LEGISLATIVE HEARING ON H.R. 784, H.R. 785, H.R. 1211, AND DISCUSSION DRAFT ON EMERGENCY CARE REIMBURSEMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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LEGISLATIVE HEARING ON H.R. 784, H.R. 785, H.R. 1211, AND DISCUSSION DRAFT ON EMERGENCY CARE REIMBURSEMENT

TUESDAY, MARCH 3, 2009

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

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

Present: Representatives Michaud, Teague, Rodriguez, Halvorson, Stearns, and Boozman.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to have the hearing come to order. I want to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans and the U.S. Department of Veterans Affairs (VA) and other interested parties to provide their views on and discuss recently introduced legislation within the Subcommittee's jurisdiction in a clear and orderly process.

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

We have four bills under consideration today. They cover a wide range of issues, including mental health, women veterans and reimbursement for emergency care treatment in non-VA facilities.

The four bills before us today are H.R. 784, sponsored by Representative Tsongas of Massachusetts; H.R. 785, sponsored by Representative Tsongas of Massachusetts; a Draft Discussion of Emergency Care Reimbursement by Mr. Filner from California; and H.R. 1211, Women Veterans Health Care Improvement Act by Representative Herseth Sandlin, who is also a Member of this Committee.

So I look forward to hearing the views of the witnesses on these bills before us today, and I would like to recognize Congressman Stearns for any opening statement that he may have.

[The prepared statement of Chairman Michaud appears on p. 35.]

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Mr. Chairman, thank you very much.

I am delighted to be here.

I think your opening statement appropriately said it, that we have four bills before us. You are not saying you agree or disagree, but you are saying let us listen to the arguments and hear what they are.

I think, particularly, every Member of Congress should realize that before we pass legislation, we should consider the impact of this legislation to the economy, and is it going to impact States and cause them to spend more money, is it going to somehow decrease jobs. So I try to look at these four pieces of legislation in that respect, too.

The first bill, H.R. 784, would require VA to submit quarterly reports on mental health professional vacancies.

The second bill, H.R. 785, would establish a pilot program to provide mental health outreach and training on certain college campuses for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans.

The Department of Veterans Affairs has made great improvements in the past 2 years to reach out to more veterans and provide better, more effective mental health services.

Mr. Chairman, with a growing number of veterans in need of mental health care, we must continue to focus on how we can build on the progress VA has made thus far, and I am very interested in hearing views on these proposals.

I thank the Chairman, Mr. Filner, for reintroducing his bill to expand the benefits for veterans related to the reimbursement of expenses for emergency treatment in the local non-VA facilities. I am pleased to see that changes have been made to the bill to clarify the requirements for VA payment under the program.

I would also like to commend my good friend, Stephanie Herseth Sandlin, for being a champion of women's veterans. Her bill, the "Women Veterans Health Care Improvement Act," includes a number of provisions designed to study, improve, and expand access to care for our courageous women veterans.

The number of women serving in the active-duty Guard and Reserve, obviously, continues to increase. Today, women represent almost 8 percent of the total veteran population and nearly 5 percent of all veterans who use VA health care services.

VA estimates that the number of women veterans enrolled in VA health care will more than double over the next decade. So, obviously, it is essential for us to be making sure that the VA is providing appropriate programs and services throughout the country to meet the unique physical and mental health needs of our women veterans.

As we examine new initiatives, we must also be careful to ensure that they complement and do not overlap existing VA efforts in research and programs for women veterans.

So, I look forward to a very productive discussion on these legislative proposals and want to thank all of our witnesses for participating in this hearing on a very cold day here in Washington. Your testimony will help guide us to best serve our veterans in our Nation.

I thank you, Mr. Chairman. With that, I yield back the balance.

[The prepared statement of Congressman Stearns appears on p. 35.]

Mr. MICHAUD. Thank you very much. I know Representative Tsongas has another meeting she has to go to, so why don't we start with Representative Tsongas. If you could explain H.R. 784 and H.R. 785 to us and we will ask you questions if we have any.

Representative Tsongas.

STATEMENTS OF HON. NIKI TSONGAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS; AND HON. STEPHANIE HERSETH SANDLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

STATEMENT OF HON. NIKI TSONGAS

Ms. TSONGAS. Thank you, Chairman Michaud and Congressman Stearns for giving me this opportunity to testify.

I have introduced two bills, H.R. 784 and H.R. 785, to improve the quality and accessibility of mental health services for our veterans.

Almost one million Operation Enduring Freedom and Operation Iraqi Freedom veterans have left active duty and become eligible for VA health care since 2002; 400,304 or 42 percent of these veterans have obtained VA care, and approximately 44 percent of that number are facing mental disorders. The three most common diagnoses are post-traumatic stress disorder (PTSD), depressive disorders and neurotic disorders. These rates are two to three times that of the general population.

My first bill, H.R. 784, simply requires that the VA report vacancies in mental health professional positions at VA facilities on a quarterly basis. With the significant influx of new war veterans facing mental health wounds, as well as the already existing veterans' populations from earlier generations receiving care at the VA, it is incumbent upon us to make sure that we have the necessary staffing to provide care. This bill will help this Congress perform our oversight role, and it will help the VA use its limited resources to effectively care for our veterans.

The second bill, H.R. 785, will help veterans seeking to improve their lives through education. The 110th Congress passed the most sweeping modernization of the Montgomery GI Bill since the program's creation after World War II. The purpose of the modernization is to give veterans of Afghanistan and Iraq access to the education and job training tools that they will need to achieve the American dream they risked so much to defend.

As I stated earlier, approximately 44 percent of Afghanistan and Iraq veterans who have sought treatment at the VA have demonstrated signs of mental health wounds, including PTSD. Studies have shown that PTSD can have a negative impact on an individual's ability to focus and ability to learn.

Returning from a war, separating from service, and then beginning school can place significant strains on the mental health of a veteran. It is critical that we provide our veterans with the assistance they need to manage and recover from these wounds so that they can take advantage of the opportunities available to them.

To that end, I have introduced H.R. 785. This bill directs the Secretary of Veterans Affairs to carry out a pilot program to provide outreach and training to certain college and university mental health centers so that they can more effectively identify and respond to the mental health needs of veterans of Operation Enduring Freedom and Operation Iraqi Freedom.

My legislation would not break the continuum of care provided by the VA. The purpose of this bill is to provide college counselors and other staff, who come in close contact with student veterans at their schools, with the tools to recognize symptoms of combat-related mental health wounds, the ability to appropriately assist a student veteran in need, and an understanding of how to effectively refer that student veteran to the VA for care.

I believe my legislation will actually augment the VA's continuum of care and bring in veterans who may be hesitant or apprehensive about seeking care from the VA. The intention of both bills is to ensure that we have adequate services to address the mental health care needs of our veterans, and that we give our veterans the opportunity to build full lives once they take off the uniform.

Thank you for the opportunity to testify before the Subcommittee. I look forward to working with you, Chairman Michaud and the other Members of this Subcommittee, to improve these bills and to improve the quality and accessibility of the care we provide our veterans. Thank you.

[The prepared statement of Congresswoman Tsongas appears on p. 36.]

Mr. MICHAUD. Thank you very much, Representative Tsongas.

I just have one question on H.R. 784. How would you respond to potential criticism that the data collection required by H.R. 784 would be burdensome?

Ms. TSONGAS. Well, as we know, data collection is an essential management tool for the VA and an essential tool for Congressional oversight. We hear about wait times and staffing shortages from our veterans. I think any Member of Congress, as we are out in our districts, often receives that input from those who have been seeking care. So it is difficult to imagine how the VA can truly understand what is happening at the local level without this data. And it will help to provide a baseline for the VA going forward so that it and we better understand their capacity to fill and augment the services they provide.

Mr. MICHAUD. Okay. Thank you very much.

Mr. Stearns, do you have any questions?

Mr. STEARNS. Thank you, Mr. Chairman.

Let me just go along with what the Chairman just sort of alluded to, the fact that these quarterly reports on mental health vacancies, obviously, I think everybody would agree, would improve care for veterans. I guess as the Chairman alluded to, is the fact that it could be duplicative.

Last year, Congress created a grant program for institutions of higher education to establish "Center of Excellence for Veteran Student Success," and it was set up to coordinate services to address the academic, financial health, and social need of veteran students.

Just a suggestion. Is it possible that within that Center for Excellence for Veterans Success, where they are coordinating services dealing with health, rather than perhaps creating a new separate pilot program, is it possible we could achieve the same goals under that Center for Excellence that is already established where they do actually coordinate dealing with, not only academic, financial, and social needs, but also health, to improve the mental health outreach? So, in a sense, coordinating with this existing legislation and just folding it in, rather than a separate program, I guess, would be a question.

Ms. TSONGAS. Well, we would be happy to work with the VA and the Committee, Subcommittee, going forward to look at ways to integrate this. In my former life, I was an administrator in a community college, and you see how often a very unique role that counselors in institutions of higher education play with incoming students.

And so we would be happy to work, as I said, with the VA to see if there is of way of integrating a program that really takes advantage of what colleges have to offer, the fact that they are often those at first—guidance systems are often the first to really deal with incoming students, and find a way that we can leverage both.

Mr. STEARNS. So you would be receptive, perhaps, to maybe even allowing a pilot program, using this existing structure to see how it would work as maybe a possibility of solving this?

Ms. TSONGAS. Well, I would be happy to look at that as a possibility, a way of going forward. But I do think that we recognize—acknowledge and recognize that there is a need out there that many returning soldiers will be taking advantage of the modernized GI bill going on to college and, yet, still suffering from the impact of their service in war.

So we do want to take advantage of that moment of contact in these institutions of higher education. And as the bill says, it focuses on those institutions that are receiving significant numbers of young people from these wars.

But, again, as I said, I would like to work with the Committee on that, and the VA.

Mr. STEARNS. Okay. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mrs. Halvorson, do you have any questions of Ms. Tsongas?

Mr. Boozman.

Mr. Teague.

Mr. TEAGUE. No, not at this time. Thank you.

Mr. MICHAUD. Thank you.

Okay. Well, thank you very much, Ms. Tsongas. I really appreciate your willingness to come today and bring forward these two pieces of legislation. I will be looking forward to working with you as we deal with this later on in the year. Thank you very much.

Ms. TSONGAS. And thank you for this opportunity. And I apologize for——

Mr. MICHAUD. No, that is totally understandable with all of our busy schedules. Thank you very much.

I am very pleased to recognize Representative Herseth Sandlin for her many years working and fighting for veterans' issues, especially women veterans' health care. I also want to thank you for

your willingness to let Representative Tsongas go through her testimony so she can get on to her next meeting.

So without any further adieu, Representative Herseth Sandlin.

STATEMENT OF HON. STEPHANIE HERSETH SANDLIN

Ms. HERSETH SANDLIN. Well, thank you and good morning, Mr. Chairman, Mr. Stearns, other Members of the Subcommittee. Thank you for holding today's hearing, and I certainly appreciate having the opportunity to be here to discuss the "Women Veterans Health Care Improvement Act."

H.R. 1211, which I introduced on February 26th, 2009, enjoys original cosponsor support from a number of Health Subcommittee Members, including Chairman Michaud; the distinguished Ranking Member of the Economic Opportunity Subcommittee, Mr. Boozman; and Mr. Moran. The bill will take important steps to expand and improve Department of Veterans Affairs Health Care Services for women veterans.

Before I talk more about the bill and the needs of women veterans, I would also like to take this opportunity to thank the Disabled American Veterans (DAV) for their continued leadership and the effort to address the needs of women veterans and their support for this important legislation.

As your Subcommittee knows, Mr. Chairman, more women are answering the call to serve and more women veterans need access to services that they are entitled to when they return. With increasing numbers of women now serving in uniform, the challenge of providing adequate health care services for women veterans is overwhelming. With more women seeking access to care and for a more diverse range of medical conditions, in the future these needs will likely be even significantly greater.

I would like to share just a few statistics with you that highlight the need for a comprehensive update of VA services for women veterans. As of October 2008, there were more than 23 million veterans in the United States. Of this total, women veterans made up 1.8 million, or as Mr. Stearns noted, 8 percent of the total veteran population.

There are increasing numbers of women veterans of childbearing age. For example, 86 percent of OEF/OIF women veterans are under the age of 40.

The VA notes that OEF/OIF female veterans are accessing health care services in large numbers. Specifically, 42.2 percent of all discharged women have utilized VA health care at least once. Of this group, 45.6 percent of them have made visits two to ten times.

Finally, according to the VA, the prevalence of potential PTSD among OEF/OIF women veterans treated at the VA from fiscal year 2002 to 2006 grew dramatically from approximately 1 percent in 2002, to nearly 19 percent in 2006. So the trend is clear, but not surprising. More women are answering the call to serve, and more women veterans need access to health services.

Clearly, we must do everything we can from a public policy standpoint to meet this new challenge. To address some of these issues, the "Women Veterans Health Care Improvement Act" calls for a study of barriers to women veterans seeking health care, an assessment of women health care programs at the VA, enhance-

ment of VA sexual trauma programs, enhancement of PTSD treatment for women, establishment of a pilot program for childcare services, care for newborn children of women veterans, and the addition of recently separated women veterans to serve on advisory committees.

The VA must ensure adequate attention as given to women veterans program so quality health care and specialized services are available equally for both men and women.

I believe my bill will help the VA better meet the specialized needs and develop new systems to better provide for the health care of women veterans, especially those who return from combat, who are sexually assaulted, who suffer from PTSD or who need childcare services.

Mr. Chairman, thank you, again, for inviting me to testify here today. I look forward to answering any questions you or other Members of the Subcommittee may have.

[The prepared statement of Congresswoman Herseth Sandlin appears on p. 36.]

Mr. MICHAUD. Thank you very much. Once again, thank you for all your work in dealing with veterans' issues during your tenure here as a Member of Congress.

I just have one question. As you know, the Senate actually introduced a companion bill. Reading that companion bill, there is one difference and that is dealing with newborn care. I believe the Senate version allocates 7 days. Your version allocates 14 days for newborn care. Is there any rationale for the difference?

Ms. HERSETH SANDLIN. Well, importantly, the 14-day provision, in my bill, that was recommended by the Women's Advisory Committee, but I am more than happy to further discuss with you, as we look at differences with the Senate bill, visiting with those women on the Women's Advisory Committee, as to the purpose of their recommendation for 14 days versus 7 days. But, certainly, I think that we can find a way to negotiate the appropriate duration of the care following birth.

Mr. MICHAUD. Do you know what the Congressional Budget Office (CBO) has scored this provision?

Ms. HERSETH SANDLIN. We have requested a cost estimate from CBO. Unfortunately, we haven't received an official cost estimate yet.

As you know, much of what is in the bill requires studies, pilot programs, updated procedures, so those provisions we anticipate the cost will be relatively small. Although I do think, as it relates to the additional provision that we have included this year in the bill that we didn't include last year, as it relates to a duration of care for newborn children, that that would probably be the largest item as it relates to the cost estimate. And as soon as we get it from CBO, we obviously—I think the Health Subcommittee has requested the score as well.

Mr. MICHAUD. Thank you very much.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. I thank the gentlelady for her bill and for her testimony.

Generally, I think my purpose is just to clarify so that we understand things.

I think you know that the VA is currently undergoing its own national survey of women veterans, which they expect to complete this fiscal year. I guess, their concern, and perhaps our concern would be, do you think we should give the VA, perhaps, some flexibility here and let them complete their own comprehensive assessment first, and let them analyze it and find the results, perhaps, before entering into a study that is mandated in this bill? It is just a consideration of what you feel.

Ms. HERSETH SANDLIN. Well, thank you for the question.

In the VA's testimony during the 110th Congress when they testified on that version of this bill, the VA acknowledged the need for such a study, but indicated that they don't have the resources, the staff or the budget needed to carry out such a study. So, while they may have undertaken that, I think it is very important that, with the authorization and, of course, with the resources that would go along with that, that we don't in any way delay.

There are other studies going on that are a little bit more narrow. They are sort of peer-reviewed studies that would occur in just one publication.

But I think that it is important now, at the beginning of this Congress, in light of the statistics that I cited, that you as well cited, Mr. Stearns, that we acknowledge that they have, perhaps, undertaken a study, but we want it to be as comprehensive as possible. And we think the provisions authorized in this bill, particularly with the input from the Women's Advisory Committee, we don't want to be duplicative at the end of the day either.

And I think it is important to add to their efforts, thus far, to make sure they understand what this Committee is looking for as they do an overall assessment of the need for women veterans and their health care services.

Mr. STEARNS. When this assessment is done under your bill, is it your intent that the contract or entity that is conducting this comprehensive assessment of women's health care programs? Would they also be required to develop the follow-up plan?

Ms. HERSETH SANDLIN. We haven't anticipated if that same contractor would be responsible for doing the follow-up. I think that is something that I can discuss with Secretary Shinseki, working with Mr. Michaud, working with you, working with Mr. Brown on this Subcommittee.

But I think, for continuity's sake, if that is what has been done in the past, when they have done, worked with a contractor, do a study, that it makes the most sense to utilize the same entity for follow-up, that that is something that we would likely want to pursue for continuity purposes.

Mr. STEARNS. My last question, Mr. Chairman. How would the requirements to provide graduate medical education, training certification and continuing medical education for mental health professionals under this Section 202 of the bill actually work towards helping the training that VA is already providing?

Ms. HERSETH SANDLIN. Well, I think that the VA has done a remarkable job in many instances, given some of the Medical Centers that I have had a chance to visit, not just in my own district, but in other parts of the country, including Virginia, including up in New Hampshire, of being very creative as it relates to identifying

those individuals who may be suffering from PTSD and what type of follow-up is going to be most aggressive and effective, given the individuals that they are working with.

But I think that they are, while their current training efforts are excellent, they fall short because they don't address the depth of education needed, as you state, for both the graduate medical education or continuing medical education, including clinical supervision, mentoring and skills testing to master the several commonly used evidence-based treatment protocols.

So H.R. 1211 authorizes that needed training, resources and certification. And I think it is important, building on the efforts of some of the Medical Centers, but they have been doing it, I think, based on the leadership at each of the Medical Centers. And I think, again, this provides more comprehensive training and needs with the graduate medical studies and the type of clinical supervision across the system in the VA, again, building on some of the very effective and successful programs that have been built and developed piecemeal among different Medical Centers across the country.

Mr. STEARNS. I thank the gentlelady.

And thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much.

Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman.

I have a couple of questions. But, first of all, thank you, thank you so much for bringing this to our attention. I know that I am very pleased that the Committee is addressing some of the issues here of the health care for women. We all know that the increase in women veterans are going to be quite a challenge, especially in the differences, culturally.

You pointed to a number of existing efforts to train mental health professionals using the evidence-based practices. However, the VA has only trained a limited number of professionals to date. What are the VA's plans, that you know of, for ensuring that the training reaches all of the mental health professionals that are practicing in the VA?

I know when Secretary was here, he said that he believes that there is a woman's outreach person at each one of the 156 centers. What is going on with regards to that?

Ms. HERSETH SANDLIN. Oh, that is a good question, and I don't know specifically. Again, I think it has varied, based on the leadership of the directors at the different Medical Centers. And, certainly, there is a sharing of information and best practices.

But as we have seen the explosion of women veterans accessing care, I think some Medical Centers have been more aggressive than others. I also think that in the early years of OEF/OIF, when we were dealing with emergency budget requests, there was a difficulty in adequately resourcing and fully funding all of the programs or new developed programs that some of the Medical Centers were trying to pursue to identify and effectively treat, both women and men veterans who suffer from PTSD.

I think as it relates to the proposed budget that we have seen from the new Administration and the increased resources, with a focus on breadth in comprehensive care, I don't know specifically

how much of those resources they would dedicate toward women's programs, specifically those addressed to PTSD for women veterans, whether it is related to combat experience, whether it is related to sexual trauma, or other circumstances.

But I do think that this bill is important because it provides the type of guidance, as well as authorizes the resources necessary, to make sure that all of those who are serving veterans and their mental health care needs have the adequate training, have the adequate education and clinical supervision necessary to ensure that the evidence-based research demonstrates can be most effective in caring for these veterans.

