

ACCESS TO VA HEALTH CARE AND BENEFITS IN HAWAII

HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE ONE HUNDRED TENTH CONGRESS FIRST SESSION

AUGUST 21, 2007, AUGUST 23, 2007, AUGUST 27, 2007

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HEARING ON HEALTH CARE AND BENEFITS FOR VETERANS IN HAWAII—HONOLULU, HAWAII

TUESDAY, AUGUST 21, 2007

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

The Committee met, pursuant to notice, at 10 a.m., in Oahu Veterans Center, Honolulu, Hawaii, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

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

Senator AKAKA. Aloha.

AUDIENCE. Aloha.

Senator AKAKA. I want to welcome you to today's hearing of the Senate Committee on Veterans' Affairs. This is the first of three field hearings that I'm chairing here in the state this week and next week.

As you know, we held similar hearings at the start of 2006. Much of it has been improved since that time for which I am grateful.

AUDIENCE. We cannot hear back here, sir. Turn the mic on, Senator Akaka.

Senator AKAKA. Can you hear now?

AUDIENCE. (Applause.)

Senator AKAKA. Thank you. We held similar hearings before. And since then. I want to tell you that the Department of Veterans Affairs has done so much more than they were doing before, and we look forward to this hearing and continuing to improve services to our veterans. And it is important for the Committee to understand the remaining challenges we have now, which is the reason for these hearings.

The VA Pacific Islands Health Care System's flagship is Hawaii. The Spark M. Matsunaga VA Medical Center is a very busy place and is in need of better ambulatory surgery space. We know, too, that the VA nursing home here is full and there are pockets on Oahu, especially on Leeward Oahu, that are underserved.

I want to applaud the efforts of every VA employee on Oahu. These men and women work hard to help the veterans who seek their assistance and there are many things that VA does well in Hawaii. However, there is always room for improvement. I want to hear about how we can give VA the tools to make a difference in the lives of Hawaii's veterans.

Back in Washington, we have worked hard to ensure that VA has the resources to provide the best possible care. The VA spending bill, which the Senate will take up early in September, includes \$43 billion for VA, \$3.6 billion more than was sought in the President's budget request. We are finally on track to adequate funding for VA mental health care and care for those veterans with traumatic brain injuries.

We have also been spending time to ensure that DOD and VA work together to improve the transition process for servicemembers and veterans. Given the existing relationship between VA and Tripler Army Hospital, Hawaii should be at the forefront of national efforts to ensure that the two departments work closely together. We will explore that issue today.

Congress has also given VA a significant increase in funding to hire new staff to deal with VA's claims backlog. The Veterans' Affairs Committee will carry out focused oversight to ensure that the hiring and training process proceeds in a timely fashion. And I've been sending my staff in Washington across the country to do this. VA and several veterans service organizations are working on innovative ways to process claims in a more efficient manner. I will ask VA to describe specific plans for using this funding to improve the claims adjudication process here in Hawaii.

Another concern that the Committee will be looking into is the status of Punchbowl. VA erected columbaria at the cemetery to accommodate cremated remains but the demand has been much greater than we anticipated. I have worked with VA on how to address this problem and look forward to VA's testimony today.

Over this week and next, I will examine health care and benefits in Hawaii. I want to tell you that when most of you were in here prior to our coming into this building and into this hall, we had a ceremony, an important ceremony outside in which Under Secretary Tuerk presented a check for \$743,035, which will fund the next phase of the West Hawaii Veterans Cemetery in Kailua-Kona. This is a great plus for Hawaii and for its cemeteries, and I want to thank Under Secretary Tuerk for that. Given the state's unique features, VA must adjust its strategies that may be successful on the mainland but do not work as well here.

It is vitally important that you share your thoughts with us so we know how to help VA help you and the rest of Hawaii's veterans. VA officials are here to listen to and respond to the concerns raised by the witnesses on the first two panels.

Finally, I note that there are many veterans today who would like to testify. Following the more formal part of today's hearing, we are going to invite members of the audience to address the Committee. We ask that your comments be focused on veterans' issues only, and that you stick to the three minutes that you will have for your comments at that time.

My staff is here to follow up with each of you and you will receive further information on that. If you do not wish to speak, feel free to provide a written comment to my staff. Once again, I want to say mahalo nui loa to all of you who are in attendance today. I look forward to hearing from today's witnesses, and we are so fortunate to have with us today, and to have him in the United States Senate, Senator Inouye. We are delighted to have him here.

We do not have time to tell you all about him, but you know about him and how he has been such a leader in helping Hawaii over the years. We are so fortunate to have him here with us today, so I call on Senator Inouye for his opening comments.

**STATEMENT OF HON. DANIEL K. INOUE,
U.S. SENATOR FROM HAWAII**

Senator INOUE. Thank you very much, Mr. Chairman, and I'm pleased to join you and the Senate Committee on Veterans' Affairs on this field hearing on the topic of health care and benefits for veterans. And I thank you for your leadership in this very important area.

Before I proceed, I'd like to join my Chairman in thanking the Department of Veterans Affairs through Under Secretary Tuerk. His presence here is a demonstration of the support of the Department that no veteran will be forgotten. It's very important. West Kona is not in the big city, but they are remembered. And Washington is here to tell us that and I'm most grateful to you, Mr. Secretary. Thank you.

Mr. Chairman, I'm a wounded veteran of World War II, the very ancient war. There are many differences between that war and the current war in which we find ourselves embroiled. These differences are in one sense very simple and yet very profound and should be taken into consideration as we all work to ensure a more seamless continuum of care for our Nation's veterans. I'd like to make a few comments on this matter.

First, the wounded veterans in the war in Iraq are usually transported on helicopters and find themselves receiving medical care in the field hospital within a half-hour of the infliction of the injury, which clearly increases their survivability rate.

In World War II, there were no helicopters. The wounded were transported by stretchers, sometimes by ambulances and often times carried over rivers and mountains. My evacuation began at 3 o'clock in the afternoon on a stretcher, and we arrived at a field hospital at midnight nine hours later. As a result of the prolonged transport period, many of those who were wounded perished before they reached the hospital. I was lucky.

Second, with the advancement of medical technology and the sophisticated capacity available in the field hospitals, today's veterans would survive much greater injuries. According to studies, double amputations are much more common in today's war as compared to World War II. Very seldom would you see a double amp World War II veteran. I think the reason is simple, the bleeding and trauma could not be sustained for nine hours.

Additionally, during World War II great battles involving divisions, regiments were commonplace. The landing on Normandy, the Battle of the Bulge, and in the case of fire rescue of the Lost Battalion, it's no secret that medical facilities were inadequate to care for the thousands of wounded. We would never readily admit, but very difficult decisions and choices had to be made.

In today's war, there are no great battles with thousands of injured. Fatalities are more likely caused by roadside bombing, terrorist suicide attacks, and loss of helicopter and the crew. The number of injured has not been too large to manage. Moreover, ad-

vancements in medical care have greatly increased the number of wounded veterans who survive life-threatening injuries.

Today's wounded veterans spend less time in hospitals than the veterans of my era. According to the best information available, if I had been wounded in Iraq with identical injuries, I would very likely be discharged from a military hospital in about six or seven months. And after that, spend a few months in a VA hospital.

I spent 21 months in a military hospital. Nine months taken up for medical and surgical purposes and the fitting of a prosthetic device. There's no question that the prosthetic device I received was inferior to the state-of-the-art prosthetic device that today's veterans are receiving. Then I spent a year in a military rehab hospital. During that period, I learned how to drive. I was young when I left Hawaii. I didn't know how to drive. I received the license to drive in all states. I was taught carpentry, plumbing, taught how to do some electrical work.

In fact, they taught me how to dine. After all, when I left Hawaii, I was accustomed to the spoon, the fork and a chopstick. I didn't know what an oyster fork looked like. I learned to play a musical instrument. It was required in my hospital. I couldn't play a saxophone because you needed two hands for that; so finally they decided to teach me how to play the piano, and I got approval of my peers and instructors to perform. And I was required to take up two sports, basketball and swimming. My swimming lessons were not in the hospital pool. It was in a public place with people all over the place.

So my first lesson was a rather difficult one. I did what most humans do. I wrapped myself in a big towel to hide my scar. I didn't want to expose them. However, after two or three lessons, no big deal. That's rehab. I remember when I returned home to Hawaii and I told my mother I'm going to Waikiki, and she was very happy. She thought I was going to do some shopping. I said, "No I'm going swimming." Her first reaction was, "Are you going to swim with your clothes on?" It's human nature to hide scars from your friends and your beloved ones.

Well, when I told her I'm going to swim in a regular pair of shorts, she was stunned. But rehabilitation is very important. It's not enough just for the physical, but you must take care of the mental and the emotional well being of the person. I can honestly tell you that I left the hospital with a measure of confidence in myself, and I was ready to face the world.

Today our advancements in technology has allowed us to swiftly transport our injured to high quality field hospitals where our advancements in medicine have resulted in a high survival rate such as brain injuries. There are very few internal injuries because you have your armored vest. The double amps are very common. Brain injuries are very common. You don't see too much of that on the front pages. That's what it is.

There are many fellow veterans who lie today looking at the ceiling and nothing else. So may I suggest that we do not forget the importance of also healing the mind, healing the spirit which comes often times from basic human contact. And advancement of technology cannot replace that. Time, patience, counseling should also be a part of the rehab package. Our obligations should not end

after the operating table. The standard for which we must strive for today's veterans is to leave government care completely healed both body, mind, and soul and be ready to face the world with a measure of confidence and hope.

Mr. Chairman, I look forward to hearing the testimony of the witness panels which we'll touch upon the issues and the needs of Hawaii's veterans, veterans of my age, veterans of those who recently came home.

Mr. Secretary, I'm happy to tell you that our VA in Hawaii is doing an absolutely great job. The service at Tripler is unbelievably good. In fact, we set the motto for the rest of the Nation to follow. But we must build upon this to continue and ensure access to quality health care services. May I once again tell you publicly you got a good man in chain. He's doing a good job in Washington.

Thank you very much.

AUDIENCE. (Applause.)

Senator AKAKA. Thank you very much, Senator Inouye. Many of you know that he has shared very personal information about what has happened to him and how much he cares for veterans. I want to welcome the first panel, and I want to thank them all for being here.

First, I welcome Ariana Del Negro. She is the wife of an Operation Enduring Freedom veteran with Traumatic Brain Injury. Second, I welcome my good friend Allen Hoe, a veteran of the Vietnam War and member of the VA's Advisory Committee on the Readjustment of Veterans. I also welcome Tom Joaquin, a member of VA's advisory council.

I welcome Victor H. Opiopio, who suffered a back injury while serving in the military. I welcome Clay Park, a case manager for Helping Hands-Hawaii and a former medic in the Vietnam War. Darryl J. Vincent will be our last witness on panel one. He is the site director of the United States Veterans Initiative.

I want to thank each of you for being here today. Your full statements will appear in the record of the Committee.

Ms. Del Negro, would you please begin with your statement.

**STATEMENT OF ARIANA DEL NEGRO,
SPOUSE OF OPERATION IRAQI FREEDOM VETERAN**

Ms. DEL NEGRO. Good morning.

Senators, thank for very much for the opportunity to share our experience regarding our medical care my husband received in Hawaii for his Traumatic Brain Injury also known as TBI. I'll do my best to keep this brief and will refer you to my written testimony for further detail and discussion.

My name is Ariana Del Negro, and, sadly, I represent one of the many military wives or caregivers coping with the hardships of having a soldier return wounded from Iraq or Afghanistan. What my husband and I have had to endure over the course of the last 10 months struggling to navigate through a convoluted, outdated, unprepared bureaucratic military health care system has been absolutely untenable.

The treatment we received here in Hawaii fell well short of what the standard of care should be for those who fought to protect democracy and freedom. It is my hope that sharing our story today

will increase awareness regarding the gaps in care for TBI, will highlight the importance of supporting and educating families and will emphasize the benefits of early and appropriate referrals to Centers of Excellence.

On September 28, 2006, my husband suffered a TBI when a 7,000 pound VBIED (vehicular-borne improvised explosive device), detonated 45 yards from where he was standing. The primary, secondary and tertiary concussive forces from the blast rendered him unconscious for at least 10 minutes. He spent three days in the intensive care ward at Balad Military Hospital and was subsequently released and returned to his base in Iraq with the anticipation that the fog of his closed-head TBI would subside sufficiently enough that he could return to duty.

An Army Ranger, my husband is a well-respected member of his battalion and held one of the most esteemed and coveted positions for a lieutenant, that of a Scout Platoon Leader responsible for collecting intelligence in an area rich with diverse religious and political sects. He commanded deep respect from his men and performed his job to the highest degree of excellence and professionalism. He deserved the same from the system that he served.

Instead, this brain-injured soldier and Purple Heart recipient was returned three weeks later to his home base in Hawaii and told to follow up with the system for evaluation and treatment. My husband could barely keep his balance, let alone figure out where he was supposed to go and who he was supposed to see. From his first doctor's appointment, it became clear that the system was reactive, not proactive. There was no initiative taken to get him care. We had to do it all alone facing obstacle after obstacle.

In short, referrals were not made and there was absolutely no communication or consensus between the providers we were ultimately able to see and only able to see after demanding that those appointments be made.

My husband describes the struggles we've had with Tripler Army Medical Center as being as painful as sustaining the injury itself. Perhaps some of our difficulties were because his injury was hidden, only overtly apparent to those familiar with the man that he was before his injury. As we would eventually learn, the subtleties of TBI often lead to claims that soldiers are malingering, shirking out of having to redeploy to the battlefield. Such flagrant accusations were thrust upon my husband adding salt to an already open wound. This was a system that was supposed to heal wounds, not create new ones.

My husband was fortunate enough to have remarkable support from his command. His commander took interest in his case, provided support and dedicated many hours of his time seeking resolution to our long list of outstanding issues. Without his support and the support of the 25th Infantry Division, it's likely I would be sharing a different story with you today.

Our frustrations with my husband's care endured for long and frustrating weeks. After not being a priority in the system and after no coordinated plan of care meeting was organized, my husband's request for a referral to an experienced center was granted. Five months after his injury, a pivotal time during the acute rehabilitation stage, and with the help of the 25th Infantry Division, we

were fortunate enough to report to the Defense and Veterans Brain Injury Center, the DVBIC, at Balboa Naval Medical Center in San Diego, which coordinated with the community reentry program at Sharp Rehabilitation Center, a civilian center for follow-up care.

The care in San Diego represented the complete antithesis of what we received in Hawaii. My husband underwent intensive rehabilitation six hours a day, four days a week, care he should have received all along. The providers at Sharp Rehabilitation Center addressed all of my husband's needs, integrated our requests into their rehab program and provided amazing support to both of us.

Importantly, they educated us. We learned that the adverse effects of the injury would have resolved faster had some of the frustration with his medical care been avoided.

My husband left San Diego a changed man. He regained his ability to accomplish complex tasks, his speech was fluid, he was able to run and he passed a driving evaluation. He has since returned to duty in an administrative capacity working with his units, Rear Detachment here in Hawaii.

Since our return to Hawaii, we learned that Tripler Army Medical Center has launched several initiatives to assist its wounded warriors.

I am pleased to know that Tripler recognizes the need to make the care of wounded soldiers its top priority and has begun to implement programs that have the potential to improve tracking and coordination of care as well as support for families. There is still much work to be done, however. My husband and I hope to collaborate with Tripler to help ensure that no other wounded warriors and their families experience similar hardships.

Senators, I urge you and your and colleagues to remain steadfast in your endeavors to ensure: (1) that programs are instituted to increase awareness of the signs, symptoms and appropriate treatments for TBI especially closed-head TBI; (2) that soldiers with TBI and their families receive education about the injury, are provided access to resources and receive unconditional support; and (3) that appropriate and early referrals are made to dedicated centers adequately prepared to treat the complexities of Traumatic Brain Injury.

Certainly we can all agree that it's time the excellence that these soldiers dedicated in the battlefield be matched by the system for which they sacrificed. I again, thank you for the opportunity to participate in this vital forum.

[The prepared statement of Ms. Del Negro follows:]

PREPARED STATEMENT OF ARIANA DEL NEGRO,
SPOUSE OF OPERATION IRAQI FREEDOM VETERAN

Mr. Chairman, Members of the Committee, and panel members, thank you for the opportunity to participate in this vital forum on veterans' care and benefits in Hawaii. By sharing our story today, I hope to increase awareness regarding the gaps in medical care for veterans receiving treatment in Hawaii, as it is my opinion that the military healthcare system here on Oahu, as it now stands, is insufficiently prepared to address the needs of our wounded veterans and their families suffering from Traumatic Brain Injury (TBI). There is much work to be done that requires diligent initiatives for research, education, and family support. My hope is that our story demonstrates the importance of prompt referral to centers specifically tailored to the individual needs of each wounded warrior and highlights the need to streamline the transition from active duty to veteran status.

My name is Ariana Del Negro and, sadly, I represent one of the many military wives/caregivers coping with the hardships of having a soldier return wounded from Iraq or Afghanistan. But I'm one of the lucky ones. My husband and I are well educated, I work in the healthcare industry, and we are financially independent. What we have had to endure over the course of the last 10+ months struggling to navigate through a convoluted, outdated, unprepared bureaucratic military healthcare system has been absolutely untenable. If it has been this difficult for us, I cannot imagine what it must be like for the other families—those with warriors who return far worse off than my husband; families with children; with mothers who have to work to supplement the family income; and those who don't know that the care they are receiving is far inferior to what they need and, importantly, deserve. The wounds suffered from these injuries extend beyond the soldier; the frustrations, gaps in care, and lack of support also wound the families fighting for their loved ones. There are soldiers and families out there that need help and the onus to get them that help falls on the Nation for whom these warriors fought to protect democracy and freedom.

On September 28, 2006, my husband suffered a TBI when a 7,000 pound VBIED (vehicular-borne improvised explosive device) detonated 45 yards from where he was standing. He was exposed to 3 concussive forces: first the explosion; then the engine block from the vehicle which struck him on the back of the head as he was thrown into the air; and finally when he hit his head again after falling to the ground on his back, where he remained unconscious for at least 10 minutes. He spent 3 days in the intensive care ward at Balad Military Hospital and was subsequently released and returned to his base in Iraq with the anticipation that the fog of his mild/moderate (closed-head) TBI would subside sufficiently enough that he could return to full duty.

An Army Ranger, my husband is a well-respected member of his battalion and held one of the most esteemed and coveted positions for a lieutenant—that of a Scout Platoon Leader responsible for collecting intelligence in an area rich with diverse religious and political sects. He commanded deep respect from his men and performed his job to the highest degree of excellence and professionalism. He deserved the same from the system that he served.

Instead, this brain-injured soldier and Purple Heart recipient was returned 3 weeks later to his home base in Hawaii and told to follow-up with the system for evaluation and treatment. My husband could barely keep his balance, let alone figure out where he was supposed to go and who he was supposed to see. Unfortunately, the system he reported to didn't know either. From his first doctor's appointment in Hawaii, it became abundantly clear that the system was "reactive," not "proactive". There was no initiative taken to get him care; we had to do it all alone, facing obstacle after obstacle along the way. In short, referrals were not made, diagnostic tests were not ordered, complaints of mental duress (anxiety) went ignored, and there was absolutely no communication or consensus between the providers we were ultimately able to see (and only able to see after demanding that those appointments be made). In my opinion, regardless of the medical setting—military or otherwise—this care or the lack thereof amounts to negligence and malpractice.

My husband describes the struggles we have had with Tripler Army Medical Center as being as painful as sustaining the injury itself. Perhaps some of our difficulties were related to the fact that a closed-head TBI is literally a hidden injury; an injury with the potential for subtle (yet devastating) sequelae that go unnoticed by those who are unfamiliar with the individual's function before his or her injury. Healthcare professionals are used to having physical evidence of an injury, but typically, the diffuse axonal injury pattern that results from the blast wave of pressure from an exploding IED cannot be neuroimaged and proper identification and referral to treatment are made on the basis of neurologic examination, self-and family reported symptoms, and the results of neuropsychological testing. Oftentimes, this can lead providers to think that soldiers are malingering, shirking out of having to return to duty in Iraq or Afghanistan. Such accusations were wrongly thrust upon my husband, adding salt to an open wound. This was a system that was supposed to heal wounds, not create new ones. It failed and it has not failed us only; it has failed many of the returning wounded warriors.

However, my husband was fortunate enough to have remarkable support from his Command. His Commander took interest in my husband's case, provided support, and dedicated many hours of his time seeking resolution to our long list of outstanding issues. Without his support (and the support of the 25th Infantry Division), it's likely that I would be sharing a different story with you.

EARLY DISAPPOINTMENTS

My husband returned to Hawaii approximately 3 weeks after he was wounded. At that time, he complained of debilitating headaches, chronic vertigo, memory lapses, anxiety, and hearing loss. He always leaned to the left, had hand and facial tics, and could not maintain eye contact when speaking. Two weeks thereafter, some symptoms worsened and new ones emerged. He developed a significant stutter, had difficulty with word recall, and had a propensity to drop things. It was also at this time that he began to withdraw socially, avoiding public and busy areas. His time was mostly spent sitting, staring blankly. My husband is an exceptionally accomplished and strong individual and it was very hard for me to see him struggle with simple tasks.

After much insistence, he was referred for speech pathology and received speech cognition therapy once a week. The next mountain to be climbed was to get his vision checked and then to obtain referral for vestibular and audiology testing. During this time his symptoms persisted, and although some subsided, they never fully resolved. After 14 long and frustrating weeks of not being a priority in the system, after no coordinated plan of care meeting was organized, and after being denied access to additional care (i.e., occupational therapy), our request to be referred to the Defense and Veterans Brain Injury Center (DVBIC) in San Diego for thorough evaluation and intensive treatment was finally granted. We waited another 6 weeks for all paperwork to be finalized and then reported to the DVBIC at Balboa Naval Medical Center who coordinated with the Community Re-entry Program at Sharp Rehabilitation Center (civilian) for follow-up care. All told, it took us more than 5 months to get access to excellent care. This was 5 months of valuable time lost, during what should have been the important acute rehabilitation stage of TBI.

FINE EXAMPLE OF EXCELLENT CARE AND INVALUABLE EDUCATION

The care in San Diego represented the complete antithesis of what we received in Hawaii. The providers at Sharp addressed all of my husband's needs (physical, occupational, and speech therapy), integrated our requests into their rehab program, and provided amazing support to both of us. My husband underwent intensive rehabilitation 6 hours a day, 4 days a week—care he should have received all along. We had biweekly coordination meetings with providers at both Sharp and Balboa who met with us to discuss his progress, make suggestions, and ask for feedback. And, importantly, they educated us. We learned that our situation was not unique and that many closed-head TBI patients face similar obstacles and frustrations that compound their symptoms. They explained that the adverse effects of the injury would have resolved faster had some of the frustration with his medical care been avoided. They also explained that my husband would have probably made greater progress during rehabilitation had he been referred earlier in the treatment process; likely he would have reached the same degree of benefit, but at a much faster rate. Importantly, they also explained to us that there may be some symptoms that will never resolve and that the success of his rehabilitative therapy requires us to recognize reasonable goals while maintaining practical expectations.

Shortly after coming home from Iraq, my husband commented that because he wasn't missing a limb and/or didn't have scars on his head or body, he didn't consider himself as seriously wounded as those with visible injuries, a sentiment reinforced by Tripler Army Medical Center's lack of initiative for his care. The absence of a visible sign of his injury took away from its severity, as well as his perceived need to treat it. The education we received from Sharp Rehabilitation as well as from the DVBIC helped alleviate some of those concerns and provided affirmation to my husband that he was seriously injured and did deserve the best possible care. It is our hope that with greater awareness of the consequences of TBI, providers will appreciate the importance of educating and supporting the patient and his/her family.

My husband left San Diego a changed man. He regained his ability to accomplish complex tasks, his speech was fluid, he was able to run, and he passed a driving evaluation. He has since returned to duty in an administrative capacity, working with his unit's Rear-Detachment here in Hawaii. Although he still suffers from intermittent headaches, vertigo, fine motor skill deficits, and some memory problems, they are far less intense than when he first came home and he has applied the lessons we learned in San Diego and is accepting and compensating for these limitations accordingly.

Our success with Sharp's Community Re-entry Program was the result of receiving excellent individualized care and education from a multidisciplinary group of providers who worked well together and integrated the family unit into the decision-making process. This medical model supports the plans outlined in Section 3 of the

Veterans Traumatic Brain Injury Rehabilitation Act of 2007 (cited as S. 1233) describing rehabilitation programs that provide individualized care and family support to veterans with TBI. Section 3 of S. 1233 also identifies the importance of periodic evaluation and adjusting care as needed, which we experienced at the Sharp Rehabilitation Center.

COMPREHENSIVE CARE: WHEN A REFERRAL IS REALLY NECESSARY

My husband was very high-functioning after his injury and was not an individual who one would typically consider eligible for intensive rehabilitation. However, with the increasing awareness of the deleterious and long-term consequences of TBI—namely through the adoption of the DVBICs across the country—my husband was properly identified as someone who could benefit from such care. We utilized all of the tools at our disposal to the fullest. We knew that he was one of the lucky ones to get treatment and it is our hope that the success he (and Sharp Rehabilitation, in collaboration with the DVBIC and Balboa Naval Medical Center) achieved sets a fine example for what the standard of care should be for all soldiers returning with TBI. Our experience at the Sharp Rehabilitation Center also represents the importance of extending civilian healthcare services to returning soldiers. Programs, such as the one at Sharp, have experience with the injury, have an effective and efficient program in place, and clearly yield excellent results. More initiatives need to be taken to institute similar programs partnering military and civilian healthcare services. In addition, consideration must be given to properly pairing the offerings of a rehabilitation center with the specific needs of a veteran with TBI. In our case, and because my husband was high-functioning, referral to the Sharp Community Re-entry Program was more appropriate than referral to the Veterans' Affairs (VA) Palo Alto Health Care System because the latter primarily manages patients with more severe TBIs. Veterans with TBI will be greatly served by having access to non-Department facilities for rehabilitation, as outlined in Section 4 of S. 1233.

Our referral to the DVBIC in San Diego was absolutely appropriate, but the decision should have been made much earlier. In fact, my husband never should have been returned to Hawaii for evaluation and treatment of TBI. Typically, soldiers that are wounded and returned home are routed to Landstuhl for referral to Walter Reed or another center adequately equipped to treat the specific injury. Tripler was not an experienced center for TBI and should have recognized the importance of referring my husband to a center that could provide the necessary comprehensive care. This also speaks to the importance of Section 4 of S. 1233 for referral to a non-Department facility when "the Secretary is unable to provide such intervention, treatment, or services at the frequency or for the duration prescribed in such plan". Tripler's unpreparedness to adequately treat TBI was reflected in the fact that appointments were few and far between and no coordination efforts were put forth to institute a plan of care for my husband's treatment—a necessary course of action mandated in Section 3 of S. 1233.

Since our return from San Diego, awareness of TBI has increased and programs are now being instituted to assist wounded warriors at all Army facilities, including Tripler. I am pleased to know that Tripler recognizes the need to make the care of wounded soldiers its top priority and has begun to implement programs that have the potential to improve tracking and coordination of care, as well as support for families.

Although these initial steps are very promising, I remain concerned that much more work needs to be done before Tripler Army Medical Center has the necessary tools in place to effectively coordinate and manage the care of soldiers or veterans with TBI. Noted in Section 3 of S. 1233, and also listed in a Veteran's Health Initiative,¹ optimal care for TBI requires a multidisciplinary approach consisting of a team of providers from at least 9 specialties. I do not believe that Tripler will be able to establish a team that could coordinate or collaborate effectively enough to yield the necessary outcomes owed to a TBI wounded warrior, at least not at the present time.

ACCESS TO RESOURCES

We hope to work with Tripler and its faculty to help ensure that no other wounded warriors and their families endure the same hardships that we faced. Furthermore, it is our hope that we will be given the opportunity to meet with some of the soldiers and their families to provide support, whether that be as simple as lending an ear or a shoulder or helping them gain access to important resources.

¹*Veterans Health Initiative. Traumatic Brain Injury.* Independent Study Course Released: January 2004.

It is critically important that soldiers and their families are proactively made aware of the resources that are available to them; they shouldn't have to seek them out. I wouldn't have known about the DVBIC unless I had actively sought out information and made contact with both Walter Reed and San Diego. I wouldn't have known that my husband wasn't getting the standard of care if I didn't work in the healthcare industry and if I hadn't done extensive research to educate myself on TBI and the multiple disciplines that must work together to treat the condition.

Our endeavors paid off, it would seem. But what about those individuals who, in addition to the needs of their wounded loved one, have to tend to the needs of their children, or who don't have the flexibility with their work, or who don't have the benefit of higher education, or who don't know that they can ask questions? Those are the families in need. These families need immediate access to resources, they need advocates, and they need support. It's one thing to develop resources—it's another to actually utilize them. If the families don't know these resources exist, then they are certainly not likely to ever reap the benefits from said programs.

TRANSITIONING FROM ACTIVE DUTY TO VETERAN STATUS

The above traces the trials and tribulations that my husband and I faced during the early phases of his injury. Our frustrations, I fear, will continue for months and years to come. My husband is still on active duty and we are no closer to definitively determining his potential for return to full duty status than we were when he first returned from Iraq in October 2006. Unfortunately, the obstacles we faced during active duty will likely be inevitably revisited once he is discharged from the service and once he enters and seeks care in a backlogged and overwhelmed VA system (described as such after reading media accounts); whether that happens in the next year or in 12 years when he retires, remains to be determined.

Although my husband is still on active duty, our experience represents what most young veterans suffering TBI have had to face before being discharged from the service. We must be able to learn from these initial experiences to avoid similar obstacles within the VA system. The continuum of care begins on the battlefield, moves to the military healthcare system, and then to the VA system. The Dignity for Wounded Warriors Act of 2007 (H.R. 1268) aims to overcome many of the limitations associated with wounded servicemembers' access to care. However, the success of both S. 1233 and H.R. 1268 are contingent on establishing an effective transition system. As noted in Section 2 of S. 1233, a collaborative effort between the Department of Defense and the VA is absolutely necessary to facilitate care and streamline the transition of soldiers from active duty to veteran status. More research and greater awareness of blast-related TBIs will likely facilitate this transition process.

MORE RESEARCH IS NEEDED

Recovery from and treatment for TBI requires patience. The complexity of the injury and its pathophysiology require a long-term multi-tiered management approach. In the acute setting, management is focused on stabilizing the patient and ruling out life-threatening complications, such as shrapnel wounds or spinal injuries. The second step is assessing and treating the intermediate effects of the injury, namely, neurocognitive difficulties, reflected in self-reports of symptoms such as forgetfulness, anxiety, headaches, balance difficulties, and other sequelae commonly associated with post-concussive syndrome. Less defined at this time, however, is what will be needed in the long run. How long should care be administered? When is a patient considered fully recovered and what are the long-term consequences of closed-head TBI (i.e., epilepsy, Alzheimer's, Parkinson's)? Answers to these questions remain ambiguous, at best.

