

LEGISLATIVE HEARING ON H.R. 949, H.R. 1075,
H.R. 2698, H.R. 2699, H.R. 2879, H.R. 3926,
H.R. 4006, H.R. 84, AND THREE
DISCUSSION DRAFTS

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

ONE HUNDRED ELEVENTH CONGRESS

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**LEGISLATIVE HEARING ON H.R. 949, H.R. 1075,
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THURSDAY, MARCH 25, 2010

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

The Subcommittee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Brown of South Carolina, and Boozman.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I want to thank everyone for coming out this morning.

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 and discussions on recently introduced legislation within this Subcommittee's jurisdiction. This is an important part of the legislative process that will help encourage frank discussions and new ideas.

We have a number of bills before us today. They cover a wide range of important issues dealing with access to VA health care; collective bargaining rights for VA employees; mental health care and counseling for individuals discharged or released from active duty; emotional and peer support for family members of the Armed Services; breast cancer among members of the Armed Forces and veterans; and rural health issues including the unique needs of Native American veterans. We also have draft bills before us today on reimbursement for continuing education, mental health counseling and bargaining rights and performance criteria.

I would ask unanimous consent that my full opening remarks be submitted for the record. Are there any objections? Hearing none, so ordered.

I look forward to hearing the views of the different panels today and at this time I would like to recognize Ranking Member Mr. Brown for any opening statement he may have.

[The prepared statement of Chairman Michaud appears on p. 32.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. I appreciate your holding this hearing today and look forward to working with you and the rest of our esteemed colleagues on these important legislative subjects.

The ten bills being discussed this morning cover a wide array of veterans' issues and I look forward to learning more about them. Of particular interest to me is H.R. 1075, the "RECOVER Act," introduced by Mr. Scalise. H.R. 1075 would provide medical service to veterans in a disaster area by allowing VA to contract with one or more non-VA facilities.

Making sure our veterans have access to the very finest care is always a top priority of this Committee, but in times of real emergency, that priority takes on a whole new level of importance. Serving a district with facilities that are vulnerable, to the sometimes destructive whims of nature, as I do in Charleston and along the coast of South Carolina, makes this a personal issue for me and I support Mr. Scalise in his efforts.

I am also excited to hear more about H.R. 84, the "Veterans Timely Access to Health Care Act," introduced by my friend Ms. Brown-Waite.

Among other provisions, this bill would make the standards of access to care for a veteran seeking primary care from the VA 30 days from the date the veteran contacts the Department. Ms. Brown-Waite has long been committed to making sure America's veterans do not have to endure long waiting periods before they can have access to VA care and I applaud her efforts.

To all the witnesses appearing in front of us this morning, thank you for your dedication to improving the lives of our veterans. Your work does not go unnoticed, and I am eager to begin our discussion on the matters at hand.

It is only by working together to advance meaningful and appropriate legislation that we can completely fulfill the promise we made to provide veterans with the best care anywhere. The men and women who served so bravely in uniform deserve nothing less.

Again, thank you, Mr. Chairman. I yield back.

[The prepared statement of Congressman Brown appears on p. 32.]

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

So we may as well begin. I will recognize the distinguished Chairman of the full Committee on Veterans' Affairs, Bob Filner of California. I want to thank you, Mr. Chairman, for all the hard work that you have done over the years fighting for our veterans. We have made a lot of progress under your leadership and look forward to continuing to work with you as we move forward to take care of the needs of those who have bravely served this great Nation of ours.

Mr. Filner.

STATEMENT OF HON. BOB FILNER, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. STEVE SCALISE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA; HON. GABRIELLE GIFFORDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA; HON. ANN KIRKPATRICK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA; HON. LEONARD L. BOSWELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA; AND HON. GINNY BROWN-WAITE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, sir. Mr. Chairman, we thank you for your leadership on this Subcommittee and your fine working relationship with Mr. Brown. We appreciate the leadership that both of you have shown and I know I speak for all of my colleagues in saying that we appreciate the opportunity to talk about our legislation today.

The bill that I am speaking on, H.R. 949, would improve the collective bargaining rights and procedures for reviews of adverse actions of certain VA employees. This bill is about ensuring equity amongst the health care professionals employed at VA so that the providers such as doctors, nurses, dentists, chiropractors, optometrists, and podiatrists who are hired under the so-called "pure title 38" system have the same rights as their fellow VA health care professionals hired under different hiring systems.

Without this bill, the "pure title 38" providers do not have the right to challenge errors in pay computations and lack other key bargaining rights enjoyed by their colleagues at the VA.

To address this problem, H.R. 949 would clarify that these "pure title 38" providers have equal rights to collective bargaining. This means they would be able to challenge personnel actions through such methods as grievances, arbitrations, and labor-management negotiations.

This bill would also require the VA to review the adverse personnel action and issue a final decision no later than 60 days after the employee appeals the adverse personnel action.

Finally, the bill would subject the VA's final decision on the employee's appealed adverse personnel action to judicial review in the appropriate U.S. District Court or the U.S. Court of Appeals for the Federal Circuit.

I know the VA has some concerns with this and they are in discussions with the stakeholders. I look forward to working with all of them as we move forward on this legislation.

Again, thank you again for the opportunity of sharing these thoughts with you.

[The prepared statement of Congressman Filner appears on p. 33.]

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

Mr. Scalise.

STATEMENT OF HON. STEVE SCALISE

Mr. SCALISE. Thank you, Mr. Chairman and Ranking Member Brown, as well as all the distinguished Members of the Sub-

committee for the opportunity to testify. I want to just let you know this bill, H.R. 1075 is bipartisan legislation with over 19 cosponsors. It seeks to maintain vital health services to veterans in the event that a VA hospital is closed due to a federally declared disaster.

Before I begin discussing my bill, I would like to thank you and all of the Members of the Committee for the work that you do on behalf of our Nation's veterans. The welfare of our veterans and their families is of great importance to me. I first filed this legislation during the 110th Congress when I served as a Member of the Veterans' Affairs Committee.

Our Nation is grateful for the courage our veterans have displayed and the sacrifices they have made in order to protect America and the freedoms we enjoy today. I believe as you do, that it is our obligation to provide them the same honor and dedication that they provided us during their service.

Hurricane Katrina flooded and closed the New Orleans VA Medical Center, leaving our veterans without the full services of their medical home. Unfortunately, nearly 5 years later, our VA hospital still remains closed. As a result, veterans throughout Southeast Louisiana face increased challenges and hardship to obtain the quality health care they deserve. The VA made a commitment to open a new hospital, which won't occur until as early as 2013, but with the current delays, I remain concerned about the status of veterans health care in the interim and want to make sure this doesn't happen again to any of our Nation's veterans in the future.

That is why I introduced H.R. 1075, the "RECOVER Act." My bill would ensure that the VA must establish a contract with at least one non-VA facility to provide inpatient services in the event that a VA hospital will be closed for at least 6 months due to any federally declared disaster.

Nothing in this bill would prevent a veteran from seeking care within the VA system, if he so chooses.

Just last week I spoke with a veteran who had to travel to another State for post-operative care because the New Orleans VA Hospital is still not open. Veterans still have to travel more than 350 miles for cardiac surgery and also have to travel to other States for mental health care as well.

Several veterans with chronic conditions did not seek care after the storm because they did not know what their options were. This concerns me very much, and my bill seeks to eliminate these hardships. The RECOVER Act will also prevent families from having to travel hundreds of miles just to visit their loved ones who are undergoing treatment in the hospital.

As the respected group Disabled American Veterans (DAV) said, when they expressed their support for this Act, "Family support and caregiving have been shown to accelerate recovery time and reduce costs and length of hospital stays."

In the aftermath of a disaster, the last thing our veterans and their families should have to worry about is where to seek basic care. I commend the Southeast Louisiana Veterans Health Care System for the initiative they have taken to provide health care in light of the hospital's closure. The community outpatient clinics have been extremely valuable in delivering primary care and other

services. We learned valuable lessons after Hurricane Katrina, and I want to make certain that no veteran has to travel long distances or experience long wait times to receive basic care in the event that their local VA hospital is closed due to a natural disaster, whether it be a hurricane, tornado, earthquake or any other disaster.

My office is working with the veterans service organizations (VSOs) to address any issues they have as this bill moves through the legislative process. Let me also emphasize that this in no way undermines our strong commitment to the VA health care system. Our goals are the same. Veterans and their families need to have options for receiving quality care close to home in the most convenient way possible, all while working to expedite the rebuilding of our VA hospital that was closed due Hurricane Katrina.

I continue working hard to cut through the red tape and expedite the rebuilding of the New Orleans Medical Center that was devastated and closed by Hurricane Katrina's devastation. I look forward to working with you and Members of the full Committee as we move forward.

Again, I thank you for your dedication to our Nation's military veterans and I appreciate this opportunity to testify before the Subcommittee. I yield back.

[The prepared statement of Congressman Scalise appears on p. 33.]

Mr. MICHAUD. Thank you very much for your testimony.

Mr. Boswell.

STATEMENT OF HON. LEONARD L. BOSWELL

Mr. BOSWELL. Thank you, Mr. Chairman and Mr. Brown. We have spent a few hours together and I know both of you are patriots and you care about veterans and I thank you for your service and I appreciate the kind words you said to Chairman Filner.

This Committee has done a lot of good work the last several years and you are to be commended.

That's why I thank you for inviting me here today to share some of the things with you that I want to talk about. As you know, women are currently the fastest growing veteran population, today, representing 8 percent of the population.

As the demographics of the military continue to change, we find our VA system is struggling to serve the unique needs of this growing population and it is believed that by 2020, 15 percent of veterans using the VA for health care will be women, and I would like to maybe step out of order a bit and introduce to you, if I could, Mr. Chairman, Alexis Taylor.

Alexis, please stand up. I hope I don't embarrass her too much, but she's my Legislative Director, she's an Iraqi veteran and because of what I am about to share with you has a lot to do with why I hope that this legislation will get serious consideration.

What this means is veterans health care, which is now primarily tailored to men needs to undergo significant changes and needs to do it quickly. In particular, one health concern that has been largely ignored is the prevalence of breast cancer in our servicewomen and women veterans. So that is why we have introduced, and I say "we," Alexis and I, H.R. 3926, the "Armed Forces Breast Cancer Research Act."

This legislation would require the Secretary of Defense and the Secretary of Veterans Affairs to collaboratively study the incidence rate of breast cancer in servicemembers and veterans. This study would focus on the number of servicemembers who have deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom, the demographic information of those servicemembers and veterans, an analysis of the clinical characteristics of breast cancer diagnosed and possible exposures to cancer-at-risk factors.

The idea of this bill came about when a member of my staff, which you have just met, Alexis, who is an Iraq veteran, went back to Iowa for a 5 year post-deployment reunion with her unit and others, and one of the women of her unit had returned home from serving her country, and was diagnosed with breast cancer and had to undergo a double mastectomy at age 25.

Through the course of the night, the servicemembers at the reunion were able to piece together, talk to one another, about six women that were deployed, they were deployed with, who had come back from their deployment in Iraq with breast cancer, all between the ages of 25 to 35 years old.

Also, there were another half a dozen women who returned with new lumps in their breasts and needed additional tests such as mammograms, ultrasounds and/or biopsies. With 70 women deployed at the battalion of about 700, the incidence rate in these young women seemed high and alarming as Alexis brought this to my attention.

I would like to note that this legislation has been endorsed by the Veterans of Foreign Wars (VFW) and the Iraq and Afghanistan Veterans of America (IAVA) and I would like to submit both letters, which I have here with me into the record.

Mr. MICHAUD. Without objection, so ordered.

Mr. BOSWELL. Thank you. In recent years the U.S. medical and research communities have stepped up their efforts on breast cancer detection, research and treatment in the country's civilian population. However, women who have served in our Nation's Armed Force have largely been excluded from these studies, despite their exposure to cancer risk factors and access to medical care.

A recent study of U.S. Department of the Defense (DoD) and National Cancer Institute compose the prevalence of certain types of cancer among active duty military personnel of the general public. The study found that breast cancer among women is more common in the military than in the general population and that further studies are needed to confirm these findings and explore contributing factors.

So that is our goal for this legislation, to find out if our service-women do have a higher risk of breast cancer than the rest of the women in the country and why that might be, so that ultimately we can determine if breast cancer, as a service-connected disability, which I truly believe it is, if it is, we need to know.

At this moment in history it is particularly important to consider what we can do to better serve the brave individuals who fight for our security and liberty once they return home.

And I would like to thank you again for allowing us to come before this Committee. And I have a personal passion about this somewhat. As you already know and I am not going to elaborate

on it, I am a veteran, too, and I know that some of the maladies I have shared with you and you know about is because of a thing called Agent Orange, new at that time. This caused a lot of problems. I was very much exposed to it.

And if something's going on in this theater of operations that exposed our women to breast cancer and we could do something about it and we don't, shame on us. I feel very strong about it and I know that you do, too. So I ask you to do everything we possibly can do to move forward on this issue, and I would look forward to any questions you might have. Thank you.

[The prepared statement of Congressman Boswell, and the referenced letters, appear on p. 36.]

Mr. MICHAUD. Thank you very much, Mr. Boswell. And Alexis, thank you for your service to our great country, as well as keeping Mr. Boswell. Thank you very much.

Ms. Brown-Waite.

STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you, Mr. Chairman and Ranking Member Lamborn. I, as you can tell, I have a little bit of laryngitis, which my husband used to call "a husband's prayers answered."

First of all, I want to say that the Committee does great work and I truly miss being on this Committee.

As of November 2009, there were nearly 8 million veterans enrolled in the VA health system. With new veterans entering the system every day and approximately 174,000 Operation Enduring Freedom and Operation Iraqi Freedom patients receiving VA care, it is clear that it is our duty, our Nation's duty to serve our veterans and I believe that that duty is as strong now as it ever was. Today, there are 153 VA medical centers and 768 community-based outpatient clinics available to serve these veterans.

When a veteran calls to schedule an appointment in one of these facilities, they should be able to receive an appointment that is timely and appropriate to their medical needs. Unfortunately, for many veterans this simply does not happen. The VA lauds itself for completing 99 percent of primary care appointments within 30 days of the desired date. However, this means if their figures are accurate, that nearly 32,000 patients are still waiting beyond the 30 days.

Additionally, there is a very discernable difference between existing patients and new patients as only 88.8 percent of new patients complete their appointments within 30 days of their desired date. We all know that health care delayed is health care denied and our Nation's veterans deserve much better than this.

In September of 2007, the VA Office of the Inspector General found that the Veterans Health Administration's method of calculating waiting times of new patients understates the real waiting times. In this report, the Inspector General made five recommendations to reduce these wait times. To date, four of the five recommendations remain unresolved.

When I was first elected to Congress, I inquired about wait times from my local VA community-based outpatient clinics and hospitals. The numbers the VA gave me, both for Veterans Integrated Services Network (VISN) 8 and nationwide, quite honestly did not

match the stories that I was hearing from my veterans. I challenged them on it and I told them that I was going to be in their offices watching and waiting and talking to individuals.

What was happening was, they were making the appointments within 30 days, but then around the 20th day they would call and change the appointment to a later date, so it would be maybe 40, maybe 50 days.

For this reason, I introduced the bill H.R. 84, the "Veterans Timely Access to Health Care Act." It would make the standard for a veteran seeking primary care from the Department of Veterans Affairs 30 days from the date the veteran actually contacts the Department with no games allowed to be played. Veterans shouldn't have to wait more than 30 days to receive an appointment.

The VA does provide a high level of care to all of the veterans who are enrolled in the system. This is why the majority of patients actually rank their care, their overall satisfaction as "very good" or "excellent," regardless of whether they are receiving inpatient or outpatient care.

I want to make sure that it is clear that this bill is not a scheme to move the VA toward privatization. I simply want to make sure that the veterans receive care in a very timely and appropriate manner.

As Members of Congress, we have an obligation to ensure that those veterans do receive the best health care available to them. If they are having problems receiving it within 30 days, then Congress needs to allow them to look for an alternative, and that's exactly what this bill does. And I appreciate this hearing today to determine whether the VA is meeting the goal of timely access to health care.

You know, our Nation's veterans did not wait 30 days to answer the call of duty. They answered the call, took up arms and protected our very freedoms. They deserve that same dedication and steadfastness from us.

With over 116,000 veterans living in my district, I have the distinguished honor to meet with these true American heroes on a regular basis. And over and over again, I still hear about how difficult it is to schedule an appointment with a doctor in a timely manner.

Congress recently allowed for advanced appropriations for the VA, and I think that is an excellent idea. This new funding structure should allow the VA to properly manage their funds and hire the necessary staff to meet the demand at the VA facilities.

Congress and the administration must not turn the care of our Nation's veterans into a political issue. Instead, we must all work together to ensure that they receive health care they risked so much to earn. We must continue these practices that already work and improve on those that may be failing. H.R. 84 does just that.

And with that, Mr. Chairman and Members, I yield back the balance of my time.

[The prepared statement of Congresswoman Brown-Waite appears on p. 38.]

Mr. MICHAUD. Thank you very much, Ms. Brown-Waite and also thank you for your years serving on this Committee as well.

Ms. Giffords.

STATEMENT OF HON. GABRIELLE GIFFORDS

Ms. GIFFORDS. Good morning, Mr. Chairman. Thank you and Ranking Member Brown for allowing me the opportunity to testify. I'd like to talk to this Committee because this is the Committee that has been specifically looking at supporting the needs of America's veterans, and I look forward to working with all of you on this Committee toward this endeavor.

I also want to thank the veterans service organizations that are in attendance today or perhaps watching, for their commitment to the men and women in uniform and their lifetime of service to our country.

The two bills that I have brought before you today that I have sponsored, H.R. 2698 and H.R. 2699, will have a direct impact on improving the behavioral health of our Nation's heroes and their families in our communities.

As a Member of the House Armed Services Committee who represents more than 25,000 servicemembers and dependents and nearly 96,000 veterans and retirees in my southern Arizona district, we have really seen firsthand the trials and tribulations of our servicemembers who are returning home from the frontlines.

I know this issue is one that is close to all of our hearts, and I am hopeful that today's hearing signifies an important step in moving this vital legislation forward and passing it this Congress.

There is no cause more honorable than service to our country. As our Nation's warriors bravely step into the breach, we must be prepared to care for them when they return home, no matter what condition they return home in.

In war, our soldiers, sailors, airmen and marines face unspeakable horrors, sometimes on a daily basis, and readjusting to every day life is a long and complicated process. Every day thousands of our Nation's bravest men and women are suffering from different degrees of post-traumatic stress disorder (PTSD). In recent years, diagnosed cases of PTSD have increased by more than 50 percent for servicemembers returning from overseas deployments, and many experts believe that the actual number is much higher because a large number of servicemembers are reluctant to seek care and seek treatment.

For an untold many diagnosed with the worst warning signs of PTSD, there simply are no easy fixes. We see each month the unfortunate and deeply saddening results of the Department of Defense when it releases its numbers of servicemember suicides. The trend is currently hovering slightly above the national average, more than double what it was 5 years ago.

PTSD and other related behavioral health issues severely affect an individual's ability to perform every day functions that we take for granted. PTSD, though, is treatable through a variety of methods, including behavioral therapy and medication with the majority of servicemembers seeing an improvement after just one or two sessions with a behavioral therapist.

Unfortunately, we all know there are not enough of these behavioral health care providers within the military or the VA to treat our servicemembers, their families or surviving spouses for the anguish that they are suffering. What is worse still is that there aren't enough therapists to treat one another.

Ultimately, our ailing heroes or the families they leave behind, must wait to see a caregiver, they often receive incomplete or inadequate care or in some cases do not receive care at all, leading to one of the few inevitable conclusions—depression, anger management problems, substance abuse or, the worst case, death.

This is the first of many clear signs the system is failing our men and women in uniform and badly needs to be fixed. H.R. 2698 establishes a scholarship for service program that provides educational benefits to those training in behavioral health care specialties critical to the operations at Vet Centers. These individuals would then pay back the investment by serving as a behavioral health care specialist at Vet Centers across the country.

Because of the unprecedented nature and a lingering lack of understanding surrounding PTSD and its symptoms, many former servicemembers do not realize they are suffering until long after they have left service. My bill, H.R. 2699, would permit our Nation's Guardsmen and Reservists to access behavioral health care at Vet Centers even after they have been released from active duty and it will then provide referrals to assist them to the maximum extent possible in obtaining behavioral health care and services from sources outside of the Department.

H.R. 2698 and 2699 will ensure that the Veterans Administration carries out a competitive grant program for non-profit organizations that provide peer-to-peer emotional support services for servicemembers, veterans, and survivors, including members of the National Guard and Reserve who are often left out because of the changing nature of their service or the accessibility of care in local communities.

I underscore that.

Mr. Chairman, you have been to my district. It is over 9,000 square miles. Many of these servicemembers return home to areas that are very far from any local Vet Center and partnering with non-profits that have the training and expertise so that they don't have to drive 3, 4, 5 hours to receive treatment is critical.

The unfortunate fact is that 10 years ago, we hardly understood the existence of PTSD, we didn't understand it quite to the extent that we do today and today we have only a patchwork quilt of treatments, forms and meetings, training seminars and online courses that these servicemembers must complete, alongside other regular recertifications and proficiency tests.

What we are not doing is taking a comprehensive look at this problem and designing a smarter and more realistic solution.

I am committed to fixing these problems and I know Mr. Chairman and Members of this Committee are committed as well, and I just want to thank you for allowing me the opportunity to share the story and to introduce these bills because I really do think it would make a significant difference to our servicemembers. Thank you.

[The prepared statement of Congresswoman Giffords appears on p. 34.]

Mr. MICHAUD. Thank you, too, for your commitment to helping our veterans.

Mrs. Kirkpatrick.

STATEMENT OF HON. ANN KIRKPATRICK

Mrs. KIRKPATRICK. Mr. Chairman, Ranking Member Brown and Members of the Committee, thank you for holding this hearing and providing me with the opportunity to address two bills that I have introduced, H.R. 4006, the "Rural, American Indian Veterans Health Care Improvement Act of 2009," and H.R. 2879, the "Rural Veterans Health Care Improvement Act of 2009."

The Rural, American Indian Veterans Health Care Improvement Act will make it easier for many Native American veterans living in rural areas to access quality health care options. So many Native Americans have sacrificed and given their lives in service to this country throughout our Nation's history with the brave and honorable service of the Navajo Code Talkers being just one example.

In fact, the VA estimates that 22 percent of Native Americans are veterans or are currently serving, more than any other ethnic group. America has a sacred obligation to keep its promises to them. Too often Washington has not met that obligation and Native American veterans frequently struggle to get the benefits they have earned.

For instance, my district is home to 11 tribal communities spread out across an area larger than 26 States and yet it is served by only one VA medical center. Many veterans in Arizona who live on tribal lands have to drive for hours to get basic care. My bill directs the VA to establish Indian Health Coordinators in areas with a high population of Native American veterans.

These coordinators will work directly with Native American veterans to find innovative ways to improve outreach to tribal communities and help those veterans work with the VA. My bill would also explore common sense ways for the VA to coordinate with the Indian Health Service (IHS).

At the national level, the Secretary of Veterans Affairs would be directed to work with the Secretary of the Interior to streamline the electronic transfer of health records for Native American veterans between the VA and IHS.

At the local level, Indian Health Coordinators would work with their IHS counterparts to better serve the medical needs of veterans in tribal communities.

Finally, my bill would require a joint report by the Secretaries of Veterans Affairs and Health and Human Services (HHS) to find other methods to expand service to Native American veterans including through the establishment of new clinics.

My other bill, the Rural Veterans Health Care Improvement Act builds on the Rural, American Indian Veterans Health Care Improvement Act with an even more comprehensive effort at allowing veterans living in rural areas to access medical services.

The health care provided by the VA is undeniably among the best in the world, but that does little good to veterans in rural areas who have trouble making the trip to the clinic. This bill helps them address this challenge by making it easier and cheaper for veterans to actually get to VA health care providers. This bill would lock in the current health care travel reimbursement rate for disabled veterans at 41.5 cents per mile, up from 11 cents just a few years ago.

Further, it authorizes the VA to award grants to veterans service organizations that transport veterans to their appointments, making it possible for them to expand and improve these helpful services.

When I visited with our troops in Afghanistan last May, I was told time and again that our brave men and women need better access to mental health services. That is why this bill also expands peer support programs and allows the VA to cooperate with community providers already in place to ensure that those who need care can get it.

I believe that it is our Nation's sacred duty to pay back the eternal debt of gratitude we owe to our veterans, starting at the very moment a citizen signs up to serve.

As the daughter and niece of veterans, this is incredibly important to me personally and I am determined to push Washington to live up to its responsibilities. I believe that these two bills are important steps in the right direction.

I thank you again for this chance to discuss these measures and I stand ready to answer any questions you may have.

Mr. MICHAUD. Thank you very much, Mrs. Kirkpatrick. I want to thank all the panel members for bringing forward these very important pieces of legislation. I look forward to working with you as we move forward with markups later this year.

I have no questions for the panel. I understand neither does Mr. Brown, so I would recognize the Ranking Member of the Economic Opportunity Subcommittee, Mr. Boozman, who has done a phenomenal job, along with Chairwoman Herseth Sandlin, in that Subcommittee and I want to thank you for working very hard with our Congresswoman Herseth Sandlin to move forward legislation on your Subcommittee in such a bipartisan manner, Mr. Boozman?

Mr. BOOZMAN. Well, thank you very much, Mr. Chairman. First of all, I would like to introduce—I have three students here that have come by. They are up here trying to figure out how Washington works, which is kind of scary, but let me introduce them real quick—Kaity Dye, Christopher Jordan and Caleb McDaniel. And these are all students from Arkansas that are part of a program that is learning more about—I think it is so neat that they are here today in the Veterans' Affairs Committee because we hear so much about all the rancor that is going on here and the lack of working together, but truly in this Committee, it comes down to veterans and we are totally, Mr. Filner's left, but under his leadership and Mr. Buyer, who truly are committed to helping veterans and I appreciate your leadership on this Subcommittee.