Mrs. HALVORSON. Great. And the only other question I have is—and excuse my ignorance, I am new—what has been done in the past with regards to newborn care of babies of veterans, female veterans?

Ms. HERSETH SANDLIN. Well, I don't believe the VA facilities have ever provided for newborn care. I remember, and I think I would need counsel to correct to me if I am wrong, I recall an early debate when I was—shortly after I was elected in 2004. I believe we were discussing the level of prenatal care for women veterans. So just as recently as 5 years ago we were discussing whether or not the VA should provide a breadth of prenatal care services.

So, in my opinion, and based on my recent experience, it seems somewhat unreasonable and an unfair financial burden for women veterans, if now that we are providing, as I think we appropriately should for prenatal care for women veterans, that we wouldn't provide for a set, a duration, whether it is 7, 10 or 14 days, of care for that newborn, which can be quite costly and could be, again, an unfair financial burden to the woman veteran.

Mrs. HALVORSON. Thank you. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Teague.

Mr. TEAGUE. Yes. Thank you. I really like the bill, but I do have a couple of concerns because I believe that there may be a lot of gender disparity occurring.

For instance, if we had a female veteran that requested a female counselor, female doctor, what are the chances of her getting that female counselor or doctor?

Ms. HERSETH SANDLIN. Well, I can't answer that. I don't have the numbers at my disposal that I could get from the VA in terms of the number of psychiatrists and clinical psychologists they currently employ that would be providing—that would be available to provide care. I don't know if Counsel has those statistics.

Ms. WIBLEMO. Well, I don't have the statistics, but the VA certainly tries to pair up, if there is a gender issue, say military sexual trauma (MST) or some type of gender issue where a female wants to see a female doctor, they try to pair up the gender-specific requests. I mean, it is not—you know, I don't know that they have an entire program where they——

Probably a better question for the Department of Veterans Affairs when they come up, but I know they do try to do that, as far as gender disparity is concerned.

Mr. TEAGUE. Thank you. And, also, like Congresswoman Halvorson said, I am new, and a lot of these things you all prob-

ably already plowed through last year and years before. But I was concerned and curious as to how to get that information because I will follow up on it and because I do hope that we are accepting the fact that they are different and that their needs are different and we need to remove all the barriers that we can to be sure that they get all of the help that they need.

Ms. HERSETH SANDLIN. Well, thank you, Mr. Teague. And I think one of the provisions in the bill, as it relates to the assessment and the evaluation as to what those barriers are, a survey of women veterans, asking them if you aren't currently receiving care, why is it that you aren't. And what we can anticipate anecdotally is one of the provisions that is included in the bill, which is a lot of women veterans are the primary caregivers to their children. And if they don't have access to childcare services at the time that they are receiving their care and their counseling, that can be a barrier. And, so that is included, and we have changed the bill in this Congress so that, not just women veterans, but male veterans who also are responsible for the care of their children can access those services under that pilot program.

But I think that we will be able to find—and, again, I know that the Department of Veterans Affairs will be testifying on these bills here today as well—is it a barrier, for example—and that is what we tried to find out in this survey—for women who may be suffering from PTSD, if they feel that their chances of getting, and let us say they are suffering PTSD from military sexual trauma, is it a barrier to them accessing services from the VA because they believe that they are quite unlikely to get a female counselor, versus who they may be aware are already providing counseling services to some of their male counterparts.

So, again, I think the bill is trying to get to some of the concerns that you have as it relates to the first provision, being one that seeks to address what are the barriers to care, so that arms the VA with information they need in developing new programs that can do a more effective outreach.

Mr. TEAGUE. Good. As I thought, you all have already checked on most of the things that I had questions about. I appreciate, not only having done that, but of both of you for giving me time today. Thank you.

Mr. MICHAUD. Thank you very much, Mr. Teague.

Once again, I want to thank you very much, Congresswoman, for coming today and bringing forward this very important piece of legislation. I look forward to working with you as we move forward in dealing with the legislation. Thank you.

I would like to call up the second panel to come testify. On the second panel we have Joy Ilem from the Disabled American Veterans; Joseph Wilson, the American Legion; Eric Hilleman from the Veterans of Foreign Wars of the United States (VFW); and Todd Bowers from Iraq and Afghanistan Veterans of America (IAVA). I want to thank each of you for coming this morning. I look forward to hearing your testimony, and we will start with Ms. Ilem.

STATEMENTS OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; ERIC A. HILLEMAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to offer our views on the bills under consideration today.

H.R. 784 would require quarterly reports to Congress regarding clinical mental health vacancies in VA networks by a medical facility.

We appreciate the intended purposes of the bill, but as written, we are concerned that enactment would not elicit the kind of information Congress needs to properly evaluate VA status and results in achieving its mental health reforms. Therefore, we ask this Subcommittee to consider expanding the scope of the bill.

Over the past several years, VA has developed an aggressive plan for reform through its mental health strategic plan and uniform mental health services package. Likewise, Congress has provided significant increases in funding to improve VA mental health programs and services.

We believe the intended purpose of this bill is to ensure there is real progress in increasing the number of mental health staff and programs, specifically to improve access to these specialized services. To achieve this result, we believe detailed oversight and monitoring are necessary now and imperative if ongoing progress in filling critical gaps in mental health services across the Nation is to be assured and the goal of recovery fully embraced.

The oversight process we envision in mental health is one that is data driven and transparent and includes local evaluations and site visits to factor in local circumstances and needs. An empowered VA organizational structure is needed to carry out this task.

Such a structure would require the Veterans Health Administration (VHA) to collect and report detailed data at the national, network and Medical Center levels, on the scope of programs available and on the net increase over time in the actual capacity to provide comprehensive, evidence-based, mental health services.

We believe the recommendations further outlined in our statement would provide the architecture for a truly effective oversight of VA mental health programs. Again, while DAV supports the basic intent behind H.R. 784, we ask this Subcommittee to consider this broader scope of oversight of VA's mental health programs.

H.R. 785 would establish a 4-year pilot program aimed at improving outreach to OEF/OIF veterans on the campuses of colleges and universities.

DAV Resolution 166 supports program improvement and enhanced resources for VA mental health programs to achieve readjustment of new combat veterans and continued effective mental

health care for all enrolled veterans needing such services. Therefore, DAV is pleased to support H.R. 785.

H.R. 1211, the "Women Veterans Health Care Improvement Act," would expand and improve VA health care services available to women veterans with a focus on women veterans returning from Operations Iraqi and Enduring Freedom.

The current number of women serving in active military service in its Guard and Reserve components has never been larger, and this trend predicts that the percentage of future women veterans who will enroll in VA health care and use other VA benefits will continue to grow proportionately.

Also, women are serving today in military occupational specialties that take them into combat theaters and expose them to some of the harshest environments imaginable. As a result, women, too, bear the cost of war.

VA must prepare to receive a significant new population of women veterans in future years who will present with needs that VA has likely not seen before in this population.

Mr. Chairman, this comprehensive legislative proposal is fully consistent with the series of recommendations that have been made in recent years by VA researchers, experts in women's health, VA's Advisory Committee on Women Veterans, the Independent Budget and the DAV.

DAV Resolution 238 seeks to ensure high quality comprehensive health care services for all women veterans, with a special focus on the unique post-deployment needs of women veterans returning from the wars in Iraq and Afghanistan. Therefore, we fully support H.R. 1211 and urge the Subcommittee to recommend its enactment.

The final bill under consideration is a draft proposal aimed at expanding eligibility for reimbursement by VA for emergency treatment in non-department facilities. This bill's purposes are in full accord with the mandate from our membership expressed in DAV Resolution 178. Its intent is also consistent with the recommendations of the Independent Budget to improve reimbursement policies for non-VA emergency health care services for enrolled veterans. For these reasons, Mr. Chairman, we urge introduction of the bill and we endorse its enactment into law.

This concludes my testimony on behalf of the Disabled American Veterans on these important bills, and I would be pleased to respond to any questions from you or other Members of the Subcommittee. Thank you.

[The prepared statement of Ms. Ilem appears on p. 37.]

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Mr. Chairman, thank you for the opportunity to present the American Legion's views on these pieces of legislation.

H.R. 784, which seeks to improve the recruitment of mental health care professionals by having the Secretary of Veterans Affairs submit quarterly reports on mental health employment vacancies at VA Medical Centers nationwide, now Section (a) requires the Secretary of Veterans Affairs to submit to Congress a report describing any vacancy in a mental health professional position at any medical facility of the Department no later than 30 days after

the last day of a fiscal quarter. Within these reports, the Secretary is to indicate, for each vacancy, the Veterans Integrated Services Network, or VISN, to which the facility with the vacancy is assigned.

Now, the American Legion's System Worth Saving Task Force visits medical facilities throughout the VA medical system—reports a constant need for additional mental health providers in almost every medical facility.

As VA continues to screen, identify, and treat veterans suffering from mental health disorders through VA outreach coordinators and Vet Center's Global War on Terror, or GWOT, counselors having the staffing capabilities to treat veterans after initial intervention is paramount.

The American Legion believes that—also, this is supported by our Resolution 150 as well. The American Legion believes that with a quarterly report, mental health care services for veterans will be more widely available because less time for recruitment will be needed.

Currently, following the interview process, the hiring process takes approximately 6 months. During that time, the competitive private sector at times hired the prospective mental health provider away from the VA.

The American Legion supports any standard that improves the mental health capability of VA and its medical facilities, and, in turn, would like to see the passage of H.R. 784.

To provide our veterans with the most adequate mental health care, there should be—the proper amount of mental health providers in the VA Medical Centers, there should be. The inadequacy of mental health providers gives way to substandard care and the possibility that veteran mental health care needs will fall through the cracks.

H.R. 785, this bill establishes a pilot program to provide outreach and training to certain college and university mental health centers relating to the mental health of veterans of OEF/OIF or Operation Enduring Freedom/Operation Iraqi Freedom, and for other purposes.

Section 1(a) seeks to establish a 4-year program under which the Secretary shall provide a counseling center, a student health or wellness center at a college or university with a large veteran population to increase outreach efforts.

Resolution 150, "The American Legion Policy on Department of Veterans Affairs Mental Health Services," states that veterans continue to need increased access to mental health care.

A RAND Study on the "Invisible Wounds of War: Addressing the Mental Health Needs of Returning Soldiers," in 2008, estimated that 300,000 veterans, or 18½ percent of those deployed, were diagnosed by VA with PTSD or major depression. This number continues to rise and efforts to increase access and quality of care at the universities and colleges are imperative to ensure assistance is available to these veterans during a time of crisis. The American Legion supports the increased outreach efforts at universities or colleges where many veteran students are not familiar with VA benefits and services.

H.R. 1211, this bill seeks to expand and improve health care services available to women veterans, especially those serving in Operation Enduring Freedom and Operation Iraqi Freedom, from the Department of Veterans Affairs and for other purposes.

Approximately 1.7 million women veterans make up approximately 7 percent of the veteran population, while 240,000 utilize VA health care services. There are currently approximately a quarter of a million women serving in the U.S. armed forces. By 2010, the percentage is projected to rise to 14 percent of the total population and 15 percent by 2020.

A National Institutes of Health study suggested several areas of improving the provision of health care to this Nation's women veterans to include the availability of needed services, particularly women-specific services and the logistics of receiving care, the VA, such as the waiting time to obtain care and the issues relating to continuity of care. The study also revealed problems with the ease of access in VA health care as the most significant barrier to VA Medical Center use.

We hereby urge Congress to pass this bill to add to the closing of gaps, as well as building on a more firm relationship between VA and this Nation's women veterans.

And on the Draft Emergency Treatment at Non-VA Facilities, this draft seeks to expand eligibility for reimbursement by the Secretary of VA for emergency treatment furnished in a non-department facility and for other purposes.

The American Legion believes it is essential for veterans to receive emergency medical care from non-VA facilities in the absence of available VA health care or when traveling presents a hazard or hardship for the veteran in accessing care.

In addition, VA must devise better methods of communicating and submitting payment to third-party facilities on behalf of the veteran. Making this so will decrease the stress added to veterans who have to answer to agencies collecting on behalf of non-VA facilities.

The American Legion supports the reimbursement of costs incurred by veterans who must receive emergency care at non-VA facilities.

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

[The prepared statement of Mr. Wilson appears on p. 44.]

Mr. MICHAUD. Thank you.

Mr. Hilleman.

STATEMENT OF ERIC A. HILLEMAN

Mr. HILLEMAN. Chairman Michaud, Members of the Subcommittee, thank you for this opportunity to present the Veterans of Foreign Wars views before the Subcommittee.

On behalf of the 2.2 million men and women of the VFW and our auxiliaries, it is my honor to urge quick passage of the four bills presented before this Subcommittee today.

First, H.R. 784, a bill to report quarterly on the vacancies in mental health professional positions in the Department of Veterans Affairs.

The VFW supports this bill, which would require the Secretary of the VA to report to Congress for vacancies of psychiatrists, psychologists, social workers, marriage and family therapists, and licensed professional mental health counselors. Reporting vacancies to Congress will elevate the issue and encourage mental health professionals to seek employment within the VA. Much needed attention has to be drawn to this issue. It is an important shortage that impacts all the lives of our veterans.

Second, H.R. 785, a bill to establish a pilot program from FY 2010 to 2013 to educate, engage—excuse me—to educate and engage in outreach to college and university mental health centers.

The VFW enthusiastically supports this legislation, which would require—excuse me—which would give the Secretary $3 million in funding to train college and university clinicians, administrators, and counselors for serving OIF and OEF veterans. We believe this bill will help combat veteran stereotypes and destigmatize mental health issues related to military service.

Through educating the education community, this information can hopefully be broadly disseminated into the counseling and social work industry. Not only is this a benefit to schools and to the community, it directly affects the lives of veterans on campuses across the Nation.

In a time where more veterans will be seeking use of their new GI bill, this benefit is crucial to their success for transition and reintegration.

Third, H.R. 1211, the "Women Veterans Health Care Improvement Act." The VFW is proud to support H.R. 1211, legislation that will improve benefits and services to female veterans, especially those who have served or are serving in OEF/OIF operations.

As the number of females in uniform grow, so too will the percentage of females seeking services at VA. VFW is encouraged by the improvements in this bill, and we remain hopeful this legislation will ease access to services at VA by female veterans.

The VFW recognizes the work VA has already done toward implementing quality health care for all female veterans. Yet, we have many challenges to overcome. I would like to highlight three areas of this bill for special focus.

First, extended health care coverage for 14 days to female veterans' newborns. This is essential to the health care of the child and the mother, allowing continuity in obstetrics and gynecological care.

Second, the provision of this bill authorizing VA to provide graduate level training, certification and continuing medical education care for military sexual trauma and PTSD.

MST and PTSD are all too common among returning OIF and OEF female veterans.

Lastly, and most importantly, assessing the impediments to care were the focus on VA's common practices. The VFW strongly believes that VA's culture contributes to the barriers faced by women. With more conscious effort, we can make a fundamental difference in the lives of female veterans and improve their quality of care.

Finally, a draft bill to close existing loopholes and law allow VA to cover unmet emergency room treatment for veterans in certain cases. The VFW is pleased to offer our support for this bill, which

will allow VA to pay for the emergency care for veterans enrolled in VHA under certain cases. It closes a loophole that sticks many veterans unfairly with a large hospital bill.

Current law unfairly penalizes veterans who receive a portion of their costs of their care covered from another source, such as an insurance settlement or judgment. They may not be eligible for reimbursement, even if the amount is a fraction of the cost of their care. This bill allows the VA to be a second payor in those situations, so every veteran will be covered.

Mr. Chairman, Members of the Subcommittee, I thank you for this opportunity and I look forward to your questions.

[The prepared statement of Mr. Hilleman appears on p. 45.]

Mr. MICHAUD. Thank you very much.

Mr. Bowers.

STATEMENT OF TODD BOWERS

Mr. BOWERS. Mr. Chairman and Members of the Subcommittee, thank you for inviting IAVA to testify today regarding this pertaining legislation. On behalf of IAVA and our 125,000 members and supporters, I thank you for this opportunity and your unwavering commitment to veterans.

I also need to point out that my testimony today does not reflect the views or opinions of the United States Marine Corps, in which I still currently serve as a staff sergeant in the Reserves. It is my gunny disclaimer so I don't get choked this weekend, so.

H.R. 784, IAVA is very concerned with the national shortage of mental health professionals and, in particular, how the shortage affects access to adequate mental health care for troops and veterans.

The VA has already been flooded by new veterans seeking care for psychological injuries. More than 178,000 Iraq and Afghanistan veterans have been seen at the VA, have been given a preliminary diagnosis of a mental health problem. That is approximately 45 percent of new veterans who have visited the VA.

Although the VA was initially caught unprepared with a serious shortage, it is important to point out that the Department has made significant progress in responding to the needs of new veterans. Thanks to a mental health budget that has doubled since 2001, the VA has been able to devote $37.7 million to placing psychiatrist, psychologists and social workers within primary care clinics.

While psychological staff levels were below 1995 levels until 2006, the VA has recruited more than 3,900 new mental health employees, including 800 new psychologists, bringing the VA's total mental health staff to about 17,000 people. The VA is now the single largest employer of psychologists in the country.

That being said, access to mental health care, particularly for rural and female veterans is still an issue, in part because of the continued shortage of mental health professionals. As an example, Montana ranks fourth in sending troops to war, but the State's VA facilities provide the lowest frequency of mental health visits.

H.R. 784 will establish Congressional oversight over vacancies in the VA's mental health professional positions, and the increased transparency will help improve staffing at VA hospitals and clinics.

IAVA fully supports this legislation and looks forward to seeing its rapid implementation.

H.R. 785, with the passage of the historic Post-9/11 GI Bill last year, there will be a flood of Iraq and Afghanistan veterans taking advantage of their new education benefits and attending universities across the Nation. It is to be expected that many of these veterans will return to their student health centers while attending school for their medical care. This is an opportune time to advertise and extend VA mental health care services to new veterans.

H.R. 785 helps facilitate this by ensuring that student health centers and counseling services at universities have the appropriate support from the VA to provide best services for our Nation's student veterans.

IAVA is pleased to support H.R. 785 and looks forward to working with Congress to ensure that this legislation is enacted in a timely manner and does not contain any technical deficiencies. It is our hope that the language within the bill will be modified to clearly define what is termed as "large enrollment." It is critical that mental health services be available to all veterans, no matter what school they attend.

Any university with Iraq and Afghanistan veterans should have the appropriate amount of counselors ready to assist veterans. If only schools with a high veteran population are allocated these resources, veterans attending institutions with smaller veteran populations will continue to fall through the cracks.

In addition, Section I contains the following language: "Training for clinicians on treatment for mental illness commonly experienced by such veterans." IAVA would like to see this language more clearly defined to reduce the risk of certain illnesses going undiagnosed and/or untreated.

H.R. 1211, IAVA is pleased to see the Subcommittee is focusing on the unique needs of women veterans. Improvement of VA health care for women veterans is one of IAVA's 2009 legislative priorities. More than 11 percent of Iraq and Afghanistan veterans are women, and they deserve the same access to health care as any other American veteran.

The "Women Veterans Health Care Improvement Act" will help gather critical information on the quality of VA care provided to women veterans. By identifying the barriers to care or gaps in services that women veterans are experiencing, the VA and Congress can better address these shortfalls.

With respect to Title II, Section 202, of what we received as the discussion draft, IAVA would like to see funding devoted to the study of the best evidenced-based treatment and care for veterans suffering from post-traumatic stress disorder as a result of, both sexual trauma and combat trauma, so that mental health care providers within the VA can be trained on these particular treatments.

This combination of traumas has rarely been studied, but with more females serving in Iraq and Afghanistan, the possibility of both these traumas occurring in new veterans is significant. The VA's mental health providers must be prepared.

In addition to this recommendation, as part of IAVA's 2009 legislative agenda, we have made multiple recommendations to adequately address the needs of women veterans. In particular, IAVA

supports prioritizing hiring of female practitioners and outreach specialists, increased funding for specialized inpatient, women-only, PTSD clinics, and significant expansion of resources made available to women coping with military sexual trauma.

At this time, I would take any questions. Thank you.

[The prepared statement of Mr. Bowers appears on p. 47.]

