medical Association (JAMA) published a study in 1996 that assessed the value of service dogs for people with ambulatory disabilities. This study found "reports of paid and unpaid assistance demonstrated dramatic economic benefits of service dogs." After one year, the study found a decrease of 68 percent in paid assistance hours and a 64 percent decrease in unpaid assistance hours.

The JAMA study also detailed the many tasks that service dogs can perform, such as "open and close doors, turn switches on and off, pull a person up from a sitting position or lying down position, assist a person in and out of baths and pools, help pull on clothing, procure and pick up objects, pull wheelchairs, and drag a person to safety in case of fire or other emergency."

PVA greatly appreciates the efforts of Chairman Rockefeller and his staff in introducing this measure. PVA would recommend that a couple of changes be made to the underlying legislation. First, we recommend that guide dogs and service dogs be made available to all veterans who need them, those with and without service-connected injuries. With health care eligibility reform we moved to a uniform benefits package it is essential that we do not take a step backwards by limiting this much-needed service. Second, we would recommend expanding the criteria for which veterans are eligible beyond those veterans with spinal cord injury or dysfunction, or hearing impairments. Veterans with traumatic brain injuries, seizure disorders, amputations and other physical or mental disabilities may also be able to realize significant quality of life and economic improvements through having a service dog. We would recommend that § 1714 (b) of title 38, United States Code, be amended to read as follows:

> (b)(1) The Secretary may provide guide dogs trained for the aid of the blind, and may also provide mechanical or electronic equipment for aiding veterans in overcoming the disability of blindness.
>
> (2) The Secretary may provide service dogs trained for the aid of persons with disabilities to veterans with spinal cord injury or dysfunction or any chronic physical or mental impairment that substantially limits mobility, hearing, or activities of daily living to assist in overcoming these disabilities.
>
> (3) In providing a guide dog or service dog under this subsection, the Secretary may pay travel and incidental expenses (under the terms and conditions set forth in section 111 of this title) of the veteran to and from the veteran's home and incurred in becoming adjusted to the guide dog or service dog.".

For over half-a-century, PVA has fought for the integration of people with disabilities into the economic and social life of our Nation. Providing service dogs to veterans who need them would be a major step forward in the ultimate realization of this goal. As one participant, who has a spinal cord injury, stated in the JAMA study, "with my [dog], I feel safe and capable, and I am no longer afraid of the future. Everyone needs someone to care for, and we care for each other with dignity."

DRAFT LEGISLATION TO CHANGE THE MEANS TEST

PVA supports changing the means test used by the VA to determine whether veterans will be placed in enrollment priority Category 5 or 7 as set forth in 38 U.S.C. § 1722. Under current law, VA sets only one means test threshold for all non-service connected disabled veterans seeking access to care regardless of their ability to defray the cost of their health care due to differences in cost-of-living from one locality to the next in the United States.

As the attached white paper discusses, we have identified an established formula implemented by the Department of Housing and Urban Development (HUD) to set income limits for eligibility for low income housing benefits. The HUD formula makes adjustments in means test eligibility based on the cost-of-living experience in most every locality in the United States. As with the current VA system it also adjusts for the number of dependents in the applicant household.

It is important to note that this proposal would not change the existing means test thresholds under current law (currently $23,688 for a veteran with no dependents and $28,430 for a veteran with one dependent) even if the HUD formula for a certain locality fell below the existing VA means test threshold. In other words, veterans currently eligible for Category 5 status because they meet the VA income standards would remain in that Category. Many veterans in high cost-of-living localities, however, could benefit from the higher income standard established by the HUD formula and be eligible for Category 5 because of their increased inability to defray co-payments.

We have identified income limits for certain localities selected from the HUD formula and matched them with VA data showing income experience for Category 7 in the same localities. The tables at the end of the white paper indicate how many veterans in each locality, selected at random, currently in VA Category 7 could move up to Category 5 using the HUD formula.

This is vital legislation if we are to care for our veterans, and will enable us to more closely follow the congressional intent underlying the provision of care to those veterans unable to meet the ever-spiraling cost of health care

S. 1042, THE "FILIPINO VETERANS' BENEFITS IMPROVEMENTS ACT OF 2001."

As the Independent Budget states, "[w]e are mindful of the brave and historic contributions made by Filipino veterans during World War II as members of the United States armed forces. Their actions as part of the allied forces are legendary. Measured in these terms, we believe Filipino veterans of World War II should be granted access to the VA health care system. These brave soldiers answered our Nation's call to duty and now it is our duty to honor our commitment to them."