I would like to just—you guys can go ahead and sit down. I know you have to go. Again, thank you for being here.

I would like to comment just briefly on Mr. Scalise's bill, H.R. 1075, and it brings to the forefront a very serious and important issue regarding how VA is providing care to veterans when a medical center is destroyed as a result of a natural disaster. Quite honestly in such cases, the entire VISN, not such that area but the entire VISN is impacted by the extra resources needed to provide fee basis care. It creates a shortfall for all of the medical facilities in the VISN. So I ask you when a disaster creates a need for a VISN to incur a substantial increase in fee basis care expenses, why that

money comes from the VISN's budget. I am really not directing that to you, Congressman. I guess that—again, this a problem that I am asking that question since this is something that we have to figure out.

The funding should come out of VA Central, the office budget, and I look forward to working with you, Steve, to see if we can maybe insert something or work with you with your legislation to really—we just have a number of different problems that are incurred as a result of these whenever incidents occur. So we look forward to working with you.

Mr. SCALISE. Thank you and I will continue to work with you and other groups. And I will commend—the Congresses over the last few years after Katrina have made a strong commitment to ensure that our VA hospital will be rebuilt and, in fact, the moneys have been appropriated. Unfortunately, there have been a lot of delays for a number of reasons why we haven't even still been able to break ground.

So at the earliest it would be 2013 before this new facility is going to be built and our veterans have been in limbo for almost 5 years now, and you know, the funding issues we will continue to work on. I understand there are some agreements now that are being put in place by the VA to at least provide some alternative sources of care in that interim. Unfortunately, some of those agreements didn't even occur for 4 years, and so this bill is just focused on making sure that the veterans are taking care of and can still get care without being shuttled around to other States in some cases, but not at the detriment of any other hospitals within the VISN. But clearly our commitment to making sure the rebuilding occurs is still strong. But in the meantime, we just want to make sure our veterans have somewhere to go to get that basic care and I will continue to work with you.

Mr. BOOZMAN. I agree with you totally. I guess, the problem is, is not only are you impacted in the New Orleans area by not having that facility, but your veterans' care throughout the entire State is impacted because instead of the money coming from the Central Office, it comes from all of our resources in the VISN, so it is kind of a two-edged sword. Not only are veterans impacted but your veterans in the rest of Louisiana and then Arkansas, the rest of the VISN, they are also impacted because instead of the money coming, like I say, from the Central Office, it is coming from the VISN, which is unfair. I mean, this is—

Mr. SCALISE. Right.

Mr. BOOZMAN [continuing]. This is not a VISN problem. This is a total—

Mr. SCALISE. It is a national problem.

Mr. BOOZMAN. It is a national VA problem, so, but we appreciate your leadership very, very much.

Mr. SCALISE. Thank you.

Mr. BOOZMAN. Thank you. I yield back.

Mr. MICHAUD. Thank you very much, Mr. Boozman, and the Veterans Equitable Resource Allocation model is another big issue that we have been trying to get a handle on and we will continue to look forward to seeing what we can do to improve on that model to

make sure that areas, especially rural areas, are not hampered in that effort, so thank you. Thank you very much.

Mr. Buchanan, do you have any questions for the panel before we dismiss them?

Mr. BUCHANAN. No.

Mr. MICHAUD. Once again, I would like to thank the panel for coming today and for bringing forward your legislation. I look forward to working with each of you as we move forward later on this year. So once again, thank you very much. And thank you for your dedication in making sure that veterans get the help that they need. Thank you.

I would ask the second panel to come forward, please. On the second panel we have Denise Williams from the American Legion, Blake C. Ortner from the Paralyzed Veterans of America, Eric Hilleman from the VFW, and Joy J. Ilem from the Disabled American Veterans. I want to thank all of you for coming here this morning. I look forward to your testimony and we will start with Ms. Williams.

STATEMENTS OF DENISE A. WILLIAMS, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; BLAKE C. ORTNER, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ERIC A. HILLEMANN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF DENISE A. WILLIAMS

Ms. WILLIAMS. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to present the American Legion's views on the several pieces of legislation being considered by the Subcommittee.

I will give oral comments on three pieces of legislation in the interest of time. H.R. 1075, timely and open access of quality care for veterans is a major priority for the American Legion and this legislation is consistent with our efforts in this regard.

The American Legion does, however, have some concerns. Although such contracts would certainly be helpful during a disaster in which VA medical facilities are not available, we do not want such an arrangement to become a disincentive for VA to quickly repair or replace damaged facilities. This bill also does not address length of the contracted care, long-term care or how quality of care would be assessed.

H.R. 3926, the "Armed Forces Breast Cancer Research Act." The American Legion fully supports this timely and important legislation given the recent breast cancer incidents among male veterans that were stationed at Camp Lejeune. Moreover, according to the Clinical Breast Care Project at Walter Reed Army Medical Center, there have been over 2,000 cases of breast cancer diagnosed in both males and female active-duty servicemembers within the last decade.

The Center further stated that breast cancer is the single greatest cause of cancer death among women under 40 and is a signifi-

cant cause of mortality for women in the Armed Forces. The American Legion would also encourage inclusion of the Reserve component in this study.

Proposed legislation to amend title 38 concerning mental health counselors.

The American Legion believes VA should be staffed with the best qualified professionals to ensure this Nation's veterans receive timely access to quality health care, especially mental health services. With servicemembers returning from Iraq and Afghanistan with complex and overlapping illnesses and injuries, it is imperative VA maintains its charge to ensure its medical professionals are properly trained and fully qualified to provide quality care. According to the National Institutes of Health, injuries and illnesses such as mild traumatic brain injury (TBI) and post-traumatic stress disorder respectively, have several symptoms in common. Among these are irritability, concentration deficits, amnesia for the causal event, reduced cognitive processing ability and sleeping disturbances.

Clearly, this situation adds to the difficulty in diagnosing PTSD in patients with TBI. The American Legion contends that due to the complexity of these illnesses and injuries, such as TBI and PTSD, the most qualified mental health professionals are required. Therefore, the American Legion is opposed to waiving current requirements relating to mental health counselors.

Mr. Chairman, once again, the American Legion appreciates the opportunity to address these issues and looks forward to working with your colleagues and the staff in advancing legislation that will make a positive difference in the lives of our servicemembers, veterans and families. This concludes my written statement and I welcome any questions that you or your colleagues may have concerning the American Legion's views, comments and recommendations.

[The prepared statement of Ms. Williams appears on p. 39.]

Mr. MICHAUD. Thank you very much, Ms. Williams.

Mr. Ortner.

STATEMENT OF BLAKE C. ORTNER

Mr. ORTNER. Mr. Chairman, Ranking Member Brown and Members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for this opportunity to present PVA's position on the legislation before the Subcommittee.

PVA generally supports most of the bills presented here today. In the interest of time, I will highlight details only for legislation with which we have specific issues.

PVA cannot support H.R. 84, the "Veterans Timely Access to Health Care Act," which would establish standards of access to care within the VA health system. PVA has testified on similar legislation in the past and is still unable to support it.

Under the provisions of this legislation, VA will be required to provide a primary care appointment to veterans seeking health care within 30 days of a request for an appointment. If a VA facility is unable to meet the 30-day standard, then the VA must make an appointment with a non-VA provider, thereby contracting out the health care service.

While access is indeed a critical concern of PVA, the number of veterans enrolled in the VA is continuing to increase. Unfortunately, funding for VA health care in the past has had difficulty keeping pace with the growing demand. Even with the passage of Advance Appropriations and the record budgets in recent years, funding is not guaranteed to be sustained at those levels. PVA is concerned that contracting health care services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care.

PVA is also concerned about the continuity of care. If veterans are shifted between the VA and non-VA facilities each time the imposed standard is not met, how will this affect the quality of care these veterans receive? This is neither an effective nor efficient way to supply health care and in the long run may be detrimental to the veteran. For these reasons, PVA cannot support H.R. 84.

PVA supports H.R. 949 introduced by Chairman Filner that will more quickly resolve adverse actions and set deadlines for final decisions and strongly supports H.R. 1075, the "RECOVER Act."

During periods of major disasters, ensuring veterans have uninterrupted access to health care is critical to their well-being. PVA would only caution that this arrangement should not inadvertently lead to delays in repairing or replacing VA facilities damaged during the disaster. More critically, this contracting authority should not become the default health care policy for meeting the needs of veterans in a disaster area.

PVA supports H.R. 2698, the "Veterans and Survivors Behavioral Health Awareness Act," and H.R. 2699, the "Armed Forces Behavioral Health Awareness Act."

While the scholarship provisions in the legislation are not targeted or reserved for veterans, PVA would encourage VA to market the scholarships to veterans who will best be able to relate to veterans visiting the Vet Centers or other facilities.

PVA supports H.R. 2879, the "Rural Veterans Health Care Improvement Act of 2009," and H.R. 4006, the "Rural, American Indian Veterans Health Care Improvement Act of 2009."

PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas and that Native Americans often face even tougher challenges. These rural veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through community-based outpatient clinics reflected the growing demand on the VA system from veterans outside typical urban or suburban settings.

However, while these paths may show promise, they should still fit within the policies that promote the use of VA facilities and should not be used as a method to eliminate VA facilities in rural areas. While all of these ideas are welcome, the greatest need still is for qualified health care providers to be located in rural settings. Only significant incentives and opportunities for these professionals will bring them to these often remote areas.

PVA strongly support H.R. 3926, the "Armed Forces Breast Cancer Research Act." With the growing number of women that com-

prise members of the Armed Forces and their increasing involvement in forward operating areas and combat activities, it only makes sense to examine the potential increased risk of breast cancer among this population.

Regarding the draft legislation before us today, PVA supports the legislation to raise the reimbursement rate for health professionals from \$1,000 to \$1,600 and cautiously supports the legislation to waive certain requirements relating to mental health counselors, but want to ensure that this is done only in the circumstances that will benefit veterans and VA health care.

Regarding collective bargaining, PVA generally supports the provisions of the draft legislation that would improve the collective bargaining rights and procedures for certain health care professionals in the VA.

VA must work with their employees to achieve a less hostile work relationship, but any changes or modifications to either side of the issue must first address the care of veterans. Furthermore, this care should not be used as a rallying cry on either side as an argument for their position. Veterans deserve better.

PVA appreciates the opportunity to comment on these bills being considered and I would be happy to answer any questions that you may have. Thank you very much.

[The prepared statement of Mr. Ortner appears on p. 41.]

Mr. MICHAUD. Thank you very much.

Mr. Hilleman.

STATEMENT OF ERIC A. HILLEMANN

Mr. HILLEMANN. Thank you, Chairman Michaud, Ranking Member Brown, Members of the Subcommittee.

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars and our auxiliaries, I thank you for the opportunity to testify before you today on the bills pending before the Subcommittee.

The VFW supports the draft bill for continuing education at Veterans Health Administration (VHA), of VHA staff. We also support the draft bill to improve performance pay and bargaining rights.

The VFW further supports H.R. 2698, the "Veterans and Survivors Behavioral Health Awareness Act," and H.R. 2699, the "Armed Forces Behavioral Health Awareness Act."

Further, VFW supports H.R. 2879, the "Rural Veterans Health Care Improvement Act of 2009," and we strongly support H.R. 3926, the "Armed Forces Breast Cancer Research Act," and we support H.R. 4006, the "Rural, American Indian Veterans Health Care Improvement Act of 2009."

If I may, Mr. Chairman, I would like to speak exclusively to our support for one piece of legislation that is of particular importance to the overall preparedness of the VA hospital network, H.R. 1075. This bill would require the VA Secretary to seek outside contacts in the event a VA hospital is closed for greater than 180 days due to a national disaster. Currently, when VA hospitals are closed, veterans must travel long distances to other VA facilities, which may be impractical or impossible following a disaster. This bill ensures that the VA secures alternative arrangements for local medical care to include non-emergency care and inpatient services.

The VFW supports this legislation. However, we feel 180 days is far too long for a veteran to wait for medical services. We urge the Veterans' Affairs Committee to hold hearings elevating VA's current disaster contracting provisions. Allowing a veteran to wait 180 days for medical care is unacceptable. Contracts to provide health care must be in place before a VA hospital shuts its doors due to a national disaster. The VFW believes that plans need to be implemented immediately in the event of disasters.

Now, moving on to H.R. 84, the "Veterans Timely Access to Health Care Act." The VFW supports the intent of this legislation, Veterans Timely Access to Health Care Act. However, we cannot support this bill.

This legislation would require the Secretary to contract for care for any veteran who would wait more than 30 days for primary care. The VFW has supported guaranteed access standards for VA health care for a number of years, but we remain concerned about the quality and the cost of care.

With the advent of advanced appropriations, VA now has the capacity to ensure the ability to properly plan and manage these dollars. Additionally, on-time funding should allow VA to recruit, train and hire doctors, nurses and other health care providers, ensuring that VA is sufficiently staffed to keep up with demand. Congress has made great strides in improving the stream of veterans' health care for which the VFW applauds your efforts, but a greater attention is needed to ensure health care dollars are spent appropriately in each medical facility.

We strongly support the reporting requirements in H.R. 84. The reporting mechanisms on wait times would help gain a better accurate measure by which to analyze wait times and access to care. Better numbers would allow us to understand the problems and prevent them in the future.

Moving on to H.R. 949, the VFW has no position on this legislation.

Finally, Draft Bill Waiving Requirements for Mental Health Counselors. The VFW opposes this legislation to allow the Secretary to waive licensure or certification requirements. The VA may be facing shortages of mental health professionals, but we believe making exceptions in lieu of valid State-issued certifications undermines the quality of care and the confidence that veterans have in speaking with VA mental health professionals.

State licensure and certification demonstrates that an individual meets the State requirements in which areas of prerequisite education and knowledge and is culpable under the law for any malpractice or abuse of the unique trust placed in that specific position.

Thank you for the opportunity to testify today, Mr. Chairman and we welcome any questions.

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

Mr. MICHAUD. Thank you.

Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman and Members of the Subcommittee.

DAV also appreciates the opportunity to offer our views on the bills under consideration today.

The stated goal of H.R. 84 is to provide timely access to VA health care. Under this bill, if VA failed to substantially comply with the 30-day standard, the facilities in that area would be required to contract for care.

DAV has always had concerns about automatic contracting of VA care to solely meet access standards. Those patients lose the quality, safety and other protections VA provides in its specialized medical programs. Additionally, we have stressed the need for VA to develop a comprehensive and systemwide process for contract care to ensure the quality of care of veterans seen by contractors is on par with that provided to veterans using VA.

While DAV does not support the automatic contract for care mechanism in this measure, we would endorse an amendment to H.R. 84 to enact data and reporting requirements of the bill. We also recommend adding provisions to identify the underlying causes for any current delays in access to VA care, an issue that is critical to VA's developing an effective solution to reducing and managing minimum waiting times.

H.R. 949 seeks to restore bargaining rights for certain VA health professionals. As a partner organization in *The Independent Budget*, DAV endorses the need for VA to address employee's concerns about their working conditions to make VA a better workplace for the best care of sick and disabled veterans. For these reasons, we support the intent of the bill, but continue to urge both VA and Federal unions to seek and find a basis for compromise on these issues.

I was pleased to see in VA's testimony this morning that a workgroup has been established to address the specific issues included in the bill. This appears to be a positive step forward and we are hopeful this process will lead to an agreement that is acceptable to both sides and one that keeps the focus squarely on the best interest of veterans' care.

H.R. 1075 requires that in the event of an officially declared disaster where a VA medical center is unable to provide inpatient care services for at least 180 days, VA must contract with one or more non-VA facilities in that area to provide those services.

This Subcommittee is aware of DAV's general cautionary position on contract care. However in the case of a significant disaster with long-term consequences in the affected area, VA should establish more temporary contracts with private facilities outside the affected city area for inpatient services. For this reason DAV supports the purposes of this bill as a contingency only and we recommend the issues related to improve contract care coordination be addressed before the bill advances.

H.R. 2698 aims to improve and enhance mental health care benefits available to all veterans, as well as to enhance counseling to survivors of veterans. In the fiscal year 2010 *Independent Budget* section on human resource challenges, we recommend that Congress, and VA work to strengthen and energize its human resource management programs to recruit, train and retain qualified employees. Therefore, we support enactment of section 2 of the bill

pertaining to health professional scholarships. We have no objection to the remaining provisions in the measure.

H.R. 2699 would make certain active servicemembers eligible for readjustment counseling in VA Vet Centers and enhance counseling available to their family members. We support a seamless transition for servicemembers to veteran status and improved collaboration between the two Departments. Therefore, we have no objection to this bill.

However, we ask the Subcommittee to consider amending section 2 of the measure to require cost sharing with DoD or to authorize additional VA resources needed to provide these services to active duty personnel.

H.R. 2879 with some concern outlined in our full statement, we support enactment of this bill in accordance with DAV's resolutions related to VA's beneficiary travel reimbursement policy and improving rural care services and access.

H.R. 3926 would direct the secretaries of DoD and VA to jointly conduct a study on the incidents of breast cancer among members of the Armed Forces and veterans. We support the passage of this bill in accordance with DAV resolution 252 which urges greater collaboration between DoD and VA to share exposure and related data for military operations in order to address the subsequent health concerns of disabled veterans, whatever the causes.

DAV also supports H.R. 4006, the "Rural, American Indian Veterans Health Care Improvement Act of 2009." Studies indicate this population reports high rates of unmet need, fragmentation of care and an overall lack of health care coordination.

The intent of this bill appears beneficial to help resolve the unique health care issues of this population. The DAV has no adopted resolutions specific to the final three draft measures under consideration, but offer no objections to these draft bills.

Mr. Chairman, that concludes my statement. I am happy to answer any questions.

[The prepared statement of Ms. Ilem appears on p. 47.]

Mr. MICHAUD. Thank you very much for your testimony, as well as the other three panelists.

I guess I have just one question. You spoke about VA working more collaboratively with DoD to study breast cancer. It is my understanding that the VA currently has nine ongoing studies on breast cancer and I believe they have already completed three studies.

Do you agree with the VA that they have to conduct broader studies rather than studying breast cancer in the way that is in the legislation? We will start with Ms. Williams.

Ms. WILLIAMS. I think there needs to be definitely more study, especially with the servicemembers on active duty that are returning. I am not exactly sure about the studies that are ongoing in VA regarding—maybe my fellow VSO members are aware of that. But we would support the DoD conducting studies because of the data that we received from Walter Reed regarding the breast cancer incidents.

Mr. MICHAUD. I don't know if any other—

Mr. ORTNER. Mr. Chairman, I think that the need for expansive studies, especially in the case of breast cancer is critical. I am not

so sure, necessarily looking and saying, well, there are nine studies ongoing, therefore, enough is being done simply because of the wide variety of studies that can be done, specific instances of studies. For instance, there may be a number of studies facing just women with breast cancer and not the incidence of men because that is an unusual or becoming for usual, but an unusual case, so I still think there is need for that legislation.

Mr. HILLEMAN. Mr. Chairman, our remarks would concur with both previous statements. I am not personally familiar with the number of studies or the studies' details, but this study being both broad and including DoD and VA seems like a logical thing to pursue.

Ms. ILEM. I would ask if any of those studies include the data information that is in the bill you are considering with regard to toxic environmental exposures and troop locations in those areas or if it is just breast cancer incidents within the veteran community because I think that would be critical. I mean, we hear more and more about burn pits and these other possibly toxic exposures that veterans are facing returning. And so it would be proper to, I think include that.

With your reference to VA making this broader and not just specific to one disease, it is noted in their testimony. I think, you know, we would like to see, surely VA tracking any sort of trends that should occur within the veteran population that may be related to these toxic exposures and the different environments that veterans are facing in these deployments. So that takes the greater collaboration of both agencies to be able to do that to avoid what happened in the Gulf War with regard to, you know, ongoing studies and the concern over health, subsequent health concerns. Thank you.

Mr. MICHAUD. Thank you. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman. First of all, I want to thank you all. We have had a number of Members offer suggestions as to how we can improve the VA situation, and as always, your all's testimony in perspective is such that what we all work toward is preventing unintended consequences of good ideas.

But H.R. 84, trying to deal with a problem that we have been dealing with forever, the lengthy waiting times. I guess my question for the panel would be, we all know this is a problem. Is there a way, do you feel like we could amend H.R. 84 in some way to make it such that waiting times are more appropriate? I know that some of you have expressed concern about the particular bill.

What could we do in your mind to go ahead and make it such that we could whittle these times down even further?

Ms. ILEM. I will take a stab at that. I think Ms. Brown-Waite made some very important points in her remarks this morning. Obviously, she is very committed to trying to address this problem and resolve it. One thing that I think we would probably like to see would be to make sure that we get accurate waiting time information from VA, which has been addressed and she mentioned the Inspector General's report and their recommendations so that we really have an accurate view across the system, as well as where are there specific target areas that really are having some access issues.

Additionally, I think we would want to have provisions in that bill that really get at what, you know, what are the real problems for this. We just don't see the benefit of sending people outside the system that may be more costly care. VA can do it in emergencies or if medically necessary and they can't get someone seen in a timely manner. They already have that authority and we would like to see VA take care of those patients so they have all the benefits of the system and find out where these waiting time issues are and if that needs to be addressed in terms of the advanced appropriation, better planning and that type of outcome versus just for having them go outside the system.

Mr. HILLEMAN. If I might, Mr. Boozman, from a personal experience, it seems that hospitals develop solutions for bottlenecks in care. I seek treatment here in Washington, DC, and I have experienced after hours of appointments for MRIs and other bottlenecks within the system where appointments can't be made in within 30 days, but I have also had the adverse experience that in a 30-day referral, I couldn't get an appointment.

There are some creative solutions that can happen locally, but I feel, and I would think that most of the organizations would have a similar approach that we can't solve problems unless we understand them first.

So a comprehensive study would be something the VFW would definitely support.

Mr. ORTNER. Sir, like all the comments of my colleagues, unfortunately when we look at this, we think the idea of setting the 30-day standard and then sending someone off to contract care is too simple an answer. It seems like the easy answer and a simple way to do it.

Our greatest concern has to do with a second and third order of facts of what that leads to. Does that then become the standard answer, hey, if we get backed up, we are going to go ahead and contract it out. But more importantly, I think, especially from PVA's standpoint, the concern about the continuity of care for our members. I know, personally, I don't like going to a different doctor. I go to my doctor. I drive a long distance to get my doctor because of that.

My concern would be if we do have, if we do have this ability to contract it out, unless you are all of the sudden going to decide that individual is now going to be contracted to a different provider indefinitely, he is going to be jumped back and forth between the system and we think that is just too much of a risk to the veteran.

Ms. WILLIAMS. The American Legion, we did state that we support this bill and that is because when we look at the overall legislation, we felt like this would give VA an opportunity to have a comprehensive view of the issue with timely access to care.

So if it is enacted, our major concern is with timely access to care. So if they do enact it, we would like for VA to utilize this as a means to examine the long wait time for veterans to receive care.

Mr. BOOZMAN. Thank you. The other thing—can I do—I guess I worry a little bit also, yeah. I alluded to this with the situation that we have in New Orleans where the VISN becomes responsible rather than district-wide, so you might have a VISN where, and you correct me if I am wrong, but you might have a VISN where

you have a problem and you don't who knows why that problem is, and then you might have a very efficient group within that VISN, too.

But theoretically, the entire VISN would pay for that contracted care. Is that correct? I mean—is that, would that be correct back there? It wouldn't? So it would come out of the system versus the VISN? Okay, good. Very good.

Thank you guys, again. I really do appreciate your perspective on these things. Thank you.

Mr. MICHAUD. Mr. Perriello or Mr. Brown.

Once again, I would like to thank you for your testimony today and I look forward to working with you as we move forward with these individual bills. Thank you.

I would ask the third and final panel to come forward, Dr. Cross, who is accompanied by Mr. Hall, Mr. McVeigh and Ms. Vandenberg from the VA.

Once again, I would like to thank you, Dr. Cross, for all the hard work you and the other panelists do to make sure that our veterans get the help that they are entitled to and deserve and your dedication to our veterans is to be commended. So, without any further ado, Dr. Cross.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, DEPUTY CHIEF FOR PATIENT CARE SERVICES AND CHIEF CONSULTANT FOR PRIMARY CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; BRIAN MCVEIGH, CHIEF CONSULTANT, HUMAN RESOURCES MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND PATRICIA VANDENBERG, MHA, BS, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. And thank you, Mr. Chairman and the Committee for the great work that you do and your dedication as well.

Good morning, Mr. Chairman and Members of the Subcommittee. It is a pleasure to appear before you again today to discuss legislation. I am accompanied by Walt Hall, Assistant General Counsel; Brian McVeigh, Chief Consultant, Human Resources Management; and Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning.

I would like to concentrate my remarks today on the three areas covered by this legislation, first, VA's human resource policies, including work with our union colleagues. Second, our efforts to improve care for rural veterans, and finally, our work to improve counseling and mental health access.

We appreciate the many positive contributions, collective bargaining and labor management partnership make to VA's mission. VA and its labor partners signed a charter in September of 2009 to develop recommendations for the Secretary to improve knowledge, understanding and consistent use of the authorities and limitations in section 7422 of title 38.

The workgroup consists of representatives from VA's five national unions and VA's lead representative is the new Assistant Secretary for Human Resources in Administration. We anticipate this workgroup will resolve the concerns that are the basis of H.R. 949. However, we strongly oppose H.R. 949. It would make patient care and clinical competency decisions subject to the review of non-clinical third parties, parties without health care expertise.

We believe that the collaborative efforts of VA and its union partners in the workgroup can address the concerns about the interpretation and application of section 7422. Until such time as those efforts have been given an opportunity, we believe that legislative changes to section 7422 are premature.

VA also does not support the draft bill that would require VA to reimburse all title 38 health professionals for up to \$1,600 per year for their continuing medical education requirements. The bill would, of course, be costly, diverting resources from the veterans health care and we believe is unnecessary. VA has no objection to the draft bill that would create an exception to allow VA to employ mental health counselors who have not yet completed their licensure or certification requirements.