Mr. MICHAUD. I would like to thank each of the witnesses for coming today to give your testimony on the four bills that we have before us.

I just have a couple of questions. In relationship to H.R. 1211, you talked about your support for the bill. Do any of the witnesses have any recommendations or thoughts on additional women's focused research that should be included in the bill?

Mr. WILSON. Mr. Chairman, let us see. From January to present, we have been, the American Legion has been on sight visits to VA medical facilities, and I, myself, have traveled this year. And what we have found is that there is a number—VA is in the spirit of providing that continuity of care, but there is a fragmentation in care amongst women.

And what that means is that they are receiving care from one provider, and then care from another provider when it has to be continuous. And what that does is, it pushes them away. We are finding that it is pushing them outside the VA system altogether. So they are choosing not to come or they are going to one provider, and not going to the other. So we would like to see that included and keep them in mind.

As I said, they are in the spirit of providing care or providing a female veteran with a female counselor, but it is a matter of availability as well.

Mr. MICHAUD. Thank you.

Ms. ILEM. Mr. Chairman, I noticed that the epidemiological study that was proposed in the bill last session, H.R. 4107, was omitted from this. And I know, we have been briefed by VA, it was some months ago, but Dr. Khan, apparently, they are conducting an epidemiological study of OEF/OIF veterans. That includes an oversampling of women veterans.

But it wasn't clear at the time that there was actually, if the funding had been approved and was, that was actually moving forward, and I would just encourage the Subcommittee to perhaps ask that question of the VA, just to ensure that that is, in fact, moving forward because I think that would be an important part to ensure, given the changing roles of women in military today and their roles, especially in Iraq and Afghanistan, to make sure that we are looking at the medical aspects and impact of that service.

Thank you.

Mr. MICHAUD. Thank you.

Mr. HILLEMAN. Thank for the question, Mr. Chairman.

Given the scope of this Committee, there are a number of other issues related to awareness among female veterans, I think, that need to be addressed on a larger scale with regard to what benefits that they are eligible for, what access they have. I imagine that some components of this study will touch on that when surveying the female veterans.

But from a broader perspective, we are concerned that many female veterans are not aware of the basic services and benefits they are entitled to.

Mr. MICHAUD. Okay. Thank you.

Mr. BOWERS. Mr. Chairman, under our 2009 legislative agenda, we make multiple recommendations in ways to help female veterans as they come back.

One of the ones that I would like to point out, the VA has made tremendous strides in trying to prevent suicide. One of these things was the establishment of the suicide prevention hotline. We would like to see that the counselors, who are on the other line of those phones, are trained and/or well versed in dealing with military sexual trauma. We think that this would be a great advancement to an initiative that the VA has really been outstanding on pushing.

One of the other recommendations that we have, and I will just read this straight out under Section 3.3, where we discuss improvement of access to care: "We recommend that the VA mandate uniform services at women clinics. Currently, women clinics vary in the services that they deliver, from gender-specific care to general primary care. Women veterans should have access to female primary care providers when requested. And if necessary, the VA should contract with local health care providers to offer this service."

One of the issues that we found with some our membership is there are many women veterans who are also rural veterans and they are falling into this very difficult place to try and find appropriate treatment.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. My second question for each of you is, as you know, the Senate has a bill dealing with women veterans and the number of days for newborn care is different between Representative Herseth Sandlin's bill and in the Senate version. What criteria would you consider important in determining the appropriate number of days for newborn care?

And we will start with Mr. Bowers.

Mr. BOWERS. Throw me right on the spot, aren't they.

This would be something, again, this falls under an issue where we are continually looking for the appropriate information to be able to determine what kind of care these individuals will need. I believe that there will be a tremendous amount of time that needs to be spent to look into this, specifically in regards to the amount of National Guardsmen and Reservists that utilize VA health care, how will they fall into this, how long with they will be on active orders in those times?

Specifically, though, I would hope that we would work with Federal agencies and mirror what other programs are available to Federal employees and things along those lines, to be able to come up with a solid determination on how many days they should have off.

Mr. MICHAUD. Okay.

Mr. Hilleman.

Mr. HILLEMAN. Thank you, Mr. Chairman.

Not having great insight into the neonatal care or the average number of days of neonatal care needed, we would defer to the common sense factor. If there is research out there that suggests

that 7 days is appropriate versus 14, I know from having a younger sister with a number of pregnancies, her last pregnancy after her child spent about a month in the hospital. So I think it would be something that we would have to view on a case-by-case basis, giving certain leniency in the law.

Thank you.

Mr. MICHAUD. Mr. Wilson.

Mr. WILSON. Mr. Chairman, to ensure that my response satisfies your question, I would like to defer to that for a later date so I can get the full consensus of the American Legion.

Mr. MICHAUD. Thank you.

Ms. ILEM. I would agree with some of the response of my colleagues. And also, I think Ms. Herseth Sandlin also pointed out some appropriate information with regard to that question. I know one of the things that we heard constantly when I was on the Women Veterans Advisory Committee, in speaking with the women's veteran program coordinators or program managers, that, you know, they were responsible as they developed the care for that, getting ready for that woman to deliver, and especially if that was for contract care outside the system that was very difficult for them to develop those contracts with regard to those private entities when they didn't have any, you know, care that would be provided for the child.

And I think that VA probably has a good idea, or at least they should have an idea and perhaps could share that with the Subcommittee regarding what is the average stay for those that they have provided so far, and to try to come up with the best, in the best interest of the veteran so that they would not be unfairly stuck with some very, very costly bill for them.

Mr. MICHAUD. Thank you.

My last question goes to Mr. Bowers.

You support H.R. 785, but you recommend the bill clearly define the terms "large enrollment" and "mental illness commonly experienced by veterans." Can you share with us some suggestions of how these terms should be defined, if you have any?

Mr. BOWERS. In the past few years since we have been fortunate enough to be working with the VA on some of their initiatives. One of the things that we have learned is that their outreach training to individuals within the VA is spectacular, whether it be a training initiative that they take upon themselves, an online training program. Things along these lines are extremely effective.

It would be interesting to hear how the VA may look at some of these things and be able to just provide and/or basic mailings to colleges that may not have a very large enrollment of Iraq and Afghanistan veterans. If these programs can be established and have them sort of spun up on the things to deal with, it would be very easy.

Myself included, 3 years ago when I came back from my second tour in Iraq, I was attending George Washington University. My first semester back, I had a real tough time just getting myself settled, and I went to my student health center.

After about an hour of me discussing the things that I faced in Fallujah, she looked at me cross-eyed and just tossed me a prescription for Methylphenidate and Sonata. After being duped up for

about 2 weeks, I realized this wasn't really effective, and eventually I had to make my way over to a Vet Center to find out the best ways to get myself focused on my schooling again.

I have talked to a lot of folks, and they really do reach out to their folks at their universities because it is much easier for them. They are close, they are nearby. There is almost a comfort level for many individuals who see these individuals as someone who is separated from the military to an extent. So, therefore, that stigma in regards to seeking treatment for mental health is very, very real for them.

I really do think that the VA would be able to identify, if it is a university that has 2,000 veterans studying there, then it would be very easy for them to send a team to train these individuals. But if there is a minimal number, if there is 5 to 10 or what not in a very rural area, that may be difficult for the VA to have those resources there.

Training programs can be established. There is a lot of smart folks over there, and I think they can come up with something.

Mr. MICHAUD. Great. Thank you.

Mr. Donnelly, any questions?

Mr. DONNELLY. Thank you, Mr. Chairman.

For the DAV, you had talked about going beyond the report and requiring the VA—this is on H.R. 784—to adopt mechanisms, ensuring that staffing levels are commensurately stated policy. What kind of mechanisms would you like to see?

Ms. ILEM. Well, we provided some very detailed recommendations in our testimony, but we thought basically into two parts, so really we need to have a good handle on because of the money that has been provided to VA for mental health services and the infusion of mental health staff, but we still would like to see some very detailed oversight into the number of, not only all the number of the staff that are at the different facilities, the level of those programs would be absolutely critical so we can just get a better handle on, what, you know, VA is facing in terms of trying to provide these forums through its uniform mental services package, its mental health strategic plan.

Those are some very big initiatives that they have undertaken. We really applaud the VA, those at the VA Central Office level that have developed those. But we think now is the time for oversight. It is very critical period as they are trying to develop recovery as a goal in terms of their mental health staff, and that they are trying to really upgrade all of their programs in substance use disorder, PTSD, and a number of other issues.

Mr. DONNELLY. And this, Mr. Bowers, for our vets coming back from Iraq and Afghanistan, how do we get them to buy into mental health screening to making sure that if they have concerns, that we can meet them because I know some of them have told me in the past we don't want to participate in this because we are afraid it might affect us employment-wise, it is a stigma. How do we get past that?

Mr. BOWERS. One of the things that we have called for at IAVA for years, and though this doesn't fully pertain to this Committee, as mandatory pre- and post-deployment screening. We see this as the only way to remove the issue. Right now, we spend six times

as much on dental care than we do mental health care, yet one-third of Iraq and Afghanistan veterans returning have a mental health issue. Getting them in the door is the difficult part.

So by making mandatory pre- and post-deployment screening, we are allowed to establish a baseline as to where they were before they deployed and where they are afterward, allowing proper treatment and also that ability to feel confident that, while they are speaking with this individual, they will not be seen by their fellow servicemembers as being weak or anything along those lines.

Currently, a lot of the screening methods that are used by the U.S. Department of Defense are woefully inadequate. They are not effective in identifying what the problems are, making individuals feel that they can reach out and get some help.

Mr. DONNELLY. And you hear so often that, you know, it is not in the first week or two back home that issues start to crop up, but a couple of months later. And, I guess, the question again is, how do we encourage them to come back in and have another check when they may not have wanted to do the first one?

Mr. BOWERS. By making it mandatory again.

Mr. DONNELLY. Okay.

Mr. BOWERS. If there is anything the military is good at, receiving orders and following those orders. We mirrored this almost very similarly to the way we had mandatory drug testing in the late 1990s, or excuse me, mid-1990s.

When that was established, that stigma of, oh, he called into the First Sergeant's office and he is getting busted right now, that is gone because, now, everybody has to do it.

This is one of the issues that, you know, we have strongly pushed. And we understand that is a very difficult issue to overcome, but stigma is a huge issue, so it is going to take great strides to really try and remove that.

Getting people to come in continually by mirroring some of the programs that have been established by the National Guard, specifically even in Maryland, where they require their servicemembers to come in up to 180 days after their deployment, we think, would be extremely helpful.

Mr. DONNELLY. Would you recommend something like, obviously, immediately post deployment, but then again, like a 3-month, 6-month, 1-year visit?

Mr. BOWERS. Yes, 3 months, 6 months, a year afterward, just sitting down with an individual and having them kind of go through everything and make sure you are squared away because right now, by watching a DVD and filling out a bubble form, it is not working, and we have seen that after the past 8 years.

Mr. DONNELLY. All right. Thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you, Mr. Donnelly.

Mr. Teague.

Mr. TEAGUE. Yes, actually, I would like to make a couple of comments to different questions that came up and one of them was about the rural communities and, as you were saying, where you have a population of 2,000 veterans, it is really easy to serve them. But my district is larger than the State of Pennsylvania, so we have a lot of small communities with just two or three people.

I think one of the things that we need to be able to look and maybe get some ideas from the panel, also, but you don't incorporate broadband so that we can do their training just like we do a lot of other education over the Internet, from the libraries or different places.

You know, there has been some pro and con here about reporting the vacancies that are of the mental health providers, you know. And, I mean, I think that that definitely has to be done. I think it is the accountability that we have to have if, for whatever reason, people are trying to hide the—maybe they think it is a reflection on how they are running their area if they continually have vacancies in these mental health places.

But if we have vacancies, then we have people that are not being served. And the only way that we can improve that is to have accountability so that everybody everywhere knows what they are doing with that.

Would anybody like to comment on that?

Ms. ILEM. I would just make mention that in talking with folks that are in the field, mental health folks that are in the field, and those that have just recently retired from VA, but have had decades of experience in understanding the changes that have occurred over the last several years and the reforms that VA is undertaking, I think they feel a tremendous amount of pressure to do what is mandated from the top down, but there is a lot of other factors involved for them, including the Veterans Equitable Resource Allocation (VERA) system that, how these programs are funded, what kind of support they get from their Medical Center directors and others, you know, that support the mental health programs.

And once these programs are ramped up and, you know, the Medical Centers are then required to sustain them. It sounds like, now, that they are going to be—instead of having fenced money or particular money dedicated to those programs for the startup, then those will be required to go into the regular allocation system through VERA.

And I think that there is, they have been asked to do different surveys about how many people, how many mental health specialists it will take to run these programs, how many staff they will need, how many support staff they will need. And when they have put those numbers forward, they have shared with us that, you know, a different number has come back in terms of, well, this is what you are going to get, or this is what you need to do make it work, versus them with their expertise and knowing how long it takes to provide these very specialized evidence-based treatments, the number of, you know, times that they need to see these patients over a longer, more extended period for these mental health evaluations and treatment.

I think all of those things are making them, you know, feel a lot of pressure at the local level, and I think the oversight that we have detailed in our testimony would really help relieve that in terms of really getting a good assessment because I think everybody is saying the same thing, that they want to see these mental health programs out there available to our veterans and have that

access. And I think the providers in the field want to have that, too.

So it is just a good mechanism not to be punitive, but to really just have, for all of you to have access to that information and us, as well.

Mr. TEAGUE. I agree because I think that by having it public and accountable, I think it protects the providers against demands being put on them and what they produce as well as protecting the veterans who need to occasionally see the providers.

One other thing that I wanted to talk about was the pre- and post-screening being mandatory, and I don't disagree with that, but I think what we need to do is be sure that we don't—when we do the post-mandatory interview, is don't make that be the, necessarily, the last one. Allow that—you know, because when that man comes back or woman comes back and is getting a chance to get away from all of this misery and get back to my family and everything, they are going to give all of the right answers to get loose. They don't want to be here next week answering questions still.

So, I think whereas, with the drug test, we do the test, and it is yes or no. When we do these tests for mental problems that they have, they are not yes or no, they are maybes and ifs, ands and buts.

So I think we need to not necessarily close the book on those people and I don't know if you all have any input on how to put that in.

Mr. BOWERS. I completely agree. What we really would like to see is ongoing screening for these individuals. It is very similar to if they receive a back injury to whatever it may be.

The key is going to be destigmatizing mental health and referring to it as an injury. It is an injury. It is something that can be treated and it is something that someone can recover from and do just fine. And that has been a problem for so many years, is that it is focused on that once you receive a mental health injury, that you are damaged goods, and that is not the case, that is not the truth. Many brave men and women have served nobly overseas and they don't deserve that when they come home, to be seen that way. And by doing that is getting themselves in the door, getting themselves the treatment that they need.

But it is the screening process that once it is made mandatory, people can go in and receive screenings up to 2 years later, and they may have issues such as sleep apnea, things along those lines, which does not mean they have full-blown PTSD. It just means that may have some reintegration problems. There is nothing wrong with that.

We strongly believe that this is going to be the only way to really get folks so that they can be established and get the health care that they need.

As I mentioned before, dental issues, servicemembers always have issues with their teeth. Well, that's why before every deployment and after every deployment I have to go see a dentist and get myself squared away. I don't have the best grill, but at least it is taken care of. Same thing needs to happen with my mind.

I just said "grill," didn't I?

Mr. TEAGUE. Thank you. Mr. Chairman, thank you.

Mr. MICHAUD. Thank you very much. Once again, I would like to thank the four of you for your testimony this morning. I look forward to working with you as we move these bills through the process. Once again, thank you very much.

I would like to call on the third panel which consists of Dr. Gerald Cross, who is the Principal Deputy Under Secretary for Health, who is accompanied by Walter Hall, who is Assistant General Counsel to the Department of Veterans Affairs.

I would like to thank both of you gentlemen for coming this morning and look forward to your testimony on the bills before us today.

So without any further adieu, Doctor Cross.

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

STATEMENT OF GERALD M. CROSS, M.D., FAAFP

Dr. CROSS. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for inviting me here today to present the Administration's views on four bills that would affect VA programs that provide veterans' health care. Joining me today is Walter Hall, Assistant General Counsel.

And I would like to request my written statement be submitted for the record.

Mr. MICHAUD. Without objection.

Dr. CROSS. We appreciate the opportunity to express our support for several bills that touch on a range of important issues, including mental health care, outreach, emergency care and women veterans care.

VA recognizes the important role mental health providers fulfill with regard to veteran care. VA has been working diligently to enhance mental health services throughout our system. We have done this in part by increasing our core mental staff by 4,000 positions over the past several years, and that expansion is continuing.

Our commitment to ensuring that veterans receive needed mental health services necessarily demands that we do our utmost to ensure that staffing levels at VA points of access are sufficient. This data is best collected and understood, however, at the local level, which is why VA does not support H.R. 784.

The bill would require the Secretary to submit quarterly reports to Congress on any vacancies in mental health professional positions by medical facility and by VISN. Staffing and workloads are dependent on local factors related to the local veteran population, usage rates, veterans' particular health care needs and local employment factors.

Oversight is most effectively achieved through the VISN managers with accountability to senior leadership and through the use of performance measures.

The current model is effective. The value in creating a quarterly reporting requirement at the national level is limited, particularly since it would necessitate the creation of a data infrastructure to meet the bill's technical requirements and have no context once removed from the local factors. We would be pleased to brief the Committee on our efforts thus far.

VA supports the intent of H.R. 785, which would require VA to conduct a 4-year pilot program to provide outreach and training services related to the mental health needs of OEF/OIF veterans to certain college or university counseling centers, student health centers and student service centers, but we can do what the bill proposes and do it more efficiently. VA already has a number of outreach programs for this population.

We can expand those to include already established training programs. VA mandates, for instance, a training requirement of suicide awareness for OEF/OIF veterans. It mandates participation in this course for certain VHA staff; I took it myself.

We have shared this module with the Department of Defense, and will direct each medical facility to offer it to their local community colleges and 4-year colleges and universities. VA has produced several public service announcements that also address the bill's concerns, and we will provide these to colleges and universities for campus broadcast. We will invite college staff to attend local conferences on the health care needs of OEF/OIF veterans and we welcome the opportunity to meet with Subcommittee staff to discuss this bill further.

VA supports the draft bill expanding the reimbursement benefits available to veterans for emergency treatment. Specifically, this bill would provide reimbursement for treatment VA has not previously approved from a non-VA provider for a non-service connected disability. This would relieve a potential burden for veterans.

Currently, VA is a payor of last resort. This means a veteran who would otherwise be eligible for reimbursement of emergency medical expenses is ineligible for the benefit if a third party makes even a partial payment. This leaves veterans with sizeable medical debts for which they are personally liable.

VA also supports most of H.R. 1211, the "Women Veterans Health Care Improvement Act." The bill would require a comprehensive assessment of all VA health care services and programs. Also, the bill would require the VA's Advisory Committees on Women Veterans and on Minority Veterans to include recently separated veterans of these populations, a practice that we already follow.

With the clarifications noted in my written statement, we would support each of these provisions. VA does not consider section 101 of this bill necessary, as we already have a similar study underway. The study is expected to be complete in the next 6 months.

Before we can take a position on Section 201, medical care for newborn children and women veterans receiving maternity care, we first need to determine whether the timeframe of 14 days is appropriate. Additionally, we must complete the cost estimate for this provision. Once we complete these analyses, we will submit our views and cost estimates for the record.

Similarly, Section 203 would establish a pilot program where VA would furnish childcare services directly or indirectly to eligible veterans. We share the Committee's interest in ensuring appropriate access to care. Once we have completed our analysis, we will submit our views for the record.

We do not support Section 202, however. This section would require VA to carry out a program to provide graduate and medical education, training, certification and continuing medical education for mental health professionals who provide care and counseling for sexual trauma and post-traumatic stress disorder. We believe this section is unnecessary because our current training and continuing medical education practices exceed the requirements of the bill.

We already train our mental health professional on evidence-based practices for PTSD and associated conditions that can result from sexual trauma, such as depression and anxiety. We are conducting two national training initiatives on cognitive processing therapy and prolonged exposure for PTSD.