Data suggest that a person with a mild TBI who does not receive early adequate treatment and education is more likely to endure a long recovery process with lingering symptoms. However, these data are largely based on older studies evaluating outcomes of patients who sustained a TBI in an automobile accident, a fall, or a sports injury. It does not take into consideration that a blast-related TBI may injure cells at a more severe microscopic, sub-cellular level.^{2, 3} Injury to this fine of a degree may influence outcomes and possibly require longer periods for maximum recovery than TBIs suffered in a non-combat setting.

There is little doubt that more research on blast-related TBI is needed, particularly as it relates to the effects of exposure to multiple primary blasts and long-term outcomes. TBI in a combat environment is a complex injury. A thorough understanding of the nuances of the injury, whether physically evident or otherwise, is

² *The Washington Post National Weekly Edition*, April 16–22, 2007, page 25.

³ Taber, et al., *J. Neuropsychiatry Clin Neurosci.* 2006;18(2):141–145.

absolutely essential to identify effective therapies and maximize outcomes. Currently, much of the evidence on blast-related TBIs is derived from animal studies, which have helped researchers understand the pathophysiologic effects of the injury; however, the implications of these findings in the clinical setting have not been well studied. As the number of TBI wounds increase, so too does the need for allocated funding to support clinical research and facilitate the drafting of practice guidelines, as well as the need to develop educational tools and implement training requirements for all providers.

The importance of more research in this area is recognized in Section 5 of S. 1233, which states that the "Secretary shall establish a program on research, education, and clinical care to provide intensive neuro-rehabilitation to veterans with a severe Traumatic Brain Injury". However, this language excludes the majority (80 percent) of TBI injuries—those classified as mild or moderate. It is my opinion that without documentation from large clinical studies with long-term follow-up, it may be premature to assume that veterans with mild or moderate TBI do not need the same services offered by this initiative. Furthermore, persistent post-concussive syndrome (defined as symptoms that continue beyond 6 months post-injury) is more common after mild TBI than moderate or severe TBI and individuals with persistent post-concussive syndrome are likely to continue to suffer symptoms for a number of years.

It took months for me to convince my husband that he deserved the same priority of care as those soldiers with visible injuries. Hopefully, with more research and greater awareness, soldiers in similar situations will be counseled appropriately by the system responsible for helping these individuals maximize their potential. These soldiers (and their families) need validation and they need dedicated support.

I am aware that this continues to be an ongoing learning process, but I also believe that measures need to be put in place to assess the efficacy of these programs, that specific benchmarks need to be set to reduce the length of time between presentation and treatment initiation, and that processing of disability claims must be streamlined. The proposed programs set forth by S. 1233 and H.R. 1268 are promising in theory, but without adequate resources and without intense coordination and organization, the therapy and these efforts will likely fail for most.

I urge you and your colleagues to remain steadfast in your endeavors to ensure: (1) that soldiers with TBI and their families get the care that they need and deserve; (2) that appropriate funding be allocated for research; and (3) that immediate actions are put into place to increase the awareness of the devastating effects of TBI. It's time that the excellence that these soldiers dedicated and displayed in the war zone be matched by the system for which they sacrificed.

I thank you for your time.

Senator INOUE. Thank you very much.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you very much, Ms. Del Negro, and now we'll receive the testimony of Allen Hoe.

STATEMENT OF ALLEN HOE, VIETNAM VETERAN

Mr. HOE. Good morning, Senator Akaka and Senator Inouye. The Hawaii Veterans Community is honored by your presence and continuing dedication in fulfilling your promise to serve those who have served our country in uniform.

My name is Allen Hoe and like many here this morning, I am a proud veteran who wore the U.S. Army jungle fatigues in combat in Vietnam in 1967 and 1968. However, for me a greater source of pride is my two sons who also wore the uniform as infantrymen in service of their country. I would like to believe that our family is not unique. Hawaii sons and daughters have a long and honored tradition of service and sacrifice to our country.

Duty, honor, country, those three simple words have the power to motivate young men and women to do remarkable things when called upon by their country. To the veteran who has worn the uniform to the young warriors who wear it today, we owe them our gratitude for their selfless service, but more importantly, we must

ensure that they receive the fullest measure of those benefits to which they are entitled to.

I have had the privilege to wear many different hats over the years. As a Vietnam veteran, the one I wear as a member of the Advisory Committee on the Readjustment of Veterans provides the greatest sense of duty for me. I accepted that role several years ago when I realized my sons would soon be going off to service and I needed to focus my energies on protecting our veterans' benefits programs and to secure them for the current generation of our brave young heroes. As we, Vietnam vets, are so fond of saying never again will one generation abandon another.

My testimony this morning is not in any official capacity with my service on the advisory committee. I'm here simply as a veteran, a member of this proud community of veterans and the father of a couple of young soldiers to whom our obligations must be fulfilled.

Earlier this year our Committee issued its 11th Annual Report. I merely wish to highlight the report's recommendations which are presented to the secretary. If there is any ulterior motive on my part, it is merely to provide this honorable Committee and its Members the perspective of "boots on the ground" regarding the importance of the work done by my colleagues who serve on the Advisory Committee on the Readjustment of Veterans.

Number one, Vet Centers have become as we say in Olelo Hawaii, "Puuhonua" or sanctuaries, special place of refuge. Veterans are utilizing its services and programs in increasing numbers. Two new Vet Centers and staff augmentation at existing Vet Centers are in progress.

However, based on a number of findings as listed, it is clear that additional augmentation of the Vet Center program is needed. The high number of National Guard and Reserve combatants in OEF and OIF and our own experience especially with the mobilization of the 29th Infantry Brigade and the 100th Battalion, along with the continuing separate unit mobilization throughout the Pacific Command, many of these young warriors are now coming from widely dispersed, rural areas. Thus, the need exists to prioritize the creation of Vet Centers outstations and augmenting staff in Vet Centers that provide access to these rural areas. The capacity to respond to the service needs of the increasing number of OEF/OIF veterans and family members will be critical for years to come and that expanding the Vet Center program to provide access would perhaps be an effective way to build and expand the veterans' benefits infrastructure to meet their needs over time.

In our Hawaiian family tradition of Ohana, we are defined as who we are as veterans and the importance of our families in every aspect of our lives as we serve our country. Thus, the recent legislative authority allowing for treating veterans' families at Vet Centers is a great accomplishment. It is truly a no brainer that a veteran's successful readjustment also includes their Ohana's readjustment as well. Providing family treatment by Vet Centers which have qualified family therapists on staff needs to be expanded. The augmentation of family counselors at Vet Centers would enhance the program's capacity to clinically address the more complicated

family adjustment problems among the increasing numbers of returning combat veterans.

A very key factor in the Vet Center program's success is its design to function as an off-campus entity, if you will. It provides a safe haven for many veterans. Thus, it is important to validate its rule with the secure and separate system of client records and related policy of guaranteeing confidentiality for the veteran. This is perhaps the most essential item in serving war-traumatized veteran population and goes a long way toward mitigating the stigmas manifested by this population against accessing care.

Nakoa Wahine or women warriors are an integral part of our ancient Hawaiian tradition and culture. They stood along side their husbands in battle. And in some instances, due to a greater family allegiance, they found themselves opposite their husband. Today American women in service uniform comprise an ever increasing component of who we are as veterans. With increasing numbers of female military personnel serving in combat areas, the Vet Centers will need to carefully monitor the demographics of this local catchment areas to ensure that the female veterans service providers are represented on the Vet Center Teams at appropriate levels.

Increasing awareness of the impacts of multiple deployments, extended deployments and traumatic battlefield experiences have exposed a higher incidence of mental health needs of returning OEF/OIF veterans as documented by the Land Combat Study research by Colonel Charles Hogue. Veterans must be extended priority access to VA medical centers for mental health screening, assessment and treatment to avoid the barrier of waiting lists of several months of appointment.

The blending of our Armed Forces of active duty, Guard and Reserve units are presenting some unique issues on tracking these individual heroes as they change out of uniform into civilian attire. The establishment of the aggressive Global War on Terrorism veteran outreach program which consists of 100 OEF/OIF veterans whose mission is to provide early contact program information and educational briefings to veterans at military demobilization and National Guard and Reserve sites, is vital to the efforts to service all our veterans. There must be a system to closely monitor the program's outcomes to further access the feasibility of further extensions to this program.

There is a realization that as time increases following demobilization and separation from active military, increasing numbers of veterans will experience readjustment concerns to include the delayed onset of PTSD. To facilitate a veteran's ease of access for care, the more traditional methods of community outreach in addition to the Global War on Terrorism outreach program at the demobilization sites need to be enhanced. Such methods would include liaison with community emergency responders, educational presentations at community mental health and social service agencies and any other form of community liaison that will result in facilitating veteran referrals for follow up readjustment counseling.

The points above clearly represent a cross section of those issues of services which are of great importance to our veteran community not just in Hawaii but at large.

More particular with regard to Hawaii veterans' community, the disability claims need more resources to decrease the current backlog in the disability claims. Two critical areas are elderly veterans who often give up or die before their claim is resolved, and the OIF/OEF veterans who often experience serious financial difficulties while awaiting a VA decision on their disability.

OIF and OEF vets need greater focus on unique needs of soldiers and veterans from those combat areas. The need for more full-time personnel assigned to coordinate care to ensure a seamless transition. Too often VA personnel are assigned duties as ancillary to primary job responsibilities.

Each VA facility should have a full-time fully staffed OIF/OEF treatment team. As pointed out by Ariana, Traumatic Brain Injury treatment, there needs to be great improvement in the VA's ability to assess and treat TBI. Increase number of neuro-psychologists to do the testing for TBI.

Eligibility periods: Returning soldiers and veterans must apply for medical benefits within two years after returning from a war zone. Unfortunately, many do not seek VA care within this allotted time period. Eligibility for peer should be extended to years after return.

In short, there are many things which the VA does that is absolutely wonderful and, as we know, there are many things that needs great improvement. And again, I wish to extend my heartfelt gratitude for the opportunity to offer some of my observations and concerns to the Committee this morning.

For those of you who know me, you understand the importance of symbolisms to me. I wear my cap. This flag is a special flag. This flag I carried 40 years ago with me in combat in Vietnam. And we carry that to honor 18 of my fellow recon team members who were killed. And we promised their families that when they were recovered and brought home, that this flag would fly at their service.

This past January we had the honor, after my lieutenant was missing for 38 years and my RTO missing for 38 years, to have this flag accompany us as we attended the services at Arlington as well as Oklahoma. And as a tribute to how important these symbols are to our kids and our families, this flag was carried by my son in Mosul in January of 2005 in honor of his dad's lieutenant who was killed and missing in Vietnam. And this flag was carried by my son the morning he was killed in Iraq. So if you look at it, it really says a lot of who we are as a people, who we are as veterans in this community and who we are as a Nation. Thank you.

[The prepared statement of Mr. Hoe follows:]

PREPARED STATEMENT OF ALLEN K. HOE, VIETNAM VETERAN

Good morning Senator Akaka, Senator Craig and Members of the Committee on Veterans' Affairs. Your presence and your continuing dedication in fulfilling your promise to serve those who have served our Country in uniform is deeply appreciated.

My name is Allen Hoe, I am a proud veteran who wore U.S. Army jungle fatigues in combat in Vietnam in 1967 and 1968; however, for me a greater source of pride is in my 2 sons who also wore the uniform as infantrymen in service of their country. I would like to believe that our family is not unique. Hawaii's sons and daughters have a very long and honored tradition of service and sacrifice to our country.

Duty, Honor, Country, those three simple words have the power to motivate young men and women to do remarkable things when called upon by their country.

To the Veteran who has worn the uniform, to the young warriors who wear it today, we owe them our gratitude for their selfless service but more importantly we must ensure that they receive, to the fullest measure those benefits to which they are entitled to.

Of the many hats which I have had the privilege to wear over the years, from my veteran's perspective, the one I wear as a member of the "Advisory Committee on the Readjustment of Veterans" provides the greatest sense of duty for me. I accepted that role several years ago, when I realized that my sons would soon be going off to serve and that I needed to focus my energies on veterans benefits programs to secure them for the current generation of our brave young heroes. As we Vietnam Vets are so fond of saying, "never again will one generation of veterans abandon another."

The Advisory Committee on the Readjustment of Veterans, which I have the honor to serve as a member is mandated under Public Law 104-262, to:

- Assemble and review information relating to the needs of veterans in readjusting to civilian life.
- Provide information relating to the nature and character of psychological problems arising from service in the Armed Forces.
- Provide an ongoing assessment of the effectiveness of the policies, organizational structures, and services of the Department of Veterans Affairs (VA) in assisting veterans in readjusting to civilian life.
- Provide ongoing advice on the most appropriate means of responding to the readjustment needs of veterans in the future.
- In carrying out these activities, the Committee shall take into special account the needs of veterans who have served in a combat theater of operations.

My testimony this morning is not in any official capacity with my service on the Advisory Committee on the Readjustment of Veterans. I am here simply as a veteran, a member of this proud community of veterans and the father of young soldiers, to whom our obligations must be fulfilled.

Earlier this year the Committee issued its Eleventh Annual Report. I would merely wish to highlight the report's recommendations which are presented to the Secretary. If there is any ulterior motive here it is merely to provide this honorable Committee and its Members, the perspective of "boots on the ground" regarding the importance of the work done by my colleagues who serve on the Advisory Committee on the Readjustment of Veterans.

1. The Vet Centers have become, as we say in Olelo Hawaii, "Puuhonua" or sanctuaries, a special place of refuge. Veterans are utilizing its services and programs in increasing numbers. Two new Vet Centers and staff augmentation at 11 existing Vet centers is in progress. However, based on a number of findings as listed below, it is clear that additional augmentation of the Vet Center program is needed:

- The growing number of separated servicemembers from OEF/OIF to date.
- The high number of National Guard and Reserve component forces who disperse to all corners of the country upon separation from OEF/OIF.
- The Army studies conducted by Colonel Charles W. Hogue, that document the incidence of combat related stigma and readjustment problems among OEF/OIF returnees.
- The effectiveness of VA's community-based Vet Centers in contacting the new veterans through an aggressive GWOT outreach campaign and in providing timely readjustment counseling to veterans and veterans' family members.

The high number of National Guard/Reserve combatants in OEF/OIF; our own experience with mobilizations of the 29th Infantry Brigade and the 100th Bn., and the continuing separate unit mobilizations throughout the Pacific Command, many of whom come from widely dispersed rural areas, the need exists to prioritize the creation of Vet Center outstations and augmenting staff in Vet Centers that serve rural areas. The capacity to respond to the service needs of the increasing number of OEF/OIF veterans and family members will be critical for years to come, and that expanding the Vet Center program is perhaps an effective way to build and expand the veterans benefits infrastructure to meet their needs over time.

2. Our Hawaiian tradition of Ohana defines who we are as veterans and the importance of our families in every aspect of our lives as we serve our country. Thus, the legislative authority for treating veterans' families at Vet Centers, is a great accomplishment. It really is a no brainer that a veterans' successful readjustment also includes the Ohana's readjustment. Providing family treatment by Vet Centers which have qualified family therapist on staff needs to be expanded. The augmentation of family counselors at Vet Centers would enhance the program's capacity to clinically address the more complicated family adjustment problems among increasing numbers of returning OEF/OIF combat veterans.

3. A key factor in the Vet Center program's success is due to structure as an "off campus" entity, if you will. Thus it is important to validate that with a secure and separate system of client records and related policy of guaranteeing confidentiality for the veteran. This is perhaps the most essential item in serving the war-traumatized veteran population and goes a long way toward mitigating the stigmas manifested by this population against accessing care.

4. Nakoa Wahine, women warriors are an ancient Hawaiian tradition, they fought along side their husbands, and in some instance due to a greater family allegiance that found themselves opposite their husband; in any regards women in service as another trait of who we are as veterans. With the higher number of female military personnel serving in OEF/OIF, the Vet Centers continue to carefully monitor the demographics of local catchment areas to ensure that female veteran service providers are represented on Vet Center teams at appropriate levels.

5. Increasing awareness of the impacts of multiple deployments, extended deployments and traumatic battlefield experiences, have exposed a higher incidence of mental health needs of returning OEF/OIF veterans as documented by the "Land Combat Study" research of Colonel Charles W. Hogue, M.D., OEF/OIF veterans must be extended priority access to VA medical centers for mental health screening, assessment and treatment to avoid the barrier of waiting lists of several months for an appointment.

6. The blending of our Armed Forces of active duty, Guard and Reserve units presents some unique issues on tracking these individual heroes as they change out of uniform into civilian attire. The establishment of the aggressive GWOT veteran outreach program which consisted of 100 OEF/OIF veterans whose mission is to provide early contact, program information and educational briefings to veterans at military demobilization and National Guard and Reserve sites is vital in the efforts to service all our veterans. Thus, there must be a system to closely monitor the program's outcomes to further assess the feasibility of further extensions to this program initiative contingent upon increasing workload volume among returning OEF/OIF veterans.

7. There is the realization that as time increases following demobilization and separation from active military, many veterans will develop readjustment problems to include the delayed onset of PTSD. To facilitate a veterans' ease of access for care, the more traditional methods of community outreach in addition to the GWOT outreach at demobilization sites need to be enhanced. Such methods would include liaison with community emergency responders, educational presentations at community mental health and social service agencies, and any other form of community liaison that will result in facilitating veteran referrals for follow-up readjustment counseling.

The points referenced above represent a cross section of those issues or services which are of great importance to our veteran community not just in Hawaii but at-large.

The following issues are what I have surmised as being specific needs to our Hawaii veterans community as they have been shared with me.

Disability Claims: More resources are needed to decrease the current backlog in the disability claims process. Two critical areas:

- Elderly veterans often "give up" or "die" before their claim is resolved.
- OIF/OEF veterans can often experience serious financial difficulties while awaiting a VA decision on their disability.

OIF/OEF: Need greater focus on unique aspects/needs of OIF/OEF soldiers/veterans:

- Need more full-time personnel assigned/designated to coordinate OIF/OEF care to ensure a seamless transition. To often VA personnel are assigned OIF/OEF duties as ancillary to primary job responsibilities. Each VA facility should have a full-time and fully staffed OIF/OEF treatment team.
- Traumatic Brain Injury treatment. Need to improve VA's ability to assess and treat TBI. Increase number of neuro-psychologists to do testing for TBI.

Eligibility Period: Returning soldiers/veterans must apply for medical benefits within 2 years after returning to the U.S. from the war zone. Unfortunately, many do not seek VA care within this allotted time period. Eligibility for care should be extended to 5 years after return.

Access to Care: Need to expand resources and increase accessibility/availability of care:

- Sometimes difficult to get an appointment in a timely manner and there often is too much time between appointments.
- Increase medical staff and expand specialties (orthopedics, endocrinologists, OB/GYN, TBI) to improve care and alleviate wait time.

- Expand hours of operation for both medical and mental health services. Present hours of 0800 to 1600 may be sufficient for unemployed and elderly veterans; however, it often poses a hardship for the younger veteran making the transition from the military to a new job or school. Often, they do not have the “sick-leave” or “vacation” time accrued.

- Develop mobile clinics that travel to communities to provide general health care. It is sometimes difficult for veterans to go to VA. This is particularly critical for elderly, disabled, or homeless veterans who often need increased medical care for chronic medical problems or for service-connected conditions. Elderly and the disabled often can’t drive, don’t want to inconvenience family and cannot endure long rides on the bus or handi-van. Taking health care to their community via a medically equipped bus/van can provide a valuable service to these veterans.

Veterans Service Organizations: Veterans Service Organizations (DAV, VFW, American Legion, etc.) are congressionally chartered organizations that advocate for veterans and assist in filing disability claims. Unfortunately only the DAV provides a full-time National Service Officer in Hawaii to assist veterans with their claims. As a result, many veterans are not properly represented in filing their disability claims.

Again I wish to extend my heartfelt gratitude for the opportunity to offer some of my observations and concerns to the Committee this morning.

A very special aloha and mahalo to Senator Akaka and to Congressman Abercrombie for being there for my family and for your loving tributes in honor of my son.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you very much, Allen Hoe, for your testimony. Now, we’ll hear from Tom Joaquin.

STATEMENT OF THOMAS L. JOAQUIN, SENIOR VICE PRESIDENT OF OPERATIONS, HAWAIIAN ELECTRIC COMPANY, INC., AND MEMBER VA ADVISORY COUNCIL

Mr. JOAQUIN. Good morning, everyone, Mr. Chairman and Members of the Committee. Mahalo for the opportunity to appear here today to discuss VA care in Hawaii. While I’m here today to praise the VA, most of my involvement over the last 43 years has been adversary.

I want to thank you, Mr. Chairman, as well as Senator Inouye for your steadfast commitment to our veterans. Legislation that you and others have introduced have led to unprecedented care for veterans. From humble beginnings on Ward Avenue in the 1960s to world-class medical facilities today, not only on Oahu, but serving all of the neighbor islands with Community Based Outpatient Clinics (CBOCs).

Recently, an accreditation audit found our facilities on Oahu to be one of the best in the VA. I can attest to the level of care and concern of my VA doctor and her staff. I can assure you that it rivals my civilian experience.

Many of these accomplishments have come about under the capable leadership of Dr. James Hastings, the director of Pacific Islands Health Care System. I belong to an advisory board that meets with Dr. Hastings and his leadership staff quite often. We have a very healthy exchange of concerns and ideas, all designed to allow input into the local VA and subsequent buy in from our constituents we serve. I suggest that the VA consider these advisory boards elsewhere.

I live in Kapolei, the fastest growing area on Oahu quickly living up to the expectations of the Second City of Oahu. I understand that we are looking to establish a CBOC in this area and are awaiting availability of facilities closed by the Navy.

I would encourage a more aggressive approach perhaps working with the state or even just building or leasing a facility. The population of the area surrounding Kapolei exceeds any of the neighbor islands and there are many, many veterans that reside in that area.

Mr. Chairman, I thank you again for the opportunity to testify at this hearing.

[The prepared statement of Mr. Joaquin follows:]

PREPARED STATEMENT OF THOMAS L. JOAQUIN, SENIOR VICE PRESIDENT OF OPERATIONS, HAWAIIAN ELECTRIC COMPANY, INC., AND MEMBER VA ADVISORY COUNCIL

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I would encourage a more aggressive approach, perhaps working with the State or even just building or leasing a facility. The population of the area surrounding Kapolei exceeds any of the neighbor islands.

Mr. Chairman, I thank you again for the opportunity to testify at this hearing. I would be happy to take any questions you might have.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you very much Tom Joaquin. And now we'll hear from Victor Opiopio.

Victor is, as you know, a kamaaina here and I know him as Crash.

STATEMENT OF VICTOR OPIOPIO, VIETNAM VETERAN

Mr. OPIOPIO. I want to say good morning to everyone, to all the ladies and gentlemen from the States that have come here. You heard me use the term "the states." People say to me, "but isn't this is a state?" And I say to them, "Well, let's look at it. I was born here, I was raised here and I live here. This is my mainland. And you guys are from the states. But welcome.

Onakala, Kaniale, aloha to your family very talented, talented family. Danny, who just happens to be my mother's godfather. He doesn't even realize. My grandfather was Byron Bridges and—well, my mom has passed away, but I remember you when I was young. But aloha and welcome and thank you for listening to us.

I don't have a prepared speech. I don't have anything in writing in front of me because when I speak, I speak from my heart. And sometimes I get messed up or I mess up along the way. But when it comes to the VA, it's an issue that is very important to me. Because, number one, I love the VA. Number two, I hate the VA.

I mean, there's no "ifs", ands and "buts." The VA has done a lot for me recently. But for 20 years I had to bang my head against the wall asking for help, and at no time did anyone step forward and say, "Could I help you?" I joined the organizations that said we are set up to help the veterans. I signed up. I sent in my money. I never heard from them.

When I received a rating, I would get a letter from them inviting me to join. I was already a lifetime member. So I felt deserted. I felt lost. This is my story because I can't speak for all the veterans. I can't. But I can speak about myself. I want to share this with all of you because I have not shared it before.

For the last 30 years here in the islands, I have been in radio and in television. I know a lot of you are smiling because I'm sure you remember me. The name Crash Kealoha was given to me by Lucky Luck many, many years ago. I was one of his students. Well, when I wanted to get into radio, I was only 14 and you had to be 15. So, I messed around till I was 15.

This was 1965. There was something going on on the other side of the world that was called a conflict or a police action. It wasn't called a war. Right? It was a conflict. It was a police action. Only now it's called a war. What happened? When we came home, there were no cheers. People didn't say, "Welcome home." Today I walk up to veterans and say welcome home. And they look at me and they know what I'm saying. So when I talk about the VA, I've got to talk about myself.

I fell and hurt myself. I hurt my back. I cracked my spine. They put me in the hospital, put me in a body cast and told me that the best way for your body to heal is to heal naturally. I was in a body cast for about six months. By the way, it was done in Missile Shack. After my fall, they found blood in my urine. It was a total surprise because that never happened to me.

I took so many physical exams before joining the military. There was no blood in my urine. And they said you know something? You have a kidney condition that you had before you joined the military. And I said what? You had this before you joined the military. So we're going to discharge you with your back condition, but your kidney condition is not service connected. And I said, now wait a minute. They said no, it's not service connected.

I did some research and what I had was a UPJ obstruction which is something that people are born with. I didn't know that. It's a more common incidence among babies. It happens that's when it's discovered. Very rarely does it linger on. Well, I did not know of this condition. But something happened to make my kidney bleed.

What happened? I fell down. I hurt my back. I was discharged for my back. And the doctors, private doctors told me it would cost about \$30,000 to work with my kidney. I couldn't afford \$30,000. So I went to VA, and I said I need help because of my kidney problem. VA said no problem, we'll take care of you. I was surprised. The next day I was at Tripler meeting with my doctor who said we're going to operate next Thursday. I said fantastic, how long is this going to keep me in the hospital? He said well, 10 days, 2 weeks at the most. Go home, relax. You'll be fine.

They worked on my kidney. The morning before the operation, I spoke with my doctor and he took my hand and I shook his hand.

I said to him, you know, God bless everything. I woke up. I was in so much pain that I could not believe it. I asked for my doctor and they said he was rotated out. I didn't know what that meant. But where is my doctor? He's rotated out. Hmm.

What's going on? Well, my kidney did not work at all after that. And I was up there for 15 months in total, total pain. Finally, they removed my kidney because there was nothing else they could do. After that I went to the VA to file a claim and they said to me, it's not service connected. I said what? That kidney condition was not service connected. You lost your kidney. Sorry.

I couldn't believe that. And then my back condition. I was given—and you guys don't know about this—painkillers and muscle relaxers. Painkillers and muscle relaxers and go home and lie down. Take it easy, painkillers and muscle relaxers. This one doctor I had—the very first doctor I had—I thought he was nuts. And I found out he was nuts because he burned his house down because he was treating his children to a lesson not to play with fire so he burned his house down. Needless to say he was let go from the VA and I was appointed another whacko. This one I won't even talk about because he's still there. And if it was up to me, I would get rid of him.

But anyway, the fight with my back I was granted for my lower back. The pain in my back started started going up to my spine. And the doctors saw all of this. They saw all of this pain, and I went through all of the MRIs and all of that, and they said your condition has worsened. And it's gotten to the point where it hit my neck, I had to have three surgeries done on my neck that VA paid for, sent me to Straub. Thank you VA. And then when I filed for a claim they said, no. The neck and the back are not service connected.

Now I'm going to wrap it up right here because, like I said, I have a love and hate relationship with the VA. After all those years of fighting, this beautiful woman walked into my life. Her name is Jane Watson, and she is a doctor at VA. She was the very first person I met who actually care about veterans. Without that lady's help, I probably would not be here today.

There's one other person, without him I probably would have blown myself away a long time ago, and this man is incredible. He suffered from a personal problem that took him away from the VA. I never thought I'd ever see him again, but he came back. I asked him why he came back, and he said because he wants to help the veterans. His name is Dr. Cameron, and I know he's sitting in the back. Dr. Cameron, thank you. Thank you for saving my life. That's why I said I have this love-hate relationship with the VA. And you guys know what I'm talking about. Mahalo.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you. Now we'll hear from Clay Park.

**STATEMENT OF WILLIAM CLAYTON SAM PARK, CASE
MANAGER/VETERANS SPECIALIST, HELPING HANDS-HAWAII**

Mr. PARK. Senator Akaka, Senator Inouye, my name is William Clayton Sam Park. I am of Native Hawaiian ancestry, a disabled veteran who served as a combat medic during the Vietnam War, and a retired master sergeant with three years active duty with

the U.S. Army and 21 years of service with the Hawaii Army National Guard.

Thank you for this opportunity to address the Senate Veterans' Affairs Committee. I am a case manager/veterans specialist with the agency on whose behalf I testify today, Helping Hands-Hawaii.

Helping Hands is a nonprofit agency with 33 years of service to the people of Hawaii, providing behavioral health and mental health service. It also offers other community-based services such as Bilingual Access Line (providing interpreters), the Community Clearinghouse and the Ready-to-Learn Program, known to many because of Senator Inouye's and his wife's (Maggie) efforts. I will speak today primarily of community, linkage and advocacy on behalf of our veterans.

Helping Hands has been an active partner in this community for over 30 years. As our community welcomes back our newest warrior, there's no doubt that we face significant challenges not only for these veterans and their families, but also for the generations of veterans who went before them who also have been affected by this war.

The need for support in our veterans community became more and more evident over the past year or two. While no formal program had yet been developed, the need did not wait. Veterans' concerns and problems began to surface on the day-to-day activities of Helping Hands' staff, such as myself. As a case manager and also as a veteran, the veterans with psychological problems, many of whom were homeless, were assigned to me.

While some came directly to us from the State Department of Health, the Adult Mental Health Division, others came by word of mouth from social service workers. A contact would say something like this: There is a veteran who lives on the side of the Pali and we have not seen him for days. Can you help? Outreach often means doing what is unconventional and that is what was required in this case. Using my tracking skills and my familiarity with the mountains as a long-time pig hunter, to find this veteran who was using his military skills to hide from the populated area.

Having found this particular veteran, it was not possible to convince him to seek VA benefits and services because he did not understand the VA system and feared that he would lose his existing social security benefits if he chose to go through the VA. While this veteran now has a different life, attending the State's Club House and sharing his life with a girlfriend, he still is not receiving services from the VA which he would be entitled to.

Outreach is not simply about finding someone and providing services. Often times it is about support and direction for the veteran who is about to give up on seeking or accepting services. Some of the time that means the veteran has become so frustrated with the obstacles along the way to accessing benefits for services that he or she would simply say forget it and struggles to survive without the VA assistance. Other times, more drastically, the veteran has decided it is better to give up his life rather than to continue to struggle.