We know that VA currently has a parallel statutory authority to appoint psychologists and clinical social workers who work under supervision for up to 2 years before they have completed their licensure or certification.

Regarding our efforts to improve care and access for rural veterans, VA has initiated a number of programs that meet the intent of H.R. 2879 and H.R. 4006. We have established three Veterans Rural Resource Centers and a Veterans Rural Health Advisory Committee to improve care and services for veterans residing in geographically isolated areas. The centers are operational and are conducting important work, which my written statement describes in greater detail.

VA also is developing pilot programs to implement innovative transportation services at various rural health care facilities and is supporting cooperation and resource sharing between the Indian Health Service and VA. Moreover, we are undertaking pilot programs at the direction of Congress in section 107 and 403 to Public Law 110-387, which will provide millions of dollars to support expanded fee-basis care in rural areas.

VA believes it is more appropriate to evaluate the results of this pilot projects before beginning new initiatives so that we can ensure resources are best used to serve veterans.

Furthermore, VA's enhancing assistance for family members. The Vet Center Program, for example, is taking steps to enhance access for veterans' families by hiring the additional staff necessary to place qualified family counselors in every Vet Center. And when it is necessary for their rehabilitation and treatment of the veteran, VA provides education and training prior to the veteran's discharge from care to ensure that family members can tend capably to the veteran's health care needs.

The final area I would like to discuss includes our efforts to improve our counseling and mental health programs. Specifically, VA supports section 3 of H.R. 2698, which would direct VA to provide

referrals, to assist individuals not otherwise eligible for VA services in obtaining mental health care and services outside VA.

In advising such individuals of their rights to apply for review of their discharge or release, this would specifically help former servicemembers with problematic discharges.

VA appreciates the concept of using scholarships to enhance succession planning, but section 2 of H.R. 2698 is unnecessary. Implementation of this provision would result in substantial costs to VA over a long period of time with very little short-term benefit. It takes 2 to 7 years of education to qualify to become a VA behavioral health specialist. VA recommends reauthorization of the Health Profession Education Assistance Scholarship Program instead, as this program would be more effective and include more disciplines. Moreover, VA has had great success in hiring new counselors. In the past 3 years, VA has hired more than 5,800 additional mental health counselors.

This concludes my prepared statement, Mr. Chairman. We would be, of course, pleased to respond to any questions that you have.

[The prepared statement of Dr. Cross appears on p. 57.]

Mr. MICHAUD. Thank you very much, Dr. Cross. I appreciate your testimony.

What is your understanding of the current status of the Indian Health Service's electronic health care records, their capacity? Is it the same capacity as in the VA system?

Dr. CROSS. My understanding is that we are going for the broader solution, working with something called National Health Information Network (NHIN), which is our strategy to move forward, not just within VA and IHS or VA and DoD, but more broadly with our community partners as well. This is more of a national strategy going far beyond what we have looked at in the past. I think that we have testified on that to some degree before, but I think the strategy to engage with them is really part of that broader strategy.

Mr. MICHAUD. Thank you. And what about with breast cancer? We heard some discussion about working with DoD and I know that there are nine ongoing VA studies and I think you have completed three. How comprehensive are those studies?

Dr. CROSS. First of all, we understand the importance and the sensitivity of this subject. We are absolutely committed to getting every bit of research done that would be beneficial to our veterans. And by the way, the research that we do helps not only our veterans but the Nation at large.

We do have about nine studies underway, working through some remarkable issues that will, I think, produce dramatic outcomes, I hope, down in years to come where, particularly regarding the DNA component of this, genes and so forth, that we are working on.

My understanding is that we have done some studies in the past on prevalence and I would be happy, you know, if the Committee prefers, to provide those for the record. But I don't want anything that I say to show any lack of concern or lack of intent to pursue this issue. We are very much committed to try and help be part of the solution for this problem.

Mr. MICHAUD. And I appreciate it. I think sometimes Members of Congress and VSOs might not know all the work that the VA is doing in these different areas, so I would be interested. If you would submit that to the Committee, I would appreciate it very much.

[The VA subsequently provided the following White Paper regarding studies done in the past by VA's Office of Research and Development (ORD) on breast cancer.]

Short Descriptions of ORD Breast Cancer Studies

Cell-Cell Interactions During Breast Tumor Angiogenesis: Role of NRP-1

Metastatic or spreading breast cancer requires a pathway to allow escape of the breast cancer cells from the breast into the general circulation and then potentially to all tissues. This proposal will delineate the mechanism whereby proteins made by the breast cancer effect changes in the vascular smooth muscle that allow the cancerous cells to escape from the breast. Understanding how these proteins effect changes in the blood vessels surrounding the cancer will provide potential targets for various therapy modalities, such as chemotherapy or using the immune system to block the action of these proteins.

The Roles of WISP-2/CCN5 Signaling in Breast Cancer Development

This project will use non-invasive human breast cancer cells to identify the mechanism that leads to inhibition of apoptosis or programmed cell death. Once the components of the mechanism are identified then it will be possible to identify inhibitors of one of these components so that apoptosis or regulated cell death in the cancerous cells would be stimulated and thereby reducing the number or possibly even eliminating the cancerous cells.

The Role of CCN5 in Breast Cancer Progression

Breast cancer cells transition from non-invasive (non-metastatic) cells into invasive or metastatic cells. A key element of the transition, which requires estrogen, will be further characterized in the hopes of developing another target for various therapeutic approaches.

Estrogen Receptor Regulates c-Jun Activity in Breast Cancer Cells

Estrogen receptor is known to play a significant role in the development of breast cancer. The investigator has identified a protein, phosphorylated (the addition of a PO₄ moiety from Adenosine triphosphate (ATP), the molecule generated from the breakdown of nutrients) c-jun, that becomes blocked from its normal action when estrogen receptor has been activated. When c-jun action is blocked, the cancerous cells multiply instead of dying (apoptosis), which results in the growth of the cancer. This study will determine the mechanism to unblock this protein, which would allow cancerous breast cells to undergo apoptosis or death instead of being stimulated to grow.

Estrogen Receptor, p38 MAPKs and Topo IIa in Breast Cancer

There are various receptors on the outer membrane of breast cancer cells that are activated when they bind a receptor-specific activator or ligand. Many of the receptors in breast cancer cells are tyrosine kinases or enzymes that are responsible for phosphorylating (putting the terminal phosphate (PO₄) from ATP onto a protein) specific tyrosines (an amino acid) in other proteins. These tyrosine phosphorylated proteins then mediate the transformation of a normal breast cell into a cancerous breast cell. There have been several clinically useful therapies based on inhibiting these receptors. However, as time passes the receptor is no longer inhibited by these treatments. This leads to renewed growth of the cancer. This proposal will test the idea that another receptor protein kinase can make the breast cancer cells more sensitive to the chemo/immuno-therapeutic agents, which would restore their ability to inhibit the growth and spread of the cancerous cells.

STATs as Key Targets in Tumor Angiogenesis

Growth and progression of breast cancer depends on the formation of new blood vessels (angiogenesis) to bring the blood nutrients and oxygen to the cancer. Cancer cells secrete several growth factors that recruit blood vessels from the surrounding tissue. Therefore, it is plausible that targeting blood vessel growth could be an effective cancer treatment approach. Recent clinical trials have shown that drugs designed to inhibit a vessel-inducing factor slow down tumor growth and prolong sur-

vival; unfortunately, blood vessels growth eventually resume that leads to resumed growth of the cancer. This proposal will focus on identifying inhibitors of several growth factors with the intent of using multiple inhibitors at one time to inhibit angiogenesis to the point that the tumor either dies or becomes much smaller because there is a lack of nutrients and oxygen needed for breast cancer to grow.

Targeting the COX-2 Pathway to Reduce Breast Cancer Mortality

Cyclooxygenase 2 enzyme, commonly known as COX-2, is highly enriched in breast cancers and treatment with COX-2 inhibitors limit breast cancer growth and metastasis or spreading to other tissues. However, COX-2 inhibitors have recently been shown to have cardiac toxicities, which limit their use in patients with breast cancer. One of the major compounds generated by COX-2 is prostaglandin. Prostaglandin is a major regulatory agent and it mediates many physiological processes such as blood clotting. Prostaglandin mediates its numerous physiological effects through interacting with prostaglandin receptors. This proposal will identify which of these receptors activates breast cancer growth. Once identified, the next step will be to find inhibitors of this receptor, which should reduce the growth of breast cancer.

Targeting Breast Cancer Metastases: Role of Chemokine Heparanase

The principal goal of this study is to investigate a possible genetic influence on the development of secondary lymphedema (LE) in breast cancer survivors. Lymphedema or swelling of the lymph nodes and lymphatic vessels in breast cancer survivors leads to swollen arms, discomfort and skin infections. This occurs because mastectomies can remove the normal pathway for the lymph to return to the general circulation. The question is of great importance, for if a genetic predisposition to secondary LE can be identified, therapy may be better tailored for patients or they can be made more aware of possible complications. Improved care of breast cancer survivors is of great significance.

Quality of Locoregional Breast Cancer Treatment for Breast Cancer in VHA

The immediate objectives of this multi-year retrospective study are: 1) To determine if the quality of surgical care provided for women with locoregional breast cancer in the VA is comparable to that provided in the private sector; 2) To identify factors within the VA system that are associated with quality of care (process and outcome measures) for locoregional breast cancer; and 3) To provide policy recommendations regarding how to improve the quality of treatment based on the results of this analysis. Ultimately, our long-term goal is to improve patient outcomes for women veterans with breast cancer.

Regulation of Breast Cancer Growth by MLK-3

A protein kinase (MLK3), an enzyme that phosphorylates another protein, has been discovered to be highly active in breast tumors and is involved in the activation of another protein (Pin1), which has previously been implicated in breast cancer pathogenesis. The project will investigate the mechanism by which MLK3 regulates Pin1, and will examine the application of MLK inhibitors as potential therapeutic approach for breast cancer treatment.

CARP-1: A Potential Therapeutic Agent for Breast Cancer

This study will further characterize how the cell cycle and apoptosis regulatory protein 1 (CARP-1) inhibits transformation of normal to cancerous breast cells. Elucidation of the mechanism of action of CARP-1 will provide specific targets to be used in the design of chemotherapeutic agents. These agents will provide additional means to limit the growth of breast tumors.

Actively Targeted Nanoparticulate Paclitaxel to Treat Breast Cancer

The proposed studies will develop nanoparticles containing Paclitaxel, a breast cancer chemotherapeutic agent. These nanoparticles will be specifically designed to enter only breast cancer cell. This will allow the delivery of higher doses of Paclitaxel without having harmful effects on normal cells throughout the body. Furthermore, this specificity will allow for much longer treatment times, which greatly increases the likelihood of arresting the further growth of the cancer and maybe even killing all of the cancerous cells.

Identification of Breast Cancer Genes in Archival Pathology Specimens

Normal breast epithelial growth and differentiation, benign proliferative growth and breast cancer are each under the complex control of various growth factor genes. This study will systematically investigate inherited genetic variation within these genes for their contribution to breast cancer risk among women with a history of benign breast disease. The combined genetic and pathological predictors of ele-

vated breast cancer risk identified in this study will enable the identification of those women who would most benefit from more intensive screening, those who may be at increased risk associated with hormone replacement therapy or those who may benefit from prophylactic therapeutic agents to alter the function of the estrogen receptor.

Mr. MICHAUD. You heard earlier testimony about what happens when a disaster strikes. Could you tell us exactly what happens when a disaster hits? How does that region get funding, if need be, from the Central Office to deal with it then and how do you cope with the disaster and how do you help veterans get care, if they do lose a hospital? How quickly can you gear up to take care of those needs?

Dr. CROSS. We don't have today, as a Department, formal comments on H.R. 1075, but I can certainly comment on what happened during Katrina and how we respond to that and those two elements that you talked about.

First of all, in regard to funding, certainly we first look to the VISN for their support when we have hurricanes and so forth, but if there's a large disaster such as a Katrina, certainly the rest of the organization comes into play and the Central Office typically has maintained a reserve fund just for this kind of situation where there is a disaster of unusual proportions to come to the rescue with funding from Washington.

In regard to New Orleans, I wanted to mention that we do have a program there working with one of our community partners, Tulane University, to provide hospital care, and we have been doing that for a long time. Our average daily census there is about 18 or 19 patients right now. And by the way, we have a floor and our staff go over there and take care of the patients as inpatients.

In regard to the concept, there's something called hospital in a hospital and we used this as a solution, a partial solution after Katrina to help maintain continuity of care and also to have a familiar face and the same kind of technology systems that VA is already famous for to continue that care even in that setting. Certainly we are looking forward to our new hospital there as well.

Mr. MICHAUD. Thank you. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Dr. Cross, are you planning to replace the hospital in New Orleans in the location where it exists now?

Dr. CROSS. Sir, I will provide that to you for the record. I don't have that in my testimony today, but I understand great progress is being made and the funding worked out and I think everybody that I am aware of at my office is very optimistic about how this is going to move forward.

Mr. BROWN OF SOUTH CAROLINA. I know you weren't here during that time. I know this is not part of the discussion, but it did come up because of the way the payments are going to be handled for lack of service; I went down with the Secretary at that time right after Katrina, and the hospital itself was in good sound condition, but what happened, was the water got into the basement and that is where most of the utilities, the air conditioning and so forth were. But it looked to me if that could have been pumped out and the air conditioning units repaired, that could have saved all that

mold that accumulated. But a veteran asked a question, if it was going to be torn down and replaced by new construction.

Dr. CROSS. Yeah, it is a different site, but I would rather give you a written response on these.

[The VA subsequently provided the following information:]

The new hospital will not be in its existing location. VA has selected a site in Mid-City New Orleans. The architect submitted the design development package of the new medical center in February 2010. As required by section 106 of the National Historic Preservation Act, consulting parties met to discuss the design. A detailed, site-specific environmental assessment (SEA) in compliance with the National Environmental Policy Act requirements was completed on March 31, 2010. The Notice of Availability for the Finding of No Significant Impact and the SEA were published on April 4, 2010. The New Orleans City Council approved revocation of rights-of-way for the streets within the site boundaries on April 22, 2010. VA obtained ownership of the Pan-Am building on June 3, 2010. VA's designers have completed the HazMat survey of the Pan-Am building and are preparing abatement plans to incorporate into construction documents for the building renovation.

Negotiations continue among the City, State and VA to expedite the acquisition process and mitigate further delays. A groundbreaking ceremony was held June 25, 2010.

Mr. BROWN OF SOUTH CAROLINA. Okay.

Dr. CROSS. That plan for the old facility. You know, there are other issues, as well, regarding that facility, the design, the changes that have taken place in medical care to better meet the needs of veterans currently in a more modern approach, you know, so much more now the VA highlights outpatient services and doing things like same-day surgery and those kind of things, more so than we did when that facility was built.

Mr. BROWN OF SOUTH CAROLINA. And I guess if I could maybe even do a little special ad for my location in Charleston. We have been trying to do something to make some accommodations between the VA and the medical university there; and it is, you know, VA hospital is basically the same existing thing, and we at Charleston are certainly prone to hurricanes, we had Hugo back about 20 years ago if Hugo would hit in direct strike to Charleston, we would have been in real trouble; that is what we are trying to do now is to be proactive so we could have some cross sharing between the VA and the medical university just as a backup.

I know down in New Orleans all those hospitals were in very low lying regions and I guess most of all the rest of those hospitals are going to probably be replaced, too. But my question in line with that is, I know that it sounds pretty simple to say if you can't provide service within 30 days, then we need to move into some kind of a private practice, but recognizing the opposite of doing that, all the records have to be transferred and a lot of times—I know just in my personal case where I go from one doctor to another doctor, they have to do a little bit of catch up procedures, too, to be sure that they have everything in—so it is not as easy to just implement it.

But in light of that, who pays for it? Do you all have a national pot of money that would handle that or would that hospital be responsible for those charges or would the VISN be responsible?

Dr. CROSS. The local facility would bear some responsibility in terms of trying to practice efficiently in covering those expenses, in-

cluding the fee-basis care but that is part of our overall appropriation for fee-basis care that we spend every year.

Let me comment on what you said earlier, sir. From my understanding first of all, the 30 days, our true objective is to give the patients care when they need it, when they want it, and to not be so arbitrarily focused on a number of days. I think that is good medical care and that produces better satisfaction.

And by the way, in regard to mental health care, we have a 15-day standard for new patients, and so we have already moved beyond 30 days in that category because we understood the challenges facing our veterans.

So for a new patient seeking mental health care, we do an evaluation within 24 hours, 7 days a week. That may be by phone, but we do some evaluation to check on them and see how acute their need is. And then we get them a comprehensive evaluation within that 15-day period.

Mr. BROWN OF SOUTH CAROLINA. I tell you what. I want to compliment you for the VA hospital in Charleston. It certainly gives a great service to the veterans in our community.

Dr. CROSS. Thank you.

Mr. BROWN OF SOUTH CAROLINA. I thank you all for being part of this discussion today.

Dr. CROSS. Thank you, sir.

Mr. MICHAUD. I know the VA works with other agencies. For instance, on nursing homes, you work with CMS in other areas, we have asked you to work with the Department of Health and Human Services on federally qualified health care clinics and there are overlays where the care has recommended certain access points.

My question is particularly in light of the new health care legislation that was passed this past Sunday, in dealing with other agencies, in this particular case Health and Human Services, how collaborative have they been and do you find that they are holding you back on issues that this Committee and other Committees might have asked the VA to look at? If you saw some of the bills we have before us today, they concern health access issues in rural areas. I think that is part of the slow process in getting access points up and running under the Capital Asset Realignment for Enhanced Services (CARES) process.

So how much delay is there, or is working with other agencies not really a problem?

Dr. CROSS. No, sir, I don't think we have any problem at all really working with other agencies, you know, whether it be HHS or DoD. I have often commented that I am absolutely surprised at the degree of intense engagement and very collaborative engagement that we have with DoD. We see the same patients at different parts of their lives, and I think people would be very pleased if they could see all the meetings and all the collaboration. I know my counterparts on a first name basis. We meet together so frequently. We share committees together. We cochair committees together. We work through so many issues together.

I think you should be well pleased that there is a great deal of work at my level and many other levels in a very collaborative framework with DoD, IHS and so forth. The head of IHS was in

my office just a few months ago talking about what we can work on together and we have already started a project. It regards our Suicide Prevention Hotline, and we have arranged for the Indian Health Service staff to train my staff at the Suicide Prevention Hotline on cultural sensitivities dealing with Native American and American Indian veterans.

I think that there were a few things that we were missing and just talking to her educating me about some terms that I may use or our staff may use, they have different meanings to them than it does to us. And so we have already started that program working with the National Suicide Prevention Hotline to make sure that we are very sensitive to their needs. That is an example of the kind of collaboration that we have been working on.

Mr. MICHAUD. Once again, thank you very much. I really appreciate all the hard work and dedication that VA employees give to our veterans and look forward to working with you as we move forward with these pieces of legislation we have before us today and other issues before this Subcommittee, and ultimately full Committee. Once again, Dr. Cross, thank you, and the panels for coming here today. I really appreciate it.

If there are no other questions, I will adjourn this hearing.

[Whereupon, at 11:36 a.m. the Subcommittee was adjourned.]

A P P E N D I X

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

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, 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. This is an important part of the legislative process that will encourage frank discussions and new ideas.

We have a number of bills before us today. They cover a wide range of important issues dealing with access to VA health care; collective bargaining rights for VA employees; mental health care and counseling for individuals discharged or released from active duty; emotional and peer support for family members of the Armed Forces; breast cancer among members of the Armed Forces and veterans; and rural health including the unique needs of Native American veterans. We also have draft bills before us today on reimbursements for continuing education, mental health counselors, and bargaining rights and performance pay criteria.

I look forward to hearing the views of our witnesses on this bill before us.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you Mr. Chairman. I appreciate you holding this legislative hearing today and I look forward to working with you and the rest of our esteemed colleagues on these important legislative subjects.

The ten bills being discussed this morning cover a wide array of veteran's issues and I look forward to learning more about them.

Of particular interest to me is H.R. 1075, the RECOVER Act, introduced by Mr. Scalise. H.R. 1075 would provide medical services to veterans in a disaster area by allowing the VA to contract with one or more non-VA facilities. Making sure our veterans have access to the very finest care is always the top priority of this Committee, but—in times of real emergency—that priority takes on a whole new level of importance. Serving a district with facilities that are vulnerable to the sometimes destructive whims of nature—as I do in Charleston and along the coast of South Carolina—makes this a personal issue for me and I support Mr. Scalise in his efforts.

I am also excited to hear more about H.R. 84, the Veterans Timely Access to Care Act, introduced by my friend Ms. Brown-Waite. Among other provisions, this bill would make the standard for access to care for a veteran seeking primary care from the VA 30 days from the date the veteran contacts the Department. Ms. Brown-Waite has long been committed to making sure America's veterans do not have to endure long waiting periods before they can access VA care and I applaud her efforts.

To all of the witnesses appearing in front of us this morning—thank you for your dedication to improving the lives of our veterans. Your work does not go unnoticed and I am eager to begin our discussion on the matters at hand.

It is only by working together to advance meaningful and appropriate legislation that we can completely fulfill the promise we made to provide veterans with the "best care anywhere." The men and women who served so bravely in uniform deserve nothing less.

Again—thank you, Mr. Chairman. I yield back the balance of my time.

**Prepared Statement of Hon. Bob Filner,
Chairman, Committee on Veterans' Affairs,
and a Representative in Congress from the State of California**

Chairman Michaud, thank you for the opportunity to testify before the Subcommittee on Health on H.R. 949, a bill that would improve the collective bargaining rights and procedures for reviews of adverse actions of certain VA employees.

This bill is all about ensuring equity among the health care professionals employed at the Department of Veterans Affairs so that VA providers such as doctors, nurses, dentists, chiropractors, optometrists, and podiatrists who are hired under the "pure title 38" system have the same rights as their fellow VA health care professionals who are hired under different hiring systems.

Without this bill, "pure title 38" providers do not have the right to challenge errors in pay computations and lack other key bargaining rights enjoyed by their colleagues at the VA.

To address this problem, H.R. 949 would clarify that these "pure title 38" providers have equal rights to collective bargaining. This means that they would be able to challenge personnel actions through such methods as grievances, arbitrations, and labor-management negotiations.

My bill would also require the VA to review the adverse personnel action and issue a final decision, no later than 60 days after the employee appeals the adverse personnel action.

Finally, H.R. 949 would subject the VA's final decision on the employee appealed adverse personnel action to judicial review in the appropriate U.S. District Court or the U.S. Court of Appeals for the Federal Circuit.

I recognize VA has concerns and I am looking forward to working with them and other stakeholders as we move forward on this piece of legislation.

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

**Prepared Statement of Hon. Steve Scalise,
a Representative in Congress from the State of Louisiana**

Thank you, Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee.

I appreciate the opportunity to testify before your Subcommittee on my bill, H.R. 1075. This bi-partisan legislation, with nineteen cosponsors, seeks to maintain vital health services to veterans in the event that a VA hospital is closed due to a federally declared disaster. Before I begin discussing my bill, I'd like to also thank you for your service on the Veterans' Affairs Committee, and for the work you do on behalf of our Nation's veterans.

The welfare of our veterans and their families is of great importance to me, and I first filed this legislation during the 110th Congress when I served as a Member of the Veterans' Affairs Committee. Our Nation is grateful for the courage our veterans have displayed and the sacrifices they have made in order to protect America and the freedom we enjoy today. I believe, as you do, that it is our obligation to provide them the same honor and dedication that they provided us during their service.

Hurricane Katrina flooded and closed the New Orleans VA Medical Center, leaving our veterans without the full services of their medical home. Unfortunately, nearly 5 years later, our VA hospital still remains closed. As a result, veterans throughout Southeast Louisiana face increased challenges and hardship to obtain the quality health care they deserve. The VA made a commitment to open a new hospital by late 2013, but with the current delays, I remain concerned about the status of veterans' health care in the interim, and want to make sure this doesn't happen to any of our Nation's veterans in the future.

That is why I introduced H.R. 1075, the RECOVER Act. My bill would ensure that the VA must establish a contract with at least one non-VA facility to provide inpatient services in the event that a VA hospital will be closed for at least 6 months due to any federally declared disaster. Nothing in this bill would prevent a veteran from seeking care within the VA system if he so chooses. But last week, I spoke with a veteran who had to travel to another state for post operative care because the New Orleans hospital is still not open. Veterans still have to travel more than 350 miles for cardiac surgery and also have to travel to other states for mental health care as well. Several veterans with chronic conditions did not seek care after the storm because they did not know what their options were. This concerns me very much, and my bill seeks to eliminate these hardships. The RECOVER

Act will also prevent families from having to travel hundreds of miles just to visit their loved ones who are undergoing treatment in the hospital. As the respected group Disabled American Veterans said when they expressed their support for this Act, "Family support and care giving have been shown to accelerate recovery time and reduce cost and length of hospital stays." In the aftermath of a disaster, the last thing our veterans and their families should have to worry about is where to seek basic health care.

I commend the Southeast Louisiana Veterans Health Care System for the initiative they have taken to provide care in light of the hospital's closure. The community outpatient clinics have been extremely valuable in delivering primary care and other services. We learned valuable lessons after Hurricane Katrina, and I want to make certain that no veteran has to travel long distances or experience long wait times to receive basic care in the event that their local VA hospital is closed due to a natural disaster, whether it be a hurricane, a tornado, earthquake, or any other natural disaster.

My office is working with the Veterans' Service Organizations to address any issues they have as this bill moves through the legislative process. Let me also emphasize that this in no way undermines our strong commitment to the VA health care system. Our goals are the same: veterans and their families need to have options for receiving quality care close to home in the most convenient way possible, all while working to expedite the rebuilding of our VA hospital that was closed due to Hurricane Katrina. I continue working hard to cut through red tape and expedite the rebuilding of the New Orleans Medical Center that was devastated and closed by Hurricane Katrina's destruction. I look forward to working with you and Members of the Committee as we move forward.