Moreover, VA has begun training our mental health professionals on acceptance and commitment therapy and cognitive behavioral therapy. Each of these training courses includes materials and information specifically educating providers about treating women veterans. My staff have just informed me, I believe that we train about 1,900 of our staff already, 1,900.

Finally, I would like to mention the VA has already established a military sexual trauma support team at the national level to monitor MST screening and treatment, oversee MST related educational training and promote best practices for screening and treatment of the mental and physical health and consequences of MST. And by the way, the Congressman who asked a question about the percentage of female providers, 52.85 percent of our psychologists are female.

Mr. Chairman, thank you, again for the opportunity to discuss these important proposals with you today. This concludes my prepared statement. I'd be pleased to answer any questions that you or the Members have.

[The prepared statement of Dr. Cross appears on p. 48.]

Mr. MICHAUD. Thank you very much, Doctor Cross for your testimony.

You noted in your testimony regarding H.R. 784 that VA achieves oversight by holding the VISN managers accountable to senior leadership. Could you please explain how the VISN managers are held accountable? For example, does the Central Office have a mechanism for monitoring what happens at the local level, and are there any rewards or penalties to the VISNs based on performance?

Dr. CROSS. The answer to that, sir, is yes. We do have a mechanism in place. An example of that would be a performance measure that we created approximately a year ago to set for our new patients a 14-day standard during which they must receive a comprehensive evaluation.

We monitor that using our electronic health system record to determine who is meeting that standard and who is not. This goes beyond the issue of staffing. This is a more effective way of managing a medical program than focusing on staffing. We want to

measure function. We want to measure what is really happening. And so we do performance measures and we have hundreds of them for various programs, one of them being, for instance, mental health, as I just mentioned.

Furthermore, the analysis that you're requesting in the bill would not answer the question that is being asked. It does not include the full scope of mental health services that we provide. Primary care provides mental health services. Vet Centers provide mental health service. Fee-basis care provides mental health services.

I work with over a hundred academic affiliates. We are reengaged with them and their staff and their residents and their fellows, who are also involved in this.

So the combination of those things, particularly with the performance measures is the better way to go.

Mr. MICHAUD. Could you provide the Subcommittee, if you don't have it now, with the current state of mental health vacancies, where they are located and what is being done to fill those vacancies?

Dr. CROSS. I don't have that report, sir. If you request it, of course, we will get it. But what we do track is the performance measures and how we are actually doing in seeing our patients.

I could give you some more information on that. For instance, on the 14-day standard, we set a 90-percent goal. All of our visits had achieved that sometime back, so we raised the goal and made it 95 percent. As of about 2 weeks ago, I believe 15 out of the 21 VISNs had achieved the goal, and the remaining 6 were very close to achieving that and will do so.

Mr. MICHAUD. Okay. Yeah, I still would like to know what that vacancy number is and what is being done to fill those vacancies.

Dr. CROSS. Yes, sir. We will issue a report.

[The VA subsequently provided the information in the Post-Hearing Questions and Responses for the Record, which appear on p. 58.]

Mr. MICHAUD. On H.R. 785, what would you recommend to improve this legislation so that it will not dilute or duplicate what the VA is currently doing?

Dr. CROSS. You must know that my fundamental concern about this is that are thousands of colleges. And to take our staff away from patient care to go train the faculty at each local community college and university, I think, is a noble endeavor, but my first responsibility is to providing care to our patients, and that is what my focus is.

So I think that what we were recommending was, what I believe to be, an alternative and more effective technique.

I have in the audience a copy of the book that we provide for training, if someone can hold that up. I can provide the Committee, if they so desire, with copies of that, and it is very substantial. This could be used by the local faculty without having to have our staff there. It is self taught. I took it online. And this particular volume is for suicide prevention, suicide awareness, detecting those signs which might indicate an individual is in some distress and doing something about it.

We like to also work with the local universities to take some of the wonderful public service announcements that we have done. We just had one done with Gary Sinise, who was Lieutenant Dan in the movie "Forrest Gump." Outstanding PSA that he did for us. Richard Petty is doing one for us on another program right now, the famous race-car driver. Deborah Norville has just completed one that we are showing nationwide. We would like to share those with our colleagues at our local colleges and universities and ask them to put those out in their own media or their own stations.

We would like to make contact with them and invite them over and say, we are having a meeting, can you come over, would you like to learn more about the care of veterans.

I think those are the healthy effective ways of doing this, rather than going out and trying to set aside, establish, and train the faculty at the university and set up a special program of training.

Mr. MICHAUD. Thank you.

My last question is, in 2006 the Advisory Committee on Women Veterans recommended that VA seek legislation to cover the cost of post-delivery care of all newborn children delivered to women veterans receiving VA maternity benefits for up to 14 days. VA had no official position back then, and in 2008 they recommended that VA support legislation regarding newborn care without a limit on the duration of the benefit. VA supported this recommendation with modifications so that it applied only to cases where a covered newborn requires neonatal care services immediately after delivery, but does not cover routine well-baby services.

Can you explain what neo-services are and what timeframe are they to provide these type of services? Also, could you explain what routine baby services encompasses and the timeframe for that as well?

Dr. CROSS. On that last part, I am a family physician. I have delivered a lot of babies. And, you know, this is a subject that the VA staff is very sensitive to and wants to be very helpful on this issue. Unfortunately, I can't give you an exact opinion on behalf of the Administration today because we are still working on the cost estimate.

Secondly, we don't really know where the 14-day requirement came from. It seems a bit arbitrary.

Most of the patients, the babies that I have delivered, you know, they were ready to go home in 2 or 3 days. If a child has certain conditions like neonatal sepsis, a bilirubin problem, so forth, several days can be, additionally, can be added on.

We need to work through this with the Committee to find out what the best answer is, and I don't think today I have the best answer for you.

[The VA subsequently provided the information in the Post-Hearing Questions and Responses for the Record, which appear on p. 58.]

Mr. MICHAUD. Okay. I appreciate that very much, Doctor, because unlike you, I have not delivered any babies and I look forward to your expertise in this particular area, as well.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you. I have participated on——

[Laughter.]

Mr. RODRIGUEZ [continuing]. On the issue of women's services, I would hope that we want to be supportive, we want to do everything we can, and I know you also want to do that, and I foresee that there will be other pieces of legislation that are going to require you to do certain things, so I am hoping that you take, as an agency, take the initiative, especially on women's services.

You mentioned that there are some things that you are already doing on sexual trauma, I kind of look at it like this Congress, when it was nothing but men, and then we had the first females. They could not find a restroom or anything like that, or a school turns coed and they continue to have problems in the near future.

I think we are going to continue to have difficulty, so I would hope that there is some mechanism throughout the system, and in each one of these hospitals and clinics that allows an opportunity to look in terms of not only the facilities, but also the type of services for women, the type of training that the people are getting to make sure that happens. And maybe that is something that you can comment on or we can hope that the system takes it upon themselves to make that initiative systemwide and consistent for a good time to come.

Secondly, in the area of mental health services. I have been a State legislator for 11 years. I have been a school board member for 12 years. Anyone who comes to Congress all of the sudden gets bombarded with a great amount of case work. In that case work, a large number, at least in my district, are veterans. And the only thing I can say is that I am handling a lot of your cases that you should be handling. And so, somehow a case management system would be something that would be beneficial at this time to try to look at.

We have done legislation to provide you the flexibility to contract out with community mental health centers, understanding that you didn't have all the staff that is required and needs and that you are overwhelmed. Can you report in terms of how we are doing from that perspective in terms of mental health services and contracting out that is occurring right now?

Dr. CROSS. Congressman Rodriguez, you ask several very good questions and I certainly support your sentiments that you express. In regard to the number of women veterans coming to see us, I strongly agree with you.

About 5½ percent of our patients right now are women, 5½ percent. I think that should be substantially higher. I want to make sure, and our staff want to make sure, that VA is the first choice, a place where they will feel most comfortable.

One of those things, of course, is to make sure that we have a staff that is well trained and that is sensitive to their needs. And we also want to make sure that we have the appropriate number or adequate numbers of female staff.

I pointed out before, 52.85 percent of our psychologists now are female; 84 percent of our nurses are female; 82 percent of our occupational therapists are female; 62 percent of our physical therapists are female; 58 percent of our pharmacists are female, on and on. I could go down the list.

We are very sensitive to this issue. We are doing a good deal. We want to do a good deal more and, as I said, make sure that we are their first choice and that those numbers increase.

We do case management. We have women's coordinators at each of our Medical Centers and we do outreach, and we are trying desperately to do better outreach, more effective outreach so that women veterans understand that there is a place that they can go that will welcome them and provide the services they need.

In terms of fee-basis care, we do it where we need to, and we are doing billions of dollars' worth of fee-basis care per year. I believe the last number I heard was about $3 billion in fee basis.

Mr. RODRIGUEZ. I have a district similar to my colleagues next to me, West Texas, which is at least 650 miles long. And in my district I know we just did a contract with one physician in one area. Other than that, the others, in West Texas, there is a big gap in those rural communities. I would hope that somehow we reach out to some of those community mental health centers that provide those kind of services to do some of that work.

What do you attribute the number of cases that our Congressional Members have with your clients?

Dr. CROSS. I can tell you that we do everything we can to work with our Congressional Members in our local communities to make sure that if they do get an inquiry, that we provide an efficient pathway to immediately resolve whatever that we can resolve.

We want to be a welcoming home for these individuals, and we are doing our absolute best to be that home.

Mr. RODRIGUEZ. Let me encourage you to be forthright with us in terms of what you might need in terms of services because we want to do the right thing, but what I foresee is additional types of legislation for additional types of reporting if the complaints continue. As you well know, that usually occurs.

No one hates more bureaucratic stuff than I do, and at the same time I would really hope that maybe the agency comes up with an aggressive program, not only reaching out to women, but looking at all of the types of things that might need to occur in each one of those facilities, as well as doing what we can to make sure that suicide numbers drop, as well as reaching out to a lot of the other ones that suffer from mental health.

I know that mental health is a real difficult area where you can have just a few individuals are bogging down the system. I don't mean to be rude in that area, but they are a difficult clientele to deal with, because of the fact that they suffer from mental health.

But there is also the problem that the ones that suffer from mental health, because of the mental health problem itself, do not seek it out and so there needs to be outreach that needs to occur and needs to happen by the agency. Otherwise, we are going to continue to have problems out there. And I am hoping that that can happen.

Now, case management, what do we have now that you say that we have a case management system?

Dr. CROSS. Sir, we have case managers for OEF/OIF, for women veterans, for MST, Federal recovery coordinators, transition patient advocates. We have a whole range, depending on the needs of the individual that we are serving.

And let me say, sir, satisfaction is something that we take very seriously. We track it, we measure it, we get third parties to do it with us. We also do mystery shoppers to make sure. Our satisfaction levels are very good and have continued to be good out here for some time.

And in regard to where we send out cases in the community, we also have to make sure that those facilities that we send them to, that we refer them to will achieve certain standards. For instance, we do screening for MST. We do screening for PTSD, for depression, for substance abuse. We have people that are specially trained in PTSD. As I mentioned, the hundreds and hundreds that we trained in special techniques, we don't want to send them somewhere where they don't have those advantages, so we are sensitive to that issue as well.

Mr. RODRIGUEZ. Thank you for all the good work that you do do.

Dr. CROSS. Thank you, sir.

Mr. RODRIGUEZ. Thank you.

Mr. MICHAUD. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

I want to apologize for running in and out to you and the panel. I have had two or three things that have just kind of cropped up that I am sure they were emergencies.

But I really do not have any questions. What I would like to do, though, is reserve the right to go ahead and submit some in writing for the future.

And it is good to be back on the Health Subcommittee. We appreciate your leadership and look forward to having a really productive Congress.

Mr. MICHAUD. Thank you very much, and we are very fortunate to have you back on the Subcommittee and look forward to working with you as we move forward, not only on these pieces of legislation, but throughout the next 2 years.

I understand that Members have a lot of other competing emergency needs as well, so you don't have to apologize. I really appreciate your willingness to participate in the process.

Mr. Teague.

Mr. TEAGUE. Yes, thank you. And I also need to apologize for running in and out. I am going to have to learn how to manage my time, I think. I am going to take advice from some people that have been here longer.

But I did want to touch on one thing and that is the fee-based services that I heard you talking a little bit about, you know, and I think we have to do more fee-based services and be sure that when we are doing them, that we are doing them for the benefit of the veteran and not for internal reasons that we are doing them.

And the reason that I am bringing that up, and I am sure that we all have scary stories and everything, but we had a gentleman that was actually a World War II veteran, that he could have gotten that service in town, but they required him to go to a VA Center. It was 285 miles. And as the young man, the Vietnam veterans, who were hauling him back and forth 3 days a week, said, we are killing him hauling him back and forth because they needed his number to justify their services at the VA Center, instead of letting him have——

So I know that we have dealt with numbers, we have to work with numbers and that, but I would like for us to also to look at the individuals so that we do take care of the people that need help and not fill our numbers. Thank you.

Dr. CROSS. Thank you, sir.

Mr. MICHAUD. Once again, I would like to thank you very much, Doctor Cross for your continued efforts to make sure that our veterans get the benefits that they have earned and deserve, and for the commitment of both you and your staff, Mr. Hall, and the entire staff at the VA. You do a phenomenal job and hopefully Congress will be able to provide a budget that will reflect the needs of taking care of our veterans. And as you mentioned earlier, Doctor Cross, it is more or less making sure that we get the work done. The numbers are good to have, but the services must be provided.

I want to thank you and all the previous witnesses for coming today. Thank you.

This hearing is adjourned.

[Whereupon, at 11:48 a.m. the Committee was adjourned.]

A P P E N D I X

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

I would like to thank everyone for coming today.

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

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

We have four bills before us today. Each of the bills address important issues affecting our veterans today. They cover a wide range of important issues including mental health; women veterans; and reimbursement for emergency care treatment in non-VA facilities.

I look forward to hearing the views of our witnesses on these bills before us.

Prepared Statement of Hon. Cliff Stearns

Thank you, Mr. Chairman.

At our hearing today we will examine four bills that have been referred to our Subcommittee.

The first bill H.R. 784 would require VA to submit quarterly reports on mental health professional vacancies. The second, H.R. 785, would establish a pilot program to provide mental health outreach and training on certain college campuses for Operation Iraqi Freedom and Operation Enduring Freedom veterans. The Department of Veterans Affairs (VA) has made great improvements in the past 2 years to reach out to more veterans and provide better, more effective mental health services. With a growing number of veterans in need of mental health care we must continue to focus on how we can build on the progress VA has made thus far and I very interested in hearing views on these proposals.

I thank our Chairman, Bob Filner, for reintroducing a bill to expand the benefits for veterans related to the reimbursement of expenses for emergency treatment in a local, non-VA facility. I am pleased to see that changes have been made to the bill to clarify the requirements for VA payment under the program.

I would also like to commend my good friend Stephanie Herseth Sandlin for being a champion of women veterans. Her bill, the Women Veterans Health Care Improvement Act, includes a number of provisions designed to study, improve and expand access to care for our women veterans.

The number of women serving in the active duty, guard and reserve continue to increase. Today, women represent almost 8 percent of the total veteran population and nearly 5 percent of all veterans who use VA health care services. VA estimates that the number of women veterans enrolled in VA health care will more than double over the next decade. It is essential for us to make sure that VA is providing appropriate programs and services throughout the country to meet the unique physical and mental health needs of our women veterans. However, as we examine new initiatives, we must also be careful to ensure that they compliment and do not overlap existing VA efforts in research and programs for women veterans.

I look forward to a very productive discussion on these legislative proposals and want to thank all of our witnesses for participating in today's hearing. Your testimony will help guide our actions to best serve our Nation's veterans.

Prepared Statement of Hon. Niki Tsongas

Chairman Michaud, Ranking Member Brown, Members of the Subcommittee, thank you for giving me this opportunity to testify.

I have introduced two bills, H.R. 784 and H.R. 785, to improve the quality and accessibility of mental health services for our veterans.

Almost 1 million (945,423) Operation Enduring Freedom and Operation Iraqi Freedom veterans have left active duty and become eligible for VA health care since 2002.

Four hundred thousand three hundred four (42 percent) of these veterans have obtained VA care and approximately 44 percent of that number are facing mental disorders (178,483). The three most common diagnoses are PTSD (92,998), depressive disorders (63,009), and neurotic disorders (50,569). These rates are two to three times that of the general population.

My first bill, H.R. 784, simply requires the VA to report vacancies in mental health professional positions at VA facilities on a quarterly basis.

With the significant influx of OEF and OIF veterans facing mental health wounds, as well as the already existing veterans populations from earlier generations receiving care at the VA, it is incumbent upon us to make sure that we have the necessary staffing to provide care.

This bill will help this Congress perform our oversight role and it will help the VA use its limited resources to effectively care for our veterans.

My second bill, H.R. 785 will help veterans seeking to improve their lives through education.

The 110th Congress passed the most sweeping modernization of the Montgomery GI bill since the program's creation after World War II. The purpose of the modernization is to give veterans of Afghanistan and Iraq access to the education and job training tools that they will need to achieve the American dream they risked so much to defend.

As I stated earlier, approximately 44 percent of Afghanistan and Iraq veterans who have sought treatment at the VA have demonstrated signs of mental health wounds, including PTSD.

Studies have shown that PTSD can have a negative impact on an individual's ability to focus and ability to learn.

Returning from a war, separating from service and then beginning school can place significant strains on the mental health of a veteran.

It is critical that we provide our veterans with the assistance they need to manage and recover from these wounds so that they can take advantage of the opportunities available to them.

To that end, I have introduced H.R. 785.

My bill directs the Secretary of Veterans Affairs to carry out a pilot program to provide outreach and training to certain college and university mental health centers so that they can more effectively identify and respond to the mental health needs of veterans of Operation Enduring Freedom and Operation Iraqi Freedom.

My legislation would not break the continuum of care provided by the VA. The purpose of this bill is to provide college counselors and other staff who come in close contact with student-veterans at their schools with the tools to recognize symptoms of combat related mental health wounds; the ability to appropriately assist a student-veteran in need; and an understanding of how to effectively refer that student-veteran to the VA for care.

I believe my legislation will actually augment the VA's continuum of care and bring in veterans who may be hesitant or apprehensive about seeking care from the VA.

The intention of both H.R. 784 and H.R. 785 is to ensure that we have adequate services to address the mental health needs of our veterans and that we give our veterans the opportunity to build full lives once they take off the uniform.

Thank you for the opportunity to testify before the subcommittee. I look forward to working with you Chairman Michaud, Congressman Brown and the other Members of this Subcommittee to improve these bills and to improve the quality and accessibility of the care we provide to our veterans.

Thank you.

Prepared Statement of Hon. Stephanie Herseth Sandlin

Good morning Chairman Michaud and Ranking Member Brown. Thank you for holding today's hearing. I appreciate having the opportunity to be here to discuss the "Women Veterans Health Care Improvement Act."

The "Women Veterans Health Care Improvement Act," which I introduced on February 26, 2009, along with the original cosponsor support of Health Subcommittee Members Representatives Boozman and Moran, will take important steps to expand and improve Department of Veterans Affairs health care services for women veterans. Before I talk more about the bill and the needs of women veterans, I also would like to take this opportunity to thank the DAV for their continued leadership in the effort to address the needs of women veterans and their support for this important legislation.

As your Subcommittee knows, more women are answering the call to serve, and more women veterans need access to services that they are entitled to when they return. With increasing numbers of women now serving in uniform, the challenge of providing adequate health care services for women veterans is overwhelming. With more women seeking access to care, and for a more diverse range of medical conditions, in the future, these needs will likely be even significantly greater.

I would like to share just a few statistics with you that highlight the need for a comprehensive update of VA services for women veterans.

- As of October 2008, there were more than 23 million veterans in the U.S. Of this, women veterans made up 1.8 million or 8 percent of the total veteran population.
- There are increasing numbers of women veterans of childbearing age. For example, 86 percent of OEF/OIF women veterans are under age 40.
- The VA notes that OEF/OIF female veterans are accessing health care services in large numbers. Specifically, 42.2 percent of all discharged women have utilized VA health care at least once. Of this group, 45.6 percent have made visits 2 to 10 times.
- Finally, according to the VA, the prevalence of potential PTSD among new OEF/OIF women veterans treated at VA from fiscal year 2002–2006 grew dramatically from approximately *one* percent in 2002 to nearly *19* percent in 2006.