PVA has long fought to right the grievous injustice of our government's actions after World War II. In the Independent Budget we advocated appropriating an additional $30 million to expand health care access for Filipino veterans. We look forward to the Committee's studied deliberation of S. 1042 as we seek how best to meet these valiant veterans' health care needs in a manner that honors their remarkable service.

This concludes PVA's testimony for the record concerning health-related legislation before this Committee. We will be happy to respond to any questions or requests that arise from this hearing.

ATTACHMENT—PROPOSAL TO ADJUST VETERANS HEALTH CARE ELIGIBILITY MEANS TEST TO MORE ACCURATELY REFLECT LOCALITY COST OF LIVING VARIATIONS

The Paralyzed Veterans of America (PVA) is requesting legislation to change the means test used by the Department of Veterans Affairs (VA) to determine whether veterans will be placed in enrollment priority Category 5 or 7 as set forth in 38 U.S.C. § 1722. Category placement is important because veterans enrolled in lower categories (i.e., 6 and 7) whose incomes are above current means test levels are required to make co-payments for much of their care. In the "discretionary" Category 7, they could also be at greater risk of disenrollment should the VA budget require it in the future.

JUSTIFICATION

In creating Category 5, Congress demonstrated its desire to provide health care to veterans who are unable to defray the cost of care. For this reason, Category 5 veterans do not pay co-payments for health care received. Category 7 veterans do pay co-payments. In addition, VA hospitals receive reimbursement for providing care to Category 5 veterans. Hospitals do not get reimbursed for Category 7 veterans.

Currently, the VA uses a national means test income threshold of $23,688 for a veteran with no dependents and $28,430 for a veteran with one dependent. This universal threshold applies regardless of the geographic cost-of-living differences. A universal income threshold does not adequately address many individual veterans' inability to "defray the cost of care" as required by 38 U.S.C. § 1722.

RELEVANT STATUTORY AUTHORITY

38 U.S.C. § 1722 establishes the criteria by which a veteran is determined to be unable to defray necessary expenses and establishes the income thresholds to be used in making this determination.

38 U.S.C. § 1705 establishes the VA's patient enrollment system. § 1705 (a) establishes the seven categories with which the VA prioritizes the provision of care. § 1705 (a) (5) establishes the fifth priority category as "veterans not covered by paragraphs (1) through (4) who are unable to defray the expenses of necessary care as determined under § 1722 (a) of this title". § 1705 (a) (7) establishes priority category seven as veterans described in § 1710 (a) (3) of this title.

38 U.S.C. § 1710 (a) (3) authorizes the VA to treat veterans in priority categories 6 and 7 on a "funds permitting" basis and at the Secretary's discretion.

42 U.S.C. § 1437a (b) (2) defines the term "low income families" as " families whose incomes do not exceed 80 per centime of the median income for the area, as determined by the Secretary (of housing and urban development) with adjustments for smaller and larger families."

PROPOSAL

The most direct way to address this problem is to adjust the national means test by locality to more accurately reflect the differences in geographic cost-of-living. This locality-adjusted means test would help veterans who have incomes slightly higher than the existing threshold who have previously been designated as Category 7. They would now fall below a newly-adjusted means test threshold for their area and be classified Category 5. The individual VA Healthcare networks, otherwise known

as VISNs (Veterans Integrated Service Networks), would no longer be able to collect co-payments for the care provided to these veterans but would begin to receive reimbursement for their care.

PROPOSED METHODOLOGY

We have identified the HUD Low Income Index as established through Section 3 of the U.S. Housing Act of 1937, as amended in 1998, as a viable index. The HUD index defines "low income" for families with incomes that do not exceed 80 percent of the median family income for the area in which they reside. The areas are broken down into a variety of categories including Metropolitan Statistical Areas (MSAs), Primary Metropolitan Statistical Areas (PMSAs) and counties. This index has defined both geographic areas and cost of living within these areas and should be relatively easy for the VA to implement.