The desperate call then comes from many family members hoping to find someone who knows what to do to change his mind. A recent example comes from a case management situation where an

individual was seen at the request of a family member concerned about how discouraged and despondent he was. He had been deployed with the Oregon Army National Guard unit to Iraq. Upon return, he applied for VA services and encouraged prior to leaving the unit, he waited for the VA's reply while trying to provide for his wife and his three children. He was not with his family since his wife already had filed a temporary restraining order on him.

He had changed so much since his return, especially in terms of his inability to control his frustration and anger, a sign that we would consider possibly related to Post Traumatic Stress Disorder from his time in combat. When the VA letter arrived, he was informed that he was not eligible since there was no evidence that he was an OEF/OIF veteran who had served in combat.

In helping this veteran follow up through the VA Benefits Administration, there had been some confusion due to the veteran's prior service with the U.S. Navy, at which time he was not deployed to combat. It is this separate DD-214 and not the one he submitted documenting his combat with the National Guard unit which was reviewed when his benefits application was not being considered. Rather than the depression he was experiencing, when he first was seen by the Helping Hands staff, he is now reconnected with the VA and is pursuing benefits and services.

Just how critical timely outreach can be was recently brought home very painfully when I and Dr. Rodney Torigoe, the psychologist who consults with Helping Hands-Hawaii, were invited to address the Army National Guard unit in Hilo. This was the unit which had made the newspapers because a fellow soldier had been arrested and charged with killing his son and his wife's unborn child, as he reportedly attacked his wife in a fit of rage.

Upon initial contact to set up a time for our visit, one of the members of the unit commented, "You're a little too late." Though they had been back from their service in Iraq for 18 months, the majority of the members of the unit did not understand that they had entitlement to VA services, because the briefing which explained this occurred only five hours after they arrived on U.S. soil.

Meanwhile, other wives were heard on news reports stating that they just wanted their husbands back, and the men who returned were not the same as those who left. By way of follow up and preventive measures, the unit's First Sergeant has now been encouraging his cunning soldiers to seek assistance from the VA. This unit is now in training and expects to be deployed again.

Being a responsible member of this community is being responsive to the needs of our veterans community. I have been joined by four other veterans, one of whom is here today who just testified. Mr. Victor Opiopio. Also included are Mr. Sam Stone, James Kimo Opiana and Mr. Charles Kanehailua, who volunteered their time and mana'o, and under the auspices of Helping Hands, began what was called the "Uncle's Project."

This project was about veterans reaching out to veterans bringing them in for services, encouraging them to have trust in the system and persist even when frustrated and undoing the attitude instilled through a military culture which labels psychological distress as a weakness.

Helping Hands now has a dedicated program to reach out to veterans and their families—veterans of all wars and all eras—in order to provide support and, when needed, direct linkage with appropriate social service and government agencies. The linkage is about providing what is needed upfront and not after the fact. It is about providing guidance to families of our veterans who help welcome back our newest veterans and their spouses, fathers, mothers sons and daughters to be sure that the transition is as smooth as possible.

For our earlier generations of veterans, it is also about continuing the transition home or, in some case, may be beginning that transition after 40 years or more of emotional pain. I want to emphasize the government agency link, especially the link with the Department of Veterans Affairs. As Senator Akaka has noted in his recent legislation S. 1233, “the Department of Defense and the Department of Veterans’ Affairs have made efforts to provide smooth transition . . . but more can be done to assist our veterans and their families in the reintegration of the wounded or injured veterans into our community.”

Our newest program is a community-based Native Hawaiian Veterans Resource Program. The cornerstone of this program is what started as the “Uncle’s Project,” and is now Na Hana No’eau No Na Mea Pono (the Work Toward Righteous Things), which is supported by grants from the Castle Foundation and from Papa Ola Lokahi. Recently, Trustees of OHA met with some of the “Uncles” and representatives of Helping Hands-Hawaii administration to discuss what role they may take in supporting this program so that no veteran will be left behind. We look forward to the benefit of their mana’o as well.

The veterans we have seen have been referred to state or private social service agencies, at times identified by our own case managers or even referred through the VA benefits system itself. We have identified our mission quite clearly as not one that will duplicate services nor in any way distract from the VA or what the VA offers. Rather, we intend to assist the veteran in navigating the VA system and support the VA system in accomplishing its mission.

As the report of 2007 President’s Commission on Care for America’s Returning Wounded Warriors acknowledges both the DOD and VA benefits and health care systems are complicated and complex. Both are difficult to understand and marked by inequities. By having Helping Hands staff available who are familiar with the VA system, and working closely with current VA staff, our goal is to help veterans become aware of and find it easier to access the services for which they may be eligible because they will have a coach, a partner, and a helping hand available to guide them.

We do not doubt that there are caring and concerned individuals among the staff at the VA, but things do not always go smoothly. The VA staff must contend with complexity of the paperwork, the rules and the regulations and they’re only human. This very same paperwork and those rules and regulations often are perceived by the veterans as obstacles and hurdles, confirming whatever beliefs they may already have developed about not trusting that their government can see them as anything other than a number.

Their frustration in dealing with the system often leads to anger or despair and a tendency to abandon any hope for assistance. It is our hope that our newest program will allow the VA to more easily find those veterans who are eligible for service and facilitate their access to the most appropriate care in a timely manner. Helping Hands is all too aware of the benefit which can come from improving access to services in order to prevent more serious problems at a later time.

For our veterans who do not find the VA system accessible, the cost in terms of economic, emotional and social hardship is an added burden to which they already are experiencing. Being successful as we carry out this newest of our missions will honor the sacrifice our soldiers have made as we support the mission of the VA in making the veteran's mental health and adjustment to civilian life among the highest priorities of our Nation.

Having addressed the importance of community partnership and linkage, I come to the final area of importance to Na Hana No'eau No Na Mean Pono, that is, advocacy. There is research showing that Native Hawaiians experience significant disparities in health care, opting to avoid health care services when dealing with bureaucratic systems, cultural insensitivity and other similar barriers to care. Our work is guided by the experience of Papa Ola Lokahi with the federally funded comprehensive health care centers so that the intimidation created by the bureaucracy and the potential for culturally insensitive delivery of service within the large and, at time, impersonal VA system can be reduced.

There is also documentation that Native Hawaiians serving in the Vietnam war experienced symptoms of Post Traumatic Stress Disorder to a greater degree than the general population of soldiers serving in that war. There is no reason to expect that there will be any significant change either in the health disparities or in the incidence of psychological symptoms among Hawaii's current military force returning from combat.

This situation is likely to be made even worse by the fact that many of the members of our Guard and Reserve units come from our rural areas both on Oahu and on our neighbor islands, where access to health care, especially mental health care and continuity of care are already problems. While our program will certainly be accepting veterans of any ethnicity, and not just Native Hawaiian veterans, our primary focus remains to provide service for our generally underserved Hawaiian population.

Consequently, the mission of our program as we extend a helping hand will be to provide the advocacy necessary to each individual veteran, their families, their family members so that they have ready and easy access to care as well as having the most appropriate care.

Mahalo nui loa for allowing me the time to share my mana'o with you today. Thank you.

[Prepared statement of Mr. Park follows:]

PREPARED STATEMENT OF WILLIAM CLAYTON SAM PARK,
CASE MANAGER/VETERANS SPECIALIST, HELPING HANDS-HAWAII

Mr. Chairman and Members of the U.S. Senate Committee on Veterans' Affairs:
My name is William Clayton Sam Park. I am of Native Hawaiian ancestry, a disabled veteran, who served as a combat medic during the Vietnam War, and a re-

tired Master Sergeant with 3 years active duty with the U.S. Army and 21 years of service with the Hawai'i Army National Guard.

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Helping Hands Hawaii has been an active partner in this community for over 30 years. As our community welcomes back our newest warriors, there is no doubt that we face significant challenges, not only for these veterans and their families, but also for the generations of veterans who went before them who also have been affected by this war. The need for support in our veteran community became more and more evident over the past year or two. While no formal program had yet been developed, the need did not wait. Veterans' concerns and problems began to surface in the day-to-day activities of HHH staff, such as myself. As a case manager but also a veteran, the veterans with psychological problems, many of whom were homeless, were assigned to me. While some came directly to us through the State Department of Health (Adult Mental Health Division), others came by word of mouth from other social service workers. A contact would say something like: "there is a veteran who lives on the side of the Pali and we have not seen him for days . . . can you help?" Outreach often means doing what is unconventional, and that is what was required in this case: using my tracking skills and familiarity with the mountain as a long-time pig hunter to find this veteran who was using his military skills to hide away from the populated area. Having found this particular veteran, it was not possible to convince him to seek VA benefits and services because he did not understand the VA system and feared that he would lose his existing Social Security benefit if he chose to go through the VA. While this veteran now has a different life, attending the State's Club House and sharing his life with a girlfriend, he still is not receiving services of the VA to which he would be entitled.

Outreach is not simply about finding someone and providing services. Oftentimes, it is about support and direction for the veteran who is about to give up on seeking or accepting services. Some of the time that means the veteran has become so frustrated with the obstacles along the way to accessing benefits or services that he or she has simply said "forget it" and struggles to survive without the VA's assistance. Other times and more drastically, the veteran has decided it is better to give up his life rather than to continue the struggle. The desperate call then comes from the family member hoping to find someone who knows what to do to change his mind. A recent example comes from a case management situation where an individual was seen at the request of a family member concerned about how discouraged and despondent he was. He had been deployed with the Oregon Army National Guard Unit to Iraq and upon return applied for VA service as encouraged prior to leaving the Unit. He waited for the VA's reply, while trying to provide for his wife and three children. He was not with his family since his wife already had filed a Temporary Restraining Order on him. He had changed so much since his return, especially in terms of his inability to control his frustration and anger—a sign that we would consider possibly related to Post Traumatic Stress Disorder from his time in combat. When the VA letter arrived, he was informed that he was not eligible since there was no evidence he was an OEF/OIF veteran who had served in combat. In helping this veteran follow-up through the VA Benefits Administration (VBA), there had been some confusion due to the veteran's prior service with the U.S. Navy, at which time he was not deployed to combat. It was this separate DD-214 and not the one he submitted documenting his combat with the National Guard Unit which was reviewed when his benefits application was being considered. Rather than the depression he was experiencing when he first was seen by HHH, he now has re-connected with the VA and is pursuing benefits and services.

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The veterans we have seen have been referred through State or private social service agencies, at times identified by our own case managers, or even referred through the VA benefits system, itself. We have identified our mission quite clearly as not one that will duplicate services nor in any way detract from what the VA offers. Rather, we intend to assist the veteran in navigating the VA system, and support the VA system in accomplishing its mission. As the report of the 2007 President's Commission on Care for America's Returning Wounded Warriors acknowledges, both the DOD and VA benefits and health care systems are complicated and complex; both are difficult to understand and marked by inequities. By having HHH staff available who are familiar with the VA system and by working closely with the current VA staff, our goal is to help veterans become aware of and find it easier to access the services for which they may be eligible because they will have a coach, a partner, and a helping hand available to guide them. We do not doubt that there are caring and concerned individuals among the staff at the VA, but things do not always go smoothly. The VA staff must contend with the complexity of the paperwork, the rules, and the regulations, and they are only human. This very same paperwork, and those rules and regulations, often are perceived by the veterans as obstacles and hurdles, confirming whatever beliefs they may already have developed about not trusting that their government can see them as anything other than a number. Their frustration in dealing with the system often leads to anger or despair, and a tendency to abandon any hope for assistance. It is our hope that our newest program will allow the VA to more easily find those veterans who are eligible for services and facilitate their access to the most appropriate care in a timely manner. HHH is all too aware of the benefit which can come from improving access to services in order to prevent more serious problems at a later time. For our veterans who do not find the VA system accessible, the cost in terms of economic, emotional, and social hardships is an added burden to that which they already are experiencing. Being successful as we carry out this newest of our missions will honor the sacrifice our soldiers have made as we support the mission of the VA in making the veteran's mental health and adjustment to civilian life among the highest priorities of our Nation.

Having addressed the importance of community partnership and linkages, I come to the final area of importance to Na Hana No'eau No Na Mea Pono—that is, advocacy. There is research showing that Native Hawaiians experience significant disparities in health care, opting to avoid health care services when dealing with bureaucratic systems, cultural insensitivity, and other similar barriers to care. Our work is guided by the experience of Papa Ola Lokahi with the federally funded comprehensive health care centers, so that the intimidation created by the bureaucracy and the potential for culturally insensitive delivery of service within the large and at time impersonal VA system can be reduced. There also is documentation that Native Hawaiians serving in the Vietnam War experienced symptoms of post traumatic stress to a greater degree than the general population of soldiers serving in that war. There is no reason to expect that there will be any significant change in either the health disparities or in the incidence of psychological symptoms among Hawaii's current military force returning from combat. This situation is likely to be made even worse by the fact that many of the members of our Guard and Reserve Units come from our rural areas, both on Oahu and on our neighbor islands, where access to health care, especially mental health care, and continuity of care are already problems. While our program will certainly be accepting veterans of any ethnicity, and not just our Native Hawaiian veterans, a primary focus remains to provide support services for our generally underserved Native Hawaiian population. Consequently, the mission of our program, as we extend a helping hand, will be to provide the advocacy necessary for each individual veteran and their family members so that they have ready and easy access to care, as well as having the most appropriate care.

Mahalo nui loa for allowing me the time to share my mana'o with you today.

Mr. Chairman, I would be pleased to answer any questions that you or the Committee Members have for me at this time.

Aloha.

Senator AKAKA. Thank you very much, Clay Park. And now the last member of this panel is Darryl Vincent, site director of U.S. Veterans Initiative.

**STATEMENT OF DARRYL J. VINCENT, SITE DIRECTOR,
UNITED STATES VETERANS INITIATIVE-HAWAII**

Mr. VINCENT. Good morning, Senator Akaka and Senator Inouye, and others distinguished officials, my name is Darryl Vincent, I'm the Hawaii Site Director of the United States Veterans Initiative, a nonprofit agency that helps military veterans experiencing homelessness. In Hawaii, our facilities are located at Kalaeloa, at the former Barbers Point Naval Air Station where we currently serve approximately 200 veterans.

I'm here to speak to you about the realities of homelessness among veterans in Hawaii, what United States Veterans Initiative is currently doing to reduce homelessness among Hawaii veterans. Most importantly, I'm here to advocate for expansion of known solutions that can reduce homelessness for military veterans and to request that solutions be seriously considered in upcoming Federal legislation and appropriations.

First the realities. For many, the face of the modern homeless began with the image of homeless veterans—sign in hand asking for food, shelter, job—on the streets, stop signs at nearly every town in America. Still today despite pockets of progress, the VA estimates that 250,000 military veterans in America will be sleeping in the streets tonight. And I hope we can only grasp that number 250,000. The number is estimated to be as many as a thousand veterans in Hawaii.

One-third of the America's adult male homeless population is estimated to be veterans, and in Hawaii it's no different. Tonight many homeless veterans in Hawaii will be sleeping at the beach,

parks, in cars, at bus stops, sidewalks and other places not suitable for human habitation. Others remain in emergency shelters without appropriate services and treatment.

And the flow of veterans continues from the older veterans who served during the Vietnam era to the veterans of the Gulf War and most tragically even young veterans back from Iraq and Afghanistan. For soldiers who escape physical and mental injury, it remains tough for many that are returning without jobs, and to a rental market that has priced them out of a home or even an affordable apartment rental.

For veterans returning with PTSD and other trauma related injuries from war, the transition back to the community will be a most difficult one. Research shows that veterans typically experience homelessness a few years after military discharge, after the support of the family and friends have been exhausted and failed attempts to successfully reintegrate back into community or after the full effects of their physical and mental injuries have taken their toll. Whenever they call for help, we must remain firm in our commitment to honor these honorable men and women.

We also wonder how many veterans will come to our doors in the next year, two years and five years. We wonder, with so many soldiers from Hawaii being deployed, will the state be prepared for their unique needs in the future. The full effects are not often seen for years, but 30 years of modern homelessness guarantee us that more veterans will need assistance. As a veteran myself, I feel that it's a crime that we have allowed those who once committed themselves to die for our freedoms to plummet to homelessness. That's the reality, past, present and future.

Now, just a little bit about what United States Veterans Initiative does. It offers a strong blueprint of what can be done to help our veterans. Since we opened up in 2002 in Hawaii, we provided services to over 800 homeless veterans with holistic, residential treatment approach, including medical, mental health and substance abuse treatment, employment reintegration and housing placement. We also provided an additional 1,500 veterans with outreach and referral to other needed programs.

Services are provided in collaboration with the local VA and through key partnerships with other service providers. The initiative in Hawaii is one of 11 sites operated by the Initiative based in Inglewood, California that's been serving homeless veterans since 1992.

The Initiative offers a two-stage housing and treatment program that incorporates time tested best practice treatments and recovery principles. The first stage is our Veterans-in-Progress program which serves about 250 homeless veterans annually. Our outreach staff scours over 60 public areas on Oahu where homeless veterans congregate. They engage them, talk to them and encourage them to come to Barbers Point facility.

Interested homeless veterans are enrolled in the program where they receive immediate housing, meals, laundry, mail, transportation and other essential services. There are no program fees if the veteran doesn't have an income. This allows the veterans to focus first on addressing substance abuse and mental health issues and medical problems, key barriers to employment, house retention

and full social integration. For those in need of substance abuse treatment, the vast majority of those we serve, the veteran immediately enrolls in intensive outpatient substance abuse treatment. Those with a little more complex dual-diagnosis needs are typically served by the VA.

At our site in Hawaii, eight out of every ten veterans that are enrolled in our program need substance abuse and/or mental health services. All receive a minimum of 90 days of treatment, more depending on their needs. To be sure, many veterans have lost their job, housing and too often their family because of substance abuse. Substance abuse is often caused by underlying mental illness like depression and PTSD. Substance abuse often grows worse during the time of service and we certainly advocate for better identification, prevention and treatment of substance abuse while in the military.

Our program works. During 2006, 83 percent of our veterans maintain their sobriety while in the program. Seventy-three percent of veterans enrolled in workforce development found a job, and 76 percent transitioned to some type of permanent housing or appropriate transitional housing. Many of those that were unsuccessful become successful after reenrolling in a program for the second time. Much of the success of our program is due to a therapeutic community we foster at Barbers Point. Staff cannot do it alone. Veterans help veterans as buddies, peers, chaperones and informal counselors. We attribute our success to the fact that after a veteran completes our program, they have the opportunity to move into a sober-living, long-term affordable housing which is co-located right there at Barbers Point. The long term housing is offered to veterans who have successfully completed the program and have at least 90 days of being clean and sober and can support living independently.

The veteran continues to receive supportive services through case management and workforce development, but they're not held to the same structure as they were in the program. They continue to be drug tested and this allows them to stay connected with the services that helped them in the first place. More than over 150 veterans have taken advantage of this sober living.

So what do we need to handle both today's homeless veterans and tomorrow's homeless veterans?

There are three things that I'd like to emphasize.

First, funding must be increased through the VA's Grant and Per Diem program. Success from our VIP program funded by the Grant and Per Diem Program shows that, yes, money when funding a successful program model can reduce homelessness. Currently, the approximate rate is \$29.00 per day per person. In Hawaii, it takes about \$55.00 a day to serve a homeless veteran in our program. And while we do look for collateral funding sources, it becomes more competitive as the cost of services grow. A long-term commitment to funding the VA's Grant and Per Diem Program must include greater funding commitment. Programs like ours need to spend less time trying to find additional money each year and more time serving homeless veterans. Veterans deserve high quality treatment by skilled professionals not barely above minimum wage

workers. We would like to open a program on outer islands, but it would not be possible without other funding.

Second, more allocations are needed for funding alternative vocational training programs. We found it very effective to place veterans in the early stages of substance abuse into pre-employment vocational internship positions. These positions such as running our veteran store, supervising the career center, directing meal services, apprenticing to be a resident manager and assisting our maintenance and landscaping manager, providing the veteran with a transitional period of employment-like experience while they go through their treatment program. They can be given a small stipend while they learn a new skill and maintain participation in a treatment program.

We feel modest funding in these areas can produce great benefits. As you know, getting a job is the easy part. Maintaining the job and getting a job that has a career is the difficult part. Veterans often need a stepping stone that vocational program, which we refer to as the Transitional Work Experience, can offer. A program that they can participate in while in treatment, that complements the success achieved in treatment while laying a stronger foundation for long-term recovery and self-sufficiency. An increase in the general per diem rate could help fund this type of program or through separate appropriations.

Congress can also take a more active role in helping to provide scholarships for retraining veterans in union apprentice programs and business training programs which are quite costly.

Finally, more funding is needed for sober housing supportive housing services. As I mentioned, the key component of our long-term success of our program and the key component of any substance abuse program is the ability to maintain individuals in a sober and supportive atmosphere.

Our independent living apartments offer that opportunity and over 150 veterans have taken advantage of that opportunity. As we expand these units, we ask that the VA consider a funding stream to provide long-term supportive services to sober-living housing like ours. The cost is minimal. We estimate \$5.00 per day per individual compared to the cost of relapse, recidivism to homelessness.

On behalf of all the veterans we serve at the United States Veterans Initiative, I appreciate the time you've given me to share with you, how together, we can do a much better job for our military veterans in Hawaii and throughout the country. These three points I've emphasized come from day-to-day tasks of delivering high-quality services to your veteran heroes that have served our country. Thank you, sir.

[The prepared statement of Mr. Vincent follows:]

PREPARED STATEMENT OF DARRYL J. VINCENT, SITE DIRECTOR,
UNITED STATES VETERANS INITIATIVE-HAWAII

Aloha Senator Akaka and other distinguished officials, my name is Darryl Vincent and I am the Hawaii Site Director for the United States Veterans Initiative, a non-profit agency that helps military veterans experiencing homelessness. In Hawaii, our facilities are located at Kalaeloa, at the former Barbers Point Naval Air Station, where we currently serve approximately 200 veterans.

I am here today to speak to you about the realities of homelessness among veterans in Hawaii, what United States Veterans Initiative is currently doing to reduce homelessness among Hawaii veterans, and, most importantly, I am here today to

advocate for an expansion of known solutions that can reduce homelessness for our military veterans—and to request that these solutions be seriously considered in upcoming Federal legislation and appropriations.

First the realities—

For many, the face of modern homelessness began with the image of the homeless veteran—sign in hand, often wheelchair-bound, asking for food, shelter, a job—on the streets and at the stop signs of nearly every town in America. Still today, despite pockets of progress, the VA estimates that 250,000 military veterans in America will be sleeping on the streets tonight. In Hawaii, that number is estimated to be as many as one thousand (1,000) veterans. One third of America's adult male homeless population is estimated to be veterans and in Hawaii it is no different. Tonight, many homeless veterans in Hawaii will be sleeping at beach parks, in cars, at bus-stops, on sidewalks, and other places not suitable for human habitation. Others remain in emergency shelters, without appropriate services and treatment.

And the flow of veterans continues—from older veterans who served during the Vietnam era, to veterans of the Gulf War, and most tragically even young veterans back from Iraq and Afghanistan.

For soldiers who escape physical and mental injury, it remains tough for many that are returning without jobs, and to a rental market that has priced them out of a home or even an affordable apartment rental. For veterans returning with Post Traumatic Stress Disorder and other trauma-related injuries from war, the transition back into their community will be a most difficult one. Research shows that veterans typically experience homelessness a few years after military discharge, after the support of family and friends has been exhausted, after failed attempts at successfully reintegrating back into the community, or after the full effects of their physical and mental injuries have taken their toll. Whenever they call for help, we must remain firm in our commitment to these honorable men and women.

We also wonder how many more veterans will come through our doors in the next year, 2 years, and 5 years. We wonder, with so many soldiers from Hawaii having been deployed, will the state be prepared for their unique needs in the future? The full effects are often not seen for a few years—but 30 years of modern homelessness guarantees us—that more veterans will need assistance. As a veteran myself, I feel that is a crime that we have allowed those who once committed themselves to die for our freedoms to plummet to homelessness.

That's the reality—past, present and future. Now, a little about what United States Veterans Initiative does—which offers a strong blueprint for what can be done to help more veterans.

Since opening in 2002, United States Veterans Initiative has provided over 800 homeless veterans with holistic, residential treatment services—including medical, mental health and substance abuse treatment, employment reintegration and housing placement. We have also provided an additional 1,500 veterans with outreach and referral to other needed programs. Services are provided in collaboration with the local VA and through key partnerships with other service provider agencies. United States Veterans Initiative-Hawaii is one of 11 sites operated by the United States Veterans Initiative, based in Inglewood, California that has been serving homeless veterans since 1992.

United States Veterans Initiative offers a two-stage housing and treatment program that incorporates time-tested, best-practice treatment and recovery principles. The first stage is our Veterans-in-Progress, or VIP program which serves about 250 homeless veterans annually. Our outreach staff scours over 60 public areas on Oahu where homeless veterans congregate—they engage them, talk to them, and encourage them to come to the Barbers Point facilities. Interested homeless veterans are then enrolled in the VIP program, where they receive immediate housing, meals, laundry, mail, transportation and all other essential services. Program fees are waived for veterans, until they begin receiving income. This allows the veterans to focus first on addressing substance abuse, mental illness and other medical problems—key barriers to employment, housing retention and full social integration.

For those in need of substance abuse treatment—the vast majority of those we serve—the veteran immediately enrolls in intensive outpatient substance abuse treatment—those with more complex dual-diagnosis needs are typically served by the VA. At our site in Hawaii, 8 of every 10 veterans we enroll will need substance abuse services. All receive a minimum of 90 days of treatment, more depending on their needs. To be sure, many veterans have lost their job, housing, and too often their family, because of substance abuse. Substance abuse is often caused by underlying mental illnesses like depression and Post Traumatic Stress Disorder. Substance abuse often grew worse during their time of service. And we certainly advocate for better identification, prevention and treatment of substance abuse while in the military.

And our VIP program works. During 2006, over 83 percent maintain their sobriety while in the program and at time of discharge, 73 percent of veterans enrolled in Workforce Development find jobs, and 76 percent successfully transition into permanent housing or appropriate transitional housing. Many of those unsuccessful can often be served by re-enrolling them into the program—a second chance—when they are better ready and able to change their lives. Much of the success of the VIP program is due to the therapeutic community we foster at Barbers Point—staff cannot do it alone, veterans help fellow veterans, as buddies, peers, chaperones and informal counselors.

We also attribute program success to the fact that after a veteran completes our VIP program they have the opportunity to move into our sober-living, long-term affordable housing, co-located at the Barbers Point facility.

This long-term housing is offered to veterans who have successfully completed the requirements of the VIP program, that have at least 90 days of being clean and sober, and that have an income to support living independently. The veteran continues to receive supportive services through case management and workforce development, but they are not held to the same structure as if they were in the program. And Veterans continue to be drug-tested on a regular basis. This allows a veteran to stay connected with the services that helped them in first place, while allowing the veteran to become more independent and self reliant—knowing there is still help just a few feet away. More than 150 individuals have taken advantage of these sober-living independent housing, with many using it as a stepping-stone to full community reintegration.

So, what do we need? To handle both today's homeless veterans and tomorrow's homeless veterans there are three things that I would like to emphasize:

(1) Funding Must Be Increased Through the VA's Grant and Per Diem Program—Success with our VIP program funded by the Grant and Per Diem program shows that yes, money, when funding a successful program model, can reduce homelessness. Unfortunately, the current Per Diem rate of approximately \$29 per day per person, pays for only half of the real costs of effective treatment services—which for our Hawaii site is about \$55 per day—and that cost is delivered with a bare bones staff, paid much lower than VA staff salaries.

Access to collateral funding sources through HUD and the DOL have slowly evaporated—while the cost of services continues to grow. A long-term commitment to funding the VA's Grant and Per Diem program must include a greater funding commitment.

Programs like ours need to spend less time trying to find this additional money each year, and more time serving homeless veterans. Veterans deserve high-quality treatment by skilled professionals, not barely above minimum wage workers. We would like to open a program on Maui and the Big Island, but collateral funds will not be present. Try providing housing, treatment, transportation, food and other amenities on Maui for \$850 a month (the monthly per diem for one veteran)—you can't even rent an apartment for that amount.

At a minimum, we strongly advocate for a 20 percent increase in the Per Diem rate, an annual cost to the Federal Government of \$15–\$20 million, a sum that will ensure the continuation of services provided by the other 300 per diem veteran service providers throughout America, and one that will ensure new programs can open to serve the remaining gap of homeless veterans identified by the VA.

(2) Second, More Allocations Are Needed for Funding Alternative Vocational Training at Our Barbers Point Program—We have found it very effective to place veterans in the early stages of substance abuse into pre-employment vocational internship positions. These positions, such as running our veteran store, supervising the career center, directing meal services, apprenticing to be a resident manager, and assisting our maintenance and landscaping manager, provide the veteran with a transitional period of an employment-like experience while they go through our treatment program. Veterans are given small, but important stipends, \$200 per month or so, and learn a new skill, while maintaining participation in the treatment program, contributing to the healthy environment at United States Veterans Initiative and preparing for the eventual re-entry into the marketplace.

We feel modest funding in this area can produce great benefits. As you know, getting a job is often the easy part, maintaining the job and getting a job that has a career is the difficult job. Veterans often need a stepping stone that a vocational program—which we refer to as the Transitional Work Experience program—can offer. A program that they can participate in while still in treatment—that complements the successes achieved in treatment while laying a stronger foundation for long-term recovery and self-sufficiency. An increase in the general per diem rate could help fund this type of program, and through separate appropriations. Congress can also take a more active role in helping to provide scholarships for retrain-

ing veterans in union apprentice programs and business training programs which are quite costly.

(3) Finally, More Funding is Needed For Sober Housing Supportive Housing Services—As I mentioned, a key component of the long-term success of our program, and the key component of any substance abuse program is the ability to maintain individuals in a sober and supportive atmosphere. Our independent living apartments offer that opportunity and over 150 veterans have taken advantage of this opportunity. As we expand these units, we ask that the VA consider a funding stream to provide long-term supportive services to sober-living housing like ours—the cost is so minimal—we estimate \$5 per day per individual—compared to the cost of relapse and recidivism to homelessness.

On behalf of all the veterans we serve at United States Veterans Initiative, I appreciate the time given to me to share with you how, together we can do a much better job for our military veterans—in Hawaii and throughout the country. These three points I have emphasized come from the day-to-day tasks of delivering high-quality services—to our veteran heroes that have served their country.

I am available for questions or further elaboration. I would like to specifically thank Senator Akaka for his tireless dedication to serving our veterans and the people of Hawaii. As a veteran himself we know that he can relate and empathize with the many issues faced by our veterans and with his strong leadership and vision we can start to address and solve these issues one day at a time.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you very much.

I want to thank this panel very much for your personal and heartfelt testimony. For the Committee, we are really grateful for what you have shared with us. You have questions that will be helpful to the work that the Committee will be doing.