So the trend is clear, but not surprising: More women are answering the call to serve . . . and more women veterans need access to services that they are entitled to. Clearly, we must do everything we can from a public policy standpoint to meet this new challenge of women veterans.

To address some of these issues, the "Women Veterans Health Care Improvement Act" calls for a study of barriers to women veterans seeking health care, an assessment of women health care programs at the VA, enhancement of VA sexual trauma programs, enhancement of PTSD treatment for women, establishment of a pilot program for child care services, care for newborn children of women veterans, and the addition of recently separated women veterans to serve on advisory committees.

The VA must ensure adequate attention is given to women veterans' programs so quality health care and specialized services are available equally for both women and men. I believe my bill will help the VA better meet the specialized needs and develop new systems to better provide for the health care of women veterans—especially those who return from combat, who were sexually assaulted, suffer from PTSD, or who need child care services.

Chairman Michaud and Ranking Member Brown, thank you again for inviting me to testify. I look forward to answering any questions you may have.

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

Mr. Chairman and other Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this legislative hearing of the Subcommittee on Health. DAV is an organization of 1.2 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

We appreciate the opportunity to offer our views on the bills under consideration by the Subcommittee—specifically two bills focused on mental health care services provided by the Department of Veterans Affairs (VA), a measure focused on women veterans health, and one draft measure—related to expansion of eligibility for reimbursement for emergency treatment in non-VA facilities. Our comments related to the four measures are expressed in numerical sequence of the bills.

H.R. 784—To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to submit to Congress quarterly reports on vacancies in mental health professional positions in Department of Veterans Affairs medical facilities.

This bill would require the Secretary of Veterans Affairs to report quarterly to Congress to describe each mental health professional vacancy in every medical facility in the Department, and to indicate to which Veterans Integrated Services Network (VISN) the facility is assigned. The bill would define mental health professionals to include psychiatrists, psychologists, social workers, marriage and family therapists, and licensed professional mental health counselors. While we appreciate the intended purposes of this bill, we ask the Subcommittee to expand its scope to better account for the current situation in VA mental health services, and to consider our recommendations for an enhanced means of achieving better oversight and accountability in that program.

We recognize the unprecedented efforts made by VA over the past several years to improve the consistency, timeliness, and effectiveness of mental health care programs for disabled veterans. We are especially pleased that VA has committed through its national Mental Health Strategic Plan (MHSP) to reform VA mental health programs, moving from the traditional treatment of symptoms to embrace recovery potential in every veteran under VA care. We also appreciate the will of Congress in continuing to insist that VA dedicate sufficient resources in pursuit of comprehensive mental health services to meet the needs of veterans. One key part of improving mental health services and increasing access to those specialized services is through sufficient staffing levels. The DAV supports the intent of this measure (H.R. 784) that would attempt to verify the current vacancies in mental health positions in VA facilities and thus the gap in mental health professionals needed to provide timely, high quality mental health services to veterans who need them. DAV is concerned, nevertheless, that the intended goal of the bill will be unfulfilled unless Congress goes beyond requiring VA to provide simply the number of vacancies but rather requiring VA to adopt and enforce mechanisms to assure its policies at the top are reflected as results in the field. As written, we are concerned that enactment of the bill would not surface the kind of information Congress needs to conduct proper oversight of VA's results and status in achieving mental health reforms.

The development of the MHSP and the new Uniformed Mental Health Services (UMHS) policy (detailed in VHA Handbook 1160.01, dated September 11, 2008) provide an impressive and ambitious roadmap for VHA's transformation of its mental health services. However, we have expressed continued concern about oversight of the implementation phase of these initiatives. The VA MHSP was developed before the impact of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) was evident, and we believe a pressing need is emerging for Congress to ramp up the monitoring of VA's strategies, policies, and operating plans being implemented to deliver on the promise of the current strategic plan. We believe VHA must also conduct accurate annual needs and gap assessments to take into account the changing needs of the veteran population, including the newest generation of combat veterans.

Historically approximately one fifth (20 percent) of veterans receiving any kind of VA care consumed a mental health service. This use rate in general is well above the rate for the private sector. According to VA, the needs of OEF/OIF veterans for mental health services are even greater, with almost 45 percent having been evaluated for, or having received, a possible diagnosis of a mental health disorder. Based on past experience and confirmed in the scientific literature, it is clear that the needs and greater demand for mental health services continue for 5 to 10 years following combat exposure. In a recent compilation of screening data for servicemembers returning from deployments in Iraq, nearly 40 percent of active duty soldiers and more than 30 percent of active duty Marines screened positive for a psycho-social problem. The rates for reservists were even higher—over 45 percent for Army reserve, 50 percent for Army National Guard and nearly 45 percent for Marine reserves. On all surveys of psychological concerns among OEF/OIF servicemembers, these rates rise as they experience repeated deployments. For some, the pressures become unbearable. While the wars continue and the number of deployments per servicemember climbs, rates of suicide in the military are rising. Given these findings, easily accessible, high quality VA mental health and substance-use disorder treatment is essential to address the post-deployment mental health needs of combat veterans early on, before symptoms become chronic. Today, VA is challenged to meet these needs, and without meaningful oversight that challenge will grow as time goes along.

VA has been chronically plagued with wide variation among medical centers on the adequacy of the continuum of care of mental health services offered. Wide

unexplainable variations were documented every year from 1996 when Congress first mandated that VA track whether it was maintaining its capacity to provide mental health services, until the final report from that expired mandate was delivered to Congress. In February 2004 the VA Capital Asset Realignment for Enhanced Services (CARES) Commission included a special section on mental health services underscoring its assessment that the breadth of services and access to mental health care were unacceptably variable across the system. In June 2004, a VA mental health task force again documented wide variation in the availability of and access to a full continuum of mental health care services, particularly in substance-use disorder treatment, and in use of evidence-based approaches to the care of post-traumatic stress disorder (PTSD) and other mental disorders.

In response to the 2003 *New Freedom Commission's* call for action, VA developed a national strategic plan for mental health services which was finalized in November 2004. In showing sensitivity to VA's commitment to reform, Congress allocated new funds to enhance mental health services and required VA to spend these funds in pursuit of that reform. Despite these efforts, in May 2007 the VA Inspector General again criticized the consistency and adequacy of mental health services throughout the system.

To address these concerns VA has been provided with targeted mental health funds in more recent years' appropriations to augment mental health staffing across the system. This funding was intended to address widely recognized gaps in the access and availability of mental health and substance-use disorder services that existed prior to the development of the MHSP, to address the unique and increased needs of veterans who served in OEF/OIF and to create a comprehensive mental health and substance-use disorders system of care within VHA that is focused on recovery—a hallmark goal of the *New Freedom Commission*. In addition, VHA developed its UMHS policy so that veterans nationwide can be assured of having access to the full range of high quality mental health and substance-use disorder services in all VA facilities and at the time that they are most needed. Timely, early intervention services can improve veterans' quality of life, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. These funds have been dispersed as part of special initiatives, with a clear mandate that they would be used to augment current mental health staffing, not merely replace older positions as they become vacant.

While the specialized mental health augmentation funding has significantly improved mental health services across VHA, a recent gap analysis conducted by VHA, resulting in the UMHS plan, underscores how much still needs to be done to assure equity of access for all veterans. Furthermore we understand that this analysis (one that VA has not released to the Congress or the veterans service organization community) does not fully take into account many important factors such as the cost and effort required to provide newer evidence-based treatments for priority conditions such as PTSD.

Supplementary mental health funds were allocated as time-limited, annual "special purpose" funding allocations that occurred outside of the usual Veterans Equitable Resource Allocation (VERA) process. Although there was a clear expectation by Congress that the services based on these funds would be maintained into the foreseeable future, within VA the continued medical center funding has not been promised or assured. It is critical that these programs and the UMHS package be maintained, since, as was learned tragically after the Vietnam War, the needs for mental health services are not time-limited, since many veterans of that era first sought care long after the conflict ended. We understand that VHA now proposes to move funding for these programs into the VERA process. We are concerned that if all mental health funds moved into VERA and mixed with other medical care funds allocated to the medical centers, mental health and substance-use disorder programs will be again at great risk for erosion. In fact this has been the case in the past when mental health and substance-use disorder funds were allocated under VERA and were required to compete directly with other acute care programs.

VHA is a large integrated health care system with national policy and program mandates but today is characterized as a largely decentralized management system. While local flexibility has many strengths, the budgetary discretion granted at the Network and local medical center levels for the use of funds allocated through VERA could have unwarranted consequences for vulnerable veteran populations who have special needs. Comprehensive and detailed oversight and monitoring is imperative if ongoing progress in filling critical gaps in mental health services across the Nation is to be assured and recovery is to be fully embraced.

We believe the solution to this pressing problem would need two major components: an attentive oversight process, and an empowered organizational structure to inform that oversight responsibility.

The oversight process we envision in mental health would be a constructive one that is helpful to VA facilities, rather than punitive. It should be data-driven and transparent, and should include local evaluations and site visits to factor in local circumstances and needs. Such a process could assure that ongoing progress is made in achieving the goal of the VA MHSP and UMHS package to provide easily accessible and comprehensive mental health services equitably across the Nation.

Mr. Chairman, the second component necessary to make the first one meaningful would be putting in place an empowered VA organizational structure to assure that this oversight process is robust, timely and utilizes the best clinical and research knowledge available. Such a structure would require VHA to collect and report detailed data, at the national, network and medical center levels, on the net increase over time in the actual capacity to provide comprehensive, evidence-based mental health services. Using data available in current VA data systems, such as VA's payroll and accounting systems, supplemented by local, audited reports where necessary, could provide information down to the medical center level on at least the following for the period fiscal year 2004 to the present fiscal year:

- The number of full-time and part-time equivalents of psychiatrists and psychologists;
- The number of mental health nursing staff;
- The number of social workers assigned to mental health programs;
- The number of other direct care mental health staff (e.g. counselors, outreach workers);
- The number of administrative and support staff assigned to mental health programs;
- As a basis for comparison, the total number of direct care and administrative full-time employee equivalents (FTEE) for all programs, mental health and others; and
- The number of unfilled vacancies for mental health positions that have been approved, and the average length of time vacancies remain unfilled.

The current practice of reporting only the number of offers made to prospective new mental health staff members, and not the number who are actually on board, should be immediately halted, since we know there are lags of several months in actually bringing these new clinicians on board.

Mr. Chairman, we believe VA should be required to establish a web-based clinical inventory instrument to gather information from the field about existing mental health programs (i.e., PTSD, substance-use disorder, etc.) in each VA facility including hours of operation, caseloads and panel sizes, staffing levels and current capacity to provide evidence-based treatments as specified in published *VA/DoD Evidence-Based Practice Guidelines*.

VA should also develop an accurate demand model for mental health and substance-use disorder services, including veteran users with chronic mental health conditions and projections for the needs of OEF/OIF veterans. This model development should be created parallel to the VA mental health strategic planning process. This model should include estimated staffing standards and optimal panel sizes for VA to provide timely access to services while maintaining sufficient appointment time allotment.

Assuming the creation of these resource tools, Congress should also require VA to establish an independent body, a "VA Committee on Veterans with Psychological and Mental Health Needs," with appropriate resources, to analyze these data and information, supplement its data with periodic site visits to medical centers, and empower the Committee to make independent recommendations to the Secretary of Veterans Affairs and the Congress on actions necessary to bridge gaps in mental health services, or to further improve those services. Membership of the Committee should be made up from VA mental health practitioners, veteran users of the services and their advocates, including veterans service organizations and other organizations concerned about veterans and VA mental health programs. The site visit teams should include mental health experts drawn from both within and outside of VA. These experts should consult with local VA officials and seek consensual, practical recommendations for improving mental health care at each site. This independent body should synthesize the data from each of the sites visited and make recommendations on policy, resources and process changes necessary to meet the goals of the MHSP.

In addition to these changes, VA should be directed to conduct specialized studies, under the auspices of its Health Services Research and Development Program and/or by the specialized mental health centers such as the Mental Illness Education, Research and Clinical Centers (MIRECCs) in several sites, the Seriously Mentally Ill Treatment, Research Education and Clinical Center (SMITREC) in Ann Arbor;

and the Northeast Program Evaluation Center in West Haven, among others, on equity of access across the system; barriers to comprehensive substance use disorders rehabilitation and treatment; early intervention services for harmful/hazardous substance use; couples and family counseling; and programs to overcome stigma that inhibits veterans, particularly newer veterans, from seeking timely care for psychological and mental health concerns.

As an additional validation, we believe that the Government Accountability Office (GAO) should be directed to conduct a follow-on study of VA's mental health programs to assess the progress of the MHSP, the UMHS, and to provide its independent estimate of the FTEE necessary for VA to carry out the above-noted initiatives. Congress should also require GAO to conduct a separate study on the need for modifications to the current VERA system to incentivize its fully meeting the mental health needs of all enrolled veterans.

While DAV supports the basic intent behind H.R. 784, we ask the Subcommittee to consider a broader scope of oversight of VA's mental health program than envisioned by the bill. We believe the ideas above—ideas that we have gleaned from a number of mental health and research professionals in and out of VA, and from the literature, are necessary to fully ensure VA is moving its mental health policy and program infrastructure in a proper direction. Also, we urge the Subcommittee, which would be the major recipient of this new approach to reporting true VA mental health capacity, to continue its strong oversight to assure VA's mental health programs and the reforms it is attempting to meet all their promise, not only for those coming back from war now, but for those already here.

H.R. 785—To direct the Secretary of Veterans Affairs to carry out a pilot program to provide outreach and training to certain college and university mental health centers relating to the mental health of veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).

The intent of this bill is to establish a 4-year pilot program aimed at improving outreach to OEF/OIF veterans on the campuses of colleges and universities. The measure would require VA to provide training to clinicians, administrative and other relevant individuals at the selected pilot sites for the purpose of improving access to mental health treatment and services for returning war veterans from Iraq and Afghanistan. H.R. 785 would require VA to report on the selected pilot sites, the number of OEF/OIF veterans enrolled in each university or college, a description of the services to be made available under the program and assessment and effectiveness of the program. The bill would authorize appropriations of $3 million annually to carry out its intent for each fiscal year 2010 through 2013.

Current research findings indicate that combat veterans from OEF/OIF are at higher risk for post traumatic stress disorder (PTSD) and other post-deployment mental health problems. VA reports that veterans of the current wars have sought care for a wide range of medical and psychological conditions, including depression, anxiety, PTSD and substance-use disorders.

The VA has a unique obligation to meet the health care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from post-deployment readjustment problems as a result of combat exposure. The VA and Congress must remain vigilant to ensure that Federal programs aimed at meeting the needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts.

DAV Resolution 166, adopted in general session by our members at DAV's National Convention assembled in Las Vegas, Nevada, August 9–12, 2008, supports program improvement and enhanced resources for VA mental health programs to achieve adjustment of new combat veterans and continued effective mental health care for all enrolled veterans needing such services. Therefore, DAV is pleased to support H.R. 785, a bill that would offer an appropriate outreach effort and would attempt to better inform academic centers about VA services and the unique needs our newest generation of war veterans—and specifically about their post-deployment mental health needs.

H.R. 1211—Women Veterans Health Care Improvement Act

This measure seeks to expand and improve health care services available to women veterans from the Department of Veterans Affairs (VA); especially those serving in Operations Iraqi and Enduring Freedom (OIF/OEF).

Title I, section 101 would require VA to enter into a contract with an outside entity or organization to perform a comprehensive study and report on the existing bar-

riers that impede or prevent women from accessing health care and other services from VA. This study would build on the work of the *National Survey of Women Veterans in FY 2007–2008*, to ensure sufficient sample size and include reporting on such barriers as perceived stigma with seeking mental health services, child care, distance to and availability of care, acceptability of integrated primary care, perception of personal safety and gender sensitivity during care, and effectiveness of outreach.

The VA would be required to internally review the results of the study and submit findings with respect to the study to specified divisions within VA, and would be further required to submit two reports to Congress. The report to Congress would include recommendations for administrative and legislative action by the VA Secretary as deemed appropriate. The bill would authorize appropriations of $4 million to carry out the purpose of this section.

Section 102 would require VA to contract with an outside entity or organization to perform a comprehensive assessment of existing health care programs for women veterans and report the findings to Congress. This would include assessment of specialized programs, including those for women with post traumatic stress disorder (PTSD), those who are homeless, require substance-use disorder or mental health treatment, and for women who require obstetric/gynecological care. The assessment would rate the effectiveness of the VA's programs based on the frequency with which the services are provided, the demographics of women using these services, the locations of the services, and whether, and to what extent, waiting lists, distance to care, and other factors affect the receipt of services.

After the assessment is completed, and no later than 1 year after the enactment of this Act, the Secretary would be required to provide a report to Congress on a plan to improve health care services to women veterans, and project future health care needs to include mental health needs of OEF/OIF women veterans. The report would also include a list of services available at every medical center in the Department and include recommendations for administrative and legislative action that the VA Secretary deems appropriate. Within 6 months of this report, GAO would be required to submit a report to Congress based on the Secretary's report. The bill would authorize $5 million to be appropriated to carry out the purposes of this section.

Title II, section 201 would amend subchapter VIII of chapter 17 of title 38, United States Code, to authorize hospital care and services for newborn children of women veterans receiving maternity care at a Department facility or through contract care at VA expense, for a period of 14 days beginning on the date of birth of the child.

Section 202 would improve VA's ability to assess and treat veterans who have experienced military sexual trauma (MST) who exhibit symptoms of PTSD by requiring a new tailored training and certification program to ensure VA health care providers develop competencies in caring for these co-occurring conditions. Section 202 would also mandate that professionals be trained in a consistent manner to include the principles of evidence-based treatment and care for MST and PTSD.

Under this authority, the Secretary would also be required to provide Congress an annual report covering a number of areas including the number of mental health professionals, graduate medical education trainees, and primary care providers who have been certified under the program, along with the amount and type of continuing medical education that they complete for the required certification; in addition, the report would include the number of graduate medical education, training, certification and continuing medical education (CME) courses that were provided by the program. The report would also detail the number of veterans who received counseling, care and services from these certified professionals, trainees and other providers, and the number of trained full-time employee equivalents needed to meet the needs of veterans treated for MST and PTSD. Finally, the report would contain any recommended improvements for treating veterans with co-occurring MST and PTSD.

Section 203 would authorize a 2-year pilot program, in at least three VISNs, of reimbursement for the expenses of child care services for certain qualified veterans receiving mental health, intensive mental health or other intensive health care services, whose absence of child care might prevent them from obtaining these services. The term "qualified veteran" would be defined as a veteran with the primary caretaker responsibility of a child or children. Following the completion of the pilot, the Secretary would be required to report on the program, including recommendations to Congress for continuing or expanding the program. The bill would authorize appropriations of $1½ million for each of fiscal years 2010 and 2011 to carry out the pilot program under this section.

Section 204 would require recently separated women veterans and minority veterans to be appointed to certain VA advisory committees.

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

Mr. Chairman, this comprehensive legislative proposal seeking to access, improve and expand VA services for women veterans, is fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women's health, VA's Advisory Committee on Women Veterans, the *Independent Budget*, and DAV. DAV Resolution 238 seeks to ensure high quality comprehensive VA health services for all women veterans, with a special focus on the unique post-deployment needs of women veterans returning from OEF/OIF. DAVs resolution notes that VA needs to undertake a comprehensive review of its women's health programs, and seek innovative methods to address barriers to care for women veterans to ensure they receive the treatment and specialized services they need and deserve. Therefore, we fully support H.R. 1211 and urge the Subcommittee to recommend its enactment.

We note with regard to section 202 of the bill that it specifically references "women" a couple of times. VA MST and mental health specialists have reported to us that veterans currently under care for MST in VA programs are nearly equally divided by gender. While we fully support the purposes of the bill, and have no objection to the purposes of section 202 being included in the bill, we would recommend any references in section 202 to "women" be made gender neutral. Alternately, the bill could be amended to sub-divide the required report for each gender.