Again, I thank you for your dedication to our Nation's military veterans, and I appreciate this opportunity to testify before the Subcommittee.

**Prepared Statement of Hon. Gabrielle Giffords,
a Representative in Congress from the State of Arizona**

Thank you, Mr. Chairman, and I want to thank Ranking Member Brown as well for the opportunity to testify today.

This Committee has always been active in supporting the needs of America's veterans and I look forward to working with you on this endeavor.

I also want to thank the Veterans Service Organization's in attendance today for their commitment to our men and women in uniform and for their lifetime of service.

The two bills before you today that I have sponsored, H.R. 2698 and 2699, will have a direct impact on improving the behavioral health of our Nation's heroes and their families.

As a Member of the House Armed Services Committee who represents more than 25,000 servicemembers and dependants and nearly 96,000 veterans and retirees in my Southern Arizona District, I have seen firsthand the trials and tribulations of our servicemembers returning from the frontlines.

I know this issue is one that is close to both of your hearts, and I am hopeful that today's hearing signifies an important step in moving this vital legislation forward and passing it this Congress.

There is no cause more honorable than service to our country. As our Nation's warriors bravely step into the breach, we must be prepared to care for them when they return home.

In war, our soldiers, sailors, airmen and marines face unspeakable horrors—sometimes on a daily basis—and readjusting to everyday life is a long and complicated process. Every day, thousands of our Nation's bravest men AND women are suffering from different degrees of Post Traumatic Stress. In recent years, diagnosed cases of PTSD have increased by more than 50 percent for servicemembers returning from overseas deployments, and many experts believe that the actual number is much higher because a large majority of servicemembers never seek treatment.

For an untold many diagnosed with the worst warning signs of PTSD, there are no simple fixes. We see each month the unfortunate and deeply saddening results as the Department of Defense releases its number of servicemember suicides. The trend is currently hovering slightly above the national average, more than double what it was 5 years ago.

When I spoke with the Vice Chief of the Army, General Chiarelli, a year ago he agreed that even one suicide is unacceptably high, especially when there is so much

more that we can be doing. Fellow Members, there is much more we can do and, while my legislation is not a silver bullet cure it is one round in the chamber.

PTSD and other related behavioral health issues severely affect an individual's ability to perform everyday functions that we all take for granted. PTSD though, is treatable through a variety of methods including behavioral therapy and medication with a majority of servicemembers seeing an improvement after just one or two sessions with a behavioral therapist.

Unfortunately, there are not enough behavioral health care providers within the military or VA to treat these servicemembers, their families or surviving spouses for the anguish they're suffering. What's worse still is that there aren't enough therapists to treat each other.

Ultimately, our ailing heroes or the families they leave behind must wait to see a caregiver, often receive incomplete or inadequate care, or in some cases do not receive care at all leading to one of a few inevitable conclusions—depression, anger management problems, substance abuse or death.

This is the first in many clear signs that the system is failing our men and women in uniform and badly needs to be fixed.

H.R. 2698 establishes a scholarship-for-service program that provides educational benefits to those training in behavioral health care specialties critical to the operations of Vet Centers. These individuals would then pay back the investment by serving as a behavioral health care specialist at Vet Centers across the country.

Because of the unpredictable nature and a lingering lack of understanding surrounding PTSD and its symptoms, many former servicemembers do not realize they are suffering until long after they have left military service. My bill will permit our Nation's Guardsmen and Reservists to access behavioral health care at Vet Centers even after they have been released from their Active Duty service requirement and provides for referrals to assist them to the maximum extent possible in obtaining behavioral health care and services from sources outside the Department.

In such cases where a servicemember may have been discharged for actions connected to his or her PTSD, my bill would ensure that they are apprised of their rights to petition for a review of their discharge on those grounds, ending forever the practice of discharging those suffering from PTSD because of the nature of their disease.

H.R. 2698 and H.R. 2699 also ensure that the Veterans Administration carry out a competitive grant program for nonprofit organizations that provide peer-to-peer emotional support services for servicemembers, veterans and survivors including members of the National Guard and Reserve who are often left out because of the changing nature of their service or the accessibility of care in local communities.

But what additional counselors and additional opportunities cannot do is force a servicemember or veteran to get care. For too many, PTSD is still an inescapable sentence. Servicemembers and vets are bound on one side by their service and the other by the deep stigma that still surrounds behavioral health issues. Rumors persist within the rank and file that behavioral health disorders cause you to lose your clearance or that PTSD treatment will be reported up the chain of command, ruining an otherwise promising career. According to a report by the American Psychiatric Association, an estimated 60 percent of those surveyed feared reporting that they were suffering from behavioral health-related problems.

The unfortunate fact is that 10 years ago we hardly acknowledged the existence of PTSD and had no logical measure of its effects. Five years ago, we began acknowledging it was a real problem. Today we have in place only a patchwork quilt of forms and meetings, training seminars and online courses that our servicemembers must complete along with dozens of other regular re-certifications and proficiency tests. What we are not doing is taking a comprehensive look at the problem and designing a smarter and more realistic solution.

H.R. 2699 provides for just that by establishing a pilot program at three Posts across the country that each house high op-tempo mission sets—Fort Leonard Wood, home of our Military Police Corps and the NCO Academy; Fort Carson, home of the 10th Special Forces Group, 4th Infantry Division and 10th Combat Support Hospital; and Fort Huachuca, the home of our Nation's Center of Intelligence Excellence that trains and supports the best intelligence professionals in the world.

By focusing on these three bases we can ensure that a new program focuses on the most stressed and most over-utilized units across the force and use real-life feedback from soldiers and their families on the best way to provide treatment and track their results.

We cannot continue to accept that what is being done is the best we can do.

I am committed to fixing the problems we know about and uncovering those we don't. I know that you Mr. Chairman and the Ranking Member and the others on

this Committee share my passion and my commitment to those in service to our country and the families who serve in their own way as well.

I look forward to receiving the feedback of the VA and from the Veterans Service Organizations in attendance today. And I look forward to working with the Committee to make these necessary changes into law.

Thank you.

**Prepared Statement of Hon. Leonard L. Boswell,
a Representative in Congress from the State of Iowa**

Chairman Michaud, Ranking Member Brown, and Members of the Committee, I would like to thank you for inviting me to speak before you today and for holding this hearing over many important pieces of veteran's health legislation.

Women are currently the fastest-growing veteran population—representing 8 percent of the population. As the demographics of the military continue to change, we find our VA system is struggling to serve the unique needs of this growing population. By 2020, 15 percent of veterans using the VA for health care will be women.

What this means is that veterans' health care, which is now primarily tailored to men, needs to undergo significant changes—and fast.

Particularly, one health concern that has been largely ignored is the prevalence of breast cancer in our servicewomen and women veterans. That is why I have introduced H.R. 3926, the Armed Forces Breast Cancer Research Act. This legislation would require the Secretary of Defense and the Secretary of Veteran Affairs to collaboratively study the incidence rate of breast cancer in servicemembers and veterans. This study would focus on the number of servicemembers who have deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom, the demographic information of those servicemembers and veterans, an analysis of the clinical characteristics of breast cancer diagnosed, and possible exposures to cancer risk factors.

The idea for this bill came about when a member of my staff, who is an Iraq veteran, went back to Iowa for a 5 year post-deployment reunion. One of the women at the reunion had returned home from serving her country and was diagnosed with breast cancer and had to undergo a double mastectomy, at age 25. Through the course of the night the servicemembers at the reunion were able to piece together about six women they were deployed with who had come back from their deployment in Iraq with breast cancer—all between the ages of 25 to 35 years old. Also, there were another half dozen women who returned with new lumps in their breasts that needed additional tests such as mammograms, ultrasounds, and/or biopsies. With 70 women deployed with the battalion (of 700), this incidence rate in young women seemed high and alarming to me.

In recent years, the U.S. medical and research communities have stepped up their efforts on breast cancer detection, research, and treatment in the country's civilian population. However, women who serve or have served in our Nation's Armed Forces have largely been excluded from these studies, despite their exposure to cancer risk factors and access to medical care. A recent study of Department of Defense (DoD) and National Cancer Institute (NCI) compares the prevalence of certain types of cancer among active-duty military personnel with the general public. The study found that breast cancer among women is more common in the military than in the general population and that further studies are needed to confirm these findings and explore contributing factors.

That is my goal for this legislation. To find out if our servicewomen do have a higher risk of breast cancer than the rest of the women in the country and why that might be. So that ultimately, we can determine if breast cancer is a service-connected disability—which I truly believe it is.

At this moment in history it is particularly important to consider what we can do to better serve the brave individuals who fight for our security and liberty once they return home.

I would again like to thank Members of this Committee for allowing me the time to speak and your diligence on this matter. I would be happy to answer any questions you might have.

Veterans of Foreign Wars of the United States
Washington, DC.
October 26, 2009

The Honorable Leonard Boswell
United States House of Representatives
1427 Longworth House Office Building
Washington, DC 20515

Dear Representative Boswell:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States and our Auxiliaries, I would like to offer our support for your proposed legislation, the *Armed Forces Breast Cancer Research Act*.

Your important legislation would direct the Secretary of Defense and the Secretary of VA to work jointly in conducting a study on the incidence of breast cancer among our Nation's veterans. The valuable study would provide insight on breast cancer rates of servicemembers and document any harmful exposure the servicemembers were subjected to during their service. The *Armed Forces Breast Cancer Research Act* would provide crucial information on an important veteran issue that has otherwise been neglected.

Representative Boswell, we thank you for proposing legislation that would greatly benefit our Nation's heroes. We need to do everything in our power to provide for these brave Americans who have sacrificed for their country. The VFW looks forward to working with you and your staff to ensure the passage of this legislation.

Thank you for your continued support of America's veterans.

Sincerely,

ERIC A. HILLEMANN
Director, National Legislative Service

Iraq and Afghanistan Veterans of America
Washington, DC.
December 2, 2009

The Honorable Leonard Boswell
1427 Longworth House Office Building
Washington, DC 20515

Dear Congressman Boswell,

Iraq and Afghanistan Veterans of America (IAVA) is honored to offer our full support for H.R. 3926, the "Armed Forces Breast Cancer Research Act." The "Armed Forces Breast Cancer Research Act" will establish a collaborative effort between the Department of Defense and the Department of Veterans Affairs to study incidences of breast cancer among those who serve, their demographic information, possible exposures to carcinogenic material while serving our country and any treatments they have received.

Civilian sector advances infesting and treatments for breast cancer have largely been determined without specific consideration of the men and women in our Armed Forces. However, in October 2009, there have been reports of 40 former Marines with breast cancer, who were potentially exposed to contaminated water at Camp Lejeune. As these reports evidence, there is a dire need for further research into the incidences of breast cancer among the unique population of troops and veterans.

We are proud to offer our assistance and thank you for this vital legislation. If we can be of help, please feel free to contact Erin Mulhall, Deputy Policy Director for Research, at (202) 544-7692 or erin@iava.org.

We look forward to working with you.

Sincerely,

Paul Rieckhoff
Executive Director and Founder

**Prepared Statement of Hon. Ginny Brown-Waite,
a Representative in Congress from the State of Florida**

Thank you, Mr. Chairman,

I appreciate the opportunity to testify before the Subcommittee today.

As of November 2009, there were nearly 8 million veterans enrolled in the VA health care system. With new veterans entering the system every day and approximately 174,000 Operation Enduring Freedom and Operation Iraqi Freedom patients receiving VA health care, it is clear that our duty to our Nation's veterans is as strong now as it has ever been.

Today, there are 153 VA medical centers and 768 Community Based Outpatient Clinics (CBOC) available to serve the needs of these veterans.

When a veteran calls to schedule an appointment in one of these 921 facilities, they should be able to receive an appointment that is timely and appropriate to their medical needs.

Unfortunately, for many veterans, this does not happen.

The VA lauds itself for completing 99 percent of its primary care appointments within 30 days of the desired date. However, this means that nearly 32,000 patients still are waiting beyond 30 days for their primary care appointment.

Additionally, there is a discernable difference between existing patients and new patients, as only 88.8 percent of new patients complete their appointments within 30 days of the desired date.

Health care delayed is health care denied and our Nation's veterans deserve better.

In September 2007, VA Office of the Inspector General found that the Veterans Health Administration's method of calculating the waiting times of new patients understates the actual waiting times. In this report, the Inspector General made five recommendations to reduce wait times at VHA facilities. To date, four of these five recommendations remain unresolved.

When I first was elected to Congress, I inquired into the wait time numbers from Veterans Health Administration facilities in my District and across the country. The numbers the VA gave me both for VISN 8 and nationwide did not match with the stories I heard from my veterans. It was clear the VA was playing games with scheduling and canceling appointments. I fear these games are still being played today.

For this reason, I introduced H.R. 84, the *Veterans Timely Access to Health Care Act*. This bill would make the standard for a veteran seeking primary care from the Department of Veterans Affairs 30 days from the date that the veteran contacts the Department.

Veterans should not need to wait more than 30 days to receive an appointment from their primary care physician.

The VA does provide a high level of care to all of the veterans who are enrolled in the system. This is why the majority of patients rate their level of overall satisfaction with their treatment as "very good" or "excellent," regardless of whether they are receiving inpatient or outpatient services.

I want to be clear: this bill is NOT a scheme to move the VA toward privatization. I simply want to ensure that veterans receive care in a reasonable amount of time.

As Members of Congress, we have an obligation to ensure that veterans receive the best health care available to them. If veterans are having problems receiving care within 30 days of contacting the Department of Veterans Affairs, then Congress needs to allow them to look for an alternative. That is what this bill does.

This hearing today is to determine whether the VA is meeting the goal of timely access to care.

Our Nation's veterans did not wait 30 days to answer the call of duty.

They answered their Nation's call and took up arms to protect our freedom.

They deserve the same dedication and steadfastness from us.

With over 116,000 veterans living in my District, I have the distinguished honor to meet with these true American heroes on a regular basis. I hear about the issues they have with the VA. Over and over again, I still hear about how difficult it is to schedule an appointment with a doctor in a timely matter.

This is unacceptable and must be corrected. The *Veterans Timely Access to Health Care Act* is an important step in fixing this persistent problem.

Congress recently allowed for advanced appropriations for the VA. This new funding structure should allow the VA to properly manage their funds and hire the staff necessary to meet the demand at VA facilities.

However, when the VA still fails to meet the needs of our veterans seeking health care, this legislation provides an effective alternative.

Congress and administrations must not turn the care of our Nation's veterans into a political issue.

Instead, we must all work together to ensure that they receive the health care they risked so much to earn. We must continue those practices that already work and improve those that are failing. H.R. 84 does just that.

Thank you again, Mr. Chairman, and I yield back the balance of my time.

**Prepared Statement of Denise A. Williams, Assistant 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 the several pieces of legislation being considered by the Subcommittee.

H.R. 1075, RECOVER Act (Restoring Essential Care for Our Veterans for Effective Recovery)

This bill would expand access to hospital care for veterans in major disaster areas and for other purposes. In addition, it directs the Secretary of the Department of Veterans Affairs (VA) to enter into a contract with non-Department facilities located in the disaster areas to facilitate covered medical services to veterans, if their designated VA medical facility is unable to do so within 180 days due to the disaster.

Timely and open access to quality health care for veterans is a major priority of The American Legion and this legislation is consistent with our efforts in this regard. The American Legion does, however, have some concerns. Although such contracts would certainly be helpful during a disaster in which VA medical facilities are not available, we do not want such an arrangement to become a disincentive for VA to quickly repair or replace damaged facilities. This bill also does not address length of the contracted care, long-term care or how quality of care will be assessed.

H.R. 84, Veterans Timely Access to Health Care Act

This legislation would seek to establish standards of access to care for veterans seeking health care from VA. It also directs the Secretary to set standards for timeliness and to report how these standards were carried out.

The American Legion supports this bill and believes that this endeavor will provide VA with a comprehensible overview of the challenges that veterans face in gaining timely access to care. This measure could prove to be a valuable asset in their undertaking to improve access to care, especially among veterans living in rural and highly rural geographic areas.

H.R. 4006, Rural, American Indian Veterans Health Care Improvement Act of 2009

This bill would require the VA Secretary to designate Indian Health Care Coordinators at 10 VA medical centers that serve communities with the greatest number of American Indian veterans. Additionally, a year after the bill has been enacted; the VA Secretary is directed to establish a Memorandum of Understanding with the Secretary of the Interior to authorize the electronic transfer of American Indian veterans' health records between the Indian Health Services (IHS) and the VA. The provisions of this bill also authorize the VA Secretary to transfer surplus medical and information technology equipment to IHS.

The American Legion advocates timely access to quality health care to all veterans and is on record in strong support of VA's collaboration with other Federal health care providers to provide the best care, at the right time, in the most appropriate medical care setting. This legislation appears to address these goals to better serve veterans enrolled in the VA health care delivery system.

H.R. 3926, Armed Forces Breast Cancer Research Act

This bill would direct the Secretaries of the Departments of Defense (DoD) and VA to jointly conduct a study on the incidence of breast cancer among members of the Armed Forces and veterans. This study would determine the number of service-members and veterans diagnosed with breast cancer; their demographic information; and any possible exposure to hazardous elements or chemical or biological agents.

The American Legion fully supports this timely and important legislation given the recent breast cancer incidences among male veterans that were stationed at Camp Lejeune. Moreover, according to the Clinical Breast Care Project at Walter Reed Army Medical Center, there have been over 2,000 cases of breast cancer diagnosed in both male and female active-duty servicemembers within the last decade.

The Center further stated that breast cancer is the single greatest cause of cancer deaths among women under 40 and is a significant cause of mortality for women in the Armed Forces. The American Legion would also encourage inclusion of the Reserve component in this study.

H.R. 949, Improving the Collective Bargaining Rights of Certain VA Employees

This legislation would seek to amend section 7422 of title 38, United States Code (USC), which would improve the collective bargaining rights and procedures for review of adverse actions of certain VA employees.

Although The American Legion strongly supports the recruitment and retention of quality VA employees, it has no official position on this legislation.

Proposed Legislation to Amend Title 38, USC, Concerning Performance Pay and Collective Bargaining

This legislation would seek to amend section 7431 and section 7422 of title 38, USC, which would make certain improvements in the laws relating to the performance pay and collective bargaining right for certain VA employees.

Although The American Legion strongly supports the recruitment and retention of quality VA employees, it has no official position on this legislation.

Proposed Legislation to Amend Title 38, USC, Concerning Continuing Professional Education

This bill would seek to amend title 38, USC, to improve the continuing professional education reimbursement provided to health professionals employed by VA. This proposal would not only maintain VA's presence in the competitive medical professional market, but also help decrease the attrition rate among VA medical centers' medical professionals.

The American Legion supports this draft proposal because it will serve to provide professional education reimbursement for eligible health professional. The expansion of this benefit may also diminish the attrition rate of medical professionals within VA medical facilities because it will be an added benefit to more staff in various disciplines.

Proposed Legislation to Amend Title 38, USC, Concerning Mental Health Counselors

This proposal would seek to amend title 38, USC, to authorize the VA Secretary to waive certain requirements relating to mental health counselors.

The American Legion believes VA should be staffed with the best qualified professionals to ensure this nation's veterans receive timely access to quality health care, especially mental health services. With servicemembers returning from Iraq and Afghanistan with complex and overlapping illnesses and injuries, it is imperative VA maintains its charge to ensure its medical professionals are properly trained and fully qualified to provide quality care.

According to the National Institute of Health, injuries and illnesses such as mild Traumatic Brain Injury (TBI) and Posttraumatic Stress Disorder (PTSD) respectively, have several symptoms in common. Among these symptoms are irritability, concentration deficits, amnesia for the causal event, reduced cognitive processing ability and sleeping disturbances. Clearly, this situation adds to the difficulty in diagnosing PTSD in patients with TBI. The American Legion contends that due to the complexity of these illnesses and injuries, such as TBI and PTSD, the most qualified mental health professionals are required. Therefore, The American Legion is opposed to waiving current requirements relating to mental health counselors.

H.R. 2698, Veterans and Survivors Behavioral Health Awareness Act

This bill would seek to improve and enhance the mental health care benefits available to veterans. The legislation would also enhance counseling and other benefits available to survivors of veterans, and for other purposes.

The American Legion fully supports this legislation. VA's Vet Centers have served as one of the main catalysts that have assisted with successfully transitioning servicemembers and veterans to VA. Section 3 of this bill would seek to restore the authority of Vets Centers to provide referral and other assistance upon request to veterans currently not authorized counseling. This provision would allow Vet Centers to cast a broader net in further minimizing veterans who would otherwise continue to face transition challenges.

H.R. 2699, Armed Forces Behavioral Health Awareness Act

This bill would seek to improve the mental health care benefits available to servicemembers, to enhance counseling available to their family members, and for other purposes.

While The American Legion agrees with the intent of this bill, we disagree with the restrictive nature of section 4, which would seek to carry out a pilot program, for servicemembers of the Army only, to enhance awareness of PTSD. This pilot program should be open to members of all five branches of the Armed Services with a presence in Iraq or Afghanistan. In addition, the locations should be expanded to include venues near all of the respective servicemembers.

The American Legion believes the success of the Armed Forces Behavioral Health Awareness Act, with the amendment of section 4, would assist with timely intervention to help minimize issues plaguing veterans and their families that possibly lead to substance abuse, suicide, and homelessness.

H.R. 2879, Rural Veterans Health Care Improvement Act of 2009

This legislation would seek to amend title 38, USC, to improve health care for veterans who live in rural and highly rural geographic areas, and for other purposes.

VA's Office of Rural Health held their inaugural meeting in August 2008. During that time, VA established Rural Health Centers located in three regions of the country:

- Eastern Region RHRC: White River, Vermont
- Central Region RHRC: Iowa City, Iowa
- Western Region RHRC: Salt Lake City, Utah

These three regions also partner with various VA medical centers and universities. Section 3 of this bill proposes Centers of Excellence for Rural Health Research, Education, and Clinical Activities. The American Legion believes there should be interaction between the abovementioned Rural Health Centers to prevent redundancy. Due to the vastness of rural areas, Rural Health Centers should be increased to accommodate various issues such as lack of access to medical facilities, lack of medical professionals, women veteran issues, and homelessness.

This bill would also seek to increase transportation options for rural veterans. The American Legion believes this is imperative and will increase veterans' options of receiving timely access to quality health care. The American Legion also believes that veterans should not be penalized due to the geographical location in which they choose to reside.

Mr. Chairman, once again The American Legion appreciates the opportunity to address these issues and looks forward to working with you, your colleagues and the staff in advancing legislation that will make a positive difference in the lives of servicemembers, veterans and their families.

That concludes this written statement and I welcome any questions you or your colleagues may have concerning The American Legion's views, comments and recommendations.

**Prepared Statement of Blake C. Ortner,
Senior Associate Legislative Director, Paralyzed Veterans of America**

Chairman Michaud and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to present PVA's position on the legislation pending before the Subcommittee, as well as the three draft bills you are preparing.

H.R. 84, the "Veterans Timely Access to Health Care Act"

H.R. 84, the "Veterans Timely Access to Health Care Act," would establish standards of access to care within the VA health system. PVA has testified on similar legislation in the past and is unable to support H.R. 84.

Under the provisions of this legislation, the Department of Veterans Affairs (VA) will be required to provide a primary care appointment to veterans seeking health care within 30 days of a request for an appointment. If a VA facility is unable to meet the 30-day standard for a veteran, then the VA must make an appointment for that veteran with a non-VA provider, thereby contracting out the health care service. The legislation also requires the Secretary of the VA to report to Congress each quarter of a fiscal year on the efforts of the VA health system to meet this 30-day access standard.

Access is indeed a critical concern of PVA. The number of veterans enrolled in the VA is continuing to increase. This is particularly true as more and more Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans continue to take advantage of the services in VA. Likewise, the effort of the administration to expand Priority Group 8 enrollments is increasing the workload.

Unfortunately, funding for VA health care in the past has had difficulty keeping pace with the growing demand. Even with the passage of Advance Appropriations and record budgets in recent years, funding is not guaranteed to be sustained at those levels and PVA is concerned that contracting health care services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care. Contracting out to private providers will leave the VA with the difficult task of ensuring that veterans seeking treatment at non-VA facilities are receiving quality health care.

PVA is also concerned about the continuity of care. If veterans are shifted between the VA and non-VA facilities each time the imposed standard is not met, how will this affect the quality of the health care these veterans receive? This is neither an effective nor efficient way to supply health care and in the long run may be detrimental to the veteran. We do think that access standards are important, but we believe that the answer to providing timely care is in providing sufficient funding in the first place in order to negate the impetus driving health care rationing. For these reasons, PVA cannot support H.R. 84.

H.R. 949 to Improve Collective Bargaining Rights and Procedures

PVA supports H.R. 949 introduced by Chairman Filner that will more quickly resolve adverse actions and set deadlines for final decisions.

H.R. 1075, the "RECOVER Act (Restoring Essential Care for Our Veterans for Effective Recovery)"

PVA strongly supports H.R. 1075, the "RECOVER Act (Restoring Essential Care for Our Veterans for Effective Recovery)." During periods of major disasters, medical care is as critical as food or water to protecting the lives and health of those in the affected disaster area. Ensuring veterans have uninterrupted access to health care during these periods is critical to their well-being. The ability of the Secretary of VA to enter into contracts for in-patient care with non-Department facilities for those veterans who otherwise would normally be provided care by Department medical facilities only makes sense. PVA would only caution that this arrangement should not inadvertently lead to delays in repairing or replacing VA facilities that may have been damaged during the disaster. VA facilities still provide a unique form and quality of care that is seldom replicated in non-VA facilities, particularly for those veterans with special health needs such as spinal cord injury, blindness and other catastrophically disabled veterans. Likewise, this contracting authority should not become the default health care policy for meeting the needs of veterans in a disaster area.