Senator Inouye will not be able to stay. I would like to ask Senator Inouye if he has any concluding remarks. And then following that, we'll conclude the first panel.

Senator INOUE. Well, Mr. Chairman, I thank you very much. I must say that I am impressed by your testimony and willing to come publicly to candidly advise us of your concerns whether it's good or bad. And Ms. Del Negro, we'll do our very best to see that it's not repeated again.

To all of you, I feel a special bond and kinship and I can assure you that I will not knowingly let my fellow veteran down. Thank you.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you, Senator Inouye. I want to again thank the first panel and mahalo nui loa, and it will be helpful to the Committee and we appreciate all that you're doing.

Mahalo. I want to welcome the second panel of witnesses. Thank you everyone. I know many of you have messages to pass on. But we would like to continue with the second panel, and I want to welcome here today, Dr. Michael Kussman, who is the former Deputy Under Secretary for Health and is now the top man here across the country in VA health care. I'm so delighted that he had the time to join us here.

He is accompanied by Dr. Jim Hastings, who is Director of the VA Pacific Islands Health Care System; and Dr. Robert Wiebe, Director of Network 21. He has been here before and he has been so helpful in our cause to improve care for Hawaii's veterans. Also, Under Secretary Tuerk is here, and he is accompanied by Gene Castignetti, the Director of the National Memorial Cemetery of the Pacific. Finally, I want to welcome Ronald Aument, who is the Deputy Under Secretary for Benefits.

We have the top people here from VA to testify this morning. And let me say that Ronald Aument here is accompanied by Gregory Reed, who has been doing a good job as the Director of the Honolulu Regional Office. Finally, I welcome Julie Watrous, Director of the Los Angeles Regional Office, Office of Healthcare Inspections, Office of the Inspector General. She is accompanied by Dr. Michael Shepherd, also from the IG's office.

I want to welcome this panel with much aloha and thank each of them for being here. I will just remind you that your full statements will appear in the record of the Committee. And with that, those of you standing if there are seats, please find a seat and be comfortable. And at this time I'd like to call Dr. Kussman to begin with his testimony.

STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., M.S., M.A.C.P., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT L. WIEBE, M.D., DIRECTOR, VISN 21, DEPARTMENT OF VETERANS AFFAIRS; AND JAMES HASTINGS, M.D., F.A.C.P., DIRECTOR, VA PACIFIC ISLANDS HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. KUSSMAN. Aloha, Mr. Chairman, mahalo nui loa. Thank you very much for the opportunity to appear before you today to discuss the VA health care services in Hawaii and the Pacific Region. It is a privilege to be here again on Oahu, the Gathering Place, to speak and answer questions about health care issues important to veterans residing in Hawaii.

As you know, I was fortunate enough to be stationed here in the past, at Tripler Army Medical Center, as a division surgeon for the 25th Infantry Division. I have a great passion for what I do and great appreciation and respect for the people of these wonderful islands.

Before I get into my prepared remarks, I'd like to make a few quick comments about the first panel, if that's OK with you. I want to recognize them and appreciate and thank them for their comments. I appreciate the good things, but I more appreciate many ways the negative things that they said, so we can learn from that and be better. As was mentioned, we believe that we're not your father's VA and that we've made quantum leap changes in our approach to the veterans on all levels. I appreciate Mrs. Del Negro's comments and thank her husband for his service and continuing service as a Ranger in the United States Army.

I did then talk to her a little bit after the testimony. And although her husband did not avail himself at the present time of the VA services, I assured her that we stand ready in every way to help her husband and people like that. We have a very robust TBI service. And as you know, Mr. Chairman, we screen everyone who comes to us from Hawaii for TBI along with other ailments. We appreciate the comments of the Vet Centers, and we're increasing our capacity. We've increased 32 Vet Centers around the country in the last year and we'll probably continue to expand that capacity.

The VA has achieved some remarkable accomplishments in providing better and more accessible care to veterans in Hawaii and

the Pacific Islands. I'd like to share some of this good news with you today, news about the superior care that we provide and information on new developments regarding our facilities. In fiscal year 2006, the VA Sierra Pacific Network, was the highest ranked network in overall performance based on quality access, satisfaction and business metrics.

The Network is home to more Centers of Excellence than any other and has the highest funded research programs in the Veterans Health Administration. In the most recent all employee survey, VA staff from this Network reported the highest overall job satisfaction throughout the Veterans Health Administration. I understand that in the next few months, the State of Hawaii Veterans Home in Hilo will accept its first patient. In no small part due to the more than \$18 million VA contributed to this project. A 95-bed facility will provide more inpatient long-term care and adult day-care center services for Hawaii veterans.

VA recently dedicated the Community Based Outpatient Clinic in America Samoa on July 21, 2007. The Capital Asset Realignment for Enhanced Services process that we use to build new facilities identified some additional locations for consideration of future CBOCs here in Hawaii. VA learned about the possibility of opening—of obtaining the vacant U.S. Navy medical clinic at Barbers Point near Kapolei.

Although this clinic is about 13 miles from Waianae, this location could open quickly to support the veterans homeless shelter at Barbers Point and relieve some of the space crunch at the VA clinic on the Tripler campus. It's not clear whether or not the VA will be able to obtain this property, and so we will continue to explore other options on the west side of Oahu if that turns out to be necessary.

In fiscal year 2005, the VA approved \$5.6 million for a minor construction project to build a 15,000 square foot facility on the Tripler campus that will house the relocated inpatient PTSD residential rehabilitation unit, and the new outpatient PTSD program. The contract for an environmental assessment and design phase of the project is expected to be awarded before the end of the current fiscal year and construction should begin in fiscal year 2008.

VA also approved a minor construction project estimated at \$6.9 million to build a new ambulatory surgery center on the Tripler campus. This will greatly enhance the ability of the health care system here to provide ambulatory services and procedures and reduce the need for referrals elsewhere. Construction should begin in fiscal year 2009. For our Guam veterans, VA determined the best option to improve care is to build a new clinic at the periphery of the U.S. Naval Hospital Guam campus.

I'm pleased to report that on July 30 of this year Secretary Nicholson announced plans for the VA to build this clinic at an estimated cost of \$5.4 million. The clinic will be about 6,000 square feet and will have its own parking. The Navy will relocate its fence around the clinic so veterans will not have to pass through the Navy security to enter the facility. The new clinic is scheduled to open in the summer of 2009.

In summary, Mr. Chairman, the support of the Senate Committee on Veterans Affairs and the Hawaiian congressional delega-

tion, VA is providing an unprecedented level of health care services to veterans residing in Hawaii and the Pacific Region. VA now has a state-of-the-art facilities and enhance services in Honolulu as well as robust staffing in the neighbor islands and has expanded or renovated clinics in many locations.

Mr. Chairman, again, mahalo nui aloha for the opportunity to testify this morning. And I and all the members of the panel and my associates, Dr. Wiebe and Dr. Hastings, will be delighted to address any questions that you may have of us. Thank you.

[The prepared statement of Dr. Kussman follows:]

PREPARED STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., M.S., M.A.C.P.,
UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, mahalo nui loa for the opportunity to appear before you today to discuss VA care in Hawaii and the Pacific Region. It is a privilege to be on Oahu—The Gathering Place—to speak and answer questions about VA health care issues that are important to veterans residing in Hawaii. I was fortunate to have been stationed in Honolulu at Tripler Army Medical Center (AMC) and Schofield Barracks (as Division Surgeon for the 25th Infantry Division) from 1979 to 1983. It is always a pleasure to return to Hawaii.

First, Mr. Chairman, I would like to thank you for your outstanding leadership and advocacy on behalf of our Nation's veterans. During your tenures as Ranking Member and Chairman of this Committee, you have consistently demonstrated your commitment to veterans by introducing legislation designed to meet the needs of veterans. As I will highlight later, your vision and support have led to an unprecedented level of health care services for veterans, construction of state-of-the-art facilities here in Honolulu and remarkable improvements in access to health care services for veterans residing on neighbor islands. In addition, I appreciate your interest in and support of the Department of Veterans Affairs (VA).

Today, I will briefly review the VA Sierra Pacific Network that includes Hawaii and the Pacific Region; provide an overview of the VA Pacific Islands Health Care System (VAPIHCS) and the VA facilities here on Oahu; and highlight issues of particular interest to veterans residing in Hawaii, including long-term care (LTC) services, potential new VA clinics on Oahu, planned VA construction projects and our VA-Department of Defense (DOD) joint venture at Tripler AMC. I will also discuss our plans to build a replacement VA clinic in Guam and address any questions you might have for me and my staff.

VA SIERRA PACIFIC NETWORK (VISN 21)

The VA Sierra Pacific Network (Veterans Integrated Service Network [VISN] 21) is one of 21 integrated health care networks in the Veterans Health Administration (VHA). The VA Sierra Pacific Network provides services to veterans residing in Hawaii and the Pacific Region (including the Philippines, Guam, American Samoa and Commonwealth of the Northern Marianas Islands), northern Nevada and central/northern California. There were an estimated 1.1 million veterans living within the boundaries of the VA Sierra Pacific Network in Fiscal Year (FY) 2006.

The VA Sierra Pacific Network includes six major health care systems based in Honolulu, HI; Palo Alto, CA; San Francisco, CA; Sacramento, CA; Fresno, CA; and Reno, NV. Dr. Robert Wiebe serves as director and oversees clinical and administrative operations throughout the Network. In FY 2006, the Network provided services to 235,000 veterans. There were about 2.9 million clinic stops and 24,500 inpatient discharges. The cumulative full-time employment equivalents (FTEE) level was 8,400 and the operating budget was about \$1.5 billion.

The VA Sierra Pacific Network is remarkable in several ways. In FY 2006, VISN 21 was the highest-ranked Network in overall performance (based on an aggregation of quality, access, patient satisfaction and business metrics). The Network hosts the most Centers of Excellence and also has the highest funded research programs in VHA. In the most recent all-employee survey, staffs in VISN 21 reported the highest overall job satisfaction in VHA. Finally, VISN 21 operates one of four Polytrauma units in VHA that are dedicated to addressing the clinical needs of the most severely wounded Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans.

VA PACIFIC ISLANDS HEALTH CARE SYSTEM (VAPIHCS)

As noted above, VAPIHCS is one of six major health care systems in VISN 21. Dr. James Hastings is the director at VAPIHCS. VAPIHCS is unique in several important aspects: its vast catchment area covering 2.6 million square-miles (including Hawaii, Guam, American Samoa and Commonwealth of the Northern Marianas); island topography and the challenges to access it creates; richness of the culture of Pacific Islanders; and the ethnic diversity of patients and staff. In FY 2006, there were an estimated 102,000 veterans living in Hawaii (representing 8 percent of the total population in Hawaii and 9 percent of total veteran population in VISN 21).

VAPIHCS currently provides care in seven locations: Ambulatory Care Center (ACC) and Center for Aging (CFA) on the campus of the Tripler AMC in Honolulu; and Community Based Outpatient Clinics (CBOCs) in Lihue (Kauai), Kahului (Maui), Kailua-Kona (Hawaii), Hilo (Hawaii), Hagatna (Guam) and Pago Pago (American Samoa). VAPIHCS also has outreach clinics in Molokai and Lanai. The inpatient Post Traumatic Stress Disorder (PTSD) unit is now also on the campus of Tripler AMC (the unit was formerly in Hilo). In addition to VAPIHCS, VHA operates five Readjustment Counseling Centers (Vet Centers) in Honolulu, Lihue, Wailuku, Kailua-Kona and Hilo that provide counseling, psychosocial support and outreach.

In FY 2006, VAPIHCS provided services to nearly 22,500 veterans, 19,000 of whom reside in Hawaii. There were 198,000 clinic stops in Hawaii during FY 2006 (7 percent of Network total). The cumulative FTEE in FY 2006 for the health care system was 502 employees. The operating budget for VAPIHCS (i.e., General Purpose allocation from appropriated funds) increased from \$68.0 million in FY 2002 to \$110 million in FY 2007—an increase of 62 percent. For comparison, during this same time period, the operating budgets for VISN 21 increased 48 percent and VHA increased 43 percent. (Please note these amounts do not include Specific Purpose funds and Medical Care Cost Funds [MCCF].)

VAPIHCS provides or contracts for a comprehensive array of health care services. VAPIHCS directly provides primary care, including preventive services and health screenings, and mental health services at all locations. VAPIHCS does not operate its own acute medical-surgical hospital and consequently, faces challenges in providing specialty services. VAPIHCS recently hired specialists in orthopedics, ophthalmology, nephrology and inpatient medicine (“hospitalist”) and is providing selected specialty care in Honolulu and to a lesser extent, CBOCs. VAPIHCS is actively recruiting additional specialists (e.g., urology) and will continue to refer patients to DOD and community facilities.

Inpatient long-term and acute rehabilitation care is available at the CFA. Inpatient mental health services are provided by VA staff on a 20-bed ward within Tripler AMC and at the 16-bed PTSD Residential Rehabilitation Program (PRRP). VAPIHCS contracts for care with DOD (at Tripler AMC and Guam Naval Hospital) and community facilities for inpatient medical-surgical care.

The current constellation of VA facilities and services represents a remarkable transformation over the past several years. Previously, the VAPIHCS (formerly known as the VA Medical and Regional Office Center [VAMROC] Honolulu) operated primary care and mental health clinics based in the Prince Kuhio Federal Building in downtown Honolulu and CBOCs on the neighbor islands that were staffed primarily with nurse practitioners. Congress approved \$83 million in Major Construction funds to build a state-of-the-art ambulatory care facility (i.e., ACC) and long-term care/rehabilitation unit (i.e., CFA) on the Tripler AMC campus and these facilities were activated in 2000 and 1997, respectively. VISN 21 allocated nearly \$17 million from FY 1998–FY 2000 to activate these projects. VISN 21 also provided dedicated funds to enhance care on the neighbor islands by expanding/renovating clinic space and adding additional staff to ensure there are primary care physicians and mental health providers at all CBOCs.

OAHU FACILITIES

VA operates the Spark M. Matsunaga VA Medical Center in Oahu, located on the campus of Tripler AMC at 459 Patterson Road, Honolulu, HI 96815. The medical center consists of the ACC, CFA and administrative space (located on the E wing of Tripler AMC). Congress appropriated \$25.1 million Major Construction funds during FY 1993/1994 to build the CFA; \$14.9 million in FY 1995 to construct the parking garage; and \$43.0 million in FY 1994/1995/1997 to build the ACC and renovate the E Wing of Tripler AMC for VA administrative use. Veterans Benefits Administration (VBA) is co-located with VHA on this campus. The Honolulu Vet Center is located nearby at 1680 Kapiolani Boulevard.

The VA facilities in Oahu serve an estimated island veteran population in FY 2006 of 73,000. In FY 2006, 25,800 veterans on Oahu were enrolled for care and 13,400 of these veterans received VA care (“users”). The market penetrations for enrollees and “users” are 35 percent and 18 percent, respectively and compare favorably with rates within VISN 21 and VHA.

The average FTEE level on Oahu in FY 2007 is 440. With this staff, VAPIHCS provides a wide range of outpatient services, including primary care, several medical subspecialties (e.g., cardiology, gastroenterology, nephrology, orthopedics, pulmonary and women’s health), mental health and dental care. In addition, VAPIHCS provides diagnostic services such as laboratory, echocardiography and radiology. As noted earlier, VA staffs a 20-bed inpatient mental health unit within Tripler AMC, 60-bed nursing home care unit (i.e., CFA) and 16-bed PRRP. If veterans need services not available at the ACC or CFA, VAPIHCS arranges and pays for care at Tripler AMC, local community or VA facilities in California.

In FY 2006, VA facilities in Oahu recorded about 161,000 clinic stops, representing a 39 percent increase from FY 2000 (i.e., 116,000 stops). Although some veterans waited more than 30 days in FY 2007 for their first primary care appointment, at this time, there are very few patients on a waiting list for an initial primary care appointment. In FY 2006, the combined average daily census (ADC) was 11 in the mental health ward and 54 at the CFA. VAPIHCS spent about \$15.5 million for clinical services for veterans at Tripler AMC and another \$20 million for non-VA care in the community.

SPECIAL ISSUES

Long-term care (LTC)

Older veterans have special needs and LTC services are a critical issue for many of them. In FY 2006, about 40 percent of all veterans seen at VAPIHCS were 65 years or older. VAPIHCS meets their special needs with a full spectrum of inpatient, ambulatory and home services.

VAPIHCS provides inpatient LTC and transitional rehabilitative care at the CFA. Over the past several years, the average daily census in the CFA has been around 90 percent of capacity. In addition, VA manages a community nursing home (CNH) care program and pays for care of eligible veterans in private nursing homes. Currently, VAPIHCS has contracts with four community LTC facilities in Oahu. VA is motivated to expand CNH in Oahu and neighbor islands, but other facilities appear to be unwilling or unable to meet VA standards (e.g., life-safety codes) and contractual requirements.

In addition to the LTC services directly provided by VAPIHCS, VA has contributed over \$18 million to construct the State of Hawaii Veterans Home in Hilo. This 95-bed facility will provide both inpatient LTC and adult day care services for Hawaii veterans. I understand the facility will accept its first admission this month (i.e., August 2007). I commend the State Advisory Board on Veterans Services for the recommendation to name the facility in honor of Mr. Yukio Okutsu. As you know, Mr. Chairman, Mr. Okutsu was a resident of Hilo and a recipient of our Nation’s highest award for valor, the Medal of Honor, for his heroism during World War II.

VA understands that most veterans prefer to remain at home for as long as possible. Consequently, VA emphasizes non-institutional care (NIC) services. NIC includes Adult Day Health Care (ADHC), Contract Adult Day Health Care (CADHC), Home-based Primary Care (HBPC), Contract Home Health Care (CHHC), Home-maker/Home Health Aid (H/HHA), Home Hospice, Home Respite and Spinal Cord Injury (SCI) Home Program.

VA has substantially increased these programs over the past several years and has ambitious plans to expand further. This trend is also present in Hawaii. Since this Committee held hearings here in January 2006, the ADC for all NIC services at VAPIHCS increased nearly 40 percent (i.e., from 109.9 in FY 2006 to 153.2 in FY 2007 through June 2007). In addition, since FY 2005, VAPIHCS has aggressively implemented Care Coordination Home Telehealth (CCHT) technologies. Through CCHT, veterans have daily contact with VA clinicians by using telehealth devices in their homes. Currently, VAPIHCS has about 60 patients utilizing CCHT.

CCHT is especially important for veterans who receive care on Oahu and live on a neighbor island. As an example, Mr. Delbert Watson is a 61 year-old disabled veteran who lives on Kauai and had major heart surgeries at Tripler AMC. In a recent letter he wrote, “The VA saved my life. I’d be dead without them. They identified my heart condition and got me where I needed to be. I had two heart operations at Tripler, but the VA was always there for me. I have a VA health buddy [Health Buddy® is a type of CCHT equipment] so the VA nurse still keeps an eye on my

blood pressure regularly.” This coordinated system of VA, DOD and telehealth care ensures veterans in Hawaii receive leading-edge medicine.

Additional Community Based Outpatient Clinics (CBOCs)

In 2000, VA formally began its long-range capital and strategic planning process known as Capital Asset Realignment for Enhanced Services (CARES). One of the major goals of the CARES initiative is to improve access to health care services and the CARES Commission specifically assessed the need for new CBOCs. The CARES Decision announced in May 2004 identified one high-priority CBOC for VAPIHCS—namely, a new outpatient facility in American Samoa. The CBOC in American Samoa was dedicated on July 21, 2007. The CARES Decision also identified two additional locations for consideration of future CBOCs. These locations are Waianae (west side of Oahu) and Kaneohe (east side of Oahu).

Waianae

Originally, VA planned to activate a CBOC on the west side of Oahu. However, recently VAPIHCS became aware of the possibility of obtaining the vacant U.S. Navy medical clinic at Barber’s Point near Kapolei (just west of Ewa Beach). Although this clinic is about 13 miles from Waianae, it offers the potential advantages of earlier activation, support for the veterans’ homeless shelter at Barber’s Point and partial decompression of the “space crunch” at the VA clinic building on the Tripler AMC campus. It is not clear whether or not VA will be able to obtain this property (i.e., Navy has until September 2008 to convey its assets at Barber’s Point), so we will continue to explore other options on the west side of Oahu.

Kaneohe

VA is also interested in the possibility of having a CBOC on the east side of Oahu since the distance and travel times (especially during “rush hour”) to and from Honolulu are significant. We are currently reviewing demographic information and potential locations. We plan to open a CBOC on the west side of Oahu first (particularly if the opportunity at Barber’s point comes to fruition).

Construction Projects

VA has several important construction projects planned for VAPIHCS that will enhance services for veterans in Hawaii. In FY 2005, VA approved a Minor Construction project to build a facility on the Tripler AMC campus that will house the relocated inpatient PRRP and new outpatient PTSD program. The facility will be about 15,000 square-feet and have an estimated total project cost of \$5.6 million. The specific location on the Tripler AMC campus has not been determined and will, in part, depend on an upcoming environmental study. The contract for the environmental assessment and design phase of the project is expected to be awarded before the end of the current fiscal year. Construction should begin in FY 2008.

Earlier this fiscal year, VA approved a Minor Construction project to build a new ambulatory surgery center on the Tripler AMC campus. The facility will be used for “same day” surgery and other outpatient procedures. This will greatly enhance the ability of VAPIHCS to provide ambulatory procedures and reduce the need for referrals elsewhere. We are also exploring the opportunities to share the facility with Tripler AMC and/or provide services to its beneficiaries through a sharing agreement. The total project cost is estimated to be about \$6.9 million. The contract for the design of the facility should be awarded in FY 2008, with construction in FY 2009 and activation in FY 2010.

In addition to these Minor Construction projects, VA spends more than \$1 million of Non Recurring Maintenance (NRM) funds annually at VAPIHCS to renovate and maintain existing structures (e.g., \$1.2 million in FY 2007). As I will discuss at the hearing in Maui on August 23, 2007, VA has and will continue to expand and improve clinic buildings and parking at CBOCs on neighbor islands. I would like to thank you, Mr. Chairman, and your colleagues in Congress for your generous support of the capital asset programs in VHA (i.e., VHA Medical Facilities Appropriation). Without this support, these improvements would not be possible.

VA–DOD Joint Ventures

VAPIHCS participates in one of the largest and most complex VA–DOD partnerships. As I noted earlier, I had the privilege of serving at Tripler AMC in the early 1980s as chief of Internal Medicine. Both my military and VA experiences have helped me understand the systemic barriers that VA–DOD joint ventures face: conflicting mission priorities, lack of computer interoperability, ambiguities regarding dual-eligible beneficiaries and differences in financial systems. Further, deployments and increased obligations to TRICARE beneficiaries have constrained the ability of Tripler AMC to provide services to VA beneficiaries.

The VA–DOD joint venture in Honolulu has addressed these challenges and made great strides in both clinical and administrative areas. The partnership with Tripler AMC accelerated when VA began to move clinical and administrative functions from the Prince Kuhio Federal Building to the Tripler AMC campus in 1997. The co-location of VAPIHCS and Tripler AMC allows functional integration and opportunities to provide high quality care to Federal beneficiaries residing in Hawaii and the Pacific Region. VAPIHCS relies on Tripler AMC for emergency room care, acute medical-surgical inpatient care (including intensive care unit), outpatient specialty care and ancillary services. Tripler AMC admits about 1,400 VA beneficiaries and provides about 12,000 specialty clinic visits to VA beneficiaries each year. VAPIHCS also partners with Tripler AMC for nutritional services (e.g., inpatient meals at Tripler AMC and CFA), housekeeping, security, instrument sterilization and medical maintenance. In FY 2006, VAPIHCS purchased a total of about \$20 million of clinical and support services from Tripler AMC.

VAPIHCS and Tripler AMC also collaborate in several other important endeavors. The joint venture in Honolulu has successfully competed for several Joint Incentive Fund (JIF) projects. JIF was established by Congress in the National Defense Authorization Act (NDAA) in FY 2003 to encourage ongoing collaboration. The VA–DOD joint venture in Honolulu has secured about \$4 million in JIF funding since FY 2004 for projects related to computer-aided design and manufacturing of prosthetic devices; chronic dialysis center; and chronic pain management program. The venture was also selected as one of eight formal VA–DOD Joint Venture Demonstration Sites and will specifically assess budget and financial management systems.

VA appreciates the leadership of Major General (MG) Carla Hawley-Bowland and the responsiveness her staff to VA concerns. She has continued the tradition of a productive working relationship between senior VA and DOD leaders. I am confident that Dr. Hastings (a former Commanding General at Tripler AMC) and MG Hawley-Bowland will continue the growth and accomplishments of this very important joint venture.

Guam

VA has operated a clinic in Guam since 1989 and potentially serves an island population of about 9,000 veterans. The VA clinic is currently located in leased space within the U.S. Naval Hospital Guam. The clinic has nine staff members, including an internal medicine physician, psychiatrist and nurse practitioner. The clinic provides primary care, mental health care, limited specialty services (through telehealth technologies and visiting clinicians) and compensation and pension (C&P) examinations. In FY 2006, the clinic evaluated and treated 1,235 veterans with 5,824 clinic stops.

The current clinic site is problematic in many respects, including its small size (i.e., 2,700 square feet), related concerns regarding patient privacy and lack of parking. Moreover, due to security measures imposed by Navy, it is often difficult for veterans to traverse the security gate and access the clinic. These challenges will be exacerbated in the upcoming years when Navy relocates an estimated 8,000 U.S. Marines (and 9,000 dependents) from Okinawa to Guam.

VA Sierra Pacific Network and VAPIHCS collaborated with U.S. Naval Hospital Guam to address these concerns. Based on a combination of cost, access, timelines and VA–DOD sharing considerations, we determined the best option is for VA to build a new clinic at the periphery of the U.S. Naval Hospital Guam campus. I am pleased to report to the Committee that on July 30, 2007, Secretary Nicholson announced plans for VA to build this clinic at an estimated cost of about \$5.4 million. The clinic will be about 6,000 square-feet and will have its own parking. Navy will relocate its fence around the clinic so veterans will not have to pass through Navy security to enter the facility. The new clinic is scheduled to open in the summer of 2009.

CONCLUSION

In summary, with the support of the Senate Committee on Veterans' Affairs and the Hawaiian congressional delegation, VA is providing an unprecedented level of health care services to veterans residing in Hawaii and the Pacific Region. VA has state-of-the-art facilities and enhanced services in Honolulu, as well as robust staffing on the neighbor islands and has expanded or renovated clinics in many locations. VA is bringing more mental health providers and specialists on board to meet the needs of veterans.

VAPIHCS still faces several challenges including timely access to health care services (in part due to the topography of its catchment area and lack of an acute medical-surgical hospital), aging veteran population and special needs of our newest veterans who bravely served in southwest Asia. VAPIHCS will meet these chal-

lenges by working with DOD and community partners, activating an ambulatory surgery center, utilizing telehealth technologies and opening new clinics as demographics suggest and resources allow. I am proud of what VA has accomplished in Hawaii and the Pacific Region, but I understand that our job is not done.

Again, Mr. Chairman, mahalo nui loa for the opportunity to testify at this hearing. I and the staff who accompany me would be delighted to address any questions you may have for us.

Senator AKAKA. Thank you. Thank you very much, Dr. Kussman.
The AUDIENCE. (Applaud.)

Senator AKAKA. Your testimony has really revealed many things that will be happening here in Hawaii and across the country, and we are delighted to hear all of that. And now I would like to welcome the testimony of William Tuerk, Under Secretary for Memorial Affairs, Department Veterans Affairs. Under Secretary Tuerk.

**STATEMENT OF HON. WILLIAM F. TUERK, UNDER SECRETARY
FOR MEMORIAL AFFAIRS, DEPARTMENT OF VETERANS
AFFAIRS; ACCOMPANIED BY GENE CASTIGNETTI, DIRECTOR,
NATIONAL MEMORIAL CEMETERY OF THE PACIFIC**

Mr. TUERK. Thank you, Mr. Chairman.

Mr. Chairman, I appreciate the opportunity to testify today on issues of great interest to Hawaii veterans. With the Committee's permission, I will offer a brief summary statement and request that my written testimony be accepted by the Committee for placement in its hearing record.

Senator AKAKA. Without objection, it will be accepted and it will be included in the record.

Mr. TUERK. Mr. Chairman, for my oral presentation, I will focus on three items, each of which, I think, represents good news for the veterans of Hawaii. The first item concerns VA initiatives to ensure that the National Memorial Cemetery of the Pacific remains open to provide uninterrupted service in meeting the burial needs of Hawaii veterans and their families. These initiatives will also ensure that the Punchbowl is preserved as an active national treasure in the spirit of the ancient Hawaiians who know this site as puuavana.

NCA is proceeding now to design a columbarium expansion project which we anticipate will add over 30,000 niches for the inurnment of cremated remains at NMCP. Subject to the availability of fiscal year 2008 funding, we intend to advance a project that would extend the life of the cemetery to approximately 2016. We are, in addition, studying the feasibility of other columbarium projects into the future.

Mr. Chairman, we will seek every opportunity, every opportunity, to maximize the space available for columbarium inurnments at the Punchbowl and to extend the time frame within which that national treasure will remain an active cemetery. We understand what the Punchbowl means to the citizens of Hawaii. We understand what it means to the citizens of the Nation.

The second item I will discuss this morning relates to the strong partnership between the Federal Government and the State of Hawaii in providing options for burial through the State Cemetery Grants Program. This morning's presentation of \$743,000 in grant funds for the phased expansion of West Hawaii State Veterans Cemetery marks the newest era in that long-standing partnership.

The state veterans cemetery expansion project at Kailua-Kona will allow for continued access to a full casket burial option on both the east and west sides of the Big Island of Hawaii. Hawaii leads all states in the development and operation of state veterans cemeteries. This grant will assist Hawaii in maintaining that national leadership position into the future. We hope, Mr. Chairman, that other states will follow Hawaii's lead in building successful partnerships with the VA.

The third item I'd like to discuss this morning relates to further future improvements planned for West Hawaii State Veterans Cemetery. Last December, staff members of both Hawaii senators expressed concerns to me about the appearance of some sections of that cemetery, and they asked me to give this matter my personal attention. As you know, Mr. Chairman, I have visited the West Hawaii State Veterans Cemetery along with four other Hawaii State Cemeteries, and today I'm prepared to report our response to those concerns.

To meet the unique challenges of this site, the state cemetery grant, which was announced this morning, will fund the purchase of grave liners to assist cemetery staff in maintaining the grounds to the highest standards of appearance. This was an issue that I know that both you and Senator Inouye were particularly concerned about. We will attend to it.

In the future, we anticipate additional funding of approximately \$3.5 million to construct a permanent committal shelter, restrooms, roadway infrastructure and other improvements at West Hawaii State Veterans Cemetery. Be assured, Mr. Chairman, that VA will continue in its strong support of the veterans cemeteries here in Hawaii today and into the future. We are grateful, Mr. Chairman, for your steadfast support of NCA, the VA, and the Nation's veterans.