Draft Bill—To amend title 38, United States Code, to expand veteran eligibility for reimbursement by the Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility.

This bill would amend subparagraph (b)(3)(C) of section 1725 of title 38, United States Code, by striking the words "or in part" where they appear in current law. In subsection (f)(2) the bill would strike subparagraph E. The bill would also add new language to clarify Congressional intent that VA would be required to assume responsibility as a secondary payer in a case in which an otherwise eligible veteran has private insurance coverage that pays a portion or part of the cost of an episode of emergency care in a private facility. Under the bill, VA would pay the remainder of the veteran's obligation, less any required copayments under the associated private insurance coverage. DAV supports the purposes of this draft bill and appreciates the sensitivity of the Subcommittee leadership in developing an effective solution to a nagging problem plaguing both service-connected and nonservice-connected veterans who rely on VA to meet their primary health care needs.

In 1999, Congress enacted the Veterans Millennium Health Care and Benefits Act, Public Law 106–117. That Act provided the authority sought by VA at the time to complete its role as a comprehensive health care system for all veterans who are enrolled, by giving VA authority to reimburse costs of emergency private care under certain circumstances. Prior to passage of the Millennium Act, VA was essentially without authority to pay emergency expenses in private facilities for its own patients, unless generally they were service-connected veterans. Under prior law VA was authorized to pay for non-VA emergency treatment for a veteran's service-connected disability, a nonservice-connected disability aggravating a veteran's service-connected condition, any condition of a veteran rated permanently and totally disabled from a service-connected condition(s), and a veteran enrolled in a VA vocational rehabilitation program.

The intent of this bill would enable a veteran, enrolled in VA health care, who otherwise is eligible for VA reimbursement of certain private emergency health care expenses under the Millennium Act authority but for the existence of coverage "in part" by a form of private health insurance (no matter how major or minor such private coverage might be), to be reimbursed as otherwise authorized under the Millennium Act's emergency care reimbursement program. Rescission of the words "or in part" in section 1725, accompanied by the striking of subparagraph E of subsection (f)(2) of that section, would provide VA a clearer authority. For a VA-enrolled veteran with minimal insurance coverage (such as a small medical rider on a state-mandated automobile insurance plan) to secure VA reimbursement for emer-

gency care under the intended authority, would be an exceedingly helpful new benefit.

Today, a number of enrolled veterans routinely are being denied reimbursement, because they are covered "in part," even if all other eligibility requirements are met. The bill would be effective as of October 8, 2007, presumably to take into account the circumstances of any individuals who may have recently been denied VA reimbursement because of the current "in part" restriction.

DAV supports the intent of this draft bill. This bill's purposes are in full accord with the mandate from our membership expressed in DAV Resolution No. 178, adopted at our National Convention assembled in Las Vegas, Nevada, August 9–12, 2008. Its purposes are also consistent with the recommendations of the *Independent Budget* to improve reimbursement policies for non-VA, emergency health care services for enrolled veterans. We urge the Subcommittee Chairman to introduce this bill, to gain its further consideration by the Full Committee, and we endorse its enactment into law. The DAV thanks those involved for their efforts to ensure this essential emergency relief benefit originally contemplated in the Millennium Act, and its improvements from this bill, are properly implemented.

With regard to this bill, we note the current renewed discussion of the need for national health reform, a major stated goal of this Administration. Emergency hospitalization of the uninsured is one of the driving forces for reform in the private sector. One of the unintended consequences of such reform might well impact on the VA health care system. In that regard, we ask the Subcommittee for vigilance to ensure that whatever shape reform may ultimately take, that veterans' rights be protected for continuation of reimbursement of their emergency health care services as authorized by section 1725, title 38, United States Code.

Mr. Chairman, this concludes the testimony of Disabled American Veterans on these important bills. I would be pleased to respond to questions from you or other Members of the Subcommittee on these matters.

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

Mr. Chairman and Members of the Subcommittee:

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

H.R. 784, Quarterly Reports on Vacancies in Mental Health Professional Positions

H.R. 784 seeks to improve the recruitment of mental health care professionals by having the Secretary of Veterans Affairs submit quarterly reports on mental health employment vacancies at VA Medical Centers nationwide.

Section (a) requires the Secretary of Veterans Affairs to submit to Congress a report describing any vacancy in a mental health professional position at any medical facility of the Department, no later than 30 days after the last day of a fiscal quarter. Within these reports, the Secretary is to indicate, for each vacancy, the Veterans Integrated Services Network (VISN) to which the facility with the vacancy is assigned.

The American Legion's "System Worth Saving" Task Force visits medical facilities around the country and reports a constant need for additional mental health providers in almost every Medical Facility. As VA continues to screen, identify, and treat veterans suffering from mental health disorders through VA outreach coordinators and Vet Center's Global War on Terror Counselors, having the staffing capabilities to treat veterans after initial intervention is paramount. Resolution 150, "The American Legion Policy on Department of Veterans Affairs Mental Health Services," states that VA now has more mental health patients seeking treatment with fewer mental health providers." The American Legion believes that with a quarterly report, mental health care services for veterans will be more widely available because less time for recruitment will be needed.

The American Legion supports any standard(s) that improve the mental health capabilities of VA and its medical facilities, and in turn would like to see the passage of H.R. 784. To provide our veterans with the most adequate mental health care, there needs to be the proper amount of mental health providers in the VA Medical Centers. The inadequacy of mental health providers gives way to substandard care and the possibility that veteran mental health care needs will fall through the cracks.

H.R. 785, Pilot Program on Outreach and Training Relating to Mental Health of Veterans of Operation Iraqi Freedom and Operation Enduring Freedom

This bill establishes a pilot program to provide outreach and training to certain college and university mental health centers relating to the mental health of veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), and for other purposes.

Section 1(a) seeks to establish a 4-year program under which the Secretary shall provide a counseling center, student health or wellness center at a college or university with a large veteran population to increase outreach efforts.

Resolution 150, "The American Legion Policy on Department of Veterans Affairs Mental Health Services," states that veterans continue to need increased access to mental health care. A RAND Study on the 'Invisible Wounds of War: Addressing the Mental Health Needs of Returning Soldiers' in 2008 estimated that 300,000 veterans, or 18½ percent of those deployed, were diagnosed by VA with Post Traumatic Stress Disorder or major depression. This number continues to rise and efforts to increase access and quality of care at the universities and colleges are imperative to ensure assistance is available to these veterans during a time of crisis. Additionally, training is needed to ensure college and university staff is prepared in the case of a veteran's mental health crisis. Moreover, The American Legion supports the increased outreach efforts at universities or colleges where many veteran students are not familiar with VA benefits and services.

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

Prepared Statement of Eric A. Hilleman, Deputy Director, National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to provide our views on the bills under consideration at today's hearing. These bills would make meaningful changes in the law, improving the quality of health care this Nation's veterans receive at the Department of Veterans Affairs (VA). We urge quick passage of all four.

H.R. 784, a bill to report quarterly on vacancies in mental health professional positions in the Department of Veterans Affairs (VA)

The VFW supports, this bill would require the Secretary of VA to report to Congress, no later than 30 days from the end of the quarter, each vacancy for: psychiatrists, psychologists, social workers, marriage and family therapists, and licensed professional mental health counselors. Each report would be required to state the Veterans Integrated Services Network (VISN) or region in which the vacancy existed. The date of termination for these quarterly reports would be December 31, 2014.

Currently, reporting on vacancies for mental health professionals is not shared with Congress. Reporting vacancies to Congress will elevate the issue of the health care professional shortage and draw much needed attention to developing these professions nationally. In breaking out the data by VISN, Congress and the VA can address regional shortages and/or barriers to employing these essential health care professionals. Fully understanding the shortages and need for mental health care professionals may also aid in creating incentives for their employment.

VFW is proud to support this legislation.

H.R. 785, a bill to establish a pilot program from FY 2010 to 2013 to educate and engage in outreach to college and university mental health centers

The VFW enthusiastically supports this legislation, which would give the VA Secretary the authority to train college and university clinicians, administrators, and counselors to serve veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). The VA would highlight illnesses common to veterans, resources available, and any other service the Secretary determined necessary for this program. The reporting component of the program would require the Secretary to report to Congress not later than 2 years after enactment of this Act. The Authorization for Appropriations of this Act would be $3 million.

This legislation follows the prevailing trend of engagement of and on behalf of OEF/OIF veterans. We believe this bill will help to combat stereotypes of veterans in the community, de-stigmatizing mental health issues related to military service. Through educating the education community this information can hopefully be broadly disseminated into the counseling and social work industry. Not only is this a benefit to schools and the community, it directly affects veterans on campuses across the Nation and eases their transition/reintegration.

The timing of this bill is especially important due to the New GI Bill the VA anticipates an increase of veterans on college campuses in the coming years. Many veterans will encounter an entirely new culture and bureaucracy not designed to support older students with unique needs. It is for these reasons that the VFW enthusiastically supports this bill.

H.R. 1211, "Women Veterans Health Care Improvement Act"

VFW is proud to support H.R. 1211, legislation that would improve benefits and services to female veterans, especially those who have served or are serving in OEF/OIF operations. Recent data collected by VA's Center for Women Veterans reports that the number of women serving on active duty is about 15 percent, and that female personnel serving in Guard and Reserve capacities is 17.6 percent and growing. VA reports that 44 percent of the transitioning female veterans are seeking care at VA. As the number of females in uniform grow, so too will the percentage of females seeking services at VA. VFW is encouraged by the improvements this bill, and we remain hopeful this legislation will ease access to servicers at VA by women veterans.

The VFW recognizes that VA has begun to compile data with the goal of better understanding the barriers facing women within VA. We encourage VA to continue studying with an eye toward creating a more accepting culture at VA for female veterans. The improvements cited in this bill are an excellent means for progressing toward that goal.

The VFW supports section 101, which would require VA to study barriers in providing comprehensive health care for women including: scope of services provided to women, effective outreach, mental health care and gender sensitivity of its health care providers. For many years, VA has been a gender-focused institution. All health care, documents, outreach, and programs were focused on male veterans, institutionalizing a lack of sensitivity for the needs of female veterans. Studies such as this will enable VA to move beyond the one-size-fits-all ideals and tailor its services to the specific needs of female veterans. It is our understanding that VA has already successfully executed a sample study of women veterans, the "Women Veterans Ambulatory Care Use Project, Phase II," in the West LA area and this study has contributed to VA's health care providers understanding of female veterans in this area. For example, the study finds that female VA users are more likely than nonusers to receive mental health services. We believe the results of this study have led to increased sensitivity and understanding of women veterans and could have positive and lasting impacts in the way female veterans are treated if implemented across the system.

The VFW also supports section 102, which would require a comprehensive assessment of current health care programs and services provided to women by the VA. The study would examine services including specialized programs to treat PTSD, substance abuse and mental illness, as well as the availability of obstetric and gynecologic care throughout the VA system. Further, it collects data on waiting times, health care services offered, demographics, geographic distance, and other factors faced by female veterans. In time, we believe this data will aid to close the existing gender gap and provide care sensitive to the needs of female veterans.

We fully support the sections contained in Title II of the legislation, which deal with the improvement and expansion of health-care programs for women veterans.

We applaud the recommendation of section 201 to extend health care coverage, for up to 14 days, to female veterans' newborns. The period of 14 days is essential to the health of the child and the veteran, allowing continuity in obstetrics and gynecologic care. The VFW would encourage research on birth defects of children born to female veterans; we are highly sensitive to unknown exposures and environmental factors related to OEF/OIF service. Further recommendations on this issue are found in the FY 2010 edition of the *Independent Budget (IB)*.

The VFW is extremely supportive of section 202, which would authorize VA to provide graduate level training, certification, and continuing medical education for counseling with specific focus on evidence-based treatment and care for Military Sexual Trauma (MST) and PTSD. This is all too common among combat theatre female veterans. In these cases, VA should strive to be hypersensitive to the environ-

ment, approach, and treatment options when providing care or evaluating veterans for their physical and mental health needs related to MST.

We also strongly support section 203, which would create a pilot program to provide childcare for veterans receiving health care through VA. This is a valuable proposal, which has the potential to eliminate a tremendous barrier for care, especially for single parents.

In addition, we applaud section 204, which adds two recently separated female veterans to the VA Advisory Committees on women veterans and minority veterans. The veteran population is increasing greatly with the return of OEF/OIF veterans. Veterans of the current conflict era have specific needs.

A Draft bill to close existing loopholes in law, allowing VA to cover unmet emergency room treatment for veterans in certain cases

The VFW is pleased to offer our support for the draft legislation that deals with an issue important to a number of our members. This bill would allow VA to pay for of emergency care for veterans enrolled in VHA under certain cases. It closes a loophole that sticks many veterans unfairly with a large hospital bill.

Section 1725 of Title 38 authorizes VA to reimburse veterans for medical expenses related to emergency care at non-VA facilities if the veteran is enrolled and using the VA health care system. This is an important safety net for many veterans who have no other means to pay for potentially life-saving care. However, veterans who receive a portion of their care cost from another source, such as an insurance settlement or judgment are not eligible for any reimbursement, even if that amount is a fraction of the cost of their care. This bill allows VA to be a secondary payer in those situations, so the vet will not have to pay out of pocket. Additionally, it removes care accidents where insurance pays out for medical coverage from the list of things that would bar VA from paying for emergency care.

This legislation lifts these restrictions, treating VA as a secondary payer to cover the remaining amount due for a veteran's emergency room care. We fully support this legislation. VFW believes that all essential emergency room care should be covered for all veterans.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions that you or the Members of the Subcommittee may have. Thank you.

Prepared Statement of Todd Bowers, Director of Government Affairs, Iraq and Afghanistan Veterans of America

Madam Chair, and Members of the Subcommittee, thank you for inviting Iraq and Afghanistan Veterans of America (IAVA) to testify today, and for giving us the opportunity to present our views on H.R. 784, H.R. 785, H.R. 1211 and drafted legislation pertaining to emergency care. On behalf of IAVA and our more than 125,000 members and supporters, I would also like to thank you for your unwavering commitment to our Nation's veterans.

H.R. 784

IAVA is very concerned with the national shortage of mental health professionals, and in particular, how this shortage affects access to adequate mental health care for troops and veterans. The VA has already been flooded by new veterans seeking care for psychological injuries. More than 178,000 Iraq and Afghanistan veterans seen at the VA have been given a preliminary diagnosis of a mental health problem, about 45 percent of new veterans who visited the VA for any reason.

Although the VA was initially caught unprepared with a serious shortage of staff and an exceedingly inadequate budget, the Department has made significant progress in responding to the needs of new veterans. Thanks to a mental health budget that has doubled since 2001, the VA has been able to devote $37.7 million to placing psychiatrists, psychologists, and social workers within primary care clinics. While psychologist staff levels were below 1995 levels until 2006, the VA has recruited more than 3,900 new mental health employees, including 800 new psychologists, bringing the VA's total mental health staff to about 17,000 people. The VA is now the single largest employer of psychologists in the country.

That being said, access to mental health care, particularly for rural and female veterans, is still an issue, in part because of the continued shortage of mental health professionals. As an example, Montana ranks fourth in sending troops to war, but the state's VA facilities provide the lowest frequency of mental health visits.

H.R. 784 will establish congressional oversight over vacancies in the VA's mental health professional positions, and the increased transparency will help improve

staffing at VA hospitals and clinics. IAVA fully supports this legislation and looks forward to seeing its rapid implementation.

H.R. 785

With the passage of the historic "Post-9/11" GI Bill last year, there will be a flood of Iraq and Afghanistan veterans taking advantage of their new education benefits and attending universities across the Nation. It is to be expected that many of these veterans will turn to their student health centers while attending school for medical care. This is an opportune time to advertise and extend VA mental health care services to new veterans.

H.R. 785 helps facilitate this by ensuring that student health centers and counseling services at universities have the appropriate support from the VA to provide the best services to our Nation's student-veterans.

IAVA is pleased to support H.R. 785 and looks forward to working with Representative Tsongas to ensure that this legislation is enacted in a timely manner and does not contain any technical deficiencies. It is our hope that language within the bill will be modified to clearly define what is termed as "large enrollment" in section 1(b)(1). It is critical that mental health services be available to all veterans no matter what school they attend. Any university with Iraq and Afghanistan veterans should have the appropriate amount of counselors ready to assist veterans. If only schools with a very high veteran population are allocated these resources, veterans attending institutions with a smaller veteran population will continue to fall through the cracks. In addition, section 1(b)(1)(A) contains the following language: "training for clinicians on treatment for mental illness commonly experienced by such veterans." IAVA would like to see this language more clearly defined to reduce the risk of certain illnesses going undiagnosed and untreated.

H.R. 1211

IAVA is pleased to see that the Subcommittee is focusing on the unique needs of women veterans. Improvement of VA health care for women veterans is one of IAVA's 2009 Legislative Priorities. More than 11 percent of Iraq and Afghanistan veterans are women, and they deserve the same access to health care as any other American veteran.

The "Women Veterans Health Care Improvement Act" will help gather critical information on the quality of VA care provided to women veterans. By identifying barriers to care or gaps in services that women veterans are experiencing, the VA and Congress can better address these shortfalls.

With respect to Title II, section 202 of the discussion draft, IAVA would like to see funding devoted to the study of the best evidence-based treatment and care for veterans suffering from post-traumatic stress disorder as a result of both sexual trauma and combat trauma, so that mental health care providers within the VA can be trained on these particular treatments. This combination of traumas has rarely been studied, but with more females serving in Iraq and Afghanistan, the possibility of both these traumas occurring in new veterans is significant. The VA's mental health providers must be prepared.

In addition to this recommendation, as part of IAVA's 2009 Legislative Agenda, we have made multiple recommendations to adequately address the needs of women veterans. In particular, IAVA supports prioritized hiring of female practitioners and outreach specialists, increased funding for specialized in-patient women-only PTSD clinics, and significant expansion of the resources available to women coping with Military Sexual Trauma.

While not all of these issues are addressed in the Herseth Sandlin bill, it is our hope that these provisions will be incorporated into future legislation. IAVA thanks the Chairwoman for her work on women veterans' issues, and looks forward to seeing the final language of the bill.

Thank you for your time. Semper Fi.

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

Good Morning Mr. Chairman and Members of the Subcommittee. Thank you for inviting me here today to present the Administration's views on four bills (one of which is in draft form) that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. We appreciate the opportunity to discuss the bills on today's agenda.

H.R. 784 Quarterly Report on Vacancies

H.R. 784 would require the Secretary to submit quarterly reports to Congress on any vacancies in mental health professional positions (i.e., psychiatrists, psychologists, social workers, marriage and family therapists, and licensed professional mental health counselors) at any VA medical facility. These reports would have to identify the Veterans Integrated Services Network (VISN) in which the medical facility is located and would be submitted to Congress not later than 30 days after the last day of a fiscal quarter. This reporting requirement would terminate after December 31, 2014.

VA does not support H.R.784 because it is unnecessary. VA has been working diligently to enhance mental health services throughout our system. We have done this, in part, by increasing our core staff to date by 4,000 positions, and we plan again this year to continue increasing the number of mental health professionals in the field to ensure sustained operations of this vital service line at our medical centers and clinics. Our commitment to ensuring that veterans receive needed mental health services necessarily demands that we do our utmost to ensure that staffing levels at VA points of access are sufficient. This data is best collected and controlled, however, at the local level. This is because staffing and workloads are inescapably dependent on local factors related to the local veteran population, usage rates, veterans' particular health care needs, and local employment factors. We achieve oversight by holding the VISN managers accountable to senior leadership. Given that the current model is effective, we think the value in creating a quarterly reporting requirement at the national level is limited, particularly given it would necessitate the creation of a new complex data infrastructure to meet the bill's requirements and have no accurate or helpful context once removed from local factors. We would be pleased to brief the Committee at any time on our efforts.

We estimate the cost of H.R. 784 to be $188,000 in Fiscal Year 2010; $1 million over a 5-year period; and just over $1 million over a 10-year period.