Using the low-income methodology would mean that all veterans residing in a defined locality would have a means test threshold that was adjusted to reflect the cost-of-living determined by the HUD formula for that particular defined area. This new threshold is more indicative of the veteran's ability to defray the cost of care. Furthermore, to insure that no veterans are bumped from Category 5 into Category 7 when these new thresholds are implemented, we propose to maintain the existing $24,000 threshold, regardless of the number of dependents, nationwide as the lowest figure for any means test variations even if the HUD formula determines that the low-income rate for a particular area is actually under $24,000. In other words, for any location where the low-income index indicates that the new threshold should actually be lower than $24,000, the means test figure will stay at $24,000, regardless of the number of dependents in the veterans' household. This provision guarantees that no VISN will lose any Category 5 veterans and only stand to gain category 5's from implementation of this new means test system.

The following explanation of HUD's methodology for determining the median income and subsequent income amounts is taken from HUD's own briefing book:

HUD METHODOLOGY FOR ESTIMATING FY 2000 MEDIAN FAMILY INCOMES (ECONOMIC AND MARKET ANALYSIS DIVISION, OFFICE OF ECONOMIC AFFAIRS, PD&R)

FY 2000 HUD estimates of median family income are based on 1990 Census data estimates updated with a combination of local Bureau of Labor Statistics (BLS) data and Census Divisional data. Separate median family income estimates (MFIs) are calculated for all Metropolitan Statistical Areas (MSAs), Primary Metropolitan Statistical Areas (PMSAs), and non-metropolitan counties.

The income adjustment factors used to update the 1990 Census-based estimates of MFIs are developed in several steps. Average wage data from the Bureau of Labor Statistics (BLS) were available for 1989 through the end of 1997 at a county level, and were aggregated to the metropolitan area level for multi-county metropolitan areas. Census Divisional level median family and household income estimates were available from the Current Population Report (CPR) March 1990–99 surveys, which measure incomes from mid-1989 through mid-1998. These data were then used to update mid-1989 income estimates from the 1990 Census to the middle of 1998. The mid-1998 estimates were trended forward to mid-FY 2000 using a factor based on past P–60 Series trends. The step-by-step normal procedures as well as the exception procedures used are as follows:

1. Estimate mid-1989 local median family incomes using 1990 Census data. (Current HUD Section 8 Fair Market Rent (FMR) program definitions are used to define metropolitan areas, which are normally the same as Office of Management and Budget metropolitan area definitions.)

2. Calculate the BLS wage change factors for each Census Division for the 1989–97 period as follows:

Census Division BLS Wages (1997)

Census Division BLS Employees (1997) = 8-year BLS wage increase factor for Census Division

Census Division BLS Wages (1989)

Census Division BLS Employees (1989)

3. Calculate the change in median family and household incomes for the nine Census Divisions for the 1989–1998 period using Census P–60 series data, as follows:

Census Division P–60 MFI (1998) = 9-year increase factor for Census

Census Division P–60 MFI (1989) Division P–60 Median Family Income

4. Compare the BLS and P–60 series Census Divisional factors calculated in steps 2 and 3 to provide a means of adjusting local BLS wage factor changes so that they aggregate to the same change factor as P–60 changes in family incomes plus contain an added year of CPS trending.

9-year increase factor for
Census Division P–60 MFI = Ratio of Census Division P–60
8-year increase factor for MFI to ratio of Census
Census Division BLS Wages Division BLS wage changes

5. Calculate the 1989–98 increase factors for the individual metropolitan areas and nonmetropolitan counties by applying the Census Divisional index factors from step 4 to local BLS data.

Local BLS Wages (1997)
Local BLS Employees (1997) Ratio of Census 9-year income
* Division P–60 = adjustment
MFI to Census factor for
Local BLS Wages (1989) Division BLS wages MSA or County
Local BLS Employees (1989) = 1989 to mid-1998 MFI Adj. factor

6. Convert 1989–98 step 5 change factor to a 1989–2000 change factor by applying an annual trending figure of 4.0 percent to update the mid-1998 estimate to mid-1999, and applying a 3.0 percent factor (3/4 of 4.0 percent) to the mid-1999 to April 1, 2000 period. (Use of a trending factor is necessary because of lags in Bureau of Labor Statistics and P–60 Series data availability; the 4.0 percent factor is based on national income change patterns in recent years.)