Thank you again for this opportunity to testify. I'd be happy to entertain any questions that you may have for me. Thank you.

[The prepared statement of Under Secretary Tuerk follows:]

PREPARED STATEMENT OF HON. WILLIAM F. TUERK, UNDER SECRETARY
FOR MEMORIAL AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, Mr. Ranking Member and Members of the Committee, thank you for the opportunity to testify today on issues of great interest to Hawaii veterans.

The National Cemetery Administration (NCA) and the Veterans Benefits Administration (VBA), which is responsible for burial flags and monetary burial benefits, jointly administer the Department of Veterans Affairs' burial and funeral benefits for veterans. We, in NCA, have four statutory missions under title 38, United States Code:

- To provide burial for eligible veterans and their eligible dependents and to maintain those places of burial as national shrines;
- To provide Government-furnished headstones and markers for the graves of eligible veterans worldwide;
- To administer the State Cemetery Grants Program (SCGP), which provides Federal funds up to 100 percent of the development cost for establishing, expanding and improving veterans cemeteries owned and operated by the States; and
- To administer the Presidential Memorial Certificate (PMC) program, which provides the families of honorably discharged, deceased veterans Certificates bearing the signature of the President, to commemorate the veterans' service.

NCA currently maintains more than 2.8 million gravesites at 125 national cemeteries in 39 States and Puerto Rico, as well as 33 soldiers' lots and monument sites. Since 1973, when Congress created a National Cemetery System under the jurisdiction of VA, annual interments in VA national cemeteries have almost tripled from

36,400 to about 97,000 in fiscal year 2006. We expect to perform nearly 105,000 interments in 2008, an 8.3 percent increase over the number performed in 2006. NCA processed more than 336,000 applications for Government-furnished headstones and markers for the graves of veterans worldwide and issued nearly 406,000 Presidential Memorial Certificates to the families of eligible veterans in fiscal year 2006. Sixty-seven State veterans cemeteries funded under the SCGP are operated in 34 States, Guam and Saipan—of which 8 are located in Hawaii.

MEETING THE BURIAL NEEDS OF VETERANS

One of VA's primary missions is to ensure that the burial needs of veterans are met. In support of this mission, VA's goal is to provide veterans with reasonable access to a burial option (whether for casketed or cremated remains) in a national or State veterans cemetery within 75 miles of their residence.

Our ability to provide reasonable access to a burial option is a critical measure of the effectiveness of our service delivery to veterans and their families. Currently, 83.5 percent of all veterans in the Nation are served by a burial option in a national or State veterans cemetery within 75 miles of their homes. NCA intends to increase the percentage of veterans served to 90 percent by fiscal year 2010. Strategic initiatives are in place to meet this goal. They are:

- Establishment of additional national cemeteries in unserved areas;
- Expansion of existing national cemeteries to provide continued service; and
- Establishment or expansion of State veterans cemeteries through the SCGP.

NCA will continue to expand, and make improvements to, existing national cemeteries by acquiring additional land, where possible, and completing development projects that make additional gravesites or columbaria available for interments. We have major and minor construction projects underway to expand the life cycles of several national cemeteries so that they can continue to meet the burial needs of veterans in their geographic regions. One such project was here at the National Memorial Cemetery of the Pacific (NMCP) where a columbarium expansion project was undertaken to add 4,160 niches to allow the cemetery to remain open for cremated remains until 2011.

Dedicated on September 2, 1949, on the fourth anniversary of the end of World War II, the National Memorial Cemetery of the Pacific (the Punchbowl) originally provided a final resting place for approximately 13,000 World War II casualties from Guadalcanal, Burma, Saipan, Guam, Iwo Jima, the prison camps of Japan and other battlegrounds of the Pacific as well as Hawaii's own sons from other theaters of war. Among the nearly 30,000 graves tended today, 57 Medal of Honor recipients are interred or memorialized.

In 2006, over 950 burials were performed at NMCP; 105 were full-casket burials of eligible family members of those already buried at the cemetery. NCA also furnished 477 headstones or markers for eligible Hawaii veterans interred at private cemeteries and provided over 500 Presidential Memorial Certificates to honor the service of Hawaii veterans.

NMCP has undergone numerous improvements over the years to ensure that it remains a national shrine to honor all those who served their country. Several projects currently in design illustrate NCA's commitment to retaining this unique national treasure as an active national cemetery and as a special ceremonial venue for commemorating the dedicated men and women who have made the ultimate sacrifice.

NCA is designing an additional columbarium expansion project at NMCP which we anticipate will add over 3,000 niches for the inurnment of cremated remains. This project would extend the life of the cemetery to approximately 2016. We are committed to constructing this project to ensure there could be no lapse in future gravesite availability until that date. We are also studying the feasibility of potential columbarium projects further into the future. Among the options to be considered will be the relocation of administrative functions, where possible, to provide for grave site expansion in suitable areas. Toward this end, options for the design of a new administration building and visitors information center are under development. I assure you that we will take every opportunity to employ innovative methods to maximize the space available to continue to serve the needs of our veterans at NMCP. We are determined to preserve NMCP as the cherished icon that it is, one that is known throughout the world.

STATE CEMETERY GRANTS PROGRAM

Established by Public Law 95-476 in 1978 to complement VA's network of national cemeteries, the NCA State Cemetery Grants Program (SCGP) provides funding up to 100 percent for the development and startup equipment costs for State

veterans cemetery projects. At the end of July 2007, VA had awarded 156 grants totaling more than \$286 million to establish, expand or improve 71 veterans cemeteries nationwide. Utilizing VA grant funding, sixty-seven State cemeteries are currently operational and four new State cemeteries are under construction. In fiscal year 2006, State veterans cemeteries provided for 22,434 burials, 19 percent of all burials in either a national or State veterans cemetery.

As a complement to our national cemeteries, the State Cemetery Grants Program is vital to achieving NCA's burial access goal and permitting NCA to meet the needs of veterans in less populated areas where the concentration of veterans cannot meet NCA's criterion for the establishment of a national cemetery. Nowhere is access to veterans cemeteries more extensive than in Hawaii, where 100 percent of veterans are served within 75 miles of their homes by the presence of a State veterans cemetery.

Hawaii leads all States in the development and operation of State veterans cemeteries, and ranks as the ninth busiest State in providing burial services to veterans and their families in State veterans cemeteries. Of its eight State veterans cemeteries, only East Hawaii Veterans Cemetery No. 1 is closed to new interments. The seven operating Hawaii veterans cemeteries are:

Hawaii State Veterans Cemetery (Island of Oahu); East Hawaii Veterans Cemetery No. 2 (in Hilo on the Island of Hawaii); West Hawaii Veterans Cemetery (on the Kona Coast of the Island of Hawaii); Kauai Veterans Cemetery (Island of Kauai); Maui Veterans Cemetery (Island of Maui); Molokai Hawaii Veterans Cemetery (Island of Molokai); and Lanai Veterans Cemetery (Island of Lanai).

I am privileged to have had an opportunity visit five of these sites. In 2006, 1,171 veterans were interred in a Hawaii veterans cemetery, either at NMCP or in one of the 7 open Hawaii State veterans cemeteries.

NCA has provided over \$11 million in grants for Hawaii State veterans cemeteries. Recently, the Hawaii Congressional delegation requested assistance from NCA to work with the West Hawaii State Veterans Cemetery to ensure national shrine standards were being met. To do so, we are currently processing an award for more than \$700,000 for the phased expansion at West Hawaii State Veterans Cemetery that will provide local veterans with access to a full-casket burial option on both the east and west side of the island of Hawaii. This project includes the purchase of grave liners to assist cemetery staff in maintaining the grounds to meet the highest standards of appearance. Project plans also address infrastructure needs at the facility, to include construction of a permanent committal shelter, rest rooms, improved equipment storage facilities, and roadways. NCA will continue to serve as a partner with the State in the expansion and improvement of Hawaii State cemeteries to serve Hawaii veterans on every island.

In addition to grants, NCA also provides technical assistance and support to State cemetery field and administrative staff through site visits and invitations to participate in NCA's annual and regional conferences where innovative operational techniques, best management practices and ideas are exchanged. Hawaii has also cultivated successful working partnerships with the counties in operating and maintaining the State cemeteries, a technique now being considered by other States.

Hawaii has met the challenge of operating multiple State cemeteries through the use of innovative cooperative agreements between public and private entities. The recent water and planting improvement project the State undertook at West Hawaii State Cemetery addressed the difficult and unique site conditions at the cemetery. Successful projects such as this demonstrate Hawaii's ingenuity in maintaining all veterans cemeteries as national shrines that honor the service of our country's servicemembers. We hope that other States will follow Hawaii's lead. We hope that they will build successful partnerships with VA as pioneered by the State of Hawaii. Be assured that NCA will continue in its strong support of the cemeteries here in Hawaii today and in the future. We are grateful for your vital cooperation in commemorating our Nation's veterans. We are also grateful, Mr. Chairman, for your steadfast support for NCA, and for our Nation's veterans.

That concludes my statement, Mr. Chairman. I would be happy to entertain any questions you or the other Members of the Committee may have.

Senator AKAKA. Thank you very much.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you very much for your work in our state, and we are really grateful for that.

Now, we will hear from Deputy Under Secretary Aument.

STATEMENT OF RONALD R. AUMENT, DEPUTY UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GREGORY REED, DIRECTOR, HONOLULU REGIONAL OFFICE, DEPARTMENT OF VETERANS AFFAIRS

Mr. AUMENT. Thank you, Mr. Chairman.

Chairman Akaka, thank you for the privilege of being here today to discuss our efforts to meet the needs of veterans residing in Hawaii and the Pacific Region. I am pleased to be accompanied by Gregory Reed, Director of the Honolulu VA Regional Office.

Like Dr. Kussman, I listened to the first panel with great interest today. We have much to learn from the veterans that we serve, the Honolulu Regional Office is responsible for delivering VA benefits and services to veterans residing in the Pacific Region including Hawaii, Guam, American Samoa and the Commonwealth of the Marianas.

Today I will discuss the important services provided by the Honolulu Regional Office. My comments will also focus on the actions we are taking to expedite the processing of claims from Operations Iraqi and Enduring Freedom veterans, VBA's national hiring initiatives that will improve our ability to provide more timely, accurate and consistent determinations on veterans' claims.

More than 107,000 veterans are served by the dedicated employees of the Honolulu Regional Office. Of these veterans, approximately 16,700 are receiving disability compensation. This fiscal year through June, the Honolulu Regional Office processed approximately 3,500 veterans disability claims. Through their aggressive outreach and public contact activities, the Regional Office employees have this year alone conducted nearly 1,350 personal interviews and 2,250 telephone interviews, and briefed approximately 800 separating servicemembers.

The Honolulu office recently extended telephone service, benefits counseling and other inter-island itinerant services to the South Pacific encompassing the Federated States of Micronesia. Expediting the claims process is critical to assisting OIF and OEF veterans in their transition from combat operations back to civilian life.

Since the onset of combat operations in Iraq and Afghanistan, VA has provided expedited and case-managed services for all seriously injured OIF/OEF veterans and their families.

These individualized service begins at the military treatment facilities where the injured servicemembers return for treatment, and continue as these servicemembers are medically separated and enter the VA medical care and benefits systems. VA assigns benefits counselors, social workers and case managers to work with these servicemembers and their families to assist in the transition to VA care and benefits systems and to ensure the expedited delivery of all benefits.

Since February of this year, VA has provided priority processing of all OIF/OEF veterans' disability claims. This issue covers all active duty, National Guard and Reserve veterans who are deployed, in the OIF/OEF or in support of these combat operations as identified by the Department of Defense. This allows all the brave men and women returning from the OIF/OEF theaters who are not seri-

ously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, to enter the VA system and begin receiving disability compensation as soon as possible after separation.

We are also continuing to focus on reducing pending workload and providing more timely claims decisions to veterans of all periods of service. I'm especially pleased today to be able to discuss with you our national hiring initiative. We've already added more than 800 new employees since April of this year and our plans call for adding a total of 3,100 new employees by the end of next fiscal year.

These employees will be placed in critically needed positions in our regional offices throughout the Nation. The Honolulu Regional Office has been authorized to increase its staffing level by over 10 percent as a result of this hiring initiative. A number of the new employees are already onboard, and the Regional Office is in the process of filling another five vacancies. These additional resources will enable the Regional Office employees to make great strides to improve the delivery of benefits and conduct more outreach in the Pacific Region.

Since 1993, VA has made almost 600 loans to Native American veterans for the purchase, construction or improvement of homes on Federal Trust land under the Native American Direct Loan program. Over 75 percent of all loans made under this program will be Native American veterans living in the Pacific Region. As an aside, I just noted today that during fiscal 2006, almost \$4 billion worth of loans are guaranteed for veterans here in Hawaii. We believe that much of the credit for these successes must go to the ongoing partnerships of the Department of Hawaiian Homelands, the Community Development Bank of American Samoa, the Territorial Government of Guam, the Commonwealth of the Northern Marianas and the Department of Community and Cultural Affairs' Veterans Affairs Office, and the Mariana Islands Housing Authority.

Further, veterans are eligible through VA-guaranteed and direct loans equal to the Freddie Mac conforming loan limit. As of January 2006, that rate increase is \$625,500 for high cost areas such as Hawaii and Guam. VA anticipates that this will make VA guaranteed home loans much more attractive to veterans.

Mr. Chairman, this concludes my testimony. I greatly appreciate being here today, and look forward to answering any questions you may have.

[The prepared statement of Deputy Under Secretary Aument follows:]

PREPARED STATEMENT OF RONALD R. AUMENT, DEPUTY UNDER SECRETARY
FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Chairman Akaka, it is my pleasure to be here today to discuss our efforts to meet the needs of veterans residing in the Pacific Region. I am pleased to be accompanied by Gregory Reed, Director of the Honolulu VA Regional Office.

The Veterans Benefits Administration (VBA) is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors. Today I will discuss the important services provided by the Honolulu Regional Office. My comments will also focus on the actions we are taking to expedite the processing of claims from Operations Iraqi and Enduring Freedom (OIF/OEF) veterans and VBA's national hiring initiative that will improve our ability to provide more timely, accurate, and consistent determinations on veterans' claims.

HONOLULU REGIONAL OFFICE

The Honolulu Regional Office is responsible for delivering VA benefits and services to veterans residing in the Pacific Region, including Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Marianas.

The Honolulu Regional Office administers the following benefits and services:

- Disability Compensation
- Dependency and Indemnity Compensation
- Disability and Death Pensions
- Vocational Rehabilitation and Employment Assistance
- Home Loan Guaranties and Native American Direct Home Loans
- Outreach
- Burial Benefits

More than 107,000 veterans are served by the dedicated employees of the Honolulu Regional Office. Of these veterans, approximately 16,700 are receiving disability compensation. This fiscal year through June, the Honolulu Regional Office provided approximately 3,500 veterans with decisions on their disability claims. Through their aggressive outreach and public contact activities, the regional office employees have this year alone conducted nearly 1,350 personal interviews and 2,250 telephone interviews, and briefed approximately 850 separating servicemembers.

The Honolulu office recently extended telephone service, benefits counseling, and other inter-island itinerant services to the South Pacific area encompassing the Federated States of Micronesia. Telephone service is also provided to veterans residing in the Republic of Palau and the Marshall Islands by the Honolulu Regional Office.

PRIORITY PROCESSING FOR OIF/OEF VETERANS

Since the onset of the combat operations in Iraq and Afghanistan, VA has provided expedited and case-managed services for all seriously injured OIF/OEF veterans and their families. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment, and continues as these servicemembers are medically separated and enter the VA medical care and benefits systems. VA assigns special benefits counselors, social workers, and case-managers to work with these servicemembers and their families throughout the transition to VA care and benefits systems, and to ensure expedited delivery of all benefits.

Since February 2007, VA has provided priority processing of all OIF/OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OIF/OEF theaters or in support of these combat operations, as identified by the Department of Defense (DOD). This allows all the brave men and women returning from the OIF/OEF theaters who were not seriously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, to enter the VA system and begin receiving disability benefits as soon as possible after separation.

We designated our two Development Centers in Roanoke, Virginia, and Phoenix, Arizona, as well as three of our Resource Centers, as a special "Tiger Team" for processing OIF/OEF claims. The two Development Centers assist regional offices in obtaining the evidence needed to properly develop the OIF/OEF claims. Medical examinations needed to support OIF/OEF veterans' claims are also expedited.

We expanded our outreach programs for National Guard and Reserve components and our participation in OIF/OEF community events and other information dissemination activities. An OIF/OEF team at VBA Headquarters addresses OIF/OEF operational and outreach issues at the national level and provides support to the newly designated OIF/OEF managers at each regional office. The OIF/OEF team is also coordinating the development of national memoranda of understanding (MOUs) with each of the Reserve Components to formalize relationships with them, mirroring the agreement between VA and the National Guard Bureau signed in 2005. Having an MOU with each Reserve Component will help ensure that VA is provided service medical records and notified of "when and where" Reserve members are available to be briefed during the demobilization process and at later times.

In order to ensure that VA benefits information is provided to all separating servicemembers, including Reserve and Guard members, we are working with DOD to expand our role in DOD's military pre-separation process. Specifically, we are now providing "Claims Workshops" in conjunction with many of our VA benefits briefings for separating servicemembers. At such workshops, groups of servicemembers are instructed on how to complete the VA application forms. Personal interviews are also conducted with those applying for VA disability benefits.

Expediting the claims process is critical to assisting OIF/OEF veterans in their transition from combat operations back to civilian life. We are also continuing to focus on reducing the pending workload and providing more timely claims decisions to veterans of all periods of service.

NATIONAL HIRING INITIATIVE

I am especially pleased today to be able to discuss with you our national hiring initiative. We are extremely grateful for the funding support we have received from Congress that has allowed us to undertake this unprecedented hiring program. We have already added more than 800 new employees since April, and our plans call for adding a total of 3,100 new employees by the end of next year. These employees will be placed in critically needed positions in our regional offices throughout the nation.

Along with the multitude of activities involved in a recruitment program of this magnitude, we have begun the critical tasks of training, equipping, and acquiring space to house our new employees. We are accelerating the training of these employees and focusing in specialized areas of claims processing in order to have them "on-line" and productive within a few months. This will be followed by ongoing, carefully structured, and progressively complex training until full journey expertise is achieved.

The Honolulu Regional Office has been authorized to increase its staffing level by over 10 percent as a result of this hiring initiative. A number of the new employees are already on board, and the Regional Office is in the process of filling another five vacancies. These additional resources will enable the Regional Office employees to make great strides in improving the delivery of benefits and conducting more outreach in the Pacific Region.

HOME LOAN GUARANTY SERVICES

Since 1993 VA has made almost 600 loans to Native American veterans for the purchase, construction, or improvement of homes on Federal Trust land under the Native American Veteran Direct Loan Program. Far and away our greatest successes under this program have been in the South Pacific. Over 75 percent of all loans made under this program have been to Native American veterans living on the homeland territories of American Samoa, Guam, Hawaii, and the Commonwealth of the Northern Marianas.

We believe that much of the credit for these successes must go to our ongoing partnerships with the Department of Hawaiian Homelands, the Community Development Bank of American Samoa, the Territorial Government of Guam, the Commonwealth of the Northern Marianas (CNMI), the CNMI Department of Community and Cultural Affairs Veterans Affairs Office and the Mariana Islands Housing Authority. These offices have played crucial roles in assisting with outreach and delivery of the VA home loan benefit to veterans located throughout the South Pacific. They have acted as our partners in assisting with loan packaging, appraisals, and construction-related inspections, as well as providing crucial communication links between our staff and the veterans we serve.

With the ongoing activation of Reserve and National Guard members in support of the military operations in Iraq and Afghanistan, servicemembers are becoming eligible for VA home loan benefits faster and in greater numbers. Instead of the time-in-service requirement of 6 years for members of the Reserves or National Guard, eligibility is established under the Loan Guaranty and Native American Veteran Direct Loan Programs after 90 days or more of active wartime service. Further, as a result of P.L. 108-454, veterans are eligible for VA-guaranteed and direct loans equal to the Freddie Mac conforming loan limit. As of January 2006, that rate increased to \$625,500 for high cost areas such as Hawaii and Guam. VA anticipates that this will make VA guaranteed home loans much more attractive to veterans. As a result, we anticipate continued growth in the Loan Guaranty Program and Native American Direct Loan Program in the Pacific Region.

Mr. Chairman, this concludes my testimony. I greatly appreciate being here today and look forward to answering your questions.

Senator AKAKA. Thank you very much.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you very, very much, Deputy Under Secretary Aument. And now we will hear from Julie Watrous, Director of the Inspector General's Regional Office.

**STATEMENT OF JULIE WATROUS, R.N., REGIONAL DIRECTOR,
OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPEC-
TOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS;
ACCOMPANIED BY DR. MICHAEL SHEPHERD, PHYSICIAN,
OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPEC-
TOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS**

Ms. WATROUS. Mr. Chairman, mahalo for the opportunity to testify today on VA health care in Hawaii. Thanks also for your strong commitment to veterans and your interest in the oversight work that we do.

I've been the Director of the Office of Healthcare Inspections Regional Office in Los Angeles for the past eight years. Prior to that, I served as a staff nurse and also a quality manager in various VA facilities. My current territory is the western United States and includes the VA Pacific Islands Health Care System. I'm accompanied today by my colleague Dr. Michael Shepherd, a physician in the Office of Healthcare Inspections.

As you requested, I will discuss the relationship between the Tripler Army Medical Center and the Pacific Islands Health Care System from our perspective as well as highlight some of the findings from two reports we issued in 2006. In preparation for this hearing, I visited Honolulu last month to interview staff at both the VA and Tripler. There are at least three issues in the sharing agreement relationship that would benefit from further attention. I believe you're familiar with all three.

The first concerns differences between the two electronic patient health record systems which cause difficulties in clinician communication and patient care coordination. I understand that efforts are underway to connect the two systems, and the sooner the better. The second issue concerns the two financial systems with problems such as late billings and delayed payments. The third issue concerns access to care for veterans at Tripler. Because of deployments and active duty military members needing care, care for veterans at Tripler is not always available or timely.

As part of our oversight mandate, we conduct periodic reviews of VA health care facilities which we call CAPs. We conducted a CAP review of the Honolulu facility in June 2006. We made recommendations to improve patient information security, community nursing home oversights and oversight of veterans' care in Tripler. The details are published in our CAP report as well as in my written testimony. We accepted the actions taken by Dr. Hastings and closed this report on March 30, 2007.

In early fiscal year 2006, at your request, we conducted a review that included access to non-institutional care and timely elective procedures. We visited five medical facilities in this national review including the Honolulu facility. Regarding non-institutional care, we made a number of recommendations to increase access. VHA agreed and submitted an action plan that included monitoring the demand and supply of non-institutional services, increasing capacity and expanding coverage to geographic areas that did not offer these services.

The Pacific Islands Health Care System's 2006 workload numbers show that the number of veterans using these services has increased. Regarding access to timely electives specialty procedures,

we reviewed procedures that had been performed in fiscal year 2005 in cardiology, gastroenterology and orthopedic surgery.

Many veterans waited a very long time for the procedures from the date they were ordered until the date they were performed. Reasons for these delays included difficulty recruiting specialists, lack of support staff and insufficient space including inpatient beds and operating rooms. These barriers to timely care existed across the country but were especially applicable to Hawaii.

This past February, the Pacific Islands Health Care System hired a part-time orthopedic surgeon to operate at Tripler. Both facilities agree that this move has helped stabilize the planning for orthopedic surgery, but stated that more staffing is needed. As Dr. Kussman mentioned, additional operating rooms will be constructed as part of the VA's same-day surgery project and will provide more capacity, but only when fully staffed.

We were told repeatedly about the difficulty in recruiting specialists to work in Hawaii. In our access to care report, we recommend that VHA establish appropriate performance metrics to evaluate and improve the timeliness of elective procedures. VHA agreed and plans to develop performance metrics to evaluate timeliness of elective procedures. This recommendation remains open and we are tracking progress to complete it.

In summary, with respect to VA care in Hawaii, Dr. Kussman for VHA, Dr. Wiebe for VISN 21 and Dr. Hastings for the VA Pacific Islands Health Care System, have responded appropriately to specific recommendations made by the OIG in these two reports. However, the three issues relating to the sharing agreement, the electronic medical record systems, billing and payment systems and consistent and timely access to care would benefit from additional attention at the highest level of VA and DOD.

Mr. Chairman, thank you again for this opportunity. Dr. Shepherd and I would be happy to answer any questions that you may have.

[The prepared statement of Ms. Watrous follows:]

PREPARED STATEMENT OF JULIE WATROUS, R.N., REGIONAL DIRECTOR, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on VA health care in Hawaii. I will discuss the relationship between the Tripler Army Medical Center (TAMC) and the Spark M. Matsunaga Medical Center (part of the VA Pacific Islands Health Care System), as well as the status of findings from two reports the Office of Inspector General (OIG) issued in 2006. I am accompanied by Michael Shepherd, M.D., Physician, Office of Healthcare Inspections, OIG.

In preparation for this hearing, I traveled to Honolulu July 23–24, 2007, to interview managers and staff at the VA Pacific Islands Health Care System and at TAMC. Based on these interviews, as well as previous reviews conducted here, I would like to highlight three issues in the sharing agreement relationship that would benefit from further attention. The first concerns differences between the two facilities' electronic patient health record systems, which make it difficult for clinicians to document veterans' care, as well as to review other clinicians' documentation. The second issue concerns the billing and payment systems, which both facilities' managers complained result in problems such as late billings and delayed payments. The third issue concerns equal access to care for veterans at the TAMC. Because of TAMC staff deployments and the influx of active duty military members

needing care, access to care for veteran patients at TAMC is not always consistently available or timely. I will discuss this issue in more detail later in my testimony.

COMBINED ASSESSMENT PROGRAM REVIEW ¹

The OIG conducts periodic reviews of VA health care facilities. These Combined Assessment Program (CAP) reviews are part of the OIG's efforts to ensure that high quality care is provided to our Nation's veterans. We reviewed documents and medical records and visited the Honolulu facility June 19 through 23, 2006, and in September 2006, we published the CAP review report of the VA Pacific Islands Health Care System.

In the CAP report, we noted four areas that were in compliance: quality management, breast cancer management, patient satisfaction survey results action plans, and monitoring patients on atypical antipsychotic medications. We made recommendations concerning security of patient information, follow-up care for patients in community nursing homes, and communication and oversight of veteran patients treated at TAMC.

With regards to security of patient information, we found unsecured patient information in hard copy paper and on unattended computer terminals and recommended that the facility's managers ensure that all patient information is protected. In response to our recommendation, managers provided privacy training and increased their oversight of patient information management throughout their facilities.

With regards to follow-up care for patients in community nursing homes, we recommended that the facility's managers improve care plans for veterans residing in community nursing homes and increase facility oversight of these homes. In response, managers standardized care plan notes and increased the membership on the oversight committee.

The issue of communication about and oversight of veteran patients treated at TAMC was not a new finding. We had a similar finding during our 2001 CAP review and closed the recommendation based on the corrective action plan submitted. However, the corrective actions were only partially implemented. We again recommended that senior managers at the two facilities formalize their communication mechanisms and ensure that key staff attend the meetings. Several committees were formed as a result of this recommendation, including a Joint Venture Committee, to address clinical care and quality improvement issues between the two organizations.

We reviewed the actions taken by the facility's managers in response to our CAP recommendations and concluded that the recommendations were appropriately addressed. We closed the report on March 30, 2007.

REVIEW OF ACCESS TO CARE IN THE VETERANS HEALTH ADMINISTRATION ²

In early fiscal year (FY) 2006, at the request of Senator Akaka, we reviewed access to non-institutional care, appropriateness of enrollment practices, and timeliness of clinically indicated elective procedures. We visited five medical facilities in this national review, including the Spark M. Matsunaga VA Medical Center. We interviewed facility personnel, reviewed medical records, and analyzed workload data through fiscal year 2005 provided to us by the facilities.

Non-Institutional Care

The Millennium Act, passed in 1999, directed VA to provide veterans eligible for medical services with certain non-institutional care services—services that are provided to veterans in their own homes or in community settings. In response, VHA implemented policies requiring medical facilities to provide non-institutional care services to all eligible veterans, when appropriate. These services include:

- Home based primary care.
- Purchased skilled home health care.
- Homemaker and home health aides.
- Adult day health care.
- Geriatric evaluation and management.
- Respite care.
- Hospice and palliative care.

¹ *Combined Assessment Program Review of the VA Pacific Islands Health Care System*, Honolulu, Hawaii, Report No. 06-02003-225, September 26, 2006.

² *Review of Access to Care in the Veterans Health Administration*, Report, No. 05-03028-145, May 17, 2006.

- Care coordination and telehealth.

We noted that veteran access to non-institutional care services had increased from fiscal year 2003 to fiscal year 2005 in several of the non-institutional care services. However, we found that improvement was still needed and made a number of recommendations aimed at further increasing access. VHA agreed with the recommendations and submitted an action plan that included monitoring the demand and supply of non-institutional services, increasing capacity, and expanding coverage to geographic areas that did not offer non-institutional care services. The VA Pacific Islands Health Care System's fiscal year 2006 workload numbers show that all the non-institutional care services are available, and the number of veterans using these services increased in fiscal year 2006 in almost all services.

Enrollment Process

The enrollment process at the five facilities we visited complied with national enrollment policies. We made several recommendations aimed at improving the tracking of new veterans who desire VA care. VHA agreed with the recommendations and planned to issue revised directives establishing policies for use of electronic wait lists and scheduling processes. VHA issued the directive "Process for Ensuring Timely Access to Outpatient Clinical Care" on May 8, 2006.

Timeliness of Elective Specialty Procedures

Eligible veterans did not always receive clinically indicated specialty procedures within reasonable time frames. VHA has not established a method to measure the length of time veterans wait for elective procedures; in some cases, veterans experienced excessive waiting times. While a VHA performance measure requires facility directors to track the length of time veterans wait for their specialty care appointments, facilities are not required to track the length of time veterans must wait from the requests or authorizations for elective procedures until the procedures are actually performed. To better assess and manage their workload and ensure that veterans receive timely care, facility managers need to track veterans' entire waiting time—not just the waiting time to the appointment.

We reviewed elective procedures that had been performed in fiscal year 2005 in three specialty areas: (1) cardiology, (2) gastroenterology, and (3) orthopedic surgery. We found lengthy average waiting times. For example, at the VA Pacific Islands Health Care System, the average wait for elective orthopedic procedures was 182 days, and the range was 14–379 days.

We could not locate any timeliness standards within VHA or United States medical organizations for the procedures we reviewed. However, several countries with national health systems have set timeliness goals of 6 months for orthopedic surgery. Evidence indicates that deterioration in functional health status occurs in patients waiting more than 6 months for joint replacement surgery.