H.R. 785 Pilot Program to Provide Outreach and Training to College and University Mental Health Centers

The key provisions of H.R. 785 would require VA to conduct a 4-year pilot to provide outreach and training services related to the mental health needs of veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) to certain college or university counseling centers, student health centers, and student service centers. Educational institutions covered by the bill would be those that have a large population of enrolled OEF and OIF veterans. Specifically, VA would be required to:

- train clinicians at those sites on mental illnesses commonly experienced by these veterans;
- train those clinicians on how to assist veterans seeking VA mental health services;
- train administrative staff who interact with these veterans on crisis management and other relevant skills;
- train peer counselors who conduct support groups for these veterans; and
- provide any other service VA deems necessary or appropriate.

VA supports the intent of the bill's drafters. While costs are not prohibitive for such a pilot project, we believe more effort needs to go into identifying the precise scope and intended objectives of the pilot program before we can analyze whether H.R. 785 constitutes an effective means of achieving those ends. We are also concerned that the pilot program not dilute or duplicate our ongoing outreach efforts targeted at this veteran population and, more importantly, not detract from our ability to provide direct patient care to these and other veterans.

That said, however, we are committed to doing more in this area. We have already developed a comprehensive training course for suicide awareness that focuses particularly on this cohort of veterans. (This training is mandatory for certain VHA staff.) We have already shared the training module with the Department of Defense, and we will next direct each VA medical facility to offer it to the clinical and administrative staff at local community colleges, 4-year colleges, and universities. The advantage to this training module is that it is targeted at veteran-patients, is self-taught, and is accessible electronically online or in hard copy.

Additionally, we have developed some excellent Public Service Announcements relevant to the bill's concerns. We will ensure these are also made available to colleges and universities for broadcast on campus stations. Included in such materials will be our advertisements and outreach materials on the Department's suicide prevention hotline and safe-driving initiative. We will also take immediate steps to establish liaisons with colleges and universities at the local level as well as enhance

our existing associations with affiliated educational institutions by, for instance, inviting their staff to attend conferences at the local VA medical facilities relating to the health needs of OEF/OIF veterans.

We welcome the opportunity to meet with the Subcommittee to discuss these initiatives further.

We estimate the cost of the pilot project to be $828,000 in Fiscal Year 2010 and just over $3 million over the 4-year duration of the pilot program.

Draft Bill to Expand Eligibility for Reimbursement for non-VA Emergency Care

This draft bill would expand the benefit available under 38 U.S.C. § 1725 related to the payment or reimbursement of expenses incurred by a veteran who received unauthorized emergency treatment from a non-VA provider for a non-service connected disability. Currently, to be eligible for reimbursement of such expenses, a veteran must meet a number of criteria, including that he or she not have "other contractual or legal recourse against a third party that would, *in whole or in part*, extinguish such liability to the provider." 38 U.S.C. § 1725(b)(3)(C). The draft bill would amend that particular eligibility criterion to require that the veteran have no other contractual or legal recourse against a third party that would *in whole* extinguish the veteran's liability to the private provider.

The draft bill would further provide for the coordination of benefits when a veteran has other legal or contractual recourse against a third party responsible for only partial payment of the veteran's financial liability for the non-VA emergency treatment. In such cases, the draft bill would require VA to be a secondary payer, but it would limit VA's financial liability to the difference between the amount already paid by the third party (excluding copayment or deductible amounts owed by the veteran) up to the amount VA would be authorized to pay under the program, i.e. 70 percent of the Medicare rate. That is, the VA-allowable amount would be offset by the amount already paid by the responsible third party. For example, if a non-VA provider billed a veteran $100 for the emergency treatment covered under section 1725, the third party paid $50 on the claim, and the VA-allowable amount for such treatment is $80, then VA would be responsible for paying $30 to the non-VA provider under the draft bill. Payment by the Secretary would then extinguish the veteran's liability to the non-VA provider for the expenses of the emergency treatment at issue. VA's payment could not include co-payments or similar payments owed by the veteran. All of these amendments would apply to non-VA emergency treatment furnished on or after October 8, 2007.

VA supports the draft bill. Under current law, VA is a payer of last resort. Consequently, a veteran who would otherwise be eligible for reimbursement or payment of private emergency medical expenses is ineligible for the benefit because a third party makes partial payment toward the veteran's emergency treatment expenses pursuant to other contractual or legal recourse available to the veteran. In these cases, veterans are often left with sizeable medical debts for which they are personally liable. We understand the purpose for the legislation is to remedy this limited situation. Payment by the Secretary as secondary payer would fully extinguish the veteran's liability to the private provider who furnished the emergency treatment.

It is not feasible to cost this proposal without extensive data on veterans' personal liability for non-VA emergency care expenses following partial payments made by third parties under various personal injury protection policies. Those data are not available. We have therefore estimated the cost of the draft bill based on the average payment made by the Secretary for unauthorized non-VA emergency treatment of veterans' non-service connected disabilities. We estimate the cost of implementing this draft bill to be $500,000 for Fiscal Year 2010, $3 million over a 5-year period, and $7.8 million over a 10-year period.

H.R. 1211 "Women Veterans Health Care Improvement Act"

The last bill on today's agenda is the "Women Veterans Health Care Improvement Act," which contains a number of provisions that I will address individually.

Section 101 would require VA to contract with a qualified independent entity or organization to carry out a comprehensive assessment of the barriers encountered by women veterans seeking comprehensive health care from VA, building on the VA's own "National Survey of Women Veterans in Fiscal Year 2007–2008" (National Survey). Many requirements related to sample size and the scope of the survey would apply to the conduct of the assessment. Section 101 would also require the contractor-entity to conduct research on the effects of the following concerns on the study participants:

- The perceived stigma associated with seeking mental health care services.

- The effect of driving distance or availability of other forms of transportation to the nearest appropriate VA facility on access to care.
- The availability of child care.
- The acceptability of integrated primary care, or with women's health clinics, or both.
- The comprehension of eligibility requirements for, and the scope of services available under, such health care.
- The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.
- The gender sensitivity of health care providers and staff to issues that particularly affect women.
- The effectiveness of outreach for health care services available to women veterans.
- The location and operating hours of health care facilities that provide services to women veterans.
- Such other significant barriers identified by the Secretary.

Additionally, section 101 would require the Secretary to ensure that the heads of the Center for Women Veterans and the Advisory Committee on Women Veterans review the results of the comprehensive assessment and submit their own findings with respect to it to the Under Secretary for Health and other VA offices administering women-veterans health care benefits.

VA supports section 101 but notes that the results of our National Survey will not be available until later in the fiscal year. Consequently, we do not think it feasible to enter into a contract for the mandated assessment and research until we have first had a chance to complete and fully analyze the results of the National Survey. Only in this way can the assessment and research adequately build on the National Survey and reliably augment, rather than duplicate, VA's efforts in this area. We estimate the cost of section 101 to be $3½ million.

Section 102 of H.R. 1211 would require VA to enter into a contract with an entity or organization to conduct a very detailed and comprehensive assessment of all VA health care services and programs provided to women veterans at each VA facility. The assessment would have to include VA's specialized programs for women with PTSD, homeless women, women requiring care for substance abuse or mental illnesses, and those requiring obstetric and gynecologic care. It would also need to address whether effective health care programs (including health promotion and disease prevention programs) are readily available to, and easily accessed by, women veterans based on a number of specified factors.

After the assessment is performed, the bill would require VA to develop an extremely detailed plan to improve the provision of health care services to women veterans, taking into account, among other things, projected health care needs of women veterans in the future and the types of services available for women veterans at each VA medical center. VA would then be required to report to Congress on the assessment and plan, including any administrative or legislative recommendations VA deems appropriate.

What is unclear in the bill is whether the contractor-entity conducting the assessment would also be required to develop the follow-up "plan," as the terms of section 102 refer to the contractor's conduct of "studies and research" required by that section.

VA supports section 102 only if the development of the mandated plan would be conducted by a contractor-entity. We estimate the total costs of this section to be $4,354,000 during the period of Fiscal Year 2010 through Fiscal Year 2012.

Section 201 of H.R. 1211 would authorize VA to provide hospital care and medical services to newborns of women-veterans who receive their maternity care through the Department. This treatment authority would be limited to 14 days, beginning on the date of the child's birth.

We appreciate and understand the Committee's interest in this issue. Before we can take a position on section 201, however, we first need to determine whether the time-frame of 14 days is appropriate. Additionally, we must complete the cost estimate for this provision. Once we complete these analyses, we will submit our views and cost estimate for the record.

Section 202 would require VA to carry out a program to provide graduate medical education, training, certification, and continuing medical education for mental health professionals who provide sexual trauma care and counseling services and care and counseling for Post-Traumatic Stress Disorder (PTSD). We do not support section 202 because it is unnecessary. Further, the training and continued medical education and training that VA currently requires of these mental health professionals far surpasses that which would be required by this provision.

We believe it is essential that our medical professionals across the system be able to effectively recognize and treat the manifestations of sexual trauma and PTSD. To that end, we train our mental health professions on evidence-based practices (EBPs) for PTSD and associated conditions that can result from sexual trauma, such as depression and anxiety. VA is also conducting two national training initiatives to educate therapists in two particular EBPs for PTSD. The first of these is Cognitive Processing Therapy (CPT), which began in 2006. Following didactic training, clinicians participate in clinical consultations to attain full competency in CPT. VA is also using new CPT treatment manuals, originally developed and tested in civilian settings for victims of rape and child sexual abuse, which had been adapted specifically for VA and the Department of Defense by inclusion of material on the treatment of issues arising from the experience of sexual trauma during military service. To date, VA has trained 1,484 VA clinicians in the use of CPT.

The second national initiative is an education and training module on Prolonged Exposure (PE) for treatment of PTSD, which began in 2008. As you are likely aware, there have been a number of studies supporting the use of exposure treatment for PTSD. Originally PE was developed to treat sexual-assault survivors, but it has been successfully adapted for the treatment of combat-related PTSD. To date, OMHS has trained 233 clinicians in the use of PE.

VA has also begun training its mental health professionals in Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Therapy (CBT), which are evidence-based psychotherapies for anxiety and depression, two mental health conditions that can result from the experience of sexual trauma. Similar to the two PTSD-related training initiatives, this training program includes the use of didactic training materials adapted for the treatment of sexual trauma experienced during military service and clinical case studies involving women veterans. This training program began in 2008, and VA has already trained 151 clinicians.

As our mental health professionals receive training under these two initiatives and other targeted training programs, we carefully monitor their clinical practice to ensure they are delivering state-of-the-art care to their patients.

Finally, I would like to mention that VA has established the Military Sexual Trauma (MST) Support Team at the national level to monitor MST screening and treatment, oversee MST-related education and training, and promote best practices for screening and treatment of the mental and physical health consequences of MST. This MST Support Team hosts monthly MST teleconference training calls. Typically, more than 100 phone-lines are used with multiple listeners on each line. Sample topics include: evidence-based psychotherapies, MST in Primary Care settings, health issues associated with men who have experienced MST, and cultural issues affecting patients suffering from MST and/or MST-related treatments. Credits for professional continuing education are available for those who participate in these training calls. The MST Support Team operates an intranet Web site homepage with links to MST-related resources and materials (including training materials), reports on MST screening and treatment of MST-related health problems, and MST-related discussion forums. The Team also hosts an annual clinical training program for MST Coordinators, which is a 5-day training session on both the treatment of MST and program development strategies for VA facilities. Lastly, the MST Support Team is currently revising the Veterans Health Initiative Independent Study course on MST for which Continuing Education credit is available.

In short, the training described above is designed to complement the professional training of VA's highly qualified mental health staff by providing them with additional training in emerging, cutting-edge therapies and practices. Note that this is in addition to the continuing medical education required by the providers' State licensing boards and/or professional specialty boards and organizations.

VA estimates the cost of implementing section 202 to be $9½ in Fiscal Year 2010, $46 million over a 5-year period, and $99 million over a 10-year period.

Section 203 would require VA, not later than 6 months after the date of the bill's enactment, to carry out a 2-year pilot program at no fewer than three VISNs to furnish child-care services (directly or indirectly) to eligible veterans as a means of improving their access to mental and health care services. Eligible veterans would include veterans who are the primary caretaker of a child and who are receiving regular or intensive mental health care services or any other intensive health care services for which the Secretary determines the provision of child care would improve the veterans' access to care. Child care would be limited to the time during which the veteran actually receives the covered services and the time required to travel to and from the VA facility for the covered services. VA would be permitted to provide child care services through a variety of means, i.e., stipends offered by licensed child care centers (directly or through a voucher system), the development

of partnerships with private agencies, collaboration with other Federal facilities or programs, or the arrangement of after-school care.

We share the Committee's interest in ensuring appropriate access to care. Once we have completed our analysis, we will submit our views and cost estimate for the record.

Section 204 would require the Department's Advisory Committee on Women Veterans to include recently-separated women veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated minority-group veterans. These requirements would apply to Committee appointments made on or after the date of this bill's enactment.

We fully support section 204. These amendments would help both Committees to better identify and address the needs of their respective veteran-populations.

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

Statement of Hon. Bob Filner, Chairman, Committee on Veterans' Affairs

Chairman Michaud, thank you for the opportunity to testify before the Sub Committee on Health on this legislation which will assist veterans who get hurt while they are off-duty and require emergency care in non-VA medical facilities.

Under current law, the VA does not pay for emergency treatment for non-service connected conditions in non-VA facilities if a veteran has third party insurance that pays either full or a portion of the emergency care. This includes veterans who carry an auto insurance policy providing minimal health care coverage.

I first became aware of this issue through Stephen Brady, a sixty percent service connected veteran who was in a serious motorcycle accident in October of 2007 and received emergency care in a non-VA facility. Mr. Brady carried an auto insurance policy which covered $10,000 in medical costs, even though his total medical bill far exceeded $10,000. As you can imagine, this has caused undue stress and financial hardship on veterans such as Stephen Brady.

In the last Congress, I introduced H.R. 5888 to address this problem. Since then, I've worked to make some improvements to the legislation by including new provisions clarifying the reimbursement responsibilities of the VA.

Specifically, the new provision defines the VA as a secondary payor where a third party insurer covers a part of the veteran's medical liability.

It also explains that the VA is only responsible for the difference between the amount paid by the third party insurer and the VA allowable amount. Veterans would continue to be responsible for copayments owed to the third party insurer.

And finally, it protects our veterans by clarifying that they are not liable for any remaining balance due to the provider after the third party insurer and the VA have made their payments.

In the new Congress, I hope that the Committee supports and passes this importance piece of legislation.

In closing, I look forward to the day when veterans like Stephen Brady can focus on their recovery, instead of being overburdened with financial concerns.

Thank you again for the opportunity to share my thoughts with you.

Statement of Paralyzed Veterans of America

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit a statement for the record on H.R. 784; H.R. 785; the "Women Veterans Health Care Improvement Act;" and draft legislation concerning emergency treatment furnished in a non-Department of Veterans Affairs (VA) facility. PVA appreciates the emphasis this Subcommittee continues to place on addressing mental health needs of veterans. We are also pleased to see that the Subcommittee intends to address the needs of a rapidly growing population—women veterans.

H.R. 784

PVA fully supports H.R. 784, a bill that requires the VA to provide quarterly reports on vacancies in mental health professional positions. As explained in the FY 2010 edition of *The Independent Budget*, there is a national shortage of behavioral health professionals. Despite this fact, the VA still must improved its succession

planning in mental health services in order to address the professional field shortages, recruitment, and retention challenges.

Ultimately, the key to ensuring that the VA is able to provide adequate mental health services to the current generation of veterans and veterans of previous eras is strong oversight. As such, this legislation establishes an additional tool that can be used for that oversight. As explained in *The Independent Budget*:

> The development of the MHSP [Mental Health Strategic Plan] and the new Uniform Mental Health Services package provide an excellent road map for the VHA's transformation of its mental health services to veterans. However . . . the IBVSOs have expressed continued concern about the pace of implementation of the mental health clinical, education, and research programs. There are also significant gaps that need to be closed, especially in oversight of mental health programs and in the case management programs for OEF/OIF combat veterans.

Given the incredible amount of resources that have been invested in VA mental health programs in recent years this oversight will be critical. For additional recommendations and discussion about VA mental health programs, please refer to the FY 2010 edition of *The Independent Budget*.

H.R. 785

PVA supports H.R. 785, a bill that requires the VA to conduct a pilot program to provide outreach and training to certain college and university mental health centers. Much like the issues addressed with regards to H.R. 784, the VA is at a critical period in its provision of mental health services. This pilot program will allow the VA to expand its efforts to meet the needs of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans. This legislation is particularly timely in light of the possibility for substantial new enrollments of this generation of veterans into colleges and universities as a result of the benefits provided under the Post-9/11 GI Bill. As with the broader mental health programs administered by the VA, the success of this program will also depend on serious oversight. However, if successful, this pilot program could provide an effective blueprint for the expansion of VA mental health services in the future.

The "Women Veterans Health Care Improvement Act"

PVA supports the draft legislation—the "Women Veterans Health Care Improvement Act." Women have played a vital part in the military service throughout our history. In the last 50 years their roles, responsibilities, and numbers have significantly increased. Current estimates indicate that there are 1.8 million women veterans comprising nearly 8 percent of the United States veteran population. According to Department of Defense (DoD) statistics, women servicemembers represent 15 percent of active duty forces, 10 percent of deployed forces, 20 percent of new recruits, and are a rapidly expanding segment of the veteran population.

Historically, women have represented a small numerical minority of veterans who receive health care at Department of Veterans Affairs (VA) facilities. However, if women veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) continue to enroll at the current enrollment rate of 42½ percent, it is estimated that the women using VA health care services will double in two to 4 years.

As the population of women veterans undergoes exponential growth in the next decade, VA must act now to prepare to meet the specialized needs of the women who served. Overall the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young working women with childcare and eldercare responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men.

This legislation is meant to expand and improve health care services available in the VA to women veterans, particularly those who have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). More women are currently serving in combat theaters than at any other time in history. As such, it is important that the VA be properly prepared to address the needs of what is otherwise a unique segment of the veterans population.

Title I of the bill would authorize a number of studies and assessments that would evaluate the health care needs of women veterans. Furthermore, these studies would also identify barriers and challenges that women veterans face when seeking health care from the VA. Finally, the VA would be required to assess the pro-

grams that currently exist for women veterans and report this status to Congress. We believe each of these studies and assessments can only lead to higher quality care for women veterans in the VA. They will allow the VA to dedicate resources in areas that it must improve upon.

Title II of the bill would target special care needs that women veterans might have. Specifically, it would ensure that VA health care professionals are adequately trained to deal with the complex needs of women veterans who have experienced sexual trauma. Furthermore, it would require the VA to disseminate information on effective treatment, including evidence-based treatment, for women veterans dealing with Post-Traumatic Stress Disorder (PTSD). While many veterans returning from OEF/OIF are experiencing symptoms consistent with PTSD, women veterans are experiencing unique symptoms also consistent with PTSD. It is important that the VA understand these potential differences and be prepared to provide care.

PVA views this proposed legislation as necessary and critical. The degree to which women are now involved in combat theaters must be matched by the increased commitment of the VA, as well as the Department of Defense, to provide for their needs when they leave the service. We cannot allow women veterans to fall through the cracks simply because programs in the VA are not tailored to the specific needs that they might have. Finally, we would encourage the Subcommittee to review the extensive policy section in the FY 2010 edition of *The Independent Budget*—"Women Veterans' Health and Health Care Programs."

Emergency Treatment in a Non-VA Facility

The draft legislation will expand eligibility for emergency medical care at the VA for some veterans. Currently, veterans who have a third-party insurance provider that pays a portion of medical expenses in the event of an emergency do not have the balance of their medical expenses covered by the VA. This proposed legislation should eliminate that situation. It will prevent the VA from denying payment for emergency service at non-VA hospitals when a veteran is partially covered by their third-party insurance.

We do have one question about the legislation. PVA is unclear about why a seemingly arbitrary date—October 8, 2007—was chosen as the effective date? Otherwise, PVA supports this legislation.

Mr. Chairman and Members of the Subcommittee, PVA would once again like to thank you for the opportunity to provide our views on this important legislation. We look forward to working with you to continue to improve the health care services available to veterans.

Thank you again. We would be happy to answer any questions that you might have.