H.R. 2698, the "Veterans and Survivors Behavioral Health Awareness Act" and H.R. 2699, the "Armed Forces Behavioral Health Awareness Act"

PVA supports H.R. 2698, the "Veterans and Survivors Behavioral Health Awareness Act" and H.R. 2699, the "Armed Forces Behavioral Health Awareness Act." The scholarships and other provisions of H.R. 2698 should increase the number of behavioral health care specialists. Additionally, we applaud provisions requiring those receiving the scholarship to serve in Vet Centers. As the increasing numbers of OEF/OIF veterans continues to grow, the need for behavioral specialists on Vet Center's staff will also grow. H.R. 2698 may help generate those additional individuals to meet this need. While the scholarships are not targeted or reserved for veterans, PVA would encourage VA to market the scholarship to veterans who will be best able to relate to veterans visiting the Vet Centers.

PVA also welcomes provisions of both H.R. 2698 and H.R. 2699 which award grants to non-profit organizations to provide emotional support to survivors of members of the Armed Forces and veterans in the case of H.R. 2698 and to members of the Reserves and all family members in the case of H.R. 2699. This is in keeping with the best traditions of VA in providing for the widow and orphans of our veterans and all family members and members of the Reserves who are facing the significant challenges of multiple OEF/OIF deployments.

Regarding sec. 3 of H.R. 2698 and sec. 2 of H.R. 2699, PVA supports these provisions of the legislation, but both sections are reflected in the recent negotiated changes in S. 1963 and as currently amended will address the specified referral and

readjustment counseling issues making these portions of the legislation no longer necessary should the amended legislation pass.

**H.R. 2879, the “Rural Veterans Health Care Improvement Act of 2009” and
H.R. 4006, the “Rural, American Indian Veterans Health Care
Improvement Act of 2009”**

PVA supports H.R. 2879, the “Rural Veterans Health Care Improvement Act of 2009” and H.R. 4006, the “Rural, American Indian Veterans Health Care Improvement Act of 2009.” PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas and that Native Americans often face even tougher challenges. These rural veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through community-based outpatient clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings. The need to determine methods to provide for these more dispersed rural veterans is a challenge. Establishing Centers of Excellence for rural health research, education and clinical activities may be a way to develop better ideas for rural veteran care and help shed light on how best to provide services in rural areas. Together with the demonstration projects outlined in section 5, a path may be identified to provide a greater level of health care for rural veterans.

However, while these paths may show promise, they should still all fit within policies that promote the use of VA facilities and should not be used as a method or course to eliminate VA facilities in rural areas. While all these ideas are welcome, the greatest need still is for qualified health care providers to be located in rural settings. Only significant incentives and opportunities for these professionals will bring them to these often remote areas. In fact, the expansion of VA facilities may be the best way to care for special needs veterans that seldom have the types of critical care services that they need in rural areas. We must be sure that veterans most in need of specialized care, provided best by VA, are not sacrificed to efficiencies discovered through these programs.

PVA also applauds the provisions of H.R. 2879 on travel reimbursement and transportation grants. Mobility, in particular for those with disabilities, is often the greatest challenge to care in a rural environment. Providing greater transportation benefits will allow veterans a better chance of receiving health care without a disproportionate cost often associated with the long distances traveled in rural areas. Both reimbursement and transportation grants are included in the recent negotiated changes in S. 1963 as currently amended address these issues. We believe this portion of the legislation would no longer be necessary should the amended legislation pass.

PVA also supports the provisions of H.R. 2879 for helping our Native American veterans through provisions for a program of readjustment and mental health care services to veterans who have served in OEF/OIF. PVA also supports the provisions of H.R. 4006 and H.R. 2879 which helps our Native American veterans by establishing Indian Veterans Health Care Coordinators. Improving outreach to this underserved population as well as expanding access and participation by VA, the Indian Health Service and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program may help to bring a larger number of Native American veterans into the health care system. Together with the integration of electronic health records in the Indian Health Service and the authority to transfer surplus VA medical and information technology equipment, Native American veterans will have better access and a higher quality of health care.

H.R. 3926, the “Armed Forces Breast Cancer Research Act”

PVA strongly supports H.R. 3926, the “Armed Forces Breast Cancer Research Act.” Recent U.S. military conflicts, as happened with Operations Desert Storm/Desert Shield, have demonstrated that members of the military deployed to foreign areas often are exposed to agents, chemicals and environments detrimental to their health. In many cases, these exposures may have long-term health effects not identified during a post deployment medical examine. With the growing number of women that comprise members of the Armed Forces, and their increasing involvement in forward operating areas and combat activities, it only makes sense to examine the potential increased risk of breast cancer among this population.

**Draft Legislation to “Improve Continuing Professional Education,”
“Waive Certain Requirements Relating to Mental Health Counselors,” and
“Make Improvement to Performance Pay and Collective Bargaining Rights”**

PVA supports the draft legislation to raise the reimbursement rate for health professionals from \$1,000 to \$1,600. In addition, PVA cautiously supports the legisla-

tion to waive certain requirements relating to mental health counselors, but want to ensure that this is done only in the circumstances that will benefit VA health care and in no way be detrimental to veterans served by a counselor whose license or certification requirement has been waived.

Regarding collective bargaining, PVA generally supports the provisions of the draft legislation that would improve the collective bargaining rights and procedures for certain health care professionals in the VA. These changes may be a positive step in addressing the recruitment and retention challenges the VA faces to hire key health care professionals, particularly registered nurses (RN), physicians, physician assistants, and other selected specialists.

As we understand current practice, certain specific positions (including those mentioned previously) do not have particular rights to grieve or arbitrate over basic workplace disputes. This includes weekend pay, floating nurse assignments, mandatory nurse overtime, mandatory physician weekend and evening duty, access to survey data for setting nurse locality pay and physicians' market pay, exclusion from groups setting physicians' market pay, and similar concerns. This would seem to allow VA managers to undermine Congressional intent from law passed in recent years to ensure that nurse and physician pay are competitive with the private sector and to ensure nurse work schedules are competitive with local markets.

Interestingly, given the VA's interpretation of current laws, these specific health care professionals are not afforded the same rights as employees who they work side-by-side with everyday. For instance, Licensed Practicing Nurses (LPN) and Nursing Assistants (NA) can challenge pay and scheduling policies, while RN's cannot. This simply makes no sense to us.

VA must work with their employees to achieve a less hostile work relationship, but any changes or modifications on either side of the issue must first address the care of veterans. Furthermore, this care should not be used as a rallying cry on either side as an argument for their position. Veterans deserve better.

PVA appreciates the opportunity to comment on the bills being considered by the Subcommittee. I would be happy to answer any questions that you might have. Thank you.

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

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I want to thank you for the opportunity to testify at today's legislative hearing. Before us is a wide range of health care related bills, all of which would make improvements to the system that benefits America's veterans.

Draft Bill for Continuing Education of VHA Staff

The VFW supports this bill, *"to improve the continuing professional education reimbursement provided to health professionals employed by the Department of Veterans Affairs."* Currently, only full-time board certified physicians and dentists are eligible for \$1,000 annually for continuing professional education. This bill would increase the annual continuing education reimbursement from \$1,000 to \$1,600 annually, and bar any potential duplicate compensation from medical centers. Further, it would expand the eligible professions from physicians and dentists to also include podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries. We urge further expansion of this legislation to include education reimbursement for other health care professionals such as mental health.

The VA has built a reputation for being an innovator in research and a teaching institution. We are encouraged to see emphasis placed on continuing education for medical professionals. Ongoing education of VHA staff will help to keep VA a leader in providing high quality medical care and attract staff that are inclined toward constant improvement.

Draft Bill to Improve Performance Pay and Bargaining Rights

This draft legislation would further clarify performance pay awarded to physicians and dentists. Existing law does not specify that performance pay can only be awarded based on an individual performance. This has led to performance rewards ambiguity. The VFW supports this bill.

Draft Bill, Waving Requirements for Mental Health Counselors

The VFW opposes this legislation to allow the Secretary to wave licensure or certification requirements. The VA may be facing shortages of mental health professionals, but we believe making exceptions in lieu of valid state-issued certifications undermines the quality of care and the confidence that veterans have in speaking with VA mental health professionals. State licensure and certification, demonstrates that an individual meets the state requirements in the areas of prerequisite education, and knowledge, and is culpable under the law for malpractice or abuse of the unique trust placed in their position.

H.R. 84, the Veterans Timely Access to Health Care Act

The VFW supports the intent of the “Veterans Timely Access to Health Care Act,” but we cannot support this bill. This legislation would require the VA Secretary to contract care for any veteran who would have to wait 30 days or more for primary care. The VFW has supported guaranteed access standards for VA Health Care for a number of years—but we remained concerned about quality and cost of contract care.

The VFW shares the desire to see all veterans have timely access to high-quality VA health care, which has been and continues to be our highest legislative priority. We feel, however, that this legislation would create more problems than it would fix. We must be mindful of the unintended consequences of the legislation.

With the advent of advanced appropriations, VA now has the capacity to ensure that it can properly plan for and manage these dollars efficiently. Additionally, on-time funding should allow VA to recruit, hire and train doctors, nurses and other health care providers, ensuring that VA has sufficient staff to keep up with demand. Congress has made great strides in improving the funding stream for veterans’ health care—for which the VFW applauds your efforts—but a greater attention is needed to ensure those health care dollars are spent appropriately at each medical facility.

We strongly support the reporting requirements of H.R. 84. The reporting mechanisms on wait times would help gain more accurate insight into hard numbers, which are always more informative than anecdotal statistics. Better numbers would allow us to understand the problem as well as see which areas are having difficulties.

H.R. 949

This bill addresses VA employee’s collective bargaining rights. Specifically, it repeals specified exceptions to rights of certain Department of Veterans Affairs (VA) employees to engage in collective bargaining. There by, allowing increased negotiation between VA employees and the VA Secretary on items such as professional conduct, competence and determination of employee compensation. It further requires a VA final decision with respect to the review of an adverse personnel action against an employee to be issued no later than 60 days after such action has been appealed. Subjects such decision to judicial review in the appropriate U.S. District Court or, if the decision is made by a labor arbitrator, in the U.S. Court of Appeals for the Federal Circuit. The VFW has no position on this legislation.

H.R. 1075

This bill would require the VA Secretary to seek outside contacts in the event a VA hospital is closed for greater than 180 days due to a national disaster. Currently, when VA hospitals are closed, veterans must travel long distances to other VA facilities, which may be impractical or impossible following a disaster. This bill would ensure that the VA secures alternative arrangements for local medical care, to include non-emergency care and inpatient medical care services as required.

The VFW supports this legislation. However, we feel 180 days is far too long for a veteran to wait for services. We urge the Veterans Affairs Committee to hold hearings evaluating the VA’s current disaster contracting provisions. Allowing a veteran to wait 180 days for medical care is unacceptable. Contracts to provide health care must be in place before a VA hospital shuts its doors due to natural disaster. The VFW believes plans need to be implemented immediately in the event of a disaster.

H.R. 2698, the Veterans and Survivors Behavioral Health Awareness Act

VFW is pleased to support this critical legislation to improve mental health care services for veterans and members of the Armed Forces and their survivors. This bill recognizes that many of today’s war wounds are invisible wounds—which often take months to appear, making the transition our service men and women face more difficult. We believe that this bill is a good first step in making positive changes for those suffering the invisible wounds of war.

Section 2 of the bill concerns Vet Centers. The VFW is a strong supporter of Vet Centers and their approach to providing mental health care to veterans. VA has done a good job expanding their reach, but they are victims of their own success. Many Vet Centers are struggling with difficult workloads as increasing numbers of veterans turn to them for the unique services they provide. Provisions provided in section 2 would give some relief by offering scholarship programs for individuals seeking education and training in health care specialties needed by the Vet Centers. Finding qualified mental health professionals is a challenge for VA, and the more incentives they can provide potential employees, the more likely that these men and women will turn to VA as their employer of choice.

Section 3 would require VA to help seek outside counseling services for veterans who are otherwise not authorized to receive care through VA. Many discharged OEF/OIF veterans who are beyond the 5-year dead line of access to VA do not have access to counseling, so this is clearly the right thing to do.

Section 4 would allow VA to provide grants to nonprofit organizations that provide support for survivors of deceased servicemembers and veterans. Family members may not know where to go to seek help, and we believe that VA can help point them in the right direction.

H.R. 2699, the Armed Forces Behavioral Health Awareness Act

This legislation would offer OEF/OIF veterans counseling services at Vet Centers before they separate from the military. VFW supports all the provisions of this bill.

Section 2 expands mental health services and counseling to active duty forces and those in the Reserve Components. VFW believes this change is important for two reasons. First, military mental health services come with a stigma. That has been shown repeatedly to be the greatest impediment to men and women seeking care. By allowing servicemembers to seek care without fear of reprisal or reporting relieves an emotional burden that can and would otherwise have a serious impact on their career. The second reason is that the military does not have a sufficient number of mental health care providers. While this legislation does not absolve the military of their responsibility to properly care for these men and women while in service, it helps fill in the gaps in care that are often not there when our servicemembers need it.

Section 3 would require DoD to provide grants to nonprofit organizations that provide support for survivors of deceased servicemembers and veterans. This provision is similar to the provision offered in H.R. 2698. It allows DoD to expand its counseling base and go beyond the limited services provided by the military's casualty assistance officers, which can help ease the burden on these families at a most difficult time in their lives.

Section 4 would require the Secretary of the Army to carry out a pilot program in three locations to improve PTSD awareness among members. The alarming rate of veterans and those on active duty suffering from mental stress has been well-documented. Providing an environment to study the neurophysiological and psychological effects associated with the stress and trauma of combat is critical to today's Armed Forces. With repeated deployments affecting servicemembers and their families, this pilot program would begin to address some of the key factors in identifying and addressing PTSD, as well as helping those involved reintegrate back into civilian life.

H.R. 2879, the Rural Veterans Health Care Improvement Act of 2009

VFW supports this comprehensive bill aimed at improving care to veterans living in rural areas across the country. We applaud the provisions in the bill that would increase the travel reimbursement rate to 41.5 cents a mile when they travel to VA facilities for treatment, as well as language authorizing VA to establish a grant program to provide innovative transportation options to veterans in rural areas. The \$50,000 grant to state veterans' service agencies and veterans' service organizations goes a long way toward helping rural veterans—oftentimes, getting to and from appointments is the largest hurdle to care.

The bill would also allow the VA Secretary to carry out demonstration projects to examine the feasibility and advisability of alternatives for expanding care to veterans in rural areas. The VA would establish partnerships with the Department of Health and Human Services, Centers for Medicare and Medicaid Services, Indian Health Services, and other programs to examine the best way to extend care to these veterans. The VFW believes that VA should explore all avenues of telemedicine for care of veterans in rural areas.

It would increase care to OEF/OIF veterans and their families by allowing VA to establish programs to provide peer outreach and support services. VA would be authorized to contract with community mental health centers and/or other qualified

entities offering readjustment services in areas where those services are not adequately provided. Further, it would establish training goals with nonprofit mental health organizations by utilizing other veterans in providing peer outreach and peer support in their communities. Offering readjustment services and counseling where the servicemembers and families live is something the VFW believes is critical to the well-being of our servicemembers and their families.

The Rural Health Care and Improvement Act would allow the VA Secretary to establish centers of excellence for rural health research, education and clinical activities. These centers would research the availability of health services in rural areas and develop specific models for furnishing those services to veterans in rural areas.

Section 7 of the bill—Indian Veterans Health Care Coordinators, would direct VA to employ an Indian Health Care Coordinator at 10 VA medical centers that serve communities with large Indian populations. This provision is the same as language found in H.R. 4006, which we will comment on in that section of our testimony.

Last, H.R. 2879 would require the VA Secretary to submit an annual report to Congress on the implementation of the provisions of this bill and any amendments. VFW looks forward to the enactment of this bill to improve the quality and access to care for veterans in rural areas.

H.R. 3926, the Armed Forces Breast Cancer Research Act

The VFW strongly supports a joint study between VA and DoD into the occurrence of breast cancer among members of the Armed Forces. Breast cancer remains the second leading cause of death among women, and the rate of incidence for men have remain steady according to the American Cancer Society. This bill would require VA and DoD to provide information on the number of servicemembers and veterans—male and female—who have been diagnosed with breast cancer, the treatment they have received and demographic information about their age and service. The report, which would be provided to Congress in 18 months, would also address whether Defense and VA officials see any service-related breast cancer risk or patterns. VFW encourages immediate passage of this bill and looks forward to reviewing the report to ensure those veterans affected receive the proper medical services they earned.

H.R. 4006, Rural, American Indian Veterans Health Care Improvement Act of 2009

VFW supports this bill which would improve care to American Indian veterans. H.R. 4006 would create an “Indian Veterans Health Care Coordinator” for 10 VA medical centers that serve the greatest number of Indian veterans per capita. This coordinator would improve outreach to tribal communities, coordinate the medical needs of Indian reservations, and expand the access and participation of VA in the Department of Veterans Affairs Tribal Veterans Representative program.

The bill would also require the VA and Department of the Interior to enter into a Memorandum of Understanding to ensure the electronic transfer of health records of Indian veterans between Indian Health Service (IHS) and VA facilities. VA would also be authorized to transfer to IHS any surplus medical and information technology equipment.

This bill would also require VA and the Department of Health and Human Services to report jointly to Congress on the advisability of the joint VHA–IHS establishment and operation of health clinics to serve eligible populations on Indian reservations.

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

Mr. Chairman, Ranking Member Brown, and Members of the Subcommittee:
Thank you for inviting the Disabled American Veterans (DAV) to testify at this legislative hearing of the Subcommittee on Health. We appreciate the Subcommittee’s leadership in enhancing the Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely, and we also appreciate the opportunity to offer our views on the eight bills and three draft measures under consideration by the Subcommittee today.

H.R. 84—Veterans Timely Access to Health Care Act

The stated goal of this bill is to provide timely access to VA health care. To accomplish this objective, a 30-day standard would be established as the maximum time that a veteran would be required to wait to receive a VA primary care appointment.

The bill would also direct VA to establish a standard for the maximum length of time that a veteran would be required to wait to actually see a provider on the day of a scheduled appointment. Under the bill, if the Secretary found that any particular VA geographic service area failed to substantially comply with the timeliness standards, facilities in that area would be required to contract for the care of a veteran in each instance it was unable to meet those standards. The contracting requirement would be mandatory for veterans who are classified within enrollment Priority Groups 1 through 7 and discretionary for those within Priority Group 8.

The bill would require the Secretary to carry out a one-time examination of waiting time data for the entire VA health care system, stratified by geographic service area. The Secretary would be required to issue a determination regarding compliance with the standard in each geographic service area. If the compliance rate for any area were below 90 percent, facilities located in that area would be subjected to the requirement to contract for care whenever they were unable to meet those standards. Facilities with a compliance rate of 90 percent or more would be prohibited from contracting out such services.

Under the bill, VA would be required to submit two reports to the Committees on Veterans' Affairs. The first would be an annual report providing an assessment of its performance in meeting the timeliness standards. The second report would be made quarterly, and would include detailed waiting-time data for each geographic service area. The bill would require quarterly reports to include the number of veterans in each geographic service area waiting for care, distinguished by primary care and specialty care, and segregated periodically by those waiting from under 30 days to those waiting over a year, plus those who cannot be scheduled at all. The quarterly reporting requirement would continue through December 2010.

The bill provides that payments under these contracts could not exceed the reimbursement rates under Medicare, and the non-VA facilities or providers would be prohibited from billing veterans affected by this process for the difference between the billed amounts and the amounts of VA payments.

Mr. Chairman, we note similar bills, H.R. 3094 from the 108th Congress and H.R. 92 from the 110th Congress, were considered by this Subcommittee in prior legislative hearings. The historical context during which the first bill was introduced is best described by then-VA Secretary Anthony J. Principi's reference to a "perfect storm" related to significantly increased demand for care and insufficient resources to meet timely access for that demand, resulting in a backlog or waiting list for access to VA medical services. Between October 1, 2001 and September 2002, VA enrolled an additional 830,237 veterans. With years of insufficient funding and an overwhelming demand for VA medical care, a July 2002 survey conducted by the Veterans Health Administration (VHA) revealed over 310,000 veterans waiting for medical appointments, half of whom were reported to be waiting 6 months or more for care and the other half having no scheduled appointments at all. In January 2003, over 200,000 were waiting 6 months or longer. At that time, exercising its annual enrollment decision authority as required by Public Law 104-262, VA suspended the enrollment of new Priority Group 8 veterans.

While DAV and many others opposed this decision on the record, we understood the reasons for it—clearly, VA was struggling from severe underfunding across its health care programs. The run-up to that decision also fueled our determination at DAV to seek a legislative remedy for VA's flawed health care budget formulation and discretionary appropriations processes.

On September 30, 2003, your Subcommittee held a legislative hearing on H.R. 3094 (a similar version of the current bill), at a time when about 130,000 veterans were still waiting 6 months or longer for access to VA care. DAV testified at that hearing that veterans must have access to timely health care and that VA must be held accountable for meeting its own access standards. However, we were deeply concerned that this bill to contract care in order to meet its proffered access standards would ultimately shift medical services and veteran patients from VA to private providers. The effect of contracting out care to non-Department facilities and providers would encourage VA to refer patients, and the dollars that would underwrite their care outside a unique governmental system of care specifically created for veterans to meet their specialized health needs. We testified at that time that if given sufficient, timely and predictable funding, VA should be held accountable for meeting all its demands, and that only as a last resort would we support the broad contracting out of their medical care.

On April 26, 2007, DAV's testimony on H.R. 92 (another similar bill to this one) recounted our position on H.R. 3094 from the 108th Congress and included the need for consideration in the bill to reinforce that VA must have a comprehensive, systemic process for contracting care to ensure:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

Therefore, we recommend the Subcommittee consider amending H.R. 84 to first implement the data requirements and reports required in the current measure prior to further considering approving provisions in the bill to automatically contract for care if the stated access standards would not be met. Over the past several years we believe VA has made tremendous effort to significantly reduce waiting times,¹ and thanks to the work of the Members of this Subcommittee VA now has the opportunity to receive timely, sufficient, and predictable funding for VA medical care through advance appropriations (Public Law 111–81).

In addition, DAV remains concerned about two weaknesses affecting the impact of H.R. 84, if enacted. Despite our recommendations in *The Independent Budget* (IB) over several years, VA has yet to establish a comprehensive, systemic program of contract care coordination to ensure that the services veterans receive in the private sector, paid for by VA, do not represent a diminished quality of care that they would have received otherwise from the VA.² Our second concern questions the validity of the reportable data for waiting times. DAV has raised this unresolved issue in concurrence with a report by the VA Office of Inspector General.³ Finally, we note the bill does not seek to identify the underlying cause(s) for delays in access to care, an issue that is critical to VA's developing an effective solution.

H.R. 949—To Improve the Collective Bargaining Rights and Procedures for Review of Adverse Actions of Certain Employees of the Department of Veterans Affairs, and for Other Purposes

This bill would repeal specified exceptions to rights of certain VA health professional employees to engage in collective bargaining over conditions of employment. It would also require reviews of adverse personnel actions of VA employees be completed within 60 days after such actions have been appealed, and would permit judicial review of these final decisions by the appropriate U.S. District Court or, if a decision were made by a labor arbitrator, review would occur within the jurisdiction of the U.S. Court of Appeals for the Federal Circuit in a manner similar to processes of the Merit Systems Protection Board in reviewing decisions related to Federal employees under title 5, United States Code.

Mr. Chairman, this bill would restore bargaining rights for clinical care employees of the VHA that have been eroded over the past several years. A similar version of this bill was introduced in both Chambers in the 110th Congress but did not advance.

DAV did not receive an adopted resolution from our membership on the specific VA labor-management dispute that prompted Chairman Filner's introduction of this bill. However, as a partner organization of the IB, DAV endorses its recommendations dealing with the need for VA to improve its human resources management systems and programs to make VA a better workplace for the care of sick and disabled veterans. Also, we believe VA-recognized labor organizations that represent employees in bargaining units within the VA health care and benefits systems have an innate right to information and reasonable participation that result in making VA a workplace of choice (a stated longstanding VA strategic goal), and particularly to fully represent VA employees on issues impacting their working conditions, ultimately protecting the quality of care for veterans.

Congress passed section 7422, title 38, United States Code (USC), in 1991, in order to grant specific bargaining rights to labor in VA professional units, and to promote effective interactions and negotiation between VA management and its labor force representatives concerned about the status and working conditions of VA physicians, nurses and other direct caregivers appointed under title 38, USC. In providing this authority, Congress granted to VA employees and their recognized representatives a right that already existed for all other Federal employees appointed under title 5, USC. Nevertheless, Federal labor organizations continue to report that

¹ *Fiscal Year 2009 Performance and Accountability Report*, Department of Veterans Affairs, Office of Management. Washington, D.C. www.va.gov/budget/report.

² *The Independent Budget, Fiscal Year 2011*; Contract Care Coordination, Non-VA Purchased Care; & Timely Access to VA Health Care. www.independentbudget.org/.

³ Department of Veterans Affairs, Office of Inspector General; *Semiannual Report to Congress, October 1, 2008–March 31, 2009*; pg. 10. <http://www4.va.gov/oig/pubs/VAOIG-SAR-2009-1.pdf>.

VA has severely restricted the recognized Federal bargaining unit representatives from participating in, or even being informed about, human resources management decisions and policies that directly impact conditions of employment of the VA professional staffs within these bargaining units. We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have used subsections (b), (c) and (d) of section 7422—subsections that this bill would repeal—as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA’s management decisions, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for nurses, physician market pay compensation panels, etc.).

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

It appears to DAV that the often contentious local environment consequent to these disagreements could diminish the VA as a preferred workplace for many of its health care professionals. As a result, veterans who depend on VA and who receive care from VA’s physicians, nurses and others in the professional ranks can be negatively affected by that environment.