We interviewed the chiefs of cardiology, gastroenterology, and orthopedic surgery services, as well as a number of primary care providers, to gain their perspectives on the timeliness of elective procedures. Although the five facilities varied greatly in size and capacity, the reasons for delays given by these providers were consistent and fell into four themes:

- Physician vacancies and difficulty recruiting specialty physicians.
- Lack of support staff, such as nurses, physician assistants, and anesthesiologists.
- Insufficient space, including inpatient beds and operating rooms.
- Lack of equipment, such as scopes and data processors for colonoscopies.

Some barriers to timely care were unique to one or two facilities. For example, some orthopedic surgery for Hawaii veterans occurs in operating rooms at TAMC. Delays occurred when procedures scheduled to be performed at TAMC were canceled due to military deployments. Some of these veterans had to be re-prioritized and worked into the referral lists to the VA Palo Alto Health Care System. In other cases, veterans were referred to community providers at VA expense, depending on veteran condition and availability of fee basis funds.

Within the past year, the VA Pacific Islands Health Care System hired a part-time orthopedic surgeon to operate at TAMC. Both facilities' managers agreed that this move has helped stabilize the planning for orthopedic surgery but stated that more staffing is needed to manage the workload. Additional operating rooms that will be constructed as part of the VA Pacific Islands Health Care System's same-day surgery project will provide more capacity, but only when fully staffed. We were told repeatedly about the difficulty in recruiting specialists to work in Hawaii. In preparation for this hearing, we reviewed the VA Pacific Islands Health Care System's fiscal year 2006 elective procedures data and found that the average wait times from authorization until the procedures had been performed had improved in

cardiology and gastroenterology, but had actually gotten worse in orthopedic surgery.

In our report, we recommended that VHA establish appropriate performance metrics to evaluate and improve the timeliness of elective procedures and implement prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs. VHA agreed with the recommendation and plans to develop performance metrics to evaluate timeliness of elective procedures. This recommendation remains open.

SUMMARY

With respect to VA care in Hawaii, we believe that VHA, Veterans Integrated Service Network 21, and the VA Pacific Islands Health Care System have responded appropriately to specific recommendations made by the OIG in these two reports. However, the three issues related to TAMC—electronic medical record systems, billing and payment systems, and consistent and timely access to care—would benefit from additional attention.

Mr. Chairman, thank you again for this opportunity. I would be pleased to answer any questions that you or other Members of the Committee may have.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you. Thank you very much, Julie Watrous, for your testimony. I have some questions for the panel. Dr. Hastings and Dr. Wiebe, these questions have to do with the new Oahu clinic.

I want you to know that I'm very concerned about the need for additional ambulatory care capacity here on Oahu. I know VA has been looking at the possibility of clinics at both Barbers Point and at Kaneohe at the east side of the island. I understand that because of the need to coordinate with the Navy, that there have been some challenges in getting the clinic at Barbers Point up and running. My question to you, Dr. Hastings and Dr. Wiebe, is whether it's possible to move forward with a clinic at Kaneohe?

Dr. HASTINGS. Mr. Chairman, thank you for the opportunity to address this very important issue for us. We are in negotiations with the Navy and with the state. They are moving forward. They're under a mandate to make progress and dispense with this land by September 2008. So they are under pressure to get the problem solved. And we think that when we look at the distribution of our patients, that the best decision would be if we could build and take over that property at Barbers Point. So we're in negotiations with them, and we think that we're going to get some decisions about that from the Navy within the next couple of months.

As I talk to the engineers, they tell me that we're much better off if we take an old existing building, we have looked at it, and it will be less costly for the government to do this than to try to go out and start from the beginning in building another facility. So we think this is the best decision to keep pushing ahead on the Barbers Point issue.

Senator AKAKA. Well, thank you very much, Dr. Hastings.

Mr. Aument, I appreciate your willingness to travel to Hawaii to participate in this hearing, and I want to thank you for your service to our Nation's veterans. Around 33 percent of rating claims at the Honolulu Regional Office have been pending for more than 180 days. This is the highest in the Western Area, as I understand.

Please explain the factors that have contributed to the already overburdened RO's problems with timeliness and adjudicating claims for compensation and what VA can do to reverse this.

Mr. AUMENT. We share your concern with that particular issue, Mr. Chairman, the timeliness of the pending claims for the regional office. I think there are three factors that we can point to that are largely responsible for this, and I believe we're trying to do something about each and every one of them.

First of all, number one, is making sure that we have an adequate workforce in place at the regional office to make sure that we're prepared to provide timely service to the veterans ourselves from the Veterans Benefits Administration perspective. As I mentioned earlier in my testimony, we've increased the staff already this year by 10 percent. We've really actually reached the limits of the physical capacity to add staff to the office, but we stand ready to add the additional staff if we find that the increase so far is insufficient.

Number two, we've been particularly challenged in obtaining transitioning servicemembers' military records. In particular, their service medical records. I am told by Dr. Wiebe, the Director of VISN 21s, that this had been a particular challenge for the servicemembers filing claims from Guam which have added to the overall timeliness of the office.

We're working very diligently to try to improve that relationship. We've recently entered into a Memorandum of Agreement with the National Guard units where we've been particularly challenged with the Guard and Reserve units obtaining those records. I believe that we're moving forward to try and improve that relationship.

Third, the final item is with the timeliness of our medical exams. We've heard before the difficulties in some cases of recruiting and maintaining medical support here in the Pacific Islands region. We've been working very closely with Dr. Wiebe and others to address this issue. And Dr. Wiebe even this morning assured me that, by the end of this year, he expects to be able to have the timeliness of the exams provided in this area up to the national standard.

Senator AKAKA. Thank you for your comment.

Dr. KUSSMAN. Mr. Chairman, I had a chance to talk to Dr. Hastings yesterday about this and he's working very aggressively making adjustments getting more space to do it and more people. And as Ron mentioned, I believe, Jim's got this under control and next time we talk, it won't be a problem.

Senator AKAKA. Thank you. I also want to say that I've heard from the Representative from Samoa and, apparently, he tells me that Samoan veterans are having problems as well. I'm sure you know about that, but I just want you to know that he did speak to me about that. I just want to say Dr. Wiebe also has been helpful in these areas.

Under Secretary Tuerk, I'm very pleased that VA recognizes the importance of Punchbowl to Hawaii's veterans. And of course, your comments and remarks today about what you are doing, please us greatly.

Can you please elaborate on the plan to provide additional niches at Punchbowl?

Mr. TUERK. I'd be delighted to elaborate on the plan, Mr. Chairman. I think the old adage that a picture is worth a thousand words might apply here. If you'll bear with me for a second, I'll show you what we intend to do.

Senator AKAKA. Thank you.

Mr. TUERK. Thank you, Mr. Chairman for your forbearance. This, as you can see, is a satellite image of the National Memorial Cemetery of the Pacific. The entrance is down here, the memorial is right here.

The existing columbarium at the cemetery is shown right here. You asked me this morning—and you asked me last December—whether we would study the feasibility of how we might expand columbarium space in the National Memorial Cemetery of the Pacific. This is what we've come up with.

We have four distinct possibilities for expansion, each of which I'll show you on a separate chart. Chart number one shows the existing columbarium. You'll notice it stops here. Our first plan—and the plan that I've already commissioned a design for—is to extend the existing columbarium space up further into the cemetery. That project, which we are committed to doing in fiscal year 2008 so long as we receive funding, will add another 1,265 niches to the cemetery's inventory and will buy us another couple of years. We currently have an inventory, as of the close of business yesterday of 1,845 niches. So this new capacity added to the 1,800 that currently exist will get us about an additional 5 years worth of inurnments at the National Memorial Cemetery of the Pacific.

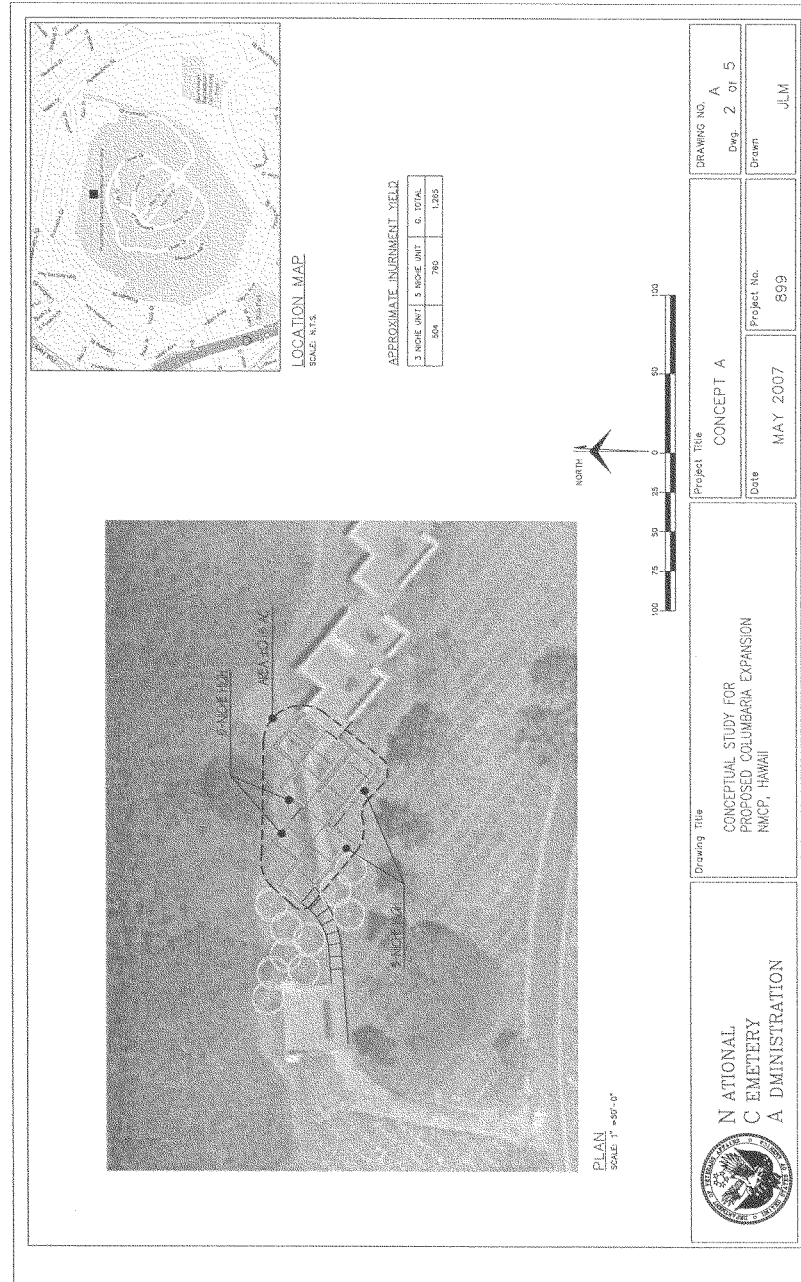
An additional proposed project will be to take the existing columbarium that extends up the perimeter of the cemetery just below the Punchbowl's rim and to add further niches on the backside and on the outside of the walls that currently house the niches. So, for example, whereas here we have columbarium niches only within these courtyards, we can add niches to the exterior walls on both the back and, I believe, the frontside of those walls. The addition of niches to the front side is not shown in this diagram but my inspection of the site yesterday revealed to me that might be a possibility. Just adding niches on the backside we can gain another 2,000-plus niches and an additional four to five years time to extend the time frame of available niches at cemetery.

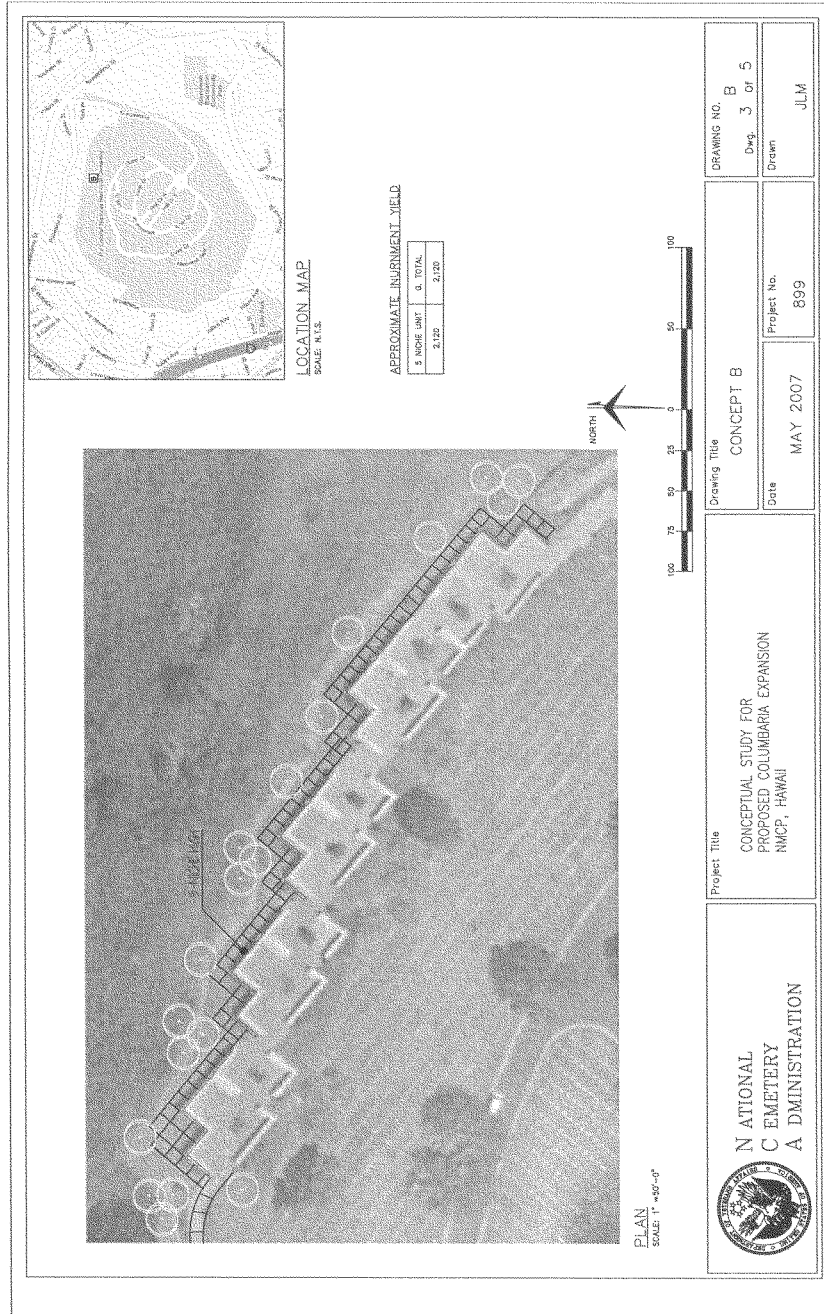
Option C. If you recall, Mr. Chairman, as you approach the memorial to the left here below the rim, there's a very, very steep slope. We propose here to terrace into the slope below the road and have stairs coming down to a terraced columbarium down from the road. There would be, first, a corridor here with niches on both sides. Additionally, there would be a second corridor on the cemetery side of the rim with an additional row of niches along here. This concept would add almost 5,000 additional niches and at current burial rates, that would buy us approximately eight additional years of life in the cemetery.

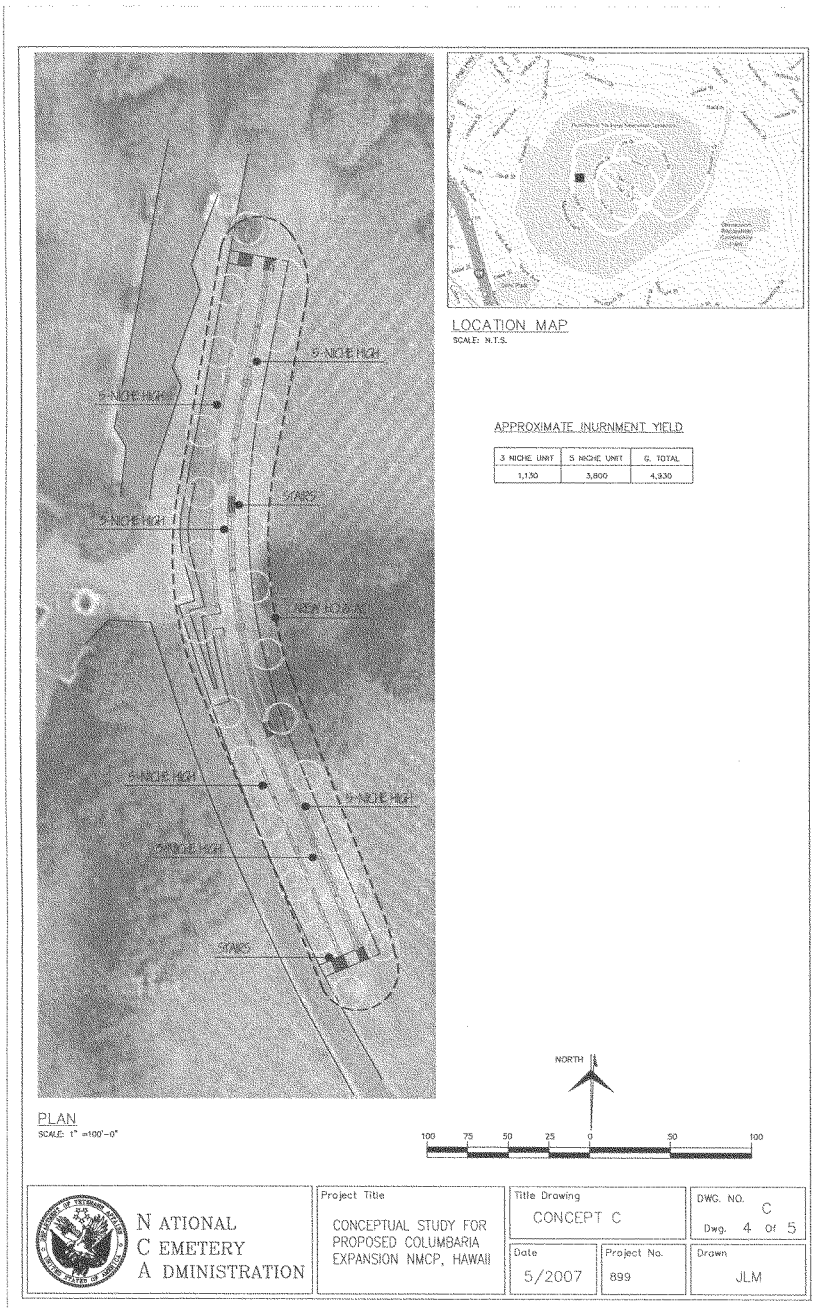
And finally, Mr. Chairman, we have a fourth concept and that is marked on this map as option D. I might add parenthetically these are labeled A, B, C and D. We might not progress in that precise order, though project A will be the first one that we will do. These are four alternatives. This one is rather straightforward. Our administration building is located right inside the gate to the right as you enter the cemetery. It's an aging facility. It's an inadequate facility. It's an inappropriate facility. We have had under consideration for time the idea of demolishing it and building a new one.

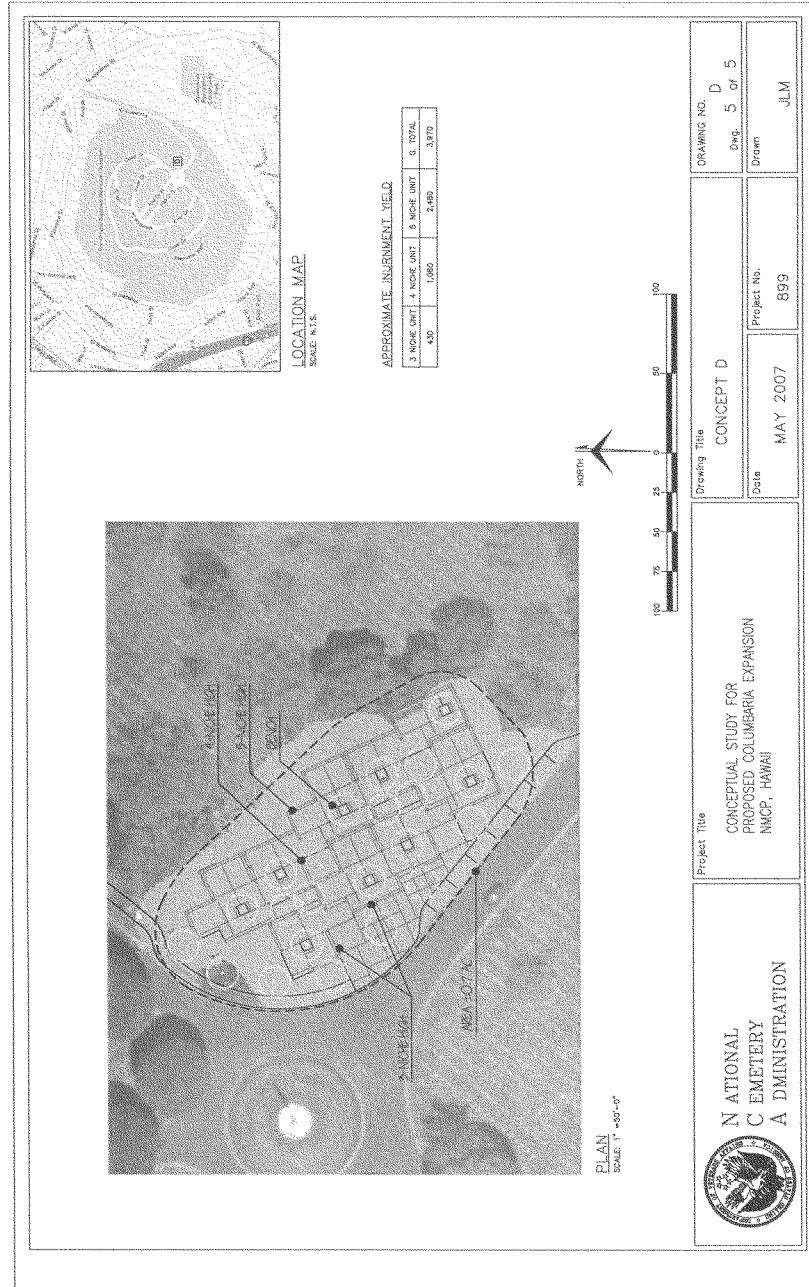
The new thought that we have is to demolish the current administration building and use the land inside the cemetery grounds to build additional columbaria inside the cemetery gate. Now the question might arise what then happens to the administration building? We're now studying the feasibility of building a new administration building outside the gate so that we can preserve the precious land within the crater itself for burial spaces.

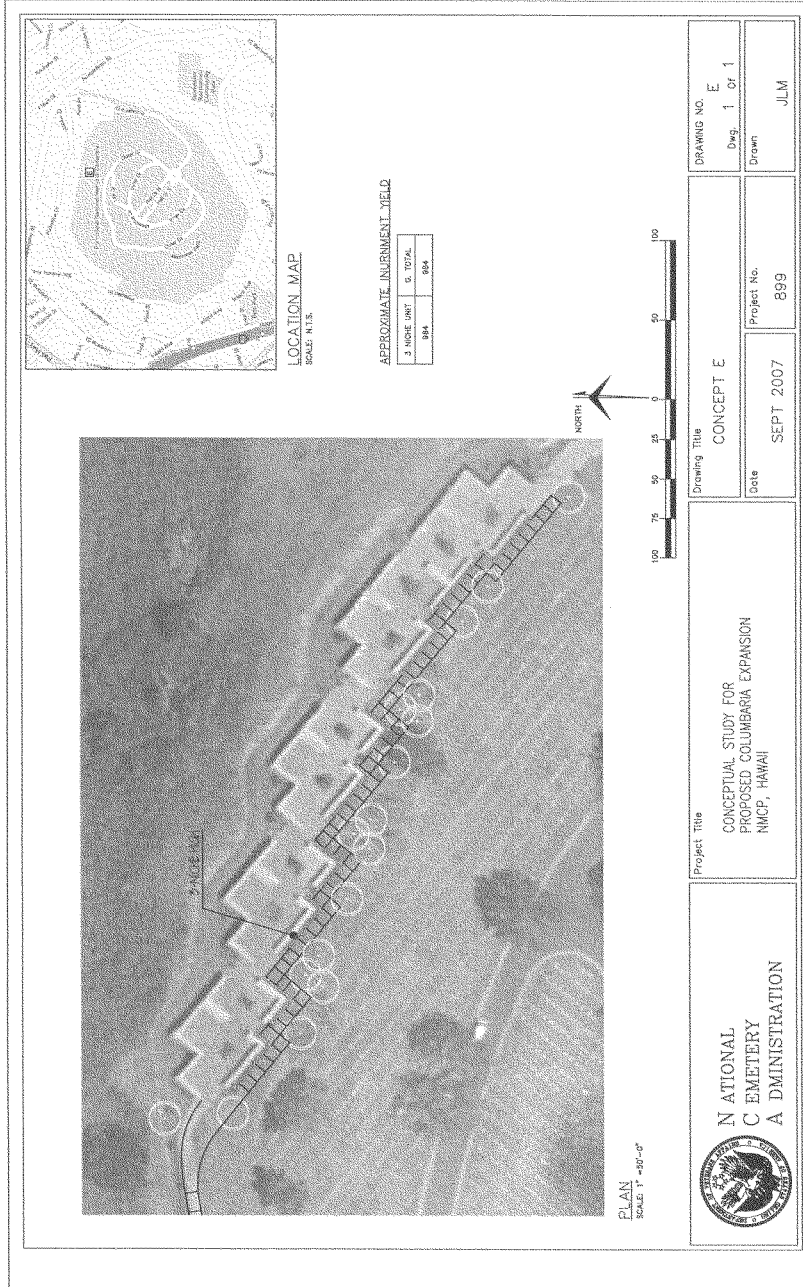
[The satellite images of the National Memorial Cemetery of the Pacific follow:]

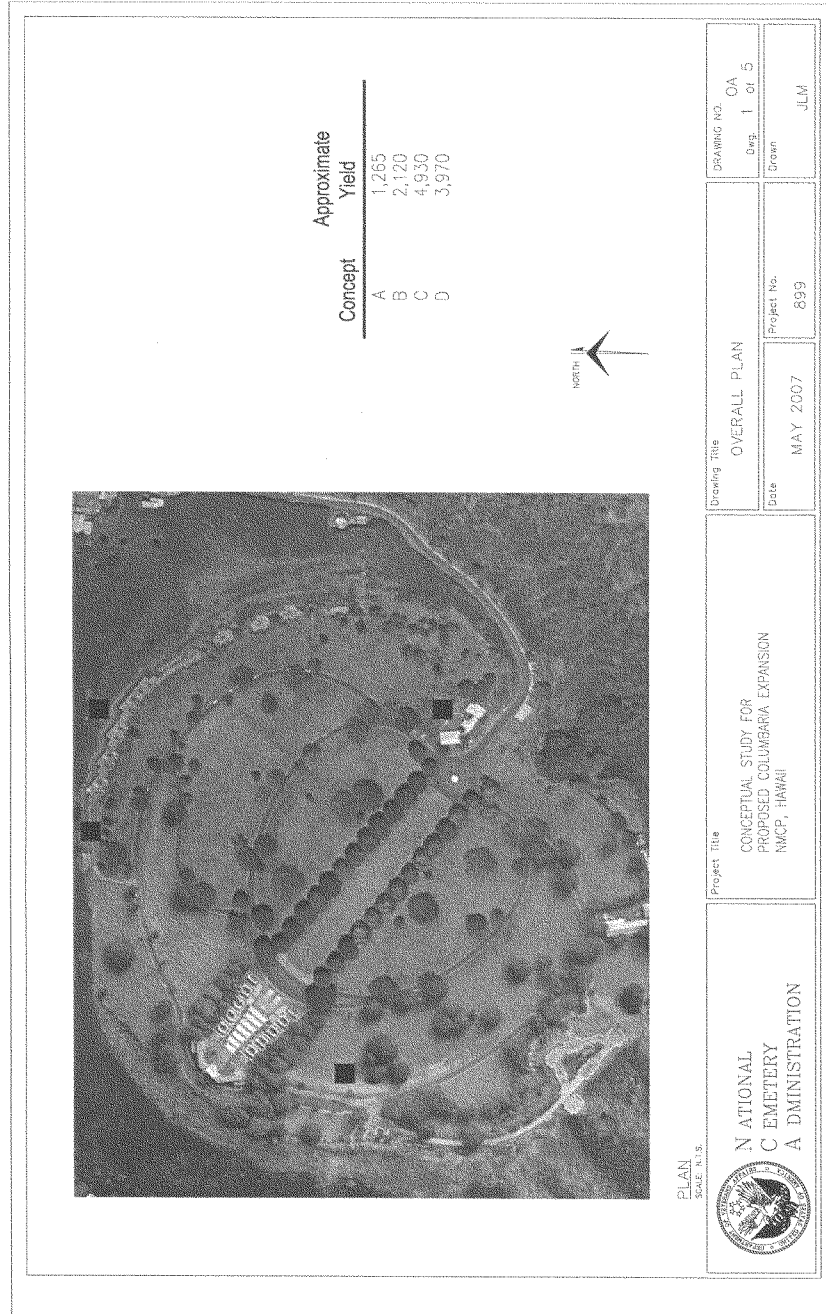












So in summary, Mr. Chairman, with these four concepts—with at least these four concepts and we're receptive to other ideas—we anticipate that we can add 12,000 additional niches or more which would allow the cemetery to conduct inurnments into the future for another 20 years.

Senator AKAKA. Thank you very much, Under Secretary Tuerk. Thank you for that presentation.

The AUDIENCE. (Applause.)

Senator AKAKA. Ms. Watrous, have you conducted oversight visits in other VA facilities that use DOD sharing agreements to provide a significant share of veterans care, as is the case in Hawaii? Do you see the same issues at those facilities?

Ms. WATROUS. Yes, Mr. Chairman. In my territory, I have two other large sharing agreements. One is in Anchorage and the other is in Las Vegas, and I have seen very similar situations in terms of the electronic medical record and also with access to care issue.

In the best of times, the consistency issues are not optimal because of the regular deployments on the military side. In this time of war, there are certain higher degrees of difficulties that both sides experience. So yes, I have seen the same issues. Those are the only two I can speak of.

Senator AKAKA. Thank you very much.

Dr. Hastings and Dr. Wiebe, I'm concerned about the overcrowding at the Center for Aging in Honolulu. I understand that this facility is at full capacity. Compounding this problem, few options exist for aging Hawaiian veterans outside of VA. What is VA doing to meet the high demand for nursing home services?

Dr. HASTING. Thank you, Mr. Chairman. As you know, Hawaii has a very extreme problem with long-term care perhaps the most challenging in the country. And we, of course, are no different. We are working very diligently at trying to develop our noninstitutional care. And as you heard the testimony today, we have significantly increased our ability to increase this noninstitutional care. And we're going to continue to try to do that. The VA is very interested in this, and we're getting a lot of support and we're putting resources into it and so I think that's going to help us out a great deal.