Statement of Thomas J. Berger, Ph.D., Senior Analyst for Veterans' Benefits and Mental Health Issues, and Marsha Four, Chair, National Women Veterans Committee, Vietnam Veterans of America

Mr. Chairman, Ranking Member Brown, Distinguished Members of the House Veterans' Affairs Subcommittee on Health and honored guests, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record views on this important veterans legislation being presented before this Subcommittee today.

It is indisputable that the number of women in the military has risen consistently since the 2 percent cap on their enlistment in the Armed Forces was removed in the early 1970s. This has resulted in an increased number of women we can now call "veterans", and most assuredly, will have a direct bearing on the number of women who will be knocking on the door of the VA in the very near future. A focus on the capacity and capability of the VA to equitably and effectively provide care and services must be a priority today. Planning and readiness is essential for the future. These responsibilities also require oversight and accountability in order to meet both VA and veteran goals, objectives, requirements, standards, and satisfaction, along with agency advancement.

While much has been done over the past few years to advance and ensure greater equity, safety, and provision of services for the growing number of women veterans in the VA system, these changes and improvements have not been completed implemented throughout the entire VA system. In some locations, women veterans still experience significant barriers to adequate health care and oversight with accountability. Thus VVA asks the new Secretary to ensure senior leadership at all VA fa-

cilities and in each VISN to be held accountable for ensuring that women veterans receive appropriate care in an appropriate environment.

Additionally, there is much to learn about women veterans as a separate patient cohort within the VA. Women's Health is now studied as a specialty in every medical school in the country. It has moved far beyond that of obstetrics and gynecology. Gender has an impact on nearly every system of the body and mind. This has great significance in the ability of any health care system to provide the most appropriate, comprehensive, and evidence-based scientific treatment and care. This also has a direct effect on the delivery system along with staff requirements to meet the needs of women now utilizing the VA health care system, as well as for those new women veterans who will be coming into the system in the future.

The VA has already identified that our country's new women veterans are younger and that they expect to use the system more consistently. For example, in December 2008, the VA reported that of the total 102,126 female OEF/OIF veterans, 42.2 percent of them have already enrolled in the VA system, with 43.8 percent using the system for 2–10 visits. Among these returning veterans, 85.9 percent are below the age of 40 and 58.9 percent are between 20 and 29. In fact, the average age of female veterans using the VA system is 48 compared with 61 for men. Therefore it is clear that the needs of women veterans are growing and already taxing the VA system, which historically has focused on an older population.

The 110th Congress put forward two bills related to women veterans S.2799 and H.R. 4107 that unfortunately were not finalized with passage. So VVA is pleased to see the reintroduction of such legislation with H.R.1211 and applauds the efforts of this Committee to bring women veterans' health care to the forefront of attention in the 111th Congress. However, VVA does wish to make comments on a number of specific provisions included in this proposed legislation.

Title I: Studies and Assessments of Department of Veterans Affairs Health Services for Women Veterans:

Section 101: Study of Barriers for Women Veterans to Health Care from the Department of Veterans Affairs—Section 101(a)(4)

VVA believes that this study is vital to understanding today's women veterans and that building on the "National Survey of Women Veterans in Fiscal Year 2007–2008" is a referenced starting point. However, VVA also believes that there is a need to expand several elements in this section. For example, section 101(a)(4) should include a survey of sufficient size *and diversity to be statistically significant for women of all ethnic groups and service periods*.

Section 101(b)—VVA believes that *this study should identify the "best practices" that facilities utilize to overcome identified barriers.*

Section 101(b)(2)—VVA believes that with the fragmentation of women's health care services there needs to be consideration for driving time/transportation to medical *facilities that offer specialty care as well as primary care*.

Section 101(d)(1)—While VVA holds great respect for and recognizes the important work of both the Office of the Center for Women Veterans and that of the Advisory Committee on Women Veterans, this section as written would limit the initial review, creating unnecessary delays. Rather, VVA believes that *this study should also go immediately to these two entities, plus the VA Undersecretary for Health, the Deputy Undersecretary for Quality and Performance, the Deputy Undersecretary for Operations, the Office of Patient Care Services, and the Chief Consultant for the Women Veterans Health Program for review and recommendations, which in turn are then forwarded to the Deputy Undersecretary for action to remove or ameliorate the identified barriers*.

Section 101(e)(2)—VVA recognizes that this section requires that 30 months after the VA publishes the 2007–08 National Survey of Women Veterans that the VA Secretary in turn is required to report to Congress on the barriers study and what actions the VA is planning. However, in reality, this means that the information/directions contained in the '07–08 report is/are put "on hold" for 2½ years. Therefore VVA believes that *the Secretary's report to Congress should also include what actions—if any—have transpired both during the survey and the 30 month hiatus*.

Section 102(1)—VVA believes *this section should include appropriate language directing the study format to include the use of evidence-based "best practices in care delivery"*.

Title II: Improvement and Expansion of Health Care Programs of the Department of Veterans Affairs for Women Veterans

Section 201—VVA asks that particular reflective consideration be given to the following—VVA seeks *a change in this section of the proposed legislation that would increase the time for the provision of neonatal care from 14 to 30 days, as needed for the newborn children of women veterans receiving maternity/delivery care through the VA*. Certainly, only newborns with extreme medical conditions would require this time extension. VVA believes that there may be extraordinary circumstances wherein it would be detrimental to the proper care and treatment of the newborn if this provision of service was limited to solely 14 days. If the infant must have extended hospitalization, it would allow time for the case manager to make the necessary arrangements to arrange necessary medical and social services assistance for the woman veteran and her child. This has important implications for our rural women veterans in particular. And this is not to mention cases where there needs to be consideration of a woman veteran's service-connected disabilities, including toxic exposures and mental health issues, especially during the pre-natal period.

Section 202—VVA has concerns about the VA establishing a "certification" program. In order to be valid, *VVA believes that such a certification program be based upon and modeled after those already utilized by many professional organizations*. Such a certification program would lend itself well to oversight and accountability. Too many VA certification programs now consist of only a 1-hour training class or reading materials.

Section 202(e)(2)—Although this section calls for reporting the number of women veterans who have received counseling, care and services under subsection (a) from "professionals and providers who received training under subsection (4)", *VVA asks "Who in the VA is already trained and holds professional qualifications under these subsections? "*

A Concern of Non-inclusion—During the 110th Congress, VVA was heartened to see that the S.2799 legislation included a "Long Term Study of Health of Women Veterans of the Armed Forces Serving Operation Iraq Freedom and Operation Enduring Freedom". However, VVA is extremely disappointed to see that any mention of this proposed study is missing from H.R. 1211 which is currently under consideration by the 111th Congress. As you know, the second round of the National Vietnam Veterans Readjustment Study was never completed by the VA, even though it was mandated by Congress to do so. VVA urges you not to let this opportunity be lost again on a statistically significant and diverse population of veterans. With regard to women veterans and the NVVRS, if and when the VA is ever held accountable and again directed to complete this important study, VVA is extremely interested in the issue of auto-immune diseases found in the study.

As time, social environments, and veterans' population demographics change, there are also cultural expectations based on scientific advancements in health care that elicit a re-definition of women veterans' needs in the VA system. Knowing the needs is vital to understanding and meeting them. The VA has recognized many of the needs of women veterans by actually creating interest groups comprised of not only VA staff, but veterans as well. For example, there is recognition that younger women veterans are also working women who need flexible clinic and appointment hours in order to also meet their employment and child-care obligations. They also need to have sexual health and family planning issues addressed, along with the needs of infertility and pre-natal maternity. And there are unanswered questions and concerns about the role of exposures to toxic substances and women's reproductive health.

The new women veterans also need increased mental health services related to re-adjustment, depression, and re-integration, along with recognition of differences among active duty, Guard, and reserve women. The VA already acknowledges the issue of fragmented primary care, noting that in 67 percent of VA sites, primary care is delivered separately from gender specific health care—in other words, two different services at two different times, and in some cases, two different services, two different times, and two different delivery sites. The VA also notes that there are too few primary care physicians trained in women's health, and at a time when medicine recognizes the link between mental and medical health, most mental health is separate from primary care. VVA seeks to ensure that every woman veteran has access to a primary care provider who meets all her primary care needs, including gender specific and mental health care in the context of an on-going patient-clinician relationship; and that general mental health providers are located within the women's and primary care clinics in order to facilitate the delivery of mental health services.

Vietnam Veterans of America applauds the VA for elevating its Office of Women's Health to the Strategic Health Care Group level. With this action, the VA has "pumped up" the volume on the attention and direction of the VA regarding women veterans. But there remains much to be learned about women veterans as a health care cohort. Data collection and analytical studies will provide increased opportunities for research and health care advancement in the field of women's health, as well as offer evidence-based "best practices" models and innovative treatments.

The VA is a massive health care system that possesses challenges for the new Secretary, VA leadership, and all those VA employees who provide and deliver care treatment, and services to our Nation's veterans. VVA is hopeful that any shortfalls can be turned into positive action with resolve through a progressive implementation plan which turns hopeful plans into reality.

H.R. 784, VVA has no objections to the proposed emendation of Title 38, U.S. Code which directs the Secretary of Veterans Affairs to submit quarterly reports to Congress on vacancies in mental health professional positions in Department of Veterans Affairs medical facilities.

H.R. 785, VVA generally supports the bill as written; however, we suggest that there be an evaluation report after 1 year of operations. The legislation should be passed as the pilot program to provide outreach, training and evaluation to certain college and university mental health centers relating to the mental health of veterans of Operation Iraq Freedom and Operation Enduring Freedom.

Emergency Treatment in Non-VA Facilities, VVA is pleased to support the proposed emendation to Title 38, United States Code, to expand veteran eligibility for reimbursement by the Department of Veterans Affairs for emergency treatment in a non-Department facility.

As you may well remember from several previous appearances before this Committee, VVA has addressed the problems associated with the VA's paradigm for delivery of health care. Until very recently this paradigm has been predicated on placing resources where there is a large concentration of veterans eligible for services. In other words, the chief mechanism for service delivery of veterans' health care has been in or near large urban centers. However, those service men and women fighting our current wars in Iraq and Afghanistan (and elsewhere) comprise the most rural fighting force since before World War I.

The Department of Defense reports that over 40 percent of our current military force originates from towns and communities of 25,000 or less. What this means is that we collectively must re-think the paradigm of how we deliver medical services, including emergency medical services, to veterans in need.

The proposed emergency care legislation is a good start in toward testing what is going to work in regard to delivering quality health care services to veterans (including demobilized National Guard and Reserves) who live in less populous areas of our country, and deserves to be enacted and implemented as quickly as possible.

VVA thanks this Committee for the opportunity to submit testimony for the record.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
March 12, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Dr. Gerald Cross, Principal Deputy Under Secretary for Health, Veterans Health Administration, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing on H.R. 784, H.R. 785, H.R. 1211, and a Draft Discussion on Reimbursement for Emergency Care that took place on March 3, 2009.

Please provide answers to the following questions by April 23, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. In your testimony on H.R. 1211, you state that VA needs to first determine if the 14 day timeframe is appropriate for newborn care. The Subcommittee would appreciate it if VA could get back to us within the next four to 6 weeks regarding section 201 of H.R. 1211.
2. As with section 201 of H.R. 1211, the Subcommittee would appreciate it if VA could get back to us within the next four to 6 weeks with their analysis, views and cost on carrying out a pilot program to furnish child-care services (directly or indirectly) to eligible veterans.
3. Please provide the Committee with information on the location and status of current mental health staff vacancies, including VA's progress in filling those vacancies.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by April 23, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman

CW/jb

Questions for the Record

Hon. Michael Michaud
Chairman
Subcommittee on Health
House Committee on Veterans' Affairs
March 3, 2009
Legislative Hearing on H.R. 784, H.R. 785, H.R. 1211 and Discussion Draft on Emergency Care Reimbursement

Question 1: In your testimony on H.R. 1211, you state that VA needs to first determine if the 14 day timeframe is appropriate for newborn care. The Subcommittee would appreciate it if VA could get back to us within the next four to 6 weeks regarding section 201 of H.R. 1211.

Response: Section 201 of H.R. 1211 would authorize the Department of Veterans Affairs (VA) to provide hospital care and medical services to newborns of women Veterans who receive their maternity care through VA. The proposal authorizes care for the first 14 days following the child's birth.

VA has evaluated the circumstances related to care for newborns and concluded the optimal period for VA coverage is 7 days, beginning with the date of the child's birth. VA has analyzed data and found that 94 percent of mothers and their infants are released from medical facilities within the first 7 days. This limit would still afford the remainder of women Veterans sufficient opportunity to make alternate financial arrangements, such as Medicaid or the State Children's Health Insurance Program for their infants. In addition, we note that this level of coverage is significantly beyond the standard provided under group health insurance policies which

typically cover only routine care for the newborn child for up to 48–96 hours of the mother's maternity stay at the hospital.

Services covered under this analysis include up to 7 days of health care services for newborns. Health care services include room and board and ancillaries, daily physician services, and post-discharge physician care delivered within the mandated period of coverage. VA estimates the cost of this program to be $55.3 million in the first year, $293.6 million over 5 years, and $589.3 million over 10 years.

Question 2: As with section 201 of H.R. 1211, the Subcommittee would appreciate it if VA could get back to us within the next four to 6 weeks with their analysis, views and cost on carrying out a pilot program to furnish child-care services (directly or indirectly) to eligible veterans.

Response: H.R. 1211, section 203, requires the Secretary of VA to carry out a 2-year pilot program under which the Secretary provides child care assistance to qualified Veterans in at least three Veterans Integrated Services Networks (VISN). Child care assistance under this section may include:

1. Stipends for the payment of child care offered by licensed child care centers (either directly or through a voucher program);
2. The development of partnerships with private agencies;
3. Collaboration with facilities or programs of other Federal departments or agencies; and
4. The arrangement of after school care.

Under this section, child care assistance may only be provided for the period of time that the qualified Veteran (1) receives a health care service at a VA facility, and (2) travel time to and from such facility for health care service. A qualified Veteran, under this section, means a Veteran who is the primary caretaker of a child and who is receiving one or more of the following health care services from VA:

1. Regular mental health care services
2. Intensive mental health care services
3. Any other intensive health care services for which the Secretary determines that providing child care would improve access by qualified Veterans.

We support the Committee's intent in removing barriers that could limit a veteran's access to health care. However, we do not support this bill because the benefits are not tailored to those Veterans who would otherwise forgo health care in the absence of Government-subsidized child care assistance. Moreover, this pilot would shift resources that could be used to support the direct delivery of health care to Veterans to those who may have existing child care options available. Since VA has no experience in predicting the use of child care services by "qualified Veterans," we estimate that costs for this pilot could be up to the $1½ million authorized by the bill.

Question 3: Please provide the Committee with information on the location and status of current mental health staff vacancies, including VA's progress in filling those vacancies.

Response: VA has developed a number of initiatives that have had a significant positive impact on the recruitment and retention of mental health professionals. With the aid of these recruitment initiatives, VA mental health staffing levels have increased by over 5,000 full time employee (FTE) since fiscal year (FY) 2005, when VA began implementing its Mental Health Strategic Plan. Currently, there are almost 19,000 mental health professionals employed by VA, and 95 percent of all Veterans seeking new mental health services are seen within 14 days for evaluation and initiation of treatment. Although vacancies exist, most are quickly filled. There is no systemic problem with "unfilled" positions that impact the delivery of timely care to Veterans. VA has recruitment goals, and those goals increase annually.

Staffing goals can not be viewed in a vacuum, and VA considers several factors in determining appropriate staffing levels for mental health professionals. This process includes sufficiently training professionals to ensure required services are delivered at facilities (or to ensure these services are available through tele-mental health) and scheduled at times convenient for Veterans. VA also is establishing productivity standards, which will be performance-based and sensitive to the multiple settings in which mental health care is provided. These standards will recognize the roles and intensity of care needed in various settings. Once established, those productivity standards will support determinations of optimal mental health staffing levels.

Although specific data on staff vacancies are not available in VA's databases, it can provide a staffing level assessment of the number of vacancies for positions funded by the Mental Health Enhancement Initiative. These positions, however, only represent about 4,500 of the approximately 19,000 total mental health professionals.

Table 1. Vacancies in mental health positions at Veterans Health Administration (VHA) medical facilities and outpatient clinics, for the core mental health professions

	FTE total for vacant positions	Vacant FTE in active recruitment (% of vacant FTE for each profession)	Vacant FTE in pre-recruitment (% of vacant FTE for each profession)	Vacant FTE not in recruitment (% of vacant FTE for each profession)	Vacancies as a percent of overall positions*
Nurses	688.00	554.05	54.00	79.95	7.3%
		(80.5%)	(7.9%)	(11.6%)	
Psychiatrists	538.16	464.43	38.35	35.38	19.4%
		(86.3%)	(6.6%)	(7.1%)	
Social Work	835.80	646.30	110.50	79.00	19.2%
		(77.3%)	(13.2%)	(9.5%)	
Psychology	680.40	553.80	66.80	59.80	21.9%
		(81.4%)	(9.8%)	(8.8%)	
Totals	**2,742.36**	**2,218.58**	**269.65**	**254.13**	**13.9%**
		(80.9%)	**(9.8%)**	**(9.3%)**	

*Reported vacancies divided by current known staff positions plus reported vacancies)

Table 2 shows the location of vacancies by VISN for each of the core mental health professions, as requested. While there is some variability across VISNs, it is not dramatic and is primarily accounted for by the size of the VISN, in terms of number of facilities and number of unique Veterans served. Totals nationally appear in the last row, to confirm that all vacancies shown in Table 1 also are accounted for in Table 2.

Table 2. Distribution of vacant FTE across VISNs, by profession

VISN	Nursing Vacancies in Mental Health Settings (FTE)	Psychiatry Vacancies (FTE)	Social Work Vacancies in Mental Health Settings (FTE)	Psychology Vacancies (FTE)
1	30.65	24.55	52.50	34.80
2	21.90	8.40	22.20	18.10
3	39.10	4.20	28.10	23.50
4	21.00	18.75	31.00	32.25
5	17.00	12.50	40.00	25.00
6	54.00	28.95	52.00	46.00
7	46.00	31.60	34.00	46.00
8	48.00	47.00	50.20	56.10
9	33.50	39.50	43.50	37.50
10	32.95	23.93	38.75	38.65
11	25.00	25.20	41.00	32.40
12	15.70	14.38	30.60	25.50

Table 2. Distribution of vacant FTE across VISNs, by profession—Continued

VISN	Nursing Vacancies in Mental Health Settings (FTE)	Psychiatry Vacancies (FTE)	Social Work Vacancies in Mental Health Settings (FTE)	Psychology Vacancies (FTE)
15	29.00	31.10	37.50	27.00
16	50.00	38.08	67.50	46.50
17	43.00	38.62	18.00	38.30
18	38.00	42.00	33.40	28.30
19	22.50	14.50	30.25	12.00
20	24.50	25.45	67.00	32.80
21	50.50	35.30	48.50	32.50
22	14.20	22.04	42.00	22.50
23	31.50	12.13	27.80	26.50
Totals	**688.00**	**538.16**	**835.80**	**680.40**

Of the 232 currently active vet centers, 229 have at least one VHA qualified mental health professional (psychologist, social worker, or psychiatric nurse; there are no psychiatry staff in vet centers) on staff as per the Readjustment Counseling Service Handbook. The remaining three sites (McKeesport, PA, Moline, IL, and Redwood City, CA) are recruiting for mental health professionals to fulfill this requirement. The vet center program currently employs 69 licensed psychologists, 442 licensed social workers, and 12 psychiatric nurses for a grand total of 523 mental health professionals. Sixty-four percent of all current vet center team leaders and 60 percent of all current vet center counselors are licensed psychologists, licensed social workers, or psychiatric nurses.

Readjustment Counseling Service has increased the overall number of mental health professionals on staff by 22 percent in the last 15 months. Overall, the current staffing levels are as follows.

	DEC 2007	MAR 2009	DIFFERENCE
Professional on Staff Vet Centers with Mental Health	217	229	+12
Mental Health Professionals on Staff			
Licensed Psychologists	49	69	+20
Licensed Social Workers	367	442	+75
Psychiatric Nurses	13	12	−1
Total Mental Health Professionals	429	523	+94

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