We believe this bill, that if enacted would rescind VA’s claimed authority to refuse to bargain on matters within the purview of section 7422, through striking of subsections (b), (c) and (d), would clarify other critical appeal and judicial rights of title 38 appointees, and would return VA and labor to a more balanced bargaining relationship on issues of importance to VA’s professional workforce. In past hearings before this Committee, VA clearly has indicated vigorous disagreement with the intent of the bill, but to date has not offered to compromise its position in refusing to bargain across a wide group of issues that are defined by VA as “direct patient care.” Given the continuing stalemate, our only recourse is to support the intent of the bill in the spirit of the recommendations we have made in the IB, yet continue to urge both VA and Federal labor organizations to seek and find a basis for compromise on these matters.

**H.R. 1075—RECOVER Act
(Restoring Essential Care for Our Veterans for Effective Recovery)**

In the event of a declared major disaster, on or after August 29, 2005, where a VA medical facility is unable to provide covered health care services for at least 180 days due to the disaster, this measure would direct VA to contract with one or more non-VA facilities in that area to provide such services to veterans who reside within 150 miles of the affected VA facility(s). The requirement would not be applicable to VA facilities that were closed, or were intended to be closed as part of the Capital Asset Realignment for Enhanced Services (CARES) process.

Nearly 4 years after Hurricane Katrina, the House Veterans’ Affairs Committee conducted a field hearing on July 9, 2009, in New Orleans, Louisiana, to explore the challenges faced by the VA and other local health care facilities to provide high quality safe health care to area veterans and citizens. Believing geographic and timely access to care is particularly important to disabled veterans in need of medical attention, DAV testified that our Nation owes it to our veterans to properly care for them now—and not keep them waiting.

Prior to and during the disaster, VA did an admirable job of ensuring veteran patients were expeditiously evacuated, relocated and kept safe, and that local veterans’ medical records were available to other VA medical facilities to meet immediate needs for medications and specialized care. However, over the last 4-plus years, VA has struggled to re-establish *comprehensive* care services in the area following the devastating effects of Hurricane Katrina, and ensuring the immediate health care needs of our veterans are met without undue hardship. The network of community-based outpatient clinics and deployment of mobile clinics have created capacity to meet veterans’ basic outpatient primary care needs; however, reports from many affected veterans indicated that if hospitalization or inpatient treatment in a tertiary care facility were necessary, they must still travel great distances to the nearest VA health care facilities that can provide their needed care. For some elderly, ill, brittle and disabled veterans this creates a travel hardship. In addition, family members are often unable to accompany veterans due to travel restrictions, given the cost of travel without financial assistance for subsistence or lodging. Of note, research has proven that family support during hospitalizations and recovery,

or during difficult or stressful medical procedures can assist with accelerating recovery time and lowering length of stay, both resulting in cost savings for the VA.

This Subcommittee is aware of DAV's position regarding contracting care, specifically that it be utilized judiciously by VA. Current law places limits on VA's ability to contract for private health care services in instances where VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has the authority to contract to obtain the services of scarce medical specialists in VA facilities.

Hurricane Katrina impacted all of the major medical facilities in the immediate city area affected and we understand most are still not operational. However, in retrospect, it seems possible that VA could have established more contracts with other medical facilities just outside the affected city area. DAV is concerned that VA sparingly used existing authority in the instance of this major disaster, to contract with local non-VA facilities in the region to provide inpatient care but rather required veterans who were sick and in need of inpatient care to make long trips to the nearest VA facility in many cases.⁴ We do not believe such actions are in the best interest of sick and disabled veterans who rely on VA, nor are they an acceptable standard in this instance, given the length of time it has taken to reestablish and rebuild new VA facilities in that location. We hope, in considering this bill, the Subcommittee will note that within mere weeks of the disaster, Congress provided billions of dollars to restore the Gulf Coast region. Those funds and mandates failed to include mandates for replacement of the destroyed VA medical centers in New Orleans and Gulfport. While Congress eventually acted to authorize the funds and projects to replace these facilities destroyed by the storm, nearly 5 years after Katrina, sick and disabled veterans still await the opening of the replacement facilities.

The delegates to our most recent National Convention passed DAV Resolution No. 037, calling on VA to ensure timely access to quality health care and medical services. We therefore support the purposes of this bill as a contingency, but point out concerns that we recommend be addressed before final passage. The operational loss of a VA medical facility due to a major disaster and subsequent contracting with non-VA facilities as proposed by this measure should not become a foundation for delay of replacement facilities, or repair of the affected VA facility. Also, the bill should reflect Congressional intent that upon the completion of replacement or repair of an affected VA facility, veterans who have received care under a contract arrangement with a non-VA facility will return to the repaired or replaced VA facilities for their continuing health care needs. Accordingly, we recommend improvements outlined in DAV Resolution No. 232 (on the need for better coordination of VA contract care programs), to include ensuring that service-connected disabled veterans would not be financially encumbered in receiving non-VA care at VA's expense; and that VA would establish a systemic, comprehensive contract care coordination program for these patients.

H.R. 2698—Veterans and Survivors Behavioral Health Awareness Act

The intent of this measure would improve and enhance the mental health care benefits available to veterans as well as to enhance counseling and other benefits to survivors of veterans.

Section 2 of this bill would direct the VA Secretary to provide scholarships to individuals pursuing education or training leading to licensure or other certified proficiency in behavioral health care specialties that are critical to the operations of Vet Centers for readjustment counseling and related mental health services for veterans. These scholarships would assist in recruitment and in retaining individuals within such specialties. In order to accept scholarships, the recipients would agree to continue to serve in such a capacity for defined periods the Secretary specified in agreements—including repayment of the scholarships if encumbered individuals subject to these scholarships failed to fulfill the service requirements of the aforementioned agreements. The VA Secretary would determine the amount of the scholarships and amounts under the program would be derived amounts available to the Secretary for readjustment benefits—but would not exceed \$2 million in any fiscal year (FY).

⁴Travel times and distances from the New Orleans VAMC to: Biloxi VAMC—1.5 hours/85 miles; Sonny Montgomery (Jackson) VAMC—3 hours/189 miles; Alexandria VAMC—3.5 hours/199 miles; the Michael E. DeBakey (Houston) VAMC—6 hours/352 miles; Overton Brooks (Shreveport) VAMC—5.5 hours/319 miles.

Section 3 of this bill would stipulate that upon receipt of a request for counseling from an individual discharged or released from active service, but who would not be otherwise eligible for such counseling, the Secretary would be required to (1) provide referrals to assist the individuals in obtaining mental health care and services outside the VA to extent practicable; and (2) if pertinent, would advise such individuals of their rights to apply for review of their military discharge documentation.

Section 4 would direct the Secretary to award grants to nonprofit organizations that provide emotional support services for survivors of deceased members of the Armed Forces (including National Guard and Reserves) and deceased veterans through peers of such survivors. The Secretary would establish the criteria for nonprofit organizations' eligibility through an application process to be specified by the Secretary as well as the amounts for such awards.

While the DAV has no specific resolution pertaining to section 2 of the measure, related to scholarships, we have two national resolutions that apply to the main intent of this section of the bill. The first is DAV's resolution number 101, which calls for adequately funding and sustaining the successful readjustment counseling services of the VA and its highly effective Vet Center programs. The second DAV resolution is number 243, which strongly supports program improvement and enhanced resources for VA mental health programs to achieve readjustment of new war disabled veterans and continued effective mental health care for all enrolled veterans needing such services.

In addition, the FY 2011 IB contains a section on human resources challenges facing VA. We remain concerned about the current status of human resources challenges faced in the VA and the need to consider creative and alternative programs to ensure veterans have access to the best medical and mental health services for rehabilitation of their service-related injuries. We have recommended that Congress and VA continue to work to strengthen and energize VA's human resources management programs to recruit, train, and retain qualified VA employees and to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for veterans.

Therefore, since the intent of the section is to recruit and retain mental health care providers at VA's Vet Centers, we support enactment of this section of the bill.

DAV has no objection to the provisions in section 3 of H.R. 2698 related to referrals to assist individuals, who are not otherwise eligible for Vet Center counseling services, in obtaining mental health care and services outside the VA or to advise such individuals of their rights to apply for review of their military discharge determinations.

The DAV does not have a specific resolution related to section 4 of the bill that pertains to Federal funding through a grant program for nonprofits to provide emotional support through peer groups to survivors of deceased servicemembers and veterans. We do support the peer-to-peer initiatives that have been employed in the VA's Vet Center program. However, DAV would not be able to participate in the program that would be authorized in this section of the bill because, as a matter of principle, DAV does not accept federally appropriated grants to provide services to disabled veterans.

H.R. 2699—Armed Forces Behavioral Health Awareness Act

The purpose of this measure would be to improve the mental health care benefits available to members of the Armed Forces, including Reserve components, and to enhance counseling available to servicemembers' family members.

Section 2 of this measure would make any servicemember of the Armed Forces who deploys in support of Operations Enduring Freedom or Iraqi Freedom (OEF/OIF) eligible for readjustment counseling and related mental health services through VA Vet Centers, regardless of the member's duty status.

Section 3 would require that the Secretary of Defense award grants to nonprofit organizations that provide emotional support services for family members of members of the Armed Forces, including members of the Reserve components. The amount of each grant and duration of the program would be determined by the Secretary based on the scope of the proposed program. Such funding would be derived from the amounts authorized to be appropriated to the Department of Defense (DoD) for military personnel.

Section 4 would require the Secretary of the Army to carry out a 3 year pilot program to enhance awareness and understanding of post traumatic stress disorder (PTSD) among members of the Army at three military base locations: Fort Huachuca, Arizona, Fort Carson, Colorado, and Fort Leonard Wood, Missouri, and for the family members of servicemembers covered under the bill in order to assist the families in recognizing and addressing PTSD. No later than 2 years after the

date of enactment, the DoD Secretary would be required to submit a report to Congress assessing the effectiveness of the pilot program.

DAV takes no position on provisions in H.R. 2699 related to enhancement of post-deployment mental health services for active duty servicemembers, Reserve components or their family members. These matters are under the jurisdiction of the Committees on Armed Services. We do provide the following comments on section 2 of the bill related to expansion of eligibility of readjustment counseling services at Vet Centers under section 1712 A of title 38, United States Code.

DAV's resolution number 243 strongly supports program improvement and enhanced resources for VA mental health programs to achieve readjustment of new war disabled veterans and continued effective mental health care for all enrolled veterans needing services. Although we do not have a resolution specific to expanding eligibility for Vet Center services to active duty status servicemembers, we have supported seamless transition for servicemembers and veterans and improved collaboration between the two Departments to achieve this goal. Therefore, we have no objection to such expansion, since it would likely be most beneficial for certain servicemembers to obtain early interventions of any deployment-related mental health concerns to avoid more complicated health challenges and costly treatment interventions at a later date. We note similar provisions are included in Title IV of the proposed negotiated agreement on an omnibus VA health care bill, the vehicle for which will be S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2010.

Should the Subcommittee plan to report this measure to the full Committee, we ask you to consider amending section 2 of the bill to include provisions to authorize either a cost sharing agreement with DoD, as envisioned in Public Law 97-174, to cover the VA's costs of servicemembers' care based on data verifying the number of servicemembers who access such counseling, or to authorize additional VA resources in the bill specifically for this care of the active force, as well as the cost of the additional staff needed to provide such services. Additionally, consideration should be given to include provisions to provide proper outreach to active servicemembers about this exceptional service and assured confidentiality when accessing such care at a VA Vet Center, to ensure the intended purpose of the program is achieved.

H.R. 2879—Rural Veterans Health Care Improvement Act of 2009

Section 2 of this bill would amend section 111, title 38, USC, to insert a fixed rate of 41.5 cents per mile in reimbursement for the purposes of VA's travel beneficiary program. Reimbursement at this rate may exceed the cost of travel by public transportation regardless of medical necessity. A report is required no later than 14 months after enactment of the Act.

Section 3 of this bill would require VA to establish at least one and no more than five centers of excellence for rural health research, education, and clinical activities.

Section 4 would require the Secretary to establish a transportation grant program to veterans service organizations to allow for other transportation options to assist veterans residing in highly rural areas to travel to VA facilities.

Section 5 would require the VA's Office of Rural Health to conduct demonstration projects with the goal of expanding care in rural areas.

Section 6 of the bill would require the VA to establish a contract care program through community mental health centers and other "qualified entities" for the provision of certain readjustment, mental health, peer counseling and similar services to OEF/OIF veterans and their dependents in rural and remote regions. The program would be restricted to areas determined by the Secretary to be inadequately served by direct VA services.

Section 7 of the bill would establish a Native American health care coordination function in the 10 VA medical centers that serve the greatest number of Native Americans per capita, with specification of the duties associated with the new function. Also, the bill would require the Secretary and the Secretary of the Interior to execute a memorandum of understanding that would ensure the health records of Indian veterans may be transferred electronically between the Indian Health Service (IHS) and the VHA.

Section 8 would require an annual report to Congress as a part of the President's budget on a variety of matters concerned with rural veterans.

The DAV appreciates the intent of this measure to improve health care for veterans residing in rural and remote areas. With some concern outlined below, we support enactment of this bill as consistent with DAV resolution numbers 240 (related to VA's beneficiary travel reimbursement policy) and 247 (related to improved health care services and access for veterans living in rural areas), adopted by our membership at DAV's 2009 National Convention.

As this Subcommittee is aware, the conference report accompanying the Consolidated Appropriations Act of 2008 (Public Law 110–161), specified that \$125 million of the funds provided for veterans medical services should be used to increase the travel reimbursement rate. The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009 (Public Law 110–329), provided an additional \$133 million to increase the beneficiary travel reimbursement mileage rate to 41.5 cents per mile, while freezing the deductible at current levels. Subsequently, the Veterans’ Mental Health and Other Care Improvements Act of 2008 reduced the mileage deductible to \$3 for each one-way trip; \$6 per round trip; with a calendar month cap of \$18 as specified in title 38, United States Code, Subsection 111(c)(1) and (2) for travel expenses incurred on or after January 9, 2009.

DAV supported the increase in mileage reimbursement afforded under Public Law 110–329. However, by prescribing in law the current travel reimbursement rate of 41.5 cents per mile without any mechanism for annual adjustment may lead to the situation that occurred prior to enactment of Public Law 110–161 to break the long period where the beneficiary travel mileage reimbursement rate had not been changed in over 30 years.

Additionally, in eliminating title 38, USC, Subsection 111(g), we are concerned this bill does not replace the required report from VA containing full justification (including the ramifications of diverting funds not provided for in appropriations, such as those in Public Laws 110–161 and 110–329, from direct medical care for the purpose of increasing mileage) when exercising its authority to increase or decrease the rates of allowances or reimbursements. We refer the Subcommittee to section 305 of the recently reached proposed negotiated agreement on an omnibus VA health care bill, the vehicle for which will be S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2010. In amending title 38, USC, Subsection 111(g), S. 1963 provides certain flexibility to the Secretary as it relates to investigating and determining the actual cost of travel for establishing VA mileage reimbursement rates.

Finally, should Congress decide to strike Subsection (g) of title 38, USC, Subsection 111, as is proposed by this measure, we recommend a technical correction be made to Subsection 111(b)(1) because it references Subsection (g)(2)(A).

H.R. 3926—Armed Forces Breast Cancer Research Act

This Act would direct the Secretaries of DoD and VA to jointly conduct a study on the incidence of breast cancer among members of the Armed Forces, including National Guard and Reserve components, and veterans and report those study results to Congress.

H.R. 3926 would also require demographic information on study participants including information on possible exposure to hazardous elements or chemical or biological agents (including vaccines), locations in which the servicemembers or veterans were deployed, and analysis of breast cancer treatments received by Armed Forces members and veterans.

DAV Resolution No. 252 urges greater collaboration between DoD and VA to share necessary deployment, health and exposure data from military operations and deployments, in order to timely and adequately address the subsequent health concerns of disabled veterans, whatever the causes of those disabilities. Additionally, this resolution urges Congress to provide adequate funding for research to identify all disabling conditions and effective treatment for such disabilities that may have been caused by exposure to environmental hazards and man-made toxins while serving in the Armed Forces of the United States.

DAV is committed to ensuring veterans disabled by exposure to environmental hazards and toxins receive effective high quality health care and that the biomedical research and development programs of the Department are fully addressing their needs. For these reasons we are pleased to support H.R. 3926, the Armed Forces Breast Cancer Research Act, and urge its passage.

H.R. 4006—Rural, American Indian Veterans Health Care Improvement Act of 2009

The Rural, American Indian Veterans Health Care Improvement Act of 2009 directs the Secretary of VA to assign an Indian Veterans Health Care Coordinator for each of the ten VA facilities that serve communities with the greatest per capita number of Indian veterans. The Indian Veterans Health Care Coordinator would be tasked with: (1) improving outreach to tribal communities; (2) coordinating the medical needs of Indian veterans on Indian reservations with the VHA and the IHS; and (3) acting as an ombudsman for Indian veterans enrolled in the VHA health care system.

The bill would require the VA and the Department of the Interior to enter into a memorandum of understanding to ensure the electronic transfer of health records of Indian veterans between IHS and VA facilities. Moreover, VA would be authorized to transfer to IHS any surplus medical and information technology equipment.

This measure would also require VA and the Department of Health and Human Services (HHS) to report jointly to Congress on the advisability of the joint VHA–IHS establishment and operation of health clinics to serve populations of Indian reservations, including Indian veterans.

Since 2003, the IHS and the VHA have collaborated using a memorandum of understanding (MOU) to promote greater cooperation and resource sharing to improve the health of American Indian/Alaska Native (AI/AN) veterans. The MOU encourages VA and IHS programs to collaborate and improve beneficiaries' access to health care services, improve communications between IHS and VHA and to create opportunities to develop strategies for sharing information, services, and information technology. In some areas, this coordination between IHS and VHA has improved while in other areas, such coordination needs improvement.

A recent study examined AI/AN veterans' utilization of the IHS and VA health services. Based on the study's survey, 25 percent of AI/AN veterans receive care through both IHS and VA, while over 25 percent of AI/AN veterans accessed care through VA only and nearly 50 percent of AI/AN veterans accessed care through IHS only.⁵ Those AI/AN veterans who used both VA and IHS for medical care actively matched health care resources to their medical needs, generally use IHS for primary care and VA for specialty care, thus using VA as a form of supplemental coverage. The report also indicates that AI/AN veterans report a high rate of unmet health care needs and experience a lack of coordination of health care.

Another study concluded fostering closer alignment between VHA and IHS would reduce care fragmentation and improve accountability for patient care.⁶ This study found coordination between VA and IHS providers occurred on an ad hoc basis. Although both VA and IHS could share information through medical releases, veterans were dissatisfied with the burdensome process when it was made available as an option. Since medical information was not routinely shared, treating chronic health conditions was challenging, especially when providers were unaware of their counterpart's recommendations of treatments, including medications and dosage. Appropriate referrals to VHA from the IHS would be a significant step toward resource sharing that would benefit both organizations financially. By displaying leadership in coordination of care, VHA and IHS can demonstrate how to overcome technical, policy and administrative challenges in implementing the Institute of Medicine recommendations to enhance quality through data sharing and care coordination.⁷

As with section 7 of H.R. 2879, the Rural Veterans Health Care Improvement Act of 2009, DAV supports this measure based on DAV Resolution No. 247 (supporting improved access to rural health care services for veterans residing in those areas), adopted by our membership at DAV's 2009 National Convention. We are aware that better collaboration between VA and IHS is critical, particularly in the behavioral health understanding and accommodation of the cultural needs of American Indian, Alaska Native and Pacific Islander veterans—and that culturally traditional treatments should be considered as an option for tribal veterans.

**Draft Bill—To Amend Title 38, United States Code, To Make
Certain Improvements in the Laws Relating to Performance Pay and
Collective Bargaining Rights for Certain Employees of the
Department of Veterans Affairs**

This measure would amend section 7431(d)(2) of title 38 by inserting “individual” after “dentist’s” and by inserting “in accordance with regulations” after “objectives,” in addition to editing section 7422 by inserting “rates” after “employee compensation.” Further, “patient care” would be inserted in subsection (c)(1) after “not including procedures or appropriate arrangements as such terms are used in section 7106(b) of title 51 and in subsection (d) by inserting “rates” after “employee compensation.”

⁵ B.J. Kramer, M. Wang, et al; *Veterans Health Administration and Indian Health Service—Healthcare Utilization by Indian Health Service Enrollees*, Medical Care, Vol. 47, No. 6. June 2009.

⁶ B.J. Kramer, R.L. Vivrette, MA, et al; *Dual Use of Veterans Health Administration and Indian Health Service: Healthcare Provider and Patient Perspectives*, Gen Intern Med. 24(6): 758–764. Published online April 18, 2009.

⁷ Institute of Medicine, Committee on Enhancing Healthcare Quality Programs. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*; National Academy Press. 2002.

Section 1 of this bill would clarify Congressional intent in establishing performance pay elements for VA physicians and dentists in Public Law 108-445, the VA Health Care Personnel Enhancement Act of 2004, by sharpening its intent to measure performance of individual physicians and dentists, rather than groups of these key VA professionals in establishing performance pay. The bill would also require the Secretary to establish by published regulation (presumably in the Federal Register) in advance the performance objectives that VA would use to justify awarding performance-based salary increments, or performance bonuses, to VA physicians and dentists who chose to function under those performance objectives. Under the bill, such regulations would be required to be published within 60 days post-enactment of this bill.

The DAV has no adopted resolution on these particular matters, but we again refer the Subcommittee to the FY 2011 IB discussion on the need for VA to improve human resources programs. Publishing performance objectives for VA physicians and dentists in the Federal Register in advance of their use would be a novel but probably effective way to guarantee VA would be required to consider their views before adopting new procedures that impacted their conditions of employment. We believe this bill's enactment would be consistent with our views in the IB. Thus, we would have no objection to passage of this section.

Section 2 of the bill would make a series of amendments to section 7422 of title 38, USC, in subsections (b), (c) and (d), to narrow the definition of exclusions from collective bargaining dealing with the interests of certain health professional employees of the Department. Again, DAV refers the Subcommittee to our human resources discussion in the IB for FY 2011. These changes would afford recognized employee units more ability to bargain with VA on policies that would make VA a preferred workplace for clinical professional staffs. DAV would offer no objections to enactment of this section of the bill. However, we remind the Subcommittee of our comments on H.R. 949, a bill that would repeal each of the subsections of title 38 that this bill would amend.

Draft Bill—To Amend Title 38, United States Code, To Improve the Continuing Professional Education Reimbursement Provided to Health Professionals Employed by the Department of Veterans Affairs

This bill would expand from VA physicians and dentists to a wider group of VHA professional employees who are eligible for annual continuing education allowances, and would increase such allowances from \$1,000 to \$1,600 per annum per employee. amendments to effect this change would be made to section 7411(1) of title 38, USC, by striking “physician or dentist” and replacing it with “health professional” employees appointed under paragraph (1) or (3) of section 7401 of the title. The bill would also specify that no health professional could receive reimbursement under this section in addition to any other reimbursement for expenses incurred for education provided by a Department medical center.

While we have no resolution adopted on this specific matter from our membership, the purpose of the bill is consistent with VA's maintaining technical proficiencies of VA clinical professionals. On that basis, DAV would offer no objection to its enactment into law.

Draft Bill—To Amend Title 38, United States Code, To Authorize the Secretary of Veterans Affairs to Waive Certain Requirements Relating to Mental Health Counselors

This bill would amend section 7202(b)(11)(B) by inserting “except that the Secretary may waive the requirement of licensure or certification for an individual licensed professional mental health counselor for a reasonable period of time recommended by the Under Secretary for Health” before the period where it appears. We noted a technical error in the text in that it refers to “section 7202,” a section that does not exist in title 38, rather than section 7402, a section that refers to “Qualifications of appointees” in the VHA.

Assuming it would apply to section 7402, this bill would grant the VA Secretary a temporary period to retain VA mental health professional employees while they sought professional certifications and state licensures within their fields. Given the shortage of mental health professionals today in general, and given VA's need to continue to prepare for a major growth of mental health workloads due to the anticipated end of wars in Iraq and Afghanistan and the mental health legacy associated with these wars, this proposal seems reasonable as a needed human resources flexibility. Also, given VA's massive academic programs in which tens of thousands of professional and technical students rotate in VA facilities each year as a part of their practica, this tool might help VA with a number of its chronic recruitment

challenges. Thus, while DAV has no adopted resolution from our membership on this particular issue, we would not object to enactment of this bill.

Mr. Chairman, this concludes DAV's testimony. Again, we thank the Subcommittee for its leadership, and for requesting our views on the legislation under consideration by the Subcommittee at this hearing. I would be pleased to respond to any questions from you or other Members of the Subcommittee on these issues.

**Prepared Statement of Gerald M. Cross, M.D., FAAFP, Deputy Chief for
Patient Care Services and Chief Consultant for Primary Care,
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 several bills that would affect Department of Veterans Affairs (VA) benefits programs and services. Joining me today are Walter A. Hall, Assistant General Counsel; Brian McVeigh, Chief Consultant, Human Resources Management; and Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning. Unfortunately, we do not yet have views and costs for H.R. 84, H.R. 1075 and a draft bill regarding performance pay and collective bargaining. We will forward them as soon as they are available.

H.R. 949—Repeal of 38 U.S.C. § 7422 Collective Bargaining Exclusions; Adverse Action Decisions and Appeals; Disciplinary Appeals Board Transcripts

When Congress first authorized VA clinicians to engage in collective bargaining in 1991 it did so acknowledging that clinical decisions and clinical management decisions should not be decided through the collective bargaining process. Congress provided that only the Secretary, and by delegation the Under Secretary for Health may decide when one of the statutory bargaining exclusions in section 7422 applies. However they did provide that, if a party believes that the Under Secretary for Health has acted arbitrarily or capriciously in issuing a 7422 decision, the party may seek judicial review of the decision pursuant to section 7422(e).