We are also working with Tripler to look at trying to get some more beds that we can use for an intermediate care ward which would give us a little more flexibility and give Tripler a little more flexibility. Many of our hospitals in Hawaii cannot place patients and Tripler is one of them.

As a result, beds are held for patients that can be placed. So we are in the process of studying with Tripler the possibility of getting a ward there that we can operate which would also give us more flexibility and allow us to use more of the resources at Tripler for acute care patients.

The other issue, of course, is that we are trying to contract with nursing homes. Since the last hearings, we have had two more nursing homes that we were able to work with and develop agreements with so that we can place veterans. And of course, the big issue is the new veterans homes in Hilo that we have been very much involved with. It's a state home, but we are looking at it. And

hopefully, this process of looking at some other homes in the state will be able to take place in the future. Thank you, sir.

Senator AKAKA. Thank you, Dr. Hastings. Dr. Wiebe has been a part of this effort.

Dr. Wiebe, do you have any comments to make at this time?

Dr. WIEBE. Mr. Chairman, just to add one other option we're looking at to extend long-term care services and that's to use telehealth. As you know with the island geography, telehealth is especially applicable here in the islands. And so we're looking at telehealth technologies not only for long-term care, but also for our specialty services.

As you know, VA has a very aggressive telehealth program where we can put devices in the homes of the veterans and have daily contact with the veterans and their caretakers to help them stay at home where otherwise they would have to be in institutions. So we appreciate the leadership that you and your colleagues here in Hawaii have provided in the telehealth arena and these applications are being extended across the United States. Again, thank you, Mr. Chairman.

Senator AKAKA. Thank you very much, Dr. Wiebe.

May I ask Dr. Kussman for any final comments?

Dr. KUSSMAN. Well, sir, again thank you very much for inviting us. We very much appreciate your leadership on the Senate Veterans' Affairs Committee, and we very much appreciate the partnering that we do together. And again, Mahalo.

Senator AKAKA. Thank you very much, Dr. Kussman. I want to thank this panel very much.

As you know, this is a high-ranking panel that we have before us today. And I want to thank them for coming out to Hawaii to testify as they have. As you have heard, they are really making a difference in helping our veterans in Hawaii and across the country, as well. Without question, all of us, as was mentioned, are partners in trying to bring this about. The Senate, the Congress, the Administration and VA have been working at this and will continue to do that, so it is great to hear from you all.

I want you to know that I have more questions, but we do not have the time, so we will include them in the record for this panel. So I want to thank you again very much for your appearance today and for coming to Hawaii to testify.

The AUDIENCE. (Applause.)

Senator AKAKA. Now, I would like to invite the third panel to come forward. The hearing will be in order.

I want to welcome our third and final panel of witnesses. First I welcome Colonel Arthur Wallace, Deputy Commander for Nursing of the U.S. Army Pacific Regional Command at Tripler Medical Center. I also want to welcome General Robert Lee, Adjutant General for the State of Hawaii Department of Defense. And finally, I welcome Mark Moses, Director of Office of Veterans Services for the State of Hawaii. I want to thank the panel for being here. Your full statements will appear in the record of the Committee.

Colonel Wallace, will you please begin with your testimony.

COLONEL ARTHUR P. WALLACE, DEPUTY COMMANDER FOR NURSING, TRIPLER ARMY MEDICAL CENTER; ON BEHALF OF MAJOR GENERAL CARLA HAWLEY-BOWLAND, COMMANDING GENERAL, TRIPLER ARMY MEDICAL CENTER (TAMC) AND PACIFIC REGIONAL MEDICAL COMMAND

Colonel WALLACE. Aloha, Mr. Chairman.

Aloha on behalf of Major General Hawley-Bowland who's currently off island. Thank you for the opportunity to share information about the collaborative relationship between Tripler Army Medical Center and the VA Pacific Islands Health Care System. At this time, I would like to submit my written testimony for the record.

Senator AKAKA. It will be included in the record.

Colonel WALLACE. Thank you. Mr. Chairman, Tripler represents the largest military medical treatment facility in the entire Pacific Region providing medical support to nearly 450,000 beneficiaries. Our partnership with the Veterans' Administration here is the largest integrated joint venture in the Nation.

What was initially conceived as a small veterans hospital adjunct to the military medical center is now a vast \$20 million sharing agreement spanning inpatient medical, surgical and psychiatric services, as well as outpatient specialty services and non-medical support such as security, meals, and housekeeping.

Within the past year, the VA relocated the Post Traumatic Stress Disorder (PTSD) Residential Rehabilitation Program or PRRP from Hilo to Tripler. The current PRRP program admits both veteran and active duty patients as a cohort group and provides a 7-week program of integrated treatment. In the past year, we've also signed several new sharing agreements including provision of central sterilization support for the ambulatory care clinic at Matsunaga, provision of meals to the VA Center for Aging, and several agreements supporting joint clinical research projects.

Our dedicated staff continues to identify and develop new initiatives to provide a seamless transition between our organizations. As mentioned earlier by Dr. Hastings, we are planning to create the shared same day surgery center in 2009. On a daily basis, VA patients represent a noteworthy part of Tripler's workload. Last month, approximately 22 percent of our hospital average daily census and 29 percent of our average daily admissions from the emergency room were veterans. Also the VA operated psychiatric inpatient ward averaged nine psychiatric veterans as patients daily.

Over the years, additional clinical staff have been hired to accommodate the growing VA workload. This year, we also started to imbed VA providers into Tripler specialty clinics to add stability and support of VA requirements and Graduate Health Education programs. These providers are now evident in our hospitalist program, ophthalmology and orthopedic surgery with plans to continue to evaluate other areas for expansion. For the military, caring for veterans represents a commitment to sustain the services provided when they were on active duty. We must remain competent and caring for acutely ill patients through our Graduate Health Education programs.

Recently several new initiatives have occurred under the Joint Incentive Fund Program including state-of-the-art computer aided

system for orthotics and prosthetics with tele medicine capability, a chronic dialysis center for veterans, and a joint pain management improvement project. These initiatives will improve access to care to our joint beneficiaries and decrease wait times. Last week, two new Joint Incentive Fund Programs were approved. These include a sleep study laboratory and an integrated pain management program. Our ongoing joint demonstration project establishes technical improvements in how we exchange information for referrals and clinical documentation.

This year, the Army Medical action plan has placed emphasis on care of our warriors in transition and the seamless transition to care under the Veterans Benefits Administration and Veterans Health Administration. Our programs in support of returning warriors and our ties between Tripler and the VA have been longstanding and well established. We assigned case managers to all returning wounded and had specialized treatment programs such as our Soldier and Family Assistance Center at Schofield Barracks providing a whole range of behavioral health and advocacy programs.

We have had representation from the Veterans Benefits Administration on our Patient and Family Assistance Team since inception. Our case managers work daily with the Veterans Benefits Administration and Veterans Health Administration to foster a smooth transition to VA benefits, including health care. The Oahu Joint Executive Council's Behavioral Health working group, which includes the VA, is taking a greater role in determining needs for PTSD and mild Traumatic Brain Injury or TBI. Tripler recently launched training for all military personnel on recognizing PTSD and mild TBI to encourage self-reporting and referrals of OIF/OEF soldiers and reduce the stigma associated with reporting. This field is an excellent opportunity for DOD and VA collaboration, and we are already moving forward with such joint planning.

As with most larger type activities, there continue to be challenges. We need interoperability of health care computer systems between DOD and the VA to coordinate patient care and conduct financial business. Lack of integrated computerized patient record will continue to cause inefficiency and impact patient care until resolved. In terms of DOD-VA joint venture development, our future is now. This functional integration is just the beginning. The additional opportunities for improved coordination and cooperation are numerous. Achieving these goals will be dependent upon obtaining needed policy, program and resource support.

There is local VA and DOD top management support to make Tripler a model joint venture site. We must address and resolve the challenges to achieve our ultimate goal: High quality care for our beneficiaries in a seamless health care system.

Thank you, Mr. Chairman, for this opportunity to share our thoughts and this important topic. Mr. Chairman, I'm now ready to take any questions.

[The prepared statement of Colonel Wallace follows:]

PREPARED STATEMENT OF COLONEL ARTHUR P. WALLACE, DEPUTY COMMANDER FOR NURSING, TRIPLER ARMY MEDICAL CENTER; ON BEHALF OF MAJOR GENERAL CARLA HAWLEY-BOWLAND, COMMANDING GENERAL, TRIPLER ARMY MEDICAL CENTER (TAMC) AND PACIFIC REGIONAL MEDICAL COMMAND

Mr. Chairman and distinguished Members of the Committee, on behalf of Major General Hawley-Bowland, Commanding General of Tripler Army Medical Center (TAMC) and Pacific Regional Medical Command who is visiting medical facilities in the Pacific Region, thank you for the opportunity to share information about the collaborative relationship and initiatives under the auspices of the Department of Defense (DOD)-Department of Veterans Affairs (VA) Joint Venture in Hawaii. I represent the largest military medical treatment facility in the entire Pacific Basin. TAMC's area of responsibility spans more than 52 percent of the entire Earth's surface and provides medical support to nearly 450,000 beneficiaries, including Active Duty Service Members of all branches of service; their eligible Family Members; military Retirees and their Family Members; Veterans; and many Pacific Islands Nation Residents.

In 1991, Under Secretary of the Army and the Deputy Secretary of Veterans Affairs approved the basic concept of a Joint Venture for Hawaii. What was initially conceived as a small veteran's hospital adjunct to the military medical center, is now a vast \$20 million sharing agreement spanning inpatient medical, surgical and psychiatric services, as well as outpatient specialty services and non-medical support, such as security, meals and housekeeping. Beginning in 1997, the VA began to relocate administrative and health care services to the TAMC campus. Construction and renovation to portions of the medical center infrastructure have resulted in both new and relocated veteran services on the Tripler campus, including an inpatient psychiatric unit, a new parking structure, the Center for Aging, the Ambulatory Care Clinic and renovation of the E-Wing of TAMC for both the Veterans Health Administration and Veterans Benefits Administration (VBA) administrative functions. The relocation of the Post Traumatic Stress Disorders (PTSD) Residential Rehabilitation Program (PRRP) from Hilo to TAMC has been a very successful initiative. The current PRRP program admits both Veteran and Active Duty patients as a cohort group, and provides a 7-week program of integrated treatment, including but not limited to PTSD symptom management, communication skills, anger management, relaxation training, behavior therapy, trauma focus therapy, adjustment counseling, substance abuse and relapse prevention treatment, and general health education. The relocation of the VA to the TAMC campus has resulted in increased workload for both TAMC and the VA Pacific Islands Healthcare System (VAPIHCS). We continue to move forward, using joint strategic planning sessions. New initiatives currently underway today include planned additions for a new facility for the Post Traumatic Stress Disorder (PTSD) Residential Rehabilitation Program in 2008, a shared Same Day Surgery Center in 2009, and a proposed inpatient tower at TAMC to consolidate nursing units.

A collaborative effort of this magnitude requires diligent planning and oversight. Both the VA and TAMC have dedicated staff to ensure the exploration and development of joint efforts. On a daily basis, VA patients represent a large part of our workload. For example, last month my hospital's average daily census was 151 patients. Approximately 33 of those patients, or 22 percent, were veterans. Additionally, 29 percent of our admissions from the emergency room were veterans. The VA-operated psychiatric ward averaged nine psychiatric veterans as patients per day.

Over the years, additional clinical staff have been hired to accommodate the growing VA workload, forming a reliance on the reimbursement from the VA. We have also begun a new program of embedding VA providers into specialty clinics to add stability and increased workload to support the Graduate Health Education programs. These additions are now evident in our hospitalist program, in ophthalmology and in orthopedic surgery. There are plans to continue to evaluate other areas for expansion.

While reimbursement is essential to a successful DOD/VA partnership, it is not the primary motivation. For the military, caring for veterans represents a continuation of the services we provided when they were Active Duty. Our ultimate status will be as veterans. Another dimension of caring for the veteran is that the illnesses and surgeries associated with aging are very relevant to keeping Active Duty medical personnel trained and ready for our battlefield mission. We must remain competent caring for acutely ill patients. At Tripler we have a robust Graduate Health Education program spanning 10 different medical specialties and training 220 individuals per year. Our graduate medical education occurs in Orthopedics, Radiology, Urology, Medicine, Obstetrics and Gynecology, Psychiatry, ENT, Pediatrics, Family

Practice and General Surgery. We have found that these programs benefit from caring for the veterans population.

Recently several new initiatives have been undertaken under the Joint Incentive Program and the Joint Demonstration Project. Development of several Joint Incentive Fund proposals totaling \$4 million have been completed and funded including a state-of-the-art computer-aided design/computer-aided manufacturing system for orthotics and prosthetics with telemedicine capability, a chronic dialysis center for veterans and a joint pain management improvement project. All three of these initiatives will improve access to care to our joint beneficiaries and decrease wait times. We have submitted two additional Joint Incentive Fund projects—one for a joint sleep study lab and a second for an integrative medicine approach to pain management. These two projects are pending approval and funding at this time. The Hawaii Collaborative was also selected as one of eight sites to serve as a demonstration project. Our Joint Demonstration Collaborative proposes to meet the need of establishing a structure and process to jointly assess, execute, and evaluate improvements in Referral Management, Fee Authorization, and Document Management. The collaborative expects to garner benefits from these demonstration studies including transparent tracking of consultations and authorizations, as well as improved access to documents for information exchange between our organizations for improved continuity of patient care.

We continue to explore opportunities and initiatives that allow Tripler and VA to share staffing. In the past year, we've signed several new sharing agreements, including provision of Central Sterilization support for the Ambulatory Care Clinic, additions of VA specialists in ophthalmology and orthopedic surgery, provision of meals to the VA Center for Aging and several agreements supporting joint clinical research projects. We have also undertaken a joint approach in planning for pandemic flu response. Our dedicated staff continues to identify and develop new initiatives including joint decontamination support, joint purchase of medical supplies, evaluation of a VA transitional/subacute care unit and increased attention to the seamless transition between our organizations for our Warriors in Transition.

This year, the Department of the Army, through the Army Medical Action Plan (AMAP), has placed a lot of emphasis on care of our Wounded Warriors and a seamless transition from Active Duty military service and the Military Health System to care under the Veterans Benefits Administration and Veterans Health Administration. Our programs in support of returning Wounded Warriors and our ties between TAMC and VBA and VAPIHCS were well established even before the advent of the AMAP. We assigned Case Managers to all returning wounded and had specialized treatment programs such as our Soldier and Family Assistance Center at Schofield Barracks which provides a whole range of behavioral health and advocacy programs. We have had representation from VBA on our Patient and Family Assistance Team since inception and our Case Managers work daily with the VBA and VAPIHCS to foster a smooth transition to VA benefits including health care. We have also had VAPIHCS as a partner in our Multi-Service Market Management Office-sponsored Joint Executive Council and subordinate working groups. At these forums, we explore healthcare options for Veterans, past and future. One key group is the Behavioral Health Working Group which is taking a greater role in determining needs for PTSD and mild Traumatic Brain Injury (TBI) to serve the greater Hawaii market of eligible beneficiaries. Under the AMAP directive, Tripler has launched training of all military personnel on recognizing PTSD and mild TBI and to encourage self reporting and referrals of others returning from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF). Additionally, our Social Workers, Case Managers, Psychiatric Nurses and Psychiatric Nurse Practitioners are taking more focused clinical training courses. We are also adding Neuropsychologists and other clinical staff to assist with diagnosis and treatment. This area of urgent need is an excellent opportunity for DOD and VA collaboration and we are already leaning forward in our planning.

As with most merger type activities, there are barriers that impede unfettered, efficient coordination. I believe, however, most of our Joint Venture barriers are systemic in nature. These barriers include:

- (1) The separate VA and DOD healthcare information systems which make data sharing difficult. We need interoperability of healthcare computer systems between DOD and the VA to coordinate patient care and conduct financial business. Our demonstration project addresses a portion of the identification and business processes that will support the joint revenue process. However, we cannot continue to conduct business without commercial-type claim processing software and support. Currently, development and release of the Charge Master Based Billing module has been put on hold indefinitely. As patients move between Tripler and the VA, the

lack of an integrated, computerized patient record causes inefficiency and staff dissatisfaction.

(2) Lack of venture capital to invest in joint initiatives. We cannot pool our resources to spend for a common need. While the Joint Incentive Fund is one-step in this direction—and we have taken advantage of funding available through this program since its inception in 2004—the application and reporting processes are time consuming and complex. Again, without truly dedicated staff, many good proposals do not come to fruition due to our inability to jointly address the requirements.

(3) Business processes associated with Joint Ventures are not well defined at the VA and DOD enterprise level and impair efficient coordination locally. National guidance must be developed based on the needs of sharing sites which considers cost analyses and feedback whenever possible. Some of these processes have financial implications that cause delays in billing and payment. When there are billing and payment issues, ultimately there are cash-flow problems.

(4) Other valid business process questions and issues related to the management of the TRICARE program. For example, do VA patients compete with TRICARE patients in DOD? For TRICARE Prime, this is not an issue because by law Prime patients have precedence. Should the medical treatment facility commander dedicate capacity to TRICARE eligible beneficiaries or commit resources to caring for VA patients? This has long been a point of contention with VAPIHCS, as they desire dedicated support from military MTFs. Lack of this dedication at Joint Venture sites undermines the premise of sharing and generates additional costs when access levels cannot be maintained resulting in sporadic need for high cost contracted support. The eligibility rules and associated entitlements for the VA's categories of veterans and dual eligible beneficiaries are complex and constantly changing. This complexity is compounded when such patients seek care at a joint venture site. We need to establish joint service units at these sites to not only help these patients understand and make informed choices but also to more efficiently evaluate the need for available resources and track their use.

(5) Lack of policy guidance for dual eligibility. We don't need to require patients to choose between an entitlement to a military medical retirement benefit and a VA benefit but we do need to have the authority to coordinate access to the respective benefit. If we do not, we have patients duplicating services by seeking care from both systems. This increases the costs of providing care to both DOD and VA, and also results in patient safety concerns.

(6) Neither DOD or VA has established accountability and responsibility for the success of joint ventures. Jointly we need to develop metrics and a business strategy that reflect good stewardship of the resources invested in both systems.

(7) Competition between the convenience of healthcare that is available locally and the Veterans Integrated Service Networks' (VISNs) regional investment in healthcare delivery services produces a barrier to local coordination. For the VISNs it is an out-of-pocket cost when they pay DOD rather than use their own facilities. VISNs are structured and funded using a concept whereby satellite medical centers are supported by one or two flagship medical centers. In our case, Honolulu is a satellite center and their flagship facilities are in California at Palo Alto and San Francisco. Emergent care is provided at Tripler and, if necessary, within the local community. Non-emergent care is referred to the California facilities. The current VA resource allocation system does not provide additional dollars for VISNs to allow satellite centers to seek a significant amount of care from non-VA providers.

Despite the systemic barriers we confront, we continue to work together diligently to devise local solutions. Wherever possible, we have leveraged advances in technology to provide seamless flow of information. We have incorporated Pharmacy Bi-Directional Data Interchange, Common Data View through a program called "Janus" and Laboratory Interoperability. The Pharmacy Bi-Directional Data Interchange allows both DOD and VA providers to order and receive prescriptions from either information system. The common data view presents patient data (demographics, lab, pharmacy, etc.) on a common computer screen. Finally, the current laboratory interoperability allows lab orders and results to be communicated between both systems. We look forward to expanding this program in the near future. The common goal of these initiatives is to improve patient care by developing interfaces to allow the electronic sharing of pertinent patient information between the VA, DOD and other clinical data providers.

In terms of DOD/VA joint venture development, our future is now. We are ahead of most localities in that we are already one of the most functionally integrated joint ventures. Instead of two freestanding medical centers, we have only one emergency room; one inpatient medical, surgical, and psychiatric service; and essentially one major specialty outpatient service. We have integrated clinical services for psychiatric on-call support, hospitalist support, ophthalmology, orthopedic surgery, ne-

phrology support and psychology services. However, this functional integration is just the beginning.

While we are ahead of most of the other joint venture sites in the Nation in developing our sharing agreements and establishing policies and procedures, there are still opportunities for continued development of our joint venture. The two key determinants when developing opportunities for improved coordination are expansion of our patient care services to care for more patients and elimination of redundant overhead. We have worked diligently to develop initiatives for VA chronic dialysis, shared pain management resources and expanded orthotic/prosthetic support to veteran patients through the Joint Incentive Fund. However, additional opportunities for improved coordination and cooperation are numerous. Achieving these opportunities will be dependent upon obtaining needed policy, program, and resource support.

There is local VA and DOD top management support to make Tripler Army Medical Center a model joint venture site. In this respect, countless hours have been invested by both activities to improve our joint venture. In order to perpetuate sharing between VA and DOD entities, national initiatives applicable to all types of sharing should be developed, providing guidance and policy on dual-eligibility, authorization, and reimbursement. Venture capital monies should be allocated for developing proposals and procuring dedicated joint venture staff. Information systems must be evaluated for applicability to sharing, and solutions to systemic issues should be identified and resolved expeditiously. We must address and resolve the barriers described if we are to achieve our ultimate goal—high quality care for our respective beneficiaries in a seamless healthcare system.

Senator AKAKA. Thank you very much, Colonel Wallace.

The AUDIENCE. (Applause.)

Senator AKAKA. Now, we will receive testimony from Major General Robert Lee.

**MAJOR GENERAL ROBERT G.F. LEE,
ADJUTANT GENERAL, STATE OF HAWAII**

General LEE. Good afternoon, Chairman Akaka, I want to personally thank you on behalf of all the veterans in the State of Hawaii and the members of the Armed Forces for your superb work not only as Chairman of the Veterans' Affairs Committee, but your hard work on the Senate Armed Services Committee that we all appreciate especially during these difficult times. I know men and women in uniform always count on you and Senator Inouye for the top level support for all of us. Mahalo again.

We have five divisions in the State Department of Defense, and you help all of us out. From the big ones like the Army and the Air National Guard to our smallest Youth ChalleNGe Academy where we turn around at-risk kids, we thank you very much for it. Today, Mark Moses, the Director of Office of Veterans Services will talk a lot more on that. On behalf of Governor Lingle, thank you very much, the Office of Veterans Services of the State of Hawaii can interface with VA at the Federal level to make transition as seamless as possible and to make sure our veterans that reside in the State of Hawaii get their full benefits.

Let me talk about the veterans in the State of Hawaii. Currently, the numbers run about 10 percent of our population, our veterans who have served in the Armed Forces of the United States and other recognized agencies. But over the past decade we saw a decline in the number of veterans in the State of Hawaii. Primarily from the great World War II veterans such as yourself, Senator, I'm kind of losing my friends in Club 100 and the 442nd Veterans Club and all my friends in the other veterans organizations throughout the state.

But after September 11, the downturn stopped. Primarily with our National Guard and Reserve troops being called up at unprecedented levels and even active duty folks from the State of Hawaii serving on active duty in Iraq and Afghanistan and returning home, the trend now goes up and we need all the veterans services that the previous two panels talked about.

In the Hawaii National Guard, both Army and Air on the Army side of the house, nine out of our ten soldiers wear a combat patch. They have already served in Iraq and Afghanistan. We got a smaller group right now. We have 75 soldiers from the Hawaii Army Guard with their brothers from 1st Battalion, 158 infantry, 29th Brigade Combat Team currently hunting down the Taliban on the Afghan/Pakistan border. At the same time, we have our Black Hawk Unit, Charlie Company 207 aviation that provided the medical airlift this past year. They're now in Bilad in the center of the Sunni Triangle providing the airlift that Senator Inouye talked about for our troops should they run into trouble. We also have two dozen airmen from the Hawaii Air National Guard from the Civil Engineering Squadron recently deployed to Iraq. Although smaller numbers than before in 2005, absolutely critical in the War on Terror, the Hawaii National Guard is doing their part just like all the other Reserve forces in the State of Hawaii.

So we must ensure that these veterans from the Guard and Reserve when they return home to their civilian lives, they also can transition back from military duty to civilian life in good health. And our Office of Veterans Services enjoys a great partnership with Hawaii VA Administration, and they're with us every step of the way especially during the demobilization of our soldiers when they come off active duty.

Right now we're pretty sure that none of our soldiers or airmen will have their benefits fall through the crack because our government has an obligation to our military members from when they first enlisted through the service years to veterans benefits and finally their death benefits—they're entitled to all that they are due today and in the years to come.

I want to point out that the National Guard Bureau headed by General Blum recently authorized both the Army and the Air National Guard to release medical records to the Department of Veterans Affairs without the veteran's signature.

So Mr. Aument, I'd like some feedback whether that's working or not, and I noted your concern about lack of medical records from Guam. I'm going to see my colleague General Goldberg this weekend, and I'll mention it to him. I just wanted you to know that the medical records may be kind of lacking because all of the Guam National Guard soldiers serve all of the current rotations in Africa. As you know, the medical facilities are not as robust in Africa like in Iraq or Afghanistan. But I will surely bring this up to General Goldberg. So I'd like really some feedback whether this is working better to make sure that the records from the National Guard are reaching the Department of Veterans Affairs, and I can help to make sure the transition is a lot smoother.

This afternoon, Senator, I want to share a few concerns with your Committee. My most important concern is access to the Veterans' Administration services for all of our veterans. And I want

to talk about Hawaii National Guard's 29th Brigade Combat because it's the Brigade from Polynesia. Although I'm the Adjutant General from the State of Hawaii, it was a Polynesian Brigade from the State of Hawaii, American Samoa, Guam, Saipan, Rota and Tinian that formed the bulk of the force in Iraq.

I'm especially gratified to see finally the opening of a VA clinic in American Samoa, and I know you have facilities in Guam and that they should be beefed up to handle our soldiers from Saipan, Tinian and Rota. Telehealth is real good, but at least just a lot of cases where they need to come to Honolulu, Hawaii and Tripler to see the very expert and great physicians and caregivers in that capacity. And we just need to kind of figure out a better way to bring the injured soldiers and their family members when they need special treatment because it's quite a beauracracy to go through that right now. That's the feedback that I'm getting from my troops all across the board. Senator, I'm sure Congress and Governor Lingle have shared that with you. I've directed our C-17 squadron that flies down to Pago Pago to bring up veterans whenever they can on a space-A (available) basis.

My next concern deals with certification of disability by Department of Veterans Affairs. Rather than, I guess, pick on a wound or, you know, along we discuss the lengthy period of the caseworker taking for a certification of disability, I'd like to make a recommendation, Senator, that we kind of cut through the red tape a little bit. And my recommendation is that, if any soldier earns Combat Infantryman's Badge, shot at, gets a bomb go off close to them and earns a Combat Action Badge and is a combat medic that goes out with the troops, or it's a Marine ground pounded and earns a Combat Action Badge, that we just cut to the chase and recognize the service and the problem that servicemember has. I listened intently to Senator Inouye's World War II recollections about how things were. I can provide the records of all the attacks or the rocket attacks on Bilad with the 29th Division Headquarters and also Camp Victory and the Green Zone and the 29th Brigade Combat Team lost 16 of its 17 brave soldiers to improvise explosive devices.

I want to shed some doubt on the caseworker's ability to say hey, we give you the disability because the bomb went off 50 meters away from you, 500 meters, 1,000 meters, every soldier behaves differently. So my recommendation is to have a combat records on file, not necessarily on the medical side, because, I'll share this with you, in 2005, Brigade Commander General Chavez called me up with the time zone difference, around midnight, to report that a member of the 29th Brigade was killed in action. But at that time, I also was elated because many of the reports that I received say that patrol so and so encountered an improvised explosive device, treated for headache and returned to duty.

You know, no one got killed and I was happy then. But I know a lot more now because it came to my final concern to have adequate staffing at the VA hospitals and clinics, especially in the mental health area, to provide service to veterans who suffer from the delayed effects of PTSD.

It was earlier brought up that when our Guard troops came home, no doubt they wanted to go home to their families. Eighteen

months on active duty, 12 months in Iraq. That's why we have a program to periodically revisit these soldiers, and they're called the Post Deployment Health Reassessment program. But when the 29th Brigade came back and when we did this in early 2006, Traumatic Brain Injury was not part of the checklist. That's why we need to go back out and reconnect with all the soldiers and we have records of this, and you know the proud Polynesian warrior tradition. We're tough. We can take it. I'm OK. Let me go home. We need to make sure we have the opportunity to revisit this.

I'll be meeting with General Blum and my colleagues from the Adjutants General across the 50 states and we're going to recommend that this Post Deployment Health Reassessment not end at the 2-year period beyond active duty because everyone behaves differently. We'd like that extended. I really can't give a recommendation right now extended another year, two, three. I'd like to see how the track history goes. And this is what we're finding out. As I talk to other Guard units, I think the Hawaii National Guard is, as far as the percentage of PTSD, is no different from our active folks that have come back. But yet I've heard other stories like infantry battalions out of New Hampshire 75 percent PTSD after 2 years. So I'd like to keep that option open.

In closing, I want to make a note that all the services received by our soldiers from VA clinics and caregivers have been exceptional, and we thank you for that. We just need to close the gap of getting our soldiers there to you. Thank you very much.

[The prepared statement of General Lee follows:]

PREPARED STATEMENT OF MAJOR GENERAL ROBERT G.F. LEE,
ADJUTANT GENERAL, STATE OF HAWAII,

Chairman Akaka, Senator Craig and Members of the Senate Committee on Veterans' Affairs, I am Major General Robert G.F. Lee, the Adjutant General for the State of Hawaii.

Within the State Department of Defense, there are five major divisions: the Hawaii Army and Air National Guard, State Civil Defense, Youth Challenge Academy, and the Office of Veterans Services (OVS). The Director of Office of Veterans Service is Mr. Mark Moses, a retired Marine major and a former state legislator.

The Office of Veterans Services is the single office in the State government responsible for the welfare of our veterans and their families. OVS serves as the liaison between Governor Linda Lingle and the veterans groups and organizations. They also act as an intermediary between the Department of Veterans Affairs and Hawaii's veterans.

Veterans make up more than 10 percent of Hawaii's total population. The majority of them—about 72 percent—live on the island of Oahu. About 13 percent reside on the island of Hawaii, 10 percent live on one of the three islands that comprise Maui County, and about 5 percent live on the island of Kauai.

Within this large veteran population are many World War II veterans, many members of the famed 100th Battalion and the 442nd Regimental Combat Team. Hawaii's overall numbers were declining because many veterans of this era, most in their 80's, are passing on in large numbers.

But since September 11, 2001, mobilizations have involved nine of every ten Army National Guard and Reserve soldiers. They served honorably in Iraq, Afghanistan and other locations; and have returned to Hawaii after their 12–15 month activations. Air National Guard members have also deployed in support of Operations Iraqi Freedom and Enduring Freedom. Therefore, Hawaii's overall veteran population has increased.