(Step 5 adj. factor) * 1.04 * 1.03 = 1989 to mid-FY 2000 adjustment factor

7. Calculate median family incomes for FY 2000 by multiplying the step 1 Census estimate of median family income by the income adjustment factor derived in Step 6.

1990 Census Median Family Income * Step 6 factor = FY 2000 MFI EST.

8. For American Housing Survey areas, compare the MFI estimates from step 7 with median family income estimates based on post-1989 American Housing Survey (AHS) estimates of median family income updated to 2000. Past analysis shows that there is 95 percent likelihood that the true local median family income is within 6 percent of the AHS-based estimate. For areas where an AHS-based estimate differs by more than 6 percent from the Census-based estimate, local MFI estimates are increased or decreased so that they are within 6 percent of the AHS-based estimate.

9. Compare the 2000 MFI estimate with the 1999 MFI estimate. If the 1999 estimate is higher set the 2000 estimate at the 1999 level. (This policy is applied except when estimates are revised with decennial Census data, and serves to minimize disruption in program activities due to temporary decreases in income estimates.)

In addition to the above procedures, constraints are placed on annual changes in the Census Divisional and BLS change factors based on past experience. These guidelines constrain increases for a small number of areas with unusually high increases.

VA'S ABILITY TO COLLECT COPAYMENTS AND THIRD PARTY REIMBURSEMENT

Applying a regional adjustment to the means test would not affect VA's ability to charge third party health insurers for the cost of care provided to a veteran because VA's authority to collect insurance payments is not tied to the means test. However, the means test is used by VA to determine a veteran's obligation to pay co-payments for their care and adjusting the means test would therefore affect VA's ability to collect co-payments.

The means test used by the Department of Veterans Affairs is set forth at 38 U.S.C. § 1722. While this statutory provision sets forth the amount of the annual means test threshold, and prescribes the methodology for calculating whether a veteran's income exceeds this threshold, it does not state the purpose of the means test. Rather, the means test set forth in § 1722 is referred to in two distinct statutes that govern eligibility for care and the obligation to pay a co-payment.

The means test threshold set forth in § 1722 is expressly referred to by the statutory provision governing VA's managed care system of enrollment. See 38 U.S.C. § 1705(a)(5). Under VA's enrollment system, veterans are placed in one of seven priority categories based on consideration of such factors as income, level of disability, and percentage of service-connection. See 38 U.S.C. § 1705. Each year, VA is required to enroll only those categories of veterans that can be treated within appropriated funding. See 38 U.S.C. §§ 1705, 1710(a)(4). Veterans with income under the means test threshold are placed in priority category 5, ensuring that those veterans determined to be unable to defray the cost of their care will not be among the first cut from care when appropriations are insufficient to provide care to all veterans. Regionally adjusting the means test will therefore elevate some veterans from priority category 6 and 7 to priority category 5.

The means test threshold set forth in § 1722 is also referred to in the statutory provisions governing the determination of a veteran's obligation to pay a co-pay-

ment. See 38 U.S.C. § 1710(a)(2)(G). Under this statutory provision, veterans with income under the annual means test threshold receive cost free care, while those with income over the means test must pay co-payments for inpatient and outpatient care. See 38 U.S.C. §§ 1710(a)(3), 1710(f). Veterans with income over the means test must pay an inpatient hospital co-payment of $768 per 90 days of care, plus a per diem charge of $10 per day. See 38 U.S.C. § 1710(f). Veterans with income over the means test must also pay an outpatient co-payment of $50.80 per visit. See 38 U.S.C. § 1710(g). Regionally adjusting the means test will therefore exempt some veterans from these co-payment obligations if the means test is adjusted upward in their region to an amount in excess of their current income.

The authority for VA to bill a veteran's private health insurer is set forth in 38 U.S.C. § 1729. This statute neither references the provisions of § 1722 nor utilizes the means test threshold to determine whether a veteran's private health insurer may be billed for the cost of care provided. Rather, § 1729 broadly grants VA the authority to bill the private health insurer of any nonservice-connected veteran, regardless of priority category placement or income level, for the full cost of care provided at a VA facility. See 38 U.S.C. § 1729(a)(2)(D)(ii). VA is even permitted to bill third party health insurers for the full cost of treatment provided for the nonservice-connected disabilities of veterans with service-connected disabilities. See 38 U.S.C. § 1729(a)(2)(E). Since VA's authority to recover the cost of care from private health insurers is not related to the means test threshold set forth in § 1722, regionally adjusting the means test threshold will have no impact on insurance billing.