The key provision of H.R. 949 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. It would repeal the current restriction on collective bargaining, arbitrations, and grievances over matters that the Secretary determines to concern or arise out of the professional conduct or competence, peer review, or compensation of title 38 employees. In addition, the bill would impose a very tight time limit on the issuance of final agency decisions on employee grievances and would make such decisions subject to judicial review. Finally, the bill would require VA to provide employees who appeal adverse actions under section 7462 with a full and correct copy of the Disciplinary Appeals Board transcript at least 21 days before post-hearing briefs are submitted, despite the existence of a 120-day deadline for the issuance of Disciplinary Appeals Board decisions.

We appreciate the many positive contributions collective bargaining and labor-management partnership make to VA's mission. H.R. 949 would have an adverse impact on VA's ability to deliver quality patient care. Consistent with our views on a similar Senate bill, we strongly oppose it. Section 1 of H.R. 949, if enacted, would imperil VA's ability to furnish timely and quality care for veterans. H.R. 949 would open VA's responsibility under title 38 to (1) make direct patient care and clinical competency decisions, (2) assess title 38 professionals' clinical skills, and (3) determine discretionary compensation for title 38 professionals, to review other non-clinical third parties who lack the clinical training and health care expertise to make such determinations.

In September 2009, following extensive discussions with the American Federation of Government Employees (AFGE) regarding friction over differences of interpretation over collective bargaining authorities, VA and its labor partners signed a charter for a 38 U.S.C. 7422 Workgroup, with the purpose of formulating recommendations for the Secretary to improve knowledge, understanding, and consistent use of the authorities and limitations in section 7422. The Workgroup consists of representatives from VA's five national unions (AFGE, National Federation of Federal Employees, National Association of Government Employees, Service Employees International Union, and United American Nurses). VA's team is headed by the Assistant Secretary for Human Resources and Administration, Mr. John Sepulveda, and includes subject matter experts from the Veterans Health Administration, Office of General Counsel, and Office of Labor Management Relations. The Workgroup

charter charged its members with: (1) establishing a dialogue about the meaning of the 7422 bargaining and grievance exclusions; (2) making recommendations to the Secretary regarding consistent use of section 7422; (3) developing joint training about the section 7422 exclusions and decision process; (4) identifying strategies for enhancing collaborative efforts to resolve disputes at all levels; (5) recommending approaches for capturing data reflecting informal and formal efforts to resolve section 7422 disputes; and, (6) developing a strategic communication plan for the results of the Workgroup. Over the past 6 months, the 7422 Workgroup has held a series of multi-day face-to-face sessions, conducted in a partnership manner, where the parties engaged in a productive dialog. We are hopeful this process, when concluded, will result in actions and understandings that will address many of the unions' concerns about the manner in which section 7422 exclusions are applied.

H.R. 949 would create a number of significant problems that would impede VA's ability to operate a safe, effective and responsive health care system. The rules for collective bargaining often lead to protracted negotiations and third-party proceedings. On average, it takes 120 days to negotiate national Memorandums of Understanding (MOU) with VA's largest union, the AFGE. The 120-day average does not include local level bargaining over facility-specific aspects of a change, which can add another 30–60 days. While this kind of timeline may be acceptable for most workplace matters, it is not when it comes to patient-care matters. If H.R. 949 is enacted, critical changes in patient care, safety procedures, and policies could not be implemented until national and local bargaining had been completed. This could result in less than optimal care for veterans. Such delays, and the very practice of negotiating clinical matters, are inconsistent with patient-centered medicine.

H.R. 949 would allow title 38 professionals to grieve matters or file unfair labor practice charges on clinical matters currently exempted from collective bargaining. Grievances not resolved at the informal stage are decided by a third-party arbitrator and may be subsequently appealed to the Federal Labor Relations Authority. Labor grievance arbitrators, the Federal Labor Relations Authority, and the Federal Service Impasses Panel would have considerable discretion to impose a *clinical or patient care* resolution on the parties. VA would have limited, if any, recourse if such an external party erred in its consideration of a clinical or patient care issue; VA would be bound by that third-party's decision. VA opposes this change in the strongest possible terms—clinicians must be able to make the clinical decisions to ensure care is furnished in compliance with VA and prevailing medical practice standards. Actions concerning direct patient care and the clinical competence of VA providers must be made and reviewed by clinicians, not arbitrators.

Moreover, non-clinical third-parties are not accountable for ensuring the health and safety of the veterans receiving their care through the Department. If the Secretary and the Under Secretary for Health are going to be held responsible and accountable for the quality of care provided to veterans, they must be able to make decisions relating to patient care and the clinical competence of VA providers. Decisions must be based on what is best for our veterans from a medical perspective rather than what is the best that can be negotiated through collective bargaining, or on what a non-clinical arbitrator or the Federal Labor Relations Authority decides is appropriate in the context of collective bargaining. Our veteran patients cannot be expected to understand why their VA providers—a group of highly qualified, trained, and trusted professionals—have no option but to follow the decisions of third-parties with whom they disagree on matters affecting patient care.

This provision would also require collective bargaining related to VA's Peer Review process by which VA assess the clinical skills of title 38 health care professionals and assesses whether our patients are receiving the high standard of care they deserve. Matters relating to peer review are now expressly exempted from collective bargaining under section 7422. H.R. 949 would change that, again subjecting the process of assessing the clinical skills of title 38 professionals and determining whether they are clinically competent in their area of practice to review by non-VA, non-clinical third-parties.

In addition to clinical-care issues, H.R. 949 would permit unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under title 5, including the determination of the amount of an employee's compensation. Permitting title 38 staff to negotiate the discretionary aspects of their compensation would be at complete odds with a basic premise of Federal labor management relations.

Section 2 of the bill would establish a new section 7463(f)(1), which would require VA to decide grievance appeals no later than 60 days after a grievance is filed and would subject such decisions to judicial review. VA opposes section 2 of H.R. 949. In many cases, because of the complexity of the issues, the need to develop and review evidence, or secure the availability of witnesses, a grievance examiner's review

can take most or all of those 60 days, leaving no time for a VA higher level official to review, and decide upon, the grievance examiner's findings and recommendations as called for in section 7463(d)(3). Sixty days is not sufficient for this process.

Finally, section 3 of the bill would amend the Disciplinary Appeals Board or DAB statute in section 7462 to require the provision of a full and correct copy of a DAB transcript to an employee at least 21 days before the submission of post-hearing briefs. DABs are conducted when a title 38 employee appeals a major adverse action arising out of a question of professional conduct or competence. VA opposes section 3 of H.R. 949 because it would unnecessarily constrain the time available to DABs to make their decisions, which by law must be rendered within 45 days of the DAB hearing and no later than 120 days after commencement of the appeal. There may be instances where it will be impossible to provide the transcript to an employee within 21 days and meet the 120-day statutory time limit because of the timing of the oral hearing or the length of time it takes to prepare a full and complete transcript. Cases can involve complex clinical issues and extensive medical and expert testimony and evidence. Moreover, post-hearing briefs are neither necessary nor required by many DABs because the issues are sufficiently fleshed out in the DAB's oral hearing, the written notices provided to the employee, and the employee's written reply, oral reply, and DAB appeal.

In sum, VA's ability to manage its health care facilities and to monitor the professional conduct and competence of its employees must be reserved for the VA professionals and clinicians who are responsible for delivering quality patient care. Current law provides the appropriate balance between rightful subjects for collective bargaining and clinical need, and, as noted above, VA and its unions are engaged in a productive dialog to resolve issues of interpretation of the contours of how 7422 is applied.

H.R. 2698—"Veterans and Survivors Behavioral Health Awareness Act"

VA does not support section 2 of H.R. 2698 which would direct VA to provide scholarships to individuals pursuing education or training in behavioral health care specialties in order to recruit and retain individuals for service in Vet Centers. In exchange for the scholarship, an individual would be required to fulfill a service obligation with VA. The total amount available for scholarships could not exceed \$2,000,000 in any fiscal year.

VA appreciates the concept of using scholarships to enhance succession planning. However, this section is unnecessary. Under existing authority, VA can establish a special scholarship program to identify, educate and hire individuals for difficult-to-recruit and difficult-to-retain health care positions including individuals pursuing degrees in mental health specialties. Additionally, implementation of section 2 of H.R. 2698 would result in substantial costs to VA over a long period of time with little short-term benefits. It takes 2 to 7 years of education to qualify to become a VA behavioral health specialist. Congress has authorized and VA has taken other actions to promote recruitment and retention of qualified health professionals, including the Education Debt Reduction Program and the Employee Incentive Referral Initiative. VA takes this opportunity to again endorse reauthorization of the Health Professional Educational Assistance Scholarship Program. This program would be a more effective and broader program to support recruitment and retention efforts in a variety of career fields, including mental health counselors.

VA has not had difficulties hiring new counselors, and in the past 3 years, VA has hired more than 5,800 additional mental health workers. VA has also expanded funding for mental health training by supporting the expansion of training positions in psychology by 206 positions. Seventy percent of current VA psychologists participated in a VA training program, demonstrating that these initiatives are an exceptional resource for addressing future recruitment needs. The legislation also appears to duplicate provisions from the Montgomery GI Bill and the Post-9/11 GI Bill, which already provide mechanisms for funding graduate and post-graduate degree programs for eligible veterans. These measures do not include a specific service obligation, but do allow veterans to pursue an advanced education in the behavioral health sciences.

We have not formulated costs at this time, but will provide them for the record when they become available.

VA supports section 3 of H.R. 2698, which would direct VA, on receipt of a request for counseling from an individual who has been discharged or released from active service but who is not otherwise eligible for such counseling, to: (1) provide referrals to assist the individual in obtaining mental health care and services outside VA; and (2) if pertinent, advise such individual of the individual's rights to apply for review of the discharge or release.

This provision would allow VA to provide referral services to veterans with problematic discharges by referring them to services outside VA and by advising such veterans of their right to apply for a discharge upgrade. There are no significant costs associated with enactment of this section.

Section 4 of H.R. 2698 would direct VA to carry out a program to award grants to nonprofit organizations that provide emotional support services (i.e., bereavement counseling) for survivors of deceased members of the Armed Forces and deceased veterans through the survivors' peers.

VA currently has authority to provide bereavement services to the surviving military family members of servicemembers who die while on active duty, and to family members of veterans who die while receiving VA treatment for a service connected condition in a VA facility. Section 4 would expand bereavement services to family members of all veterans. VA has not had time to develop costs for this section, but will provide our views and costs as soon as they are available. With regards to bereavement services provided to families of servicemembers, Vet Centers have adopted standards of care to ensure that family members are contacted the same day as the referral is received, and to schedule an appointment with a counselor at the nearest Vet Center within 24 to 48 hours of receiving the referral. Through February 2010, Vet Centers have assisted the families of 1,939 fallen servicemembers; 1,152 (60 percent) were in-theater casualties in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF).

H.R. 2699—“Armed Forces Behavioral Health Awareness Act”

Section 2 of H.R. 2699 would make members of the Armed Forces, including the Reserve components, who are deployed in support of OEF/OIF eligible for readjustment counseling and related mental health services operated by VA as authorized under 38 U.S.C. § 1712A. The Department will provide its views and the cost estimate for section 2 soon.

VA defers to the Department of Defense concerning section 3 of H.R. 2699 and to the Department of the Army concerning section 4 of H.R. 2699.

H.R. 2879—“Rural Veterans Health Care Improvement Act of 2009”

Section 2 of H.R. 2879 would amend 38 U.S.C. § 111 by setting the beneficiary travel allowance rate at 41.5 cents per mile and repealing the requirement that allowances be determined using the mileage reimbursement rate under 5 U.S.C. § 5707(b) for the use of privately owned vehicles by government employees on official business. In addition, this section would repeal VA's authority to modify the allowances or reimbursement amounts in excess of the rate determined by 5 U.S.C. § 5707(b). This section would also repeal the requirement that certain beneficiaries must be unable to defray the expenses of such travel pursuant to regulations; repeal the requirement that payments may not exceed the cost of such travel by public transportation if accessible and not medically inadvisable; and repeal the requirement that payments must not exceed the actual expense incurred as certified in writing by the person. Last, this section would require that the Veterans Health Administration (VHA) Handbook on beneficiary travel be revised to clarify that a travel allowance based on mileage may exceed the cost of such travel by public transportation regardless of medical necessity.

VA does not support section 2 of H.R. 2879. While 41.5 cents per mile is the current reimbursement rate, VA would lose the authority to decrease or increase the rate using the mileage reimbursement rate under 5 U.S.C. § 5707(b). VA would also lose the flexibility to exceed the section 5707(b) rate should funding and circumstances warrant. The requirement to allow for mileage reimbursement greater than the cost of travel by public transportation regardless of medical necessity would eliminate VA's authority to pay only for the most cost-effective available and appropriate mode of transport. As a result, in some cases VA would reimburse more than the veteran actually expended for transport.

VA estimates the cost of implementing this section to be \$16.24 million over 5 years, and \$35.56 million over 10 years.

Section 3 would require the establishment of one to five centers of excellence for rural health research, education, and clinical activities, through the Director of the Office of Rural Health. The centers would be required to conduct research, develop specific models for furnishing health services, provide education and training for health care professionals, and develop and implement innovative clinical activities and systems of care.

VA does not support section 3 of H.R. 2879 because the “Centers of Excellence” proposed in this provision would be duplicative of the Veterans Rural Health Resource Centers (VRHRC) and of the efforts of VA's Veterans Rural Health Advisory Committee.

VA established the VRHRCs to improve care and services for veterans residing in geographically isolated areas. The VRHRCs conduct policy-oriented studies and analyses; function as field-based clinical laboratories for policy-relevant pilot projects and evaluations; serve as regional rural health experts organizing and sharing information within and across Veterans Integrated Service Network (VISN) boundaries; and serve as an educational repository and academic and clinical information clearinghouse. The VRHRCs are operational and conducting important work, such as a pilot project designed to develop a simulation tool for modeling rural health care access; telephone-based telehealth initiatives for diabetes, hypertension, and chronic pain; rural workforce development; utilization of mobile clinics as an alternative care delivery model; and a study on clinical practice intensity to compare VA to private sector physicians in urban and rural settings. VA's Veterans Rural Health Advisory Committee membership includes affected veterans, rural health experts in academia, State and Federal professionals who focus on rural health, State-level veterans affairs officials, and leaders of Veterans Service Organizations. The purpose of the Advisory Committee is to examine ways to enhance VA health care services for veterans in rural areas by evaluating current programs and identifying barriers to health care.

VA estimates the minimum cost of implementing section 3 to be \$10.76 million over 5 years and \$23.67 million over 10 years.

Section 4 would require the establishment of a grant program to provide innovative transportation options to veterans in rural areas. Under this section, grants awarded could be used by State Veterans' Service Agencies and Veterans Service Organizations to assist veterans in highly rural areas with travel to VA medical centers, or otherwise assist in providing medical care to these veterans. A grant awarded under this section could not exceed \$50,000.

VA agrees with the intent of this legislation and agrees that veterans in rural areas need more transportation options when seeking VA health care, but VA does not support section 4 of H.R. 2879. The specific provisions of this legislation are unnecessary, and VA already has efforts underway that will address this problem more quickly than new legislation would. VA is currently developing pilot programs to implement innovative transportation services at various rural health care facilities. Funds that would be spent for grants would be more effectively and efficiently used by VA to develop these initiatives that would include but not be limited to integrating the services of networks of volunteer, community, state and other transportation providers with veteran transportation services offered in its health care facilities. Furthermore, the administration of the grant program proposed in this section would be costly, diverting resources from either supporting new transportation options or health care for rural veterans.

VA estimates the cost of this section to be \$3 million per year, and \$15 million over 5 years.

Section 5 would require demonstration projects to examine the feasibility and advisability of alternatives for expanding care for veterans in rural areas, through the Director of the Office of Rural Health, at facilities that are geographically distributed throughout the United States. The required projects would include (1) a partnership between VA and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services (HHS) to coordinate care for veterans in rural areas at critical access hospitals, (2) a partnership between VA and HHS to coordinate care for veterans in rural areas at community health centers, and (3) expanding coordination between VA and the Indian Health Service (IHS) to expand care for Indian veterans. It would authorize the appropriation of \$350,000,000 for each of fiscal years 2009 through 2011 to carry out the projects.

VA does not support section 5 of H.R. 2879 for three reasons. First, VA already is encouraging and examining strategies to improve collaboration to increase service options for veterans in rural areas; examples include the Patient Navigator Pilot in VISN 5 that is focusing on expanding and developing public-public collaborations, and the community-based outpatient clinic (CBOC) partnership for improving rural mental health in VISN 16 that is focused on establishing collaborations within the rural health community. Second, additional legislation would impose burdens and specific restrictions upon our ability to explore these opportunities and may impede us from pursuing the best health care options for veterans. Finally, VA already is undertaking pilot programs at the direction of Congress in sections 107 and 403 of Public Law 110-387, and VA believes it is more appropriate to evaluate the results of these pilot projects before beginning new initiatives so that we can ensure resources are best used to serve veterans. Section 107 of that law requires VA to carry out a pilot program to assess the feasibility and advisability of providing peer outreach, peer support, readjustment counseling, and other mental health services to Operation Iraqi Freedom and OEF/OIF veterans, with readjustment counseling and

other mental health services provided to certain rural veterans through community health centers, IHS, or other appropriate entities. Section 403 requires VA to conduct a pilot program under which VA provides covered health services to certain highly rural veterans through qualifying non-VA health care providers. These pilots will be exploring opportunities for collaboration.

VA estimates the cost of implementing section 5 to be \$3.04 billion through fiscal year (FY) 2011, as indicated in the legislation.

Section 6 would require a program to provide peer outreach, peer support, readjustment counseling, and mental health services to OEF/OIF veterans, particularly veterans who served in OEF/OIF while in the National Guard and Reserves, to be established no later than 180 days after enactment. The program would also provide education, support, counseling, and mental health services to immediate family members of OEF/OIF veterans during the 3 years after the veteran's return from deployment. The services provided to immediate family members would assist in the readjustment of the veteran to civilian life, the recovery of the veteran (if the veteran incurred an injury or illness during deployment), and the readjustment of the family following the return of the veteran.

In carrying out this program, this section would require contracts with community mental health centers and other qualified entities only in areas not adequately served by VA health care facilities. In addition, this section would require a training program for clinicians of those community mental health centers or entities to ensure that the clinicians recognize the unique experiences of OEF/OIF veterans, and utilize best practices and technologies when providing services under this section. This section would also require a contract with a national not-for-profit mental health organization to carry out a national training program for OEF/OIF veterans to be trained to provide peer outreach and peer support services. Finally, this section would require reports to the House and Senate Committees on Veterans' Affairs.

VA opposes section 6 of H.R. 2879 because this provision duplicates existing authorities and is unnecessary. Section 107 of Public Law 110-387 requires VA to carry out a pilot program to assess the feasibility and advisability of providing OEF/OIF veterans with peer outreach, peer support, readjustment counseling, and other mental health services, with readjustment counseling and other mental health services provided to certain rural veterans through community health centers, IHS, or other appropriate entities. VA is implementing this pilot. Section 6 proposes a plan similar to that outlined in section 107. VA believes that results from the section 107 pilot will provide experience and information on how best to serve the mental health needs of the rural OEF/OIF veteran population.

In addition, VA's authority to furnish readjustment counseling services already includes authority to furnish limited mental health services to family members necessary for effective treatment of veterans' readjustment issues. The Vet Center program is also taking steps to enhance access for veterans' families. Within the context of the Vet Center mission, family members are central to combat veterans' readjustment. VA is implementing a plan to enhance its capacity to serve families by hiring the additional staff necessary to place a qualified family counselor in every Vet Center.

Vet Centers provide professional counseling for combat-related PTSD and co-morbid conditions such as depression and substance abuse. When necessary for the treatment of more complex mental health conditions, Vet Centers refer veterans to VA medical facilities. For veterans leaving a VA facility after receiving care for an injury or illness sustained during deployment, VA provides education and training prior to the veteran's discharge from care to ensure that family members can tend capably to the needs of the veteran. As a result, the authority to provide readjustment counseling and education to family members is unnecessary.

Further, VA is expanding access to mental health care to assist rural veterans. VA is integrating mental health into all of its primary care clinical settings and is significantly expanding the number of Vet Centers to almost 300 by the end of the fiscal year. VA has already deployed 50 Mobile Vet Centers to provide services and outreach to veterans, including rural veterans. Moreover, VA continues to expand the use of telemental health to connect veterans in rural areas with clinical experts from across the country. In addition, VA contracts for mental health treatment and for readjustment counseling and related readjustment services, as needed with private-sector community mental health agencies and other qualified professional entities. Most of these contract providers are located in rural areas. Section 6 is also duplicative and unnecessary because the Vet Center's model for veteran-centric services already utilizes veteran peer outreach and counseling. Almost 70 percent of all Vet Center staff members are veterans, and more than 30 percent of Vet Center staff members are OEF/OIF veterans.

VA estimates the cost of implementing section 6 to be \$115.58 million over 5 years and \$253.46 million over 10 years.

Section 7 would address improving care for American Indian veterans. Because section 7 is almost identical to H.R. 4006, VA views on this bill are addressed under our discussion of H.R. 4006 (which follows below).

Section 8 would require an annual report to Congress on the implementation of the provisions of this bill and the establishment and function of VA's Office of Rural Health. VA does not support section 8 of H.R. 2879. VA already provides a number of periodic reports (including quarterly and annual reports) to Congress on the status of our programs for rural and highly rural veterans. For example, Senate Report 110-428, which accompanied the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2009 (Division E of Public Law 110-329), directed VA to provide a quarterly report to Congress on rural health initiatives funded through rural health appropriations. A Conference Report (H. Rept. 110-424), accompanying the Consolidated Appropriations Law, 2008, required a report to Congress on access to health services in rural areas. If the Committee would like additional information on any of our programs, VA staff members are available to conduct a briefing at your request.

VA estimates the cost of implementing section 8 to be \$70,596 over 5 years, and \$155,173 over 10 years.

H.R. 3926—"Armed Forces Breast Cancer Research Act"

H.R. 3926 would direct the Department of Defense (DoD) and VA to conduct a joint study on the incidence of breast cancer within the Armed Forces and among veterans. VA supports the objective of H.R. 3926, but cannot support the bill as proposed. H.R. 3926 would provide only an estimate of incidence of one disease at one point in time. A broader study of health care outcomes would be much more cost effective and useful. A broader study would provide information regarding the frequency of occurrence of breast cancer as well as other illnesses and chronic disease outcomes of interest to veterans. For less than the costs required to conduct such a study, we could support a longitudinal study that considers breast cancer as one condition among many. This would be accomplished by collecting information on a representative sample of veterans, including demographic variables such as age, gender, era of service, and frequency of occurrence of various health outcomes of concern to veterans. Establishing a survey mechanism of this type would allow VA to repeat the study and identify trends over time, such as increases or decreases in the occurrence of various diseases, such as breast cancer.

In order to satisfy the complex requirements of H.R. 3926, the study requirements currently proposed in the bill would demand much more time than the 18-month timeframe envisioned. We estimate it would take 3 to 5 years to accomplish this work.

The total cost of this study is estimated to be \$6.34 million.

H.R. 4006—"Rural, American Indian Veterans Health Care Improvement Act of 2009"

Section 2(a) would require that an Indian Veterans Health Care Coordinator be assigned at each of the ten VA medical centers that serve communities with the greatest number of Indian veterans per capita. The coordinators would be responsible for improving outreach to tribal communities; coordinating the medical needs of Indian veterans on Indian reservations with VA and IHS; expanding the access and participation of VA, IHS, and tribal members in the VA Tribal Veterans Representative program; acting as an ombudsman for Indian veterans enrolled in VA for health care; and advocating for the incorporation of traditional medicine and healing in the VA treatment plans for Indian veterans. This section would define "Indian" as defined in 25 U.S.C. § 450b ("Indian" means a person who is a member of an Indian tribe).

VA does not support section 2(a) of H.R. 4006 because VA's Office of Rural Health (ORH) is already providing support to American Indian/Alaskan Native (AI/AN) veterans specifically as it relates to ongoing rural health initiatives. VA is also working to address the unique health care needs of all enrolled veterans residing in rural areas, including AI/AN veterans. VA encourages cooperation and resource sharing between IHS and VA to deliver quality health care services and enhance the overall health of AI/AN veterans. Most VISNs are engaged in a variety of outreach activities including: meetings and conferences with IHS program and tribal representatives; VA membership in the Native American Health Care Network; VA participation in traditional Native American ceremonies; and transportation support to AI/AN. The Veterans Rural Health Resource Center, Western Region, established a partnership with IHS and is currently working on several fronts to support ex-

panded benefits and services, such as tele-psychiatry clinics for AI/AN veterans on rural reservations, infrastructure focused on the needs of AI/AN veterans, and a Memorandum of Understanding with IHS concerning telemental health services for AI/AN veterans.

VA estimates the cost of implementing section 2(a) to be \$5.30 million over 5 years, and \$11.65 million over 10 years.

Section 2(b) would require an MOU no later than 1 year after enactment, between VA and the Department of the Interior to ensure that the health records of Indian veterans may be transferred electronically between IHS and VA facilities. VA agrees with the objectives of section 2(b), but notes that implementation would not be possible without legislative changes to 38 U.S.C. § 7332. That law restricts the ability of VA to provide health information concerning human immunodeficiency virus (HIV), sickle cell anemia and drug abuse or alcohol abuse. VA does not object in principle to requiring a MOU, but notes that VA and IHS have already taken the position that sharing of VA and IHS electronic health records should be done through the Nationwide Health Information Network (NHIN). As a result, the MOU would be unnecessary, because each party participating in the NHIN will be required to be a signatory to the Data Use and Reciprocal Support Agreement. We note that section 2(b) of H.R. 4006 refers to the Secretary of the Interior, rather than the Secretary of Health and Human Services. VA believes this is a clerical error, since IHS is responsible for providing Federal health services to AI/AN.

VA estimates there will be no costs associated with this provision.