ESTIMATES OF NUMBER OF VETERANS AFFECTED

The following chart estimates the number of veterans in certain MSAs that would be moved form category 7 into category 5 through this proposal. These numbers are based on data obtained form the VA. The MSAs listed in the chart were chosen at random.

Please note, that while we are proposing that the bottom threshold be established at $24,000, regardless of the number of dependents per family.

MSA	1 person family	2 person family	3 person family	4 person family
Abilene (TX)	0	0	0	4
Albany-Schenectady-Troy (NY)	275	319	514	422
Albuquerque (NM)	120	150	300	315
Allentown-Bethlehem-Easton (PA)	32	49	92	82
Altoona (PA)	0	0	0	0
Anchorage (AK)	190	237	216	167
Ann Arbor (MI)	97	100	77	52
Anniston (AL)	0	0	0	0
Appleton-Oshkosh-Neenah (WI)	15	27	41	30
Atlanta (GA)	1123	1060	867	647
Baltimore (MD)	1245	1133	970	709
Bangor (ME)	0	0	0	5
Baton Rouge (LA)	9	6	9	31
Bellingham (WA)	3	1	10	10
Bergen-Passaic (NJ)	685	634	500	358
Billings (MT)	7	12	23	25
Biloxi-Gulfport-Pascagoula (MS)	0	0	0	21
Bismarck (ND)	2	6	9	25
Bloomington (IN)	2	5	10	9
Boise City (ID)	40	88	129	139
Boston-Worcester-Lawrence-Lowell-Brockton (MA-NH)	1540	1568	1366	1003
Boulder-Longmont (CO)	21	21	18	13
Burlington (VT)	23	38	37	33
Casper (WY)	2	5	12	16
Cedar Rapids (IA)	4	14	9	23
Charleston (WV)	2	0	21	24
Charlotte-Gastonia-Rock Hill (NC-SC)	245	351	350	259
Charlottesville (VA)	4	3	1	1
Chattanooga (TN-GA)	10	40	47	51
Chicago (IL)	3622	3504	2792	1876
Cleveland-Lorain-Elyria (OH)	1043	1074	957	396
Corvallis (OR)	6	5	7	6
Dover (DE)	6	20	29	38
Enid (OK)	0	0	0	0

MSA	1 person family	2 person family	3 person family	4 person family
Fayetteville (NC)	0	0	0	18
Fort Lauderdale (FL)	322	384	417	303
Hartford (CT)	694	672	574	270
Honolulu (HI)	104	108	91	63
Las Vegas (NV-AZ)	542	770	866	709
Lawrence (KS)	13	7	7	10
Lexington (KY)	98	173	216	221
Lincoln (NE)	22	37	62	52
Little Rock-North Little Rock (AR)	74	170	264	275
Los Angeles-Long Beach (CA)	1006	1146	823	1064
Minneapolis-St. Paul (MN-WI)	652	653	522	386
New York (NY)	2995	2844	3059	2093
Phoenix-Mesa (AZ)	422	559	722	602
Providence-Warwick-Pawtucket (RI)	78	157	217	211
Provo-Orem (UT)	5	9	14	27
Rapid City (SD)	7	5	22	38
St Louis (MO-IL)	198	309	434	486

CONCLUSION

Implementation of the HUD low-income rates to augment VA's single means test standard and methodology will create a system that realistically and equitably reflects cost-of-living variations from one locality to the next, reflecting a veteran's ability to defray the cost of his health care as per Congress' original intent. Leaving the existing threshold as a base level guards against harm for any veteran currently meeting existing means test criteria. While VA's health care networks will lose the ability to collect co-payments from veterans formerly enrolled in category 7 who would now be bumped into category 5, under the original statutory intent governing the eligibility category placement, where the ability to defray the cost of care is the determining factor in placement in either category 5 or 7, these veterans should never have been required to pay co-payments in the first place. Furthermore, we believe that each VA health care system will be able to recoup the loss of the moneys collected as co-payments by "drawing down" reimbursement from VA central office for these new category 5 patients.