Section 2(c) would permit VA to transfer surplus VA medical and information technology equipment to IHS as is considered appropriate for IHS purposes by the Secretaries of VA and HHS jointly. VA does not object to the authority to provide surplus medical and information technology equipment, but notes that VA generally only surpluses equipment when it can no longer reasonably be used; IHS is unlikely to find such equipment of practical use. While the title of the section refers to medical equipment per se, the text of the section refers to both medical and information technology equipment. VA estimates there would be negligible costs associated with this provision.

Section 2(d) would require a report to Congress, no later than 1 year after enactment, jointly submitted by VA and HHS on the feasibility and advisability of VA and IHS jointly establishing and operating health clinics on Indian reservations to serve the populations of those reservations, including Indian veterans. VA does not support this requirement because it is unnecessary. VA would welcome the opportunity to provide a briefing to address current collaborations with IHS and efforts to support AI/AN veterans.

VA estimates that the cost of implementing this section would not be substantial.

Draft Bill—“Expanding VA Reimbursement of Continuing Medical Education Expenses to VA Health Professionals”

This bill would require VA to reimburse any full-time board certified health professional for expenses, up to \$1,600 per year, for continuing professional education, but prohibits VA from reimbursing for education provided by a Department medical center.

VA opposes this draft bill because of the cost of implementation and because our current programs are sufficient to address this need. There are currently over 170,000 health care professionals in VHA. The total cost of implementing this legislation would be \$282,000,000 per year for the next 10 years. Moreover, VA's Employee Education Service provides continuing education credits (those needed to maintain current licensure or certifications) through online learning, content distribution network and face-to-face sponsored training. In addition, medical centers host on-site training to provide continuing education credits and purchase online products that allow health care professionals to gain needed continuing education. Medical centers also have a mechanism in place for all employees (not just health care professionals) to request funding or reimbursement for training and education.

The potential cost to provide up to \$1,600 to each health care professional would be \$272 million.

Draft Bill—“Authority to Waive Requirements for Mental Health Counselors”

This bill would create an exception to the statutory requirements for eligibility for employment of licensed professional mental health counselors by allowing the Secretary to waive the licensure or certification requirement for a reasonable period of time recommended by the Under Secretary for Health. VA does not oppose the legislation. VA currently has a parallel statutory authority to appoint psychologists and clinical social workers for up to 2 years before they have completed their licensure

or certification. These employees are closely supervised by a licensed mental health professional when administering care. These are temporary, conditional appointments, and VA believes a similar model would be appropriate if this legislation is enacted.

This proposal would be cost neutral.

This concludes my prepared statement. Mr. Chairman, we would be pleased to respond to whatever questions you may have.

Statement of American Federation of Government Employees, AFL-CIO

Mr. Chairman and Members of the Subcommittee:

The American Federation of Government Employees (AFGE) appreciates the opportunity to submit a statement for the record on H.R. 949 and draft bills relating to performance pay and collective bargaining (draft dated March 8, 2010 (2:49 p.m.) and continuing professional education (draft dated December 9, 2009 (11:42 a.m.).

AFGE represents nearly 200,000 employees in the Department of Veterans Affairs (VA), more than two-thirds of whom are proud employees of a world class health care system that provides unsurpassed specialized care to the men and women who have served our Nation.

The VHA workforce includes in its ranks many physicians, registered nurses (RN), physician assistants (PA) and other clinicians who bring to this great health care system invaluable experience and compassion from their own military service where they provided medical care on the battlefield.

Sadly, back home, these fine clinicians face work environments plagued by fear, disrespect and exclusion. Their deep desire to care for veterans is challenged every day by personnel policies that demoralize them and deprive them of the basic rights and dignity provided to their colleagues working outside the VA. VA's ability to recruit and retain professionals who want to build a career in the VA is getting more difficult every day.

H.R. 949 and Draft Collective Bargaining Language

H.R. 949

Two years ago, this Subcommittee considered this legislation to restore equal collective bargaining rights to these dedicated VA clinicians. At that time, the VA's arguments in opposition to the legislation were riddled with fear and distortion, claiming it would "jeopardize[e] the lives of our veterans" (Senate Committee on Veterans Affairs, May 21, 2008 hearing).

A great deal has changed in the past 2 years and the Department appears ready to embrace a 21st century transformation of VHA labor-management relations. We urge this Subcommittee to capture that momentum through passage of H.R. 949.

The most recent example of the Department's shift away from its former, counter-productive interpretation of title 38 collective bargaining law (38 U.S.C. § 7422, or "7422") is evident in the implementation plan provided to the White House pursuant to Executive Order (EO) 13522. Its plan to fulfill this White House goal, i.e. "Creating Labor-Management Forums to Improve Delivery of Government Services," recognizes that "[c]ooperative, constructive working relations between labor and management are essential to achieving common labor-management goals and objectives." (Link: <http://www.lmrcouncil.gov/plans/index.aspx>).

The Implementation Plan also specifically addresses bargaining and negotiation rights:

"[T]he Department is committed to pre-decisional involvement in workplace matters, **without regard to whether those matters are negotiable** subjects of bargaining under 5 U.S.C. § 7106. . . . The Department is committed, wherever appropriate, to engage the labor partners on issues that historically have been **outside the scope of bargaining.**" (emphasis added).

Equally significant, last fall, the Department supported legislation to provide *full bargaining rights* for 2 years to VA physicians and RNs converting from the Defense Department (DoD) personnel system at the joint DoD-VA medical facility in North Chicago (P.L. 111-84). Despite all its past allegations that full bargaining rights will endanger patients, the Department agreed to give *full title 5 rights* to new VA clinicians treating veterans and active duty personnel at a unique joint facility that is designed to serve as a national model for the future. These clinicians, will full rights to grieve and negotiate over routine employment matters such as schedules, assignments, and additional pay for good performance or weekend shift work, will be

working side by side with VA clinicians with the same titles and duties who have very limited rights because of “7422.”

Therefore, AFGE urges this Subcommittee to vote for H.R. 949. It is time to align the law with VHA’s new workforce goals. It is time to put an end to VHA personnel policies that have decimated valuable legislation that Congress passed to improve recruitment and retention. It is time to end the inequality and arbitrariness that keep new physicians and RNs from seeking VA careers. It is time to end the demoralization of long term, valuable VA physicians, dentists, RNs, PAs, chiropractors, optometrists, and podiatrists who must work without a voice and without redress for unfair and illegal management actions. It is time to end the senseless inequality between VA clinicians without full rights and VA “hybrid” clinicians, such as pharmacists, psychologists and practical nurses with full rights. It is time to end the equally senseless inequality between physicians and nurses who treat veterans and physicians and nurses who treat active duty personnel and Federal prisoners at other Federal facilities.

Draft Collective Bargaining Language

In the alternative, AFGE asks the Subcommittee to support section 2 of the March 8, 2010 draft. This draft language is significantly narrower than H.R. 949 which also addresses bargaining rights in peer review matters, the rights of title 38 clinicians to appeal final agency decisions and arbitration decisions to Federal court, and needed changes in the Disciplinary Appeals Boards process. However, the March 8th draft focuses on the two most harmful VA “7422” exclusions to bargaining: compensation and patient care. Enactment of this draft language will yield significant benefits for workplace morale and VHA recruitment and retention.

More specifically, Subsection 2(a)(1) inserts a single word—“rates”—in 38 USC § 7422 to clarify what Congress intended in 1991 when it enacted title 38 bargaining rights. This proposed change addresses opponents’ assertions that employees will try to set pay rates, in violation of Federal law. Compensation issues *other than pay rates* cover pay issues that Congress has specifically addressed in legislation to help the VA recruit and retain such as nurse locality pay and physician performance pay. Compensation issues *other than pay rates* also cover wage law violations that public and private employees throughout this country have a right to challenge, such as failure to pay overtime or shift differential pay for weekend work.

AFGE notes that the VA has never offered an example of an employee’s attempt to use bargaining rights to set Federal pay rates, and that there are no Under Secretary of Health 7422 cases involving such an attempt.

Subsection 2(a)(2) also clarifies Congressional intent in established routine bargaining rights for title 38 clinicians for matters only *indirectly related to patient care*—rights that are no greater than the routine bargaining rights of Federal employees covered by title 5, including hybrid title 38 VHA health care professionals and DoD and BOP clinicians with the exact same job titles and scopes of practice. This subsection will not allow employees to interfere with management rights to determine the best medical procedures or skill sets for patient care, or its right to take needed actions during medical emergencies. Rather, Subsection (2)(b) only makes clear that these Federal employees have the same, routine rights to a voice in scheduling and assignment policies that other Federal employees have when they care for patients in hospitals and clinics.

Again, AFGE notes that the VA has never offered an example of labor’s attempt to use bargaining rights in scheduling and assignment matters to interfere with management’s choice of medical procedures, determination of needed medical skills or other direct patient care matters. VA has never offered an example of labor’s attempt to prevent management from responding timely to emergency medical needs. We further note that there is no Under Secretary of Health 7422 case involving any such attempts.

Draft Language on Physician and Dentist Performance Pay Criteria

AFGE supports the enactment of the December 9, 2009 draft language to provide a long overdue fix to problematic performance pay policies at local facilities. Such policies have virtually stripped this valuable recruitment and retention tool any benefit.

The problem is twofold. First, local management does not issue performance criteria in accordance with deadlines set by Congress, and in many cases, never issues them. Second, when management does set criteria, they vary widely from facility to facility, and/or they measure improper factors beyond the individual clinician’s control, such as missed appointments, clinical utilization and patients’ satisfaction with their overall hospital experiences.

This draft language will improve the uniformity and effectiveness of these measures, which in turn, will improve recruitment and retention. First, section 1(a) clarifies that these criteria should measure individual, not group, performance—a clarification that is already in VA regulations (but regularly ignored.) Second, section 1(b) ensures that the Secretary fulfills a requirement that Congress put on the books 6 years ago that has been ignored to date, specifically, to prescribe specific goals at performance objectives *at the national level* (“Performance pay shall be paid to a physician or dentist on the basis of the physician’s or dentist’s achievement of specific goals and performance objectives *prescribed by the Secretary.*”) (emphasis added) (P.L. 108–445).

Draft Language on Continuing Professional Education Reimbursement

AFGE urges the Subcommittee to approve this draft language to increase the annual reimbursement for continuing professional medical education (“CME”). The CME amount provided under current law has not increased since 1991 and other health care employers currently offer much higher reimbursement to their clinicians. We also support draft language extending CME reimbursement to other title 38 clinicians who need to meet licensing and certification requirements and update their skills.

AFGE urges the Subcommittee to add additional language to clarify the following: at facilities where some, *but not sufficient* internal CME courses are offered to maintain licensure, the law should clearly state that reimbursement for outside CME is still available.

Thank you for the opportunity to share AFGE’s views on these critical recruitment and retention legislative proposals.

**Statement of David J. Holway, National President,
National Association of Government Employees (SEIU/NAGE)**

Mr. Chairman and Members of the Subcommittee:

On behalf of the National Association of Government Employees (SEIU/NAGE), and the more than 100,000 workers we represent, including 20,000 at the Department of Veterans Affairs (VA), I would like to thank you for the opportunity to submit testimony regarding pending legislation before the Subcommittee.

H.R. 949

SEIU/NAGE strongly supports H.R. 949. This bill would restore a meaningful scope of bargaining for title 38 health care providers at the VA, a critical necessity to boost morale and strengthen recruitment and retention at the agency. Giving health care providers a meaningful voice in their workplace will without question lead to better care for the American veteran.

In 1991, Congress amended title 38 to provide VA medical professionals with collective bargaining rights (which include the rights to use the negotiated grievance procedure and arbitration). Under sec. 7422 of title 38, covered employees can negotiate, file grievances, and arbitrate disputes over working conditions, except for matters concerning or arising out of professional conduct or competence, peer review, or compensation. In recent years, VA management has interpreted these exceptions very broadly, and refused to bargain over virtually every significant workplace issue affecting medical professionals. The broad interpretation sec. 7422 has created significant dissatisfaction among rank-and-file VA health care providers.

We have heard from our members across the country, and they have urged our union to make passage of H.R. 949 our top legislative priority for legislation impacting the VA workforce. Their concern is that too many highly qualified, outstanding health care professionals have left the VA for other employment because they were unsuccessful in getting someone of authority at the agency to listen to or address legitimate concerns because managers claimed the issue fell under the ever-growing umbrella of sec. 7422.

The agency has been unwilling to address those issues that are most important to title 38 employees, including time schedules, shift rotations, evaluations, fair and equal opportunity to be considered for a different position within the facility, and fair treatment among colleagues. Rather than suffer under a system where they have no mechanism to provide input or air grievances, disenfranchised VA employees simply move on to other employment. This has gone on too long, and it has to stop.

VA medical professionals have extremely limited collective bargaining rights in the first place, and the broad interpretation of sec. 7422 of title 38 is narrowing the scope of bargaining to the point that it is practically meaningless. As a result, RNs,

doctors, and other impacted employees at the VA are experiencing increased job stress, low morale and burnout. This in turn exacerbates the VA's well-documented recruitment and retention problems. Chronic short-staffing has been shown to adversely impact quality of care, patient safety, and workplace safety, leading to costly stopgap measures such as the overuse of contract nurses and doctors.

Passing H.R. 949 would help to address many of these concerns. This bill would restore a meaningful scope of bargaining for title 38 VA professionals by eliminating the "7422 exceptions" (conduct, competence, compensation, and peer review) under the law.

Eliminating these exceptions will provide these health care providers with the same rights as other VA providers, including psychologists, LPNs, and pharmacists, as well as other Federal employees. Title 5 health care providers at the VA have full collective bargaining rights. Even nurses and doctors at Army medical centers such as the Walter Reed Army Medical Center, who perform the same exact function as nurses and doctors at the VA, have full collective bargaining rights. Many private sector health care providers have a meaningful voice on working conditions and are allowed participation in hospital affairs. There is no reason for title 38 VA workers to have these critical rights taken away.

Late last year, the VA engaged SEIU/NAGE and other unions in discussions to produce recommendations we hope will reduce the VA's invocation of sec. 7422. Our discussions through the 7422 Work Group are ongoing. Though we continue to hope that the 7422 Work Group will produce reforms, it cannot address the fundamental issue of limited collective bargaining rights. Only Congress can address that issue.

Restoring meaningful bargaining rights will greatly increase morale at the VA. It will also address recruitment and retention issues, which are critical at this time, given the veterans returning home from conflicts abroad. All this will lead to better care for our Nation's veterans.

SEIU/NAGE strongly urges the Congress to pass H.R. 949. I greatly appreciate the Subcommittee's decision to hold this hearing. I thank the Subcommittee for the opportunity to provide this statement.

**Statement of William R. Dougan,
National President, National Federation of Federal Employees**

On behalf of the National Federation of Federal Employees (NFFE) and the 110,000 Federal employees our union represents throughout the United States and abroad, including more than 5,000 Department of Veterans Affairs (VA) health care providers, I thank you for the opportunity to submit this statement regarding H.R. 949.

Summary of NFFE's Position on H.R. 949

Over the last several years, Department of Veterans Affairs (VA) health care professionals have seen their collective bargaining rights diminish appreciably. Agency management's improperly broad interpretation of a certain provision in Federal labor law has allowed them to circumvent the bargaining process on numerous critical issues, and the effect is taking its toll on the morale of VA health care providers. It is time for Congress to do what is right for VA workers and the veterans for whom they provide care by passing H.R. 949, which will eliminate the collective bargaining exceptions under sec. 7422 of title 38.

Background on Collective Bargaining for VA Title 38 Health Care Workers

In 1991, title 38 was amended by Congress to give health care providers at the VA collective bargaining rights. This was a necessary change that was supported by our union. This change allowed title 38 health care providers access to basic collective bargaining rights, including a negotiated grievance procedure and the ability to take an unsettled grievance to arbitration. However, under sec. 7422 of title 38, VA health care providers are permitted to negotiate contracts, arbitrate disputes, and file grievances over working conditions except for matters concerning or arising out of professional conduct or competence, peer review, and compensation. We refer to these as "7422 exceptions."

In the years immediately following the change in law, these 7422 exceptions were interpreted narrowly, which in our view was an appropriate interpretation of the law. However, over the past decade, the VA has greatly expanded their interpretation of sec. 7422 of title 38 so that practically any matter the VA wished to avoid bargaining with the union over could be circumvented. When you take away the right to collectively bargain over conduct, competence, peer review, and compensation, you make the negotiated grievance procedure all but meaningless. The VA's

broad interpretation of sec. 7422 has been a great disservice to VA health care providers that we represent. It has also been a disservice to the American veterans for whom our members provide care.

Why H.R. 949 Should Be Passed Into Law This Congress

For the following reasons, NFFE believes that it is critical for Congress to pass H.R. 949 in this session of Congress:

- Veterans' care suffers from the toxic labor-management climate caused by sec. 7422.
- The 7422 exceptions are completely unnecessary and inconsistent with the health care industry.
- Health care providers use collective bargaining to maintain fairness in the workplace and improve patient care; bargaining does not hurt patient care.
- There are veterans groups that support this legislation; veterans groups do not tend to support legislation that will hurt veterans' care.
- Only legislation can solve the 7422 problem permanently.
- With thousands of veterans returning from conflicts abroad, the time to address this cancer at the VA is now.

Veterans' Care Suffers from the Toxic Labor-Management Climate Caused by Sec. 7422 of Title 38

I would classify the labor-management atmosphere throughout most of the VA as toxic. Our members from across the country, who provide care to the American veteran, report that the VA's willingness to use the 7422 exceptions to circumvent their bargaining obligations and avoid legitimate employee grievances is an enormous problem that is taking a very large toll on the morale of VA health care providers.

A year ago, we were optimistic that a new Administration might usher in a new approach to labor-management relations at the Department. It is with great disappointment that I report that the labor-management relations climate at the VA is unchanged from a year ago. In fact, from many accounts we get from the field, labor-management relations at the VA are currently at an all-time low.

We believe that the failure of the VA to establish effective labor-management relationships stem from sec. 7422 of title 38. VA management have grown quite accustomed to standing behind the 7422 exceptions to avoid bargaining over workplace issues or to settle legitimate grievances that involve management's wrong-doing, including the improper firing of VA employees or the failure to provide employees with due process. The VA's broad interpretation of the 7422 exceptions has given management the ability to trump almost any action taken by the union to enforce workplace rules or defend employees against adverse actions. It is no surprise that VA employees are feeling great frustration over the practice.

Many of the issues that VA employees lose the ability to bargain over because of the 7422 exceptions are very important to the VA rank-and-file workforce. Some of these issues include: time schedules, shift rotations, evaluations, fair and equal opportunity to be considered for promotion, and fair treatment among colleagues. VA management frequently handles issues like these in ways that warrant grievances from VA employees, but workers have their efforts to maintain fairness blocked by the VA's 7422 exceptions. VA employees experience great frustration when they have no mechanism to demand fairness in the workplace.

This toxic labor-relations climate results in many title 38 health care providers being terrified to come forward with concerns—some that directly impact patient care—because VA employees know that if they are retaliated against by management, there is little that the union can do to protect them. For many VA employees, this kind of atmosphere is more than they are willing to tolerate, especially when the health care skills they have are in demand, and in all likelihood, they can get paid more elsewhere.

Poor recruitment and retention rates at the VA are well documented, and these problems adversely impact patient care. The elimination of the 7422 exceptions, which would be accomplished by passing H.R. 949, would lead to a substantially improved labor-relations climate at the VA. Improved labor-relations would lead to a fairer workplace, a happier workforce, and better recruitment and retention of VA health care providers. Improved recruitment and retention would lead to fewer staffing problems, and ultimately, better care for American veterans.

The 7422 Exceptions are Completely Unnecessary and Inconsistent with the Health Care Industry

Eliminating the 7422 exceptions to restore the scope of bargaining for title 38 employees at the VA would bring VA health care providers in line with the collective bargaining and grievance rights already enjoyed elsewhere in the health care indus-

try. The VA is unique in its ability to avoid bargaining over issues concerning conduct, competence, compensation, and peer review. The rest of the roughly 12 million health care workers in the United States have a full scope of bargaining should they choose to be represented by a union; and yes, they can bargain and file grievances over issues concerning conduct, competence, compensation, and peer review.

Eliminating the 7422 exceptions under title 38 would level the playing field with regard to collective bargaining for title 38 and title 5 employees of the VA. Some of the title 5 VA health care providers include psychologists, LPNs, pharmacists, and those holding other positions. These VA employees enjoy a broader scope of bargaining because they are under title 5. It is only title 38 VA employees who are singled out under the law, and have their scope of bargaining limited by sec. 7422 of title 38.

Even Federal employees who have the exact same positions as title 38 VA employees, but work in other Federal agencies, have a broader scope of bargaining. For example, nurses and doctors at the Army medical centers such as Walter Reed, who perform the very same function as nurses and doctors at the VA, have broader collective bargaining rights. Even VA physicians and RNs converting from a Department of Defense personnel system at the joint DoD-VA medical facility in North Chicago will be granted broader bargaining rights. All these federally employed health care providers have basic bargaining rights that the majority of Federal employees enjoy under title 5.

The bottom line is, VA title 38 health care providers are in the same basic positions as those working at DoD medical facilities, joint DoD-VA facilities, and private sector hospitals. Title 38 VA employees are just treated differently because the VA is taking advantage of, and in our opinion abusing, an outdated provision that should be eliminated from the law.

There is no real reason for title 38 VA workers to be singled out in the health care community and forced to have their critical rights taken away. There are, however, many compelling reasons to eliminate the disparity in treatment that title 38 VA health care providers are experiencing. The VA is at a distinct disadvantage to employers in other sectors of the economy, and even elsewhere in the Federal Government, where employees have a meaningful voice in the workplace on critical conditions of employment. The VA would be in a better position to recruit and retain a talented workforce if H.R. 949 was passed into law, and the 7422 exceptions under title 38 were eliminated.

Health Care Providers Use Collective Bargaining to Maintain Fairness in the Workplace and Improve Patient Care; Bargaining Does Not Hurt Patient Care

The VA, over the last several years, has perpetuated the misconception that collective bargaining would imperil the VA's ability to provide timely and quality care for veterans. This is 100 percent false, and it is offensive to the tens of thousands of dedicated VA health care providers who provide this service to veterans.

For example, last year, Gerald M. Cross, Principal Deputy Under Secretary for Health testified before the Senate Veterans' Affairs Committee on April 22, 2009 at a hearing on pending health-related legislation. Mr. Cross's testimony includes grossly inaccurate statements such as "[S. 362/H.R. 949] would give [union members] bargaining rights on clinical care matters that would clearly and foreseeably endanger the well-being of our veteran-patients" and "would thwart VA's ability to immediately re-assign staff from direct patient care duties to administrative duties based on an allegation that the staff committed patient abuse."

These claims are nothing but fear tactics. Millions of health care providers in the private sector and elsewhere in government have full collective bargaining rights, and those rights do not lead to endangering the well-being of patients. They would not lead to the endangering of veteran-patients at the VA either.

The reality is that collective bargaining improves patient care because VA health care providers have the best interest of their patients at heart. When employees have protections, they come forward when they see a practice that could be endangering veteran-patients. On the other hand, if they are intimidated by management and worried that coming forward will lead to retaliation, they will think twice about coming forward. Veterans deserve to have their care administered by employees who have basic workplace rights.

Eliminating the 7422 exceptions, which would give title 38 VA employees a sense of fairness in the workplace, would give VA employees peace of mind in speaking up about patient care problems. Not giving VA employees basic protections is, in my opinion, what leads to situations like the one experienced in the VA medical center in Marion, IL, where nine patients died due to surgical mistakes and poor post-surgical care. Giving employees the peace of mind to come forward when they see prob-

lems like these will help keep these problems from occurring. Right now, sec. 7422 of title 38 is preventing it from happening throughout the VA. Veterans deserve better.

There are Veterans Groups that Support this Legislation; Veterans Groups Do Not Tend to Support Legislation that Will Hurt Veterans' Care

The fact that some veterans groups support this legislation demonstrates that the VA's assertions that collective bargaining will hurt patient care are preposterous. Plain and simple, veterans groups do not support legislation that is going to hurt veterans' care.

The Paralyzed Veterans of America (PVA) have endorsed H.R. 949. The Disabled American Veterans (DAV) have indicated that they support the intent of the bill.

Only Legislation Can Solve the 7422 Problem Permanently

The VA and five VA employee unions, including NFFE, have assembled a 7422 Work Group to make a recommendation to the Secretary of the VA aimed at improving the consistent use of the authorities and limitations on sec. 7422 of title 38. While we hope to make some improvements, we do not expect to reach a permanent solution from this 7422 Work Group. Regardless of what changes the VA agrees to, the Work Group recommendation would not be binding on future Administrations without a change in law. The 7422 problem is a significant one that is hurting veterans' care. We should address this issue permanently by passing H.R. 949. A non-statutory fix will have very little impact on the ability to maintain a fair workplace for title 38 VA employees over the long-term.

With Thousands of Veterans Returning From Conflicts Abroad, the Time to Address This Cancer at the VA is Now

The VA is anticipating a large increase in the number of veteran-patients to whom it provides service as American veterans return from conflicts abroad. The VA should take necessary steps to improve labor-relations in anticipation of the increased demands on the Department's workforce. Our veterans deserve the best care this nation can provide them. Let's take the necessary steps to ensure the nurse or doctor who actually provide care to veterans are given basic protections under the law.

Conclusion

By passing H.R. 949, many of the concerns that that I have described would be sufficiently addressed. This bill would restore a meaningful scope of bargaining for title 38 VA health care professionals by eliminating the 7422 exceptions (conduct, competence, compensation, and peer review) under the law that the VA has continued to exploit.

The restoration of meaningful bargaining rights for title 38 VA employees will increase the morale at the VA greatly. It will also serve to improve recruitment and retention rates, issues which have been areas of great concern at the VA. With thousands of veterans returning home from conflicts abroad, the time to address this critical issue is now. Restoring a broader scope of bargaining will lead to better care for our Nation's veterans.

NFFE greatly appreciates the Subcommittee's decision to hold a hearing on this matter. I thank the Subcommittee for the opportunity to provide this statement.