We must insure these new veterans return to their civilian lives in good health. The Office of Veterans Services partners with the Veterans' Administration here during the soldiers demobilization process. This partnership works to insure no one or no benefit falls through the crack.

The United States Government has an obligation to our military members from enlistment, through their service years, to veterans' benefits and finally, death bene-

fits. We must insure that all veterans receive all entitled benefits now and in the years to come.

The National Guard Bureau recently issued a memorandum authorizing both the Army and Air National Guard to release medical records to the Department Veterans Affairs without the veteran's signature. This new procedure speeds the Department of Veterans Affairs adjudication of veterans' claims and provides medical care to Guard members.

I come to you with a few concerns.

My most important concern is the access to Veterans' Administration services to all our veterans, especially, on our neighbor islands and our Pacific Islander veterans from Tinian, Rota and Saipan. In July 2007, a VA clinic opened in American Samoa that supports our veterans there. However, veterans from other Pacific islands must pay the high cost of airline and hotel accommodations to receive follow-on VA medical treatment. In Hawaii, a similar situation occurs when neighbor island veterans must come in to Tripler Army Medical Center or the Matsunaga VA Hospital in Honolulu for treatment. We must work to find a solution to this situation.

My next concern deals with the certification of a disability by the Department of Veterans Affairs. Often a servicemember is awarded a decoration recognizing the specific incident that is associated with an injury or disability. However, when filing for a disability, the VA requires a complete recertification of the incident causing the injury or disability. Approval and certification of this letter of determination is required prior to providing any services.

My final concern is the recruitment and staffing of VA hospitals to the levels that they are authorized. For example, the Post-Deployment Health Reassessment Program (PDHRA) requires an initial appointment within 30 days of VA registration. On average, the VA hospital schedules initial appointments as much as 90–120 days from the registration date. Our local VA hospital staff has been doing their best to provide services, but needs a full staff to serve all our veterans. They have stretched their limited health care provider resources to support veterans in the Pacific Basin.

In closing, I want to thank the Committee for their continuing support of our veterans. Thank you for coming to Hawaii to conduct these hearings.

Are there any questions?

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you. And now we will hear from Mark Moses. Your testimony?

STATEMENT OF MARK MOSES, DIRECTOR, OFFICE OF VETERANS SERVICES, DEPARTMENT OF DEFENSE, STATE OF HAWAII

Mr. MOSES. Thank you, Mr. Chairman.

I'm Mark Moses, Director of the Office of Veterans Services. OVS is the state lead agency responsible for the welfare of veterans and family members. As the Governor's liaison to veterans and veteran groups, we serve as an intermediary between them and the Department of Veterans Affairs and provide access to state services and benefits.

We have provided services and information to nearly 33,000 veterans and survivors this past fiscal year. I've attached a summary sheet describing some of the services and activities made available for your review. The final service we can provide a veteran is interment in a veteran's cemetery with appropriate honors. The VA has consistently supported our efforts to expand Hawaii cemetery plots and columbarium space to keep pace with need, and they are deserving of our gratitude. And as you saw today, we got the new grant which we desperately need.

It is important for us to take this opportunity to thank you, Senator Akaka, for your unwavering support for our Veterans Cemetery Program, and our veterans in general. We are particularly

grateful for your assistance in obtaining the new grant we just discussed.

The April 2000 data from the VA Office of Actuary, Office of Policy Planning Preparedness, estimated 120,000 veterans in Hawaii. As you heard, those numbers may have changed. I don't know if they're necessarily decreasing. About 72 percent of those lived on Oahu, 13 percent on the Big Island, 10 percent on one of the Maui County islands and approximately 5 percent on Kauai. For that very reason, we have offices on neighbor islands to support our veterans.

Our Island State presents unique challenges for Department of Veterans Affairs. Despite these challenges, though, I want to share with you comments that we hear from veterans. They speak to the excellence of VA medical care, how VA staff treats veterans with dignity and respect and that the services rendered by the dedicated health care professional are superior to what they received on the mainland. In the past, you heard stories to the contrary, Senator, I share reports from veterans we have met. I think now there has been a change for the better.

These comments are from local veterans and those visiting Hawaii, and those who need to seek services from the Spark M. Matsunaga medical staff. Similar comments are shared about the VA benefit staff. As you know, though, we still have a backlog and that is being addressed. I'm not going to go into it again.

Hawaii's VA supports Guard and Reserves prior to deployment and upon their return, as well as those members in the military service from the active forces. As a disabled veteran, I can attest to the fact that the services provided by the VA locally are top in the Nation. Nevertheless, given the proper resources, they are capable of doing better. You recall that nearly 30 percent of our veterans live on the neighbor islands. Many of them are referred for surgical services to mainland VA medical centers, civilian medical facilities on Oahu or at Tripler Army Medical Center. For neighbor island veterans sent to mainland VA hospitals, this can be very traumatic. They're booked on flights, sent to a big city to find a VA facility, operated on and sent back to their homes in Hawaii.

We ask that sufficient funding be provided for direct mainland flights from, and whenever possible, return flights to the veteran's islands of residence. Now, they are, of course, placed on flights that come through Honolulu.

Changes to 38 U.S.C. 1151, Benefits for persons disabled due to treatment provided at a VA facility means that the only facilities covered under the law are those over which the VA Secretary has direct jurisdiction, or a government facility contracted by him. Tripler, Straub, Kuakini, Queen's and St. Francis do not qualify.

Veterans suffering any additional disability, or worse, are on their own and must sue the medical facility for damages. That's an overwhelming task for most veterans. We suggest the definitions that are listed in 38 U.S.C. 170 and 38 U.S.C. 1151 be changed allowing Hawaii veterans the same protection as veterans receiving care in VA facilities on the mainland.

At a minimum, veterans must be given the opportunity to make an informed consent about the benefits and shortfalls between having medical procedures performed at a mainland VA facility or lo-

cally in non-VA facilities. Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu.

Neighbor island Community Based Outpatient Clinics place veterans on a wait list where they are scheduled for specialty medical care. With the use of telemedicine and more frequent visits to CBOC, this backlog is being addressed. Nevertheless not fast enough, sir. Some veterans must wait several months to see a specialist.

VA has a difficult time recruiting and maintaining competent medical staff in these rural areas. VA should be allowed to offer a premium to rural medical service providers and be allowed to contract for additional medical care in rural areas such as the neighbor islands. Thousands of National Guardsmen and Reservists have returned. My desire is that they and those already here receive medical and benefit services in a timely manner.

We ask that VA Health and Benefits Administrations be adequately funded and staffed to provide medical care and benefit services to all Hawaii's veterans. Hawaii received a VA grant to build the Yukio Okutsu Veterans Home opening hopefully this year. We envision that eventually we will have several veterans' long-term care facilities, preferably one per county with your aid, sir.

Presently, the per day veteran reimbursement rate is \$67.71. That amount is insufficient to maintain a veteran without additional payments from the veteran and other resources that are available. We request that the reimbursement rate be raised to adequately cover long-term care services provided to assist the state in meeting the medical care of this frail group of older warriors. The cost is approximately \$300 a day.

As these veterans pass, many will utilize our state veteran cemetery system. Presently, the state and county are reimbursed \$300 for each veteran burial. This is less than the cost to open and close a gravesite and to provide for perpetual care. The cost to bury and provide perpetual care is approximately \$1,000. The burial reimbursement rate has not changed in many years, and we ask your Committee to look into increasing it to more closely reflect the true cost of these interments.

We must continue to take care of those who have served. They are our sons and our daughters, our Hawaii citizens, our veterans. I thank the Committee and you for this opportunity, and I will respond to any questions you may have.

[The prepared statement of Mr. Moses follows:]

PREPARED STATEMENT OF MARK S. MOSES, DIRECTOR, OFFICE OF VETERANS SERVICES, DEPARTMENT OF DEFENSE, STATE OF HAWAII

Chairman Akaka and Members of the Senate Committee on Veterans' Affairs, I am Mark Moses, Director of the Office of Veterans Services (OVS). The office is the single State lead agency responsible for the welfare of Veterans and their family members. We act as the Governor's liaison to veterans, veterans groups and organizations, and serve as an intermediary between the Department of Veterans Affairs and Hawaii's veterans. The office serves in partnership with the VA to provide state services and benefits. We provided services and information to nearly 33,000 veterans and eligible survivors this past fiscal year. I have attached a summary sheet describing some services and activities made available through the office for your review.

The final service we can provide a veteran is interment in a veteran's cemetery with appropriate honors. The Veterans Administration has consistently supported our efforts to expand Hawaii's cemetery plots and columbarium space to keep pace with need. They are deserving of our gratitude.

Additionally, it is important and proper to take this opportunity to thank you, Senator Akaka for your unwavering support for our veteran's cemetery program. We are particularly grateful for your assistance in obtaining the new grant for the West Hawaii Veterans Cemetery located in Kona. State veterans cemeteries are the only cemeteries accepting full body burials on a consistent basis in Hawaii. This VA grant will assure that West Hawaii will be the cemetery we all have envisioned it to be.

Based on April 2000 data from the Office of the Actuary, Office of Policy, Planning and Preparedness, Department of Veterans Affairs, there are an estimated 120,000 veterans in Hawaii. The majority, about 72 percent live on Oahu, 13 percent reside on the island of Hawaii, 10 percent live on one of the three islands which comprise Maui County, and approximately 5 percent live on Kauai. Hawaii, an island state located in the middle of the Pacific Ocean, presents unique challenges for the Department of Veterans Affairs.

Before I discuss some of these challenges, I want to share with you comments that my staff and I hear from veterans about VA health care and benefit services. These individuals speak to the excellence of VA medical care; that VA's staff treats veterans with dignity and respect, and that the services rendered by the dedicated health care professionals are superior to the care they received on the mainland United States. These comments are expressed by local veterans as well as by veterans who visit Hawaii and have a need to seek services from Spark M. Matsunaga medical staff. Similar types of comments are shared about the VA Benefit staff.

This "new" VA exemplifies the well known phrase of "supporting our troops." Hawaii's VA supports our National Guard members and Reservists prior to deployment and upon their return. They also offer services to military members who are ending their military service. As a disabled veteran, I can attest to the fact that the services provided by the VA locally are top in the Nation. Nevertheless, given the proper resource they are capable of doing better.

As mentioned earlier, Hawaii presents unique challenges to the VA. We are an island state with one large population center on Oahu. Nearly 30 percent of Hawaii's veterans live on the neighbor islands. Presently many of our veterans are referred for surgical services to mainland VA medical centers, civilian medical centers on Oahu, or to Tripler Army Medical Center. This can be very traumatic for neighbor island veterans who are sent to other VA hospitals. They are booked on flights, sent to a big city to find the VA facility, operated on and sent back to their home in Hawaii. We ask that funding be provided so that those who reside on neighbor islands be provided direct flights to the mainland. We also propose that whenever possible, return flights fly directly to the veteran's island of residence.

Another issue that affects Hawaii and Alaska involves changes that were made to 38 U.S.C. 1151, Benefits for persons disabled by treatment of vocational rehabilitation. With this change the only facilities covered by the law are those over which the Secretary of Veterans Affairs has direct jurisdiction, or Government Facilities contracted by the Secretary. Tripler Army Medical Center and other medical facilities in Hawaii, such as Straub, Kuakini, Queens, and St. Francis do not qualify under the present law. Veterans suffering an unlikely event causing any additional disability or worse are on their own and must sue the medical facility for damages. For most, obtaining an attorney to pursue this option is overwhelming.

We suggest that the definitions as listed in 38 U.S.C. 1701(3) and 38 U.S.C. 1151, be changed so that veterans in Hawaii treated outside VA facilities are afforded the same protection as veterans who receive VA medical care in VA facilities on the mainland. Hawaii's veterans must have the same right to redress as veterans treated at mainland VA facilities. At a minimum, veterans must be given the opportunity to make informed consent about the benefits and shortfalls of choosing between having surgeries or other medical procedures performed at a VA facility on the mainland or in non-VA facilities locally.

Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu. Presently neighbor island Community Based Outreach Clinics place veterans on a wait list where they are scheduled for specialty medical care. With the use of Telemedicine and more frequent visits, this problem is being addressed; however, backlogs still exist. Veterans have been known to wait several months before they see a specialist. Additionally, VA has a difficult time recruiting and maintaining competent medical staff in these rural areas. To address these needs, the VA should be allowed to offer a premium to rural medical service

providers and consider contracting for additional medical care in rural areas such as the neighbor islands.

As you are aware, Hawaii has received thousands of its returning National Guardsmen and Reservists. As Director of the Office of Veterans Services, my desire is that these returning military members and those already here be able to access medical and benefit services in a timely manner. We ask that VA Health and Benefits Administrations be adequately funded and staffed to provide medical care and benefit services to all veterans who make Hawaii their home.

Hawaii has received a grant from the VA to build its first Veteran's Home. The Yukio Okutsu Veterans Home is scheduled to open within a few months. Our concern is with the reimbursement rate that the VA pays for veterans who will be residing at the home. The present reimbursement is insufficient to maintain a veteran without payment of additional funds. We in Hawaii are not alone in requesting that the per day reimbursement rate be raised so that it adequately covers long-term care services supplied by the facility. We envision that the Yukio Okutsu Veterans Home will be the first of several veterans' long-term care facilities, preferably at least on per county due to inherent island produced isolation. Adequate per resident reimbursement will assist the state in meeting the medical care needs of this frail group of older warriors.

As these veterans pass, many will utilize our State Veteran's Cemetery system. Presently the state and county are reimbursed \$300 for each veteran burial, but the cost to open and close the grave site and provide perpetual care greatly exceeds this amount. This reimbursement rate has not changed in many years. We ask that your Committee look into increasing the present amount so that it more closely reflects the true cost associated with full body and urn burials.

We must continue to take care of our veterans. We must support our Soldiers, Sailors, Airmen, Marines, and Coast Guard members at home and abroad. They are our veterans, our sons and daughters, our citizens of Hawaii.

I thank the Committee for this opportunity to speak on this matter and I will respond to any questions that you may have.

[Note: the following is a summary of services and activities being offered by the Hawaii Office of Veterans Services.]

HAWAII OFFICE OF VETERANS SERVICES

MISSION

The Office of Veterans Services (OVS) is the principal state office responsible for the development and management of policies and programs related to veterans, their dependents, and/or survivors. The OVS acts as a liaison between the Governor and veterans' organizations and also between the Department of Veterans Affairs and individual veterans. Our objectives are to assist veterans in obtaining State and Federal entitlements, to supply the latest information on veterans' issues and to provide advice and support to veterans making the transition back into civilian life.

OVS is the State's primary advocate of veterans applying for and receiving benefits and services. The OVS may take action on behalf of veterans, their families and survivors to secure appropriate rights, benefits and services. This process includes the reception, investigation and resolution of disputes and complaints.

The OVS serves all eligible veterans, Reservists, National Guard members, active-duty military personnel and their dependents (including stepchildren). (See List of Services at end.)

STATE PROVIDED BENEFITS

Special Housing for Disabled Veterans

Payment by the State of up to \$5,000 to each qualified, totally disabled veteran for the purpose of purchasing or remodelling a home to improve handicapped accessibility.

Burials

Burials for qualified veterans (including U.S. war allies) and their dependents in Veterans Cemeteries on Oahu, Hawaii, Kauai, Maui, Molokai, or Lanai.

Vital Statistics

Free certified copies of vital statistics forms when needed for veterans' claims.

License Plates

For the same cost as regular license plates, qualified veterans can acquire distinctive veterans' license plates for their car or motorcycle. Currently available are: "Veteran," "Combat," "Combat Wounded," "Pearl Harbor Survivor," "Former POW," "World War II Veteran," "Korean War Veteran," and "Vietnam Veteran."

Tax Exemptions

Applies to real property that is owned and occupied as a home by a totally disabled veteran or their widow(er). Also applies to passenger cars when they are owned by totally disabled veterans and subsidized by the Department of Veterans Affairs.

Employment and Re-employment

Preference is given to veterans, Vietnam-era veterans, service-connected, disabled veterans and their widow(er)s for civil service positions, training programs, job counseling and referrals to civilian jobs by the Workforce Development Division, Department of Labor and Industrial Relations. Re-employment rights for veterans, Reservists or National Guard members who leave a position within State or County government for training or active military service.

We encourage you contact the Office of Veterans Services to have your questions answered. The sooner we begin the process together, the sooner you will see results. Please contact the OVS office nearest you. Walk-ins are welcome, and appointments are recommended. Home, worksite and hospital visits are available if necessary, as are Group presentations.

Office of Veterans Services—Oahu

Office: Tripler Army Medical Center E-Wing
Address: Office of Veterans Services, 459 Patterson Road,
E-Wing, Room 1-A103, Honolulu HI 96819-1522.
Telephone: (808) 433-0420; Fax: (808) 433-0385.
E-mail: OVS@ovs.hawaii.gov.
Hours: Monday-Friday, 7:45 a.m.-4:00 p.m.

Office of Veterans Services—Kauai

Address: 3215 Kapule Hwy., #2, Lihue, HI 96766.
Telephone: (808) 241-3346; Fax: (808) 241-3818.
E-mail: KOVS@ovs.hawaii.gov.
Hours: Monday-Friday, 7:30 a.m.-4:30 p.m.

Office of Veterans Services—Hawaii

Address: 101 Aupuni Street, Room 212, Hilo, HI 96720.
Telephone: (808) 933-0315; Fax: (808) 933-0317.
E-mail: HOVS@ovs.hawaii.gov.
Hours: Monday-Friday, 7:30 a.m.-4:30 p.m.

Office of Veterans Services—Maui

Address: 333 Dairy Road, Suite 201-A, Kahului, HI 96732.
Telephone: (808) 873-3145; Fax: (808) 243-5820.
E-mail: MOVS@ovs.hawaii.gov.
Hours: Monday-Friday, 7:30 a.m.-4:30 p.m.

LIST OF SERVICES FOR VETERANS, ACTIVE MILITARY,
SPOUSES AND DEPENDENTS

Assist in preparation of VA claims.
Help individuals file VA Appeals.
Represent veterans at VA hearings.
Obtain veteran birth, marriage, divorce and death certificates nationwide.
Assist with burial
Provide notary.
Assist indigents.
Maintain DD214s.
Refer individuals not qualified for VA benefits to other agencies.
Legal name change.
Review active service record.
Assist active medical boards.
Hawaii Veterans Newsletter.
Hawaii Veterans Roster.

Hawaii Veterans Website.
 Governor's Liaison to veterans.
 Legislative Advocate for veterans—State and Federal.
 Yukio Okutsu Hilo Veterans Home—development and oversight.
 State Veterans cemeteries statewide—grants and expansion.
 Grant-in-Aid for all veteran related items—veterans' cemeteries,
 Arizona Memorial, Aviation Museum, Veterans Centers
 statewide, etc.
 Tri-annual report for State Monuments.
 Coordinate veterans organizations to clean the Korean and
 Vietnam Memorials on Capitol grounds.
 Coordinate Memorial and Veterans Day ceremonies annually
 at Hawaii State Veterans Cemetery.
 Assist with Memorial and Veterans Day ceremonies at National
 Cemetery of the Pacific (Punchbowl).
 Coordinate leis for veterans cemeteries on Memorial Day.
 Staff the Advisory Board on Veterans Services.
 Hawaii Veterans Memorial Fund.
 Maintain presence on neighbor islands.
 Validate Military Service for Employee Retirement System.

The AUDIENCE. (Applause.)

Senator AKAKA. Thank you, Mark Moses.

I want to thank this panel. I want this panel to know that I do have questions for you. But, in the interests of time, I am going to submit the questions for the record. But I want to express my appreciation for your testimonies.

To conclude, I thank all of our witnesses for their participation today. We heard about what VA is doing well and about what needs improvement. The Committee will continue its oversight of VA to ensure that all veterans have access to health care and benefits.

Following the end of this hearing, we will take a 5-minute break, and then commence what we are calling the public comment session. John Yoshimura, one of my staff, will provide further information and instructions for participation in this session. So those of you who are interested in this session, please remain here.

And again, this has been a great hearing. It has taken time, but we have heard from all these witnesses, which will really help this Committee to work on improving care and benefits for veterans throughout the country and in Hawaii. And with that, I want to say aloha and this hearing is now adjourned.

[Whereupon at 12:05 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WW II FIL-AM VETERANS

Good morning to everyone, to our Comrades and fellow veterans, and to our very own Senator Daniel K. Akaka. Aloha.

On this great opportunity, the Officers, Board of Directors and Members of the WWII Fil-Am Veterans and Ladies Auxiliary, Hawaii Chapter, extend our esteemed gratitude and sincere thank you to Senator Daniel K. Akaka, as Chairman of the U.S. Senate Veterans' Affairs Committee and to all Members of the same committee for approving on June 27, 2007, legislation of the Filipino Veterans Equity Bill S. 1315.

Likewise, we extend our thanks to U.S. Senator Daniel K. Inouye for consistently introduced the Filipino Veterans Equity bill since 1992 that will restore full veterans status and benefits to the WW II Filipino veterans who were drafted into the U.S. Armed Forces and bravely fought alongside the American troops under the American flag in defense of freedom and democracy.

We understand that the bill S. 1315 passed by the U.S. Senate VA Committee will soon, sometime in September 2007, be moved to the full Senate floor, which we consider a major step toward realizing legislation of the Filipino Veterans Equity bill S. 1315 after 15 years since 1992.

While the Family Reunification bill is on hold, we propose an alternative amendment to the bill H.R. 2642, the Military Construction Veterans Affairs Budget bill approved to full Senate to incorporate as RIDER for the Family Reunification Act of 2007 or an alternative RIDER to the Filipino Veterans Equity bill S. 1315 without prejudice to pass legislation of the mother bills.

We strongly APPEAL in the intent of HUMANITARIAN reason next to our Constitutional rights the immediate need to pass legislation of S. 1315 so that the remaining elderly veterans now in their 80's of age and over can enjoy at least their equity benefits and pension during the rest of their twilight years.

Mahalo. God Bless Us All.

PREPARED STATEMENT OF LUZ N. CALEDA, PRESIDENT, LADIES AUXILIARY OF THE WWII FIL-AM VETERANS HAWAII CHAPTER

Good morning everyone, to our very own Senator Daniel K. Akaka. Aloha.

My name is Luz N. Caleda. I am the President of the Ladies Auxiliary of the WWII Fil-Am Veterans Hawaii Chapter with fifty six members—all wives of the veterans residing in Hawaii. We were organized to support and assist the veterans in carrying out their plans and programs including other related activities and functions.

On behalf of the Officers and Members of the Ladies Auxiliary, I extend our deepest gratitude and sincere thanks to U.S. Senator Daniel K. Akaka and to all the Senate VA Committee Members for approving on June 27, 2007 the legislation of the Filipino Veterans Equity Bill. On April 11, 2007, I joined my husband, Art Caleda, who gave his testimony during the Senate VA Committee hearing chaired by our beloved Senator Daniel K. Akaka in Washington, DC.

We, the Ladies Auxiliary, all shared the 65 long years of injustice suffering of our husband veterans in their fight for their equity pension and other benefits rightfully deserved by them. We suffered long enough. Many veterans already passed away and a number of wives also passed away out of their frustrations. Believe it or not, we live below the American living standard depending only on the SSI and Food Stamps from the government. Think about it, some veterans frequent to Food Banks to pick up free food stuffs and clothing. Some resort to picking up empty soda cans and empty bottles and sell them to any recycling outlets just to augment their meager SSI money.

We have been separated from our children and family when we came to Hawaii with our husband-veterans. We cannot afford to go home to the Philippines to visit our family and children once in a while because of financial problem. We are now quite old, weak, and sickly and a number are bedridden at home or in the hospitals. In many instances, when a veteran dies, none of the children from the Philippines can come to see or witness the burial or funeral. The bereaved family, on several occasions, appeals for voluntary contributions from friends and mostly from the veterans and Ladies Auxiliary members to help defray the funeral and burial expenses of the deceased veteran.

We appeal and I urge all U.S. Senators to support legislation of our very own U.S. Senator Daniel K. Akaka's bill, S. 1315, the Filipino Veterans Equity Act of 2007, the much awaited Equity pension and benefit for the Filipino veterans, who sacrificed their lives fighting alongside with the American troops in defense of freedom and democracy; and to include the family Reunification Act of 2007 which we urgently need at this point in time.

Mahalo and God Bless.

PREPARED STATEMENT OF CHARLES L. CLARK,
PRESIDENT, RADIATED VETERANS OF AMERICA

Chairman Akaka and Distinguished Panel Members:

My name is Charles L. Clark. I am a resident of Kailua.

I am a U.S. Navy Veteran of World War II and the Korean conflict. I served in the Pacific and was one of the first Americans, not counting on-site Prisoners of War, to enter Nagasaki after the August 9, 1945 atomic bombing.

I am currently the President of Radiated Veterans of America, the only Internal Revenue Service recognized 501(c)(19) Veterans Service Organization representing statutory war veterans exposed to ionizing radiation during service to this Nation.

The United States, by and large, has treated Radiated Veterans poorly. While laws have been passed, regulations created, and huge sums of money have been spent addressing ionizing radiation, precious few Veterans have been recognized, medically cared for, or compensated for their losses.

This is, I believe, because there has been little continuity in addressing the issues faced by Radiated Veterans. For example, Congress has passed laws defining and addressing "Atomic Veterans" being those potentially exposed to radiation during atmospheric, and a limited number of underground "tests", and POWs and occupying troops at Hiroshima and Nagasaki. Yet, the Veterans' Administration's Advisory Committee on Environmental Hazards, in 1993, noted 11 categories of Veterans, in addition to those statutorily listed as "Atomic Veterans" who could have been exposed to ionizing radiation as a result of their service.

Radiation is radiation, and the system, rather than treating all Radiated Veterans equally demonstrably discriminates between Veterans who have been exposed to ionizing radiation.

This is true even within the statutory "Atomic Veteran" classification where there is discrimination between those with so-called "presumptive" cancers and "non-presumptive" diseases recognized in the medical community as radiogenic in origin, for purposes of compensation.

The non-presumptive diseases require the Veteran, or his/her survivor to be subject to a Dose Reconstruction, admitted by government as "uncertain", and expensive, before any compensation is awarded. . . and much more often than not, the claim is denied.

Dose Reconstruction is flawed, yet it is kept alive by an unholy alliance between the Veterans' Administration, the Defense Threat Reduction Agency of the Department of Defense and its private contractor, SAIC.

Even some members of the congressionally mandated Veterans Advisory Board on Dose Reconstruction advocate that all "Atomic Veterans" be treated as a Special Cohort.

I strongly suggest this Special Cohort classification be adopted to law and expanded to include all Veterans whose military duties put them at risk from ionizing radiation, including the 11 classification recognized by the VA study group in 1993.

Further, I strongly urge that the Dose Reconstruction program, which is fatally flawed, because the history of dose readings is itself flawed, be scrapped. Too much time, and too much precious capital, has been spent on this program.

The shortcomings of Dose Reconstruction, primarily based on theoretical statistics, and in too few instances actual recorded radiation readings, were recognized by the 2003 report issued by the National Research Council. The report was titled

“A Review of the Dose Reconstruction Program of the Defense Threat Reduction Agency”.

Further, I urge Congress to give more deference to the medical community and less to the physical scientists, in recognizing the human damage caused by ionizing radiation, which impacts not only those subject to radiation, but even unto progeny affected by genetic changes that occurred when a Veteran was exposed.

Also, I urge Congress to merge the various programs directed at Veterans and Civilians such as “Downwinders”, Uranium Miners, and Defense Workers, so that the Nation can properly address the scourge brought about by the uncontrolled introduction of atomic energy, and the human experiments conducted to satisfy curiosities.

As an Atomic Veteran, who was damaged by residual radiation following the bombing of Nagasaki (I have, for example, had 160 skin cancers removed from my face and neck, and have other maladies the medical community attributes to ionizing radiation) I can ask no less of Congress, our elected representatives, for fellow Veterans and all Humankind.

I understand your time to listen today is short, and that you have many issues before you. I will, however be glad to respond, either verbally, or to any questions you may have, either now, or as follow-up, in writing if necessary .

The Internet Web Site for Radiated Veterans of America is www.radvets.org. That site, which is continually updated, brings together, in much more detail, much of what I have brought forth today.

Thank you for your time and attention.

FIELD HEARING ON HEALTH CARE FOR VETERANS ON MAUI

THURSDAY, AUGUST 23, 2007

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

The Committee met, pursuant to notice, at 10:30 a.m., in Maui County Council Chambers, Wailuku, Maui, Hawaii, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

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

Senator AKAKA. Aloha.

The AUDIENCE MEMBERS. Aloha.

Senator AKAKA. I'll just start by making some preliminary statements. And I want to say mahalo nui loa to all of you for coming. I wanted to thank the Maui Counsel for giving us access to this room. As you know, this is the counsel chambers. And they've offered it to us for this hearing today. And I'm extremely grateful to the counsel for that and to the people of Maui for this as well. And to see all of you here is very heartening for me. Because we want to hear from you and to see what we can do to improve what the Department of Veterans Affairs has been doing for our veterans.

And to begin with, I would like to ask Danny Kanahele to lead us in the pledge and Rogelio Evangelista to lead us in prayer. So at this moment, I ask all of you to please rise.

[Pledge of Allegiance and Prayer.]

Thank you very much. Danny Kanahele.

Mr. KANAHELE. Sir.

[Pledge to Allegiance and Prayer.]

Senator AKAKA. Aloha. I want to welcome all of you to today's hearing. And this hearing will come to order.

This is the second hearing held by the Senate Committee on Veterans' Affairs. The second of three hearings that I am chairing here in the State of Hawaii this week and next week. We held similar hearings at the start of 2006. Much has improved since that time, for which I'm very, very grateful. It took lots of work, teamwork with the Administration as well, with the VSOs as well, and with Congress. But it is important for the Committee to understand the remaining challenges.

Both the clinic and Vet Center on Maui are tremendously busy and must be available to all of Maui's veterans and to veterans living on Lanai and Molokai as well. It is my view that both the clinic

and the Vet Center are understaffed, and we need some staff enhancements. This is something that I will be exploring today.

I want to applaud the efforts of every VA employee on Maui. These men and women work hard to help veterans who seek their assistance. There are many things that VA does well in Hawaii. However, there is always room for improvement. I want to hear about how we can give VA the tools to make a difference in the lives of Hawaii's veterans.

Back in Washington, we have worked hard to ensure that VA has the resources to provide the best possible care.

The VA spending bill, which the Senate will take up early in September, includes \$43 billion for VA, \$3.6 billion more than was offered by the Administration. But we are looking forward to taking it up when we reconvene in Washington in September. We are finally on track for adequate funding for VA mental health care and for those veterans with Traumatic Brain Injuries.

Today and over this week and next, I will examine health care and benefits in Hawaii. Given the State's unique features, VA must specifically tailor its strategies that are successful on the mainland, as they may not work as well here. And many of you know what I mean.

It is vitally important that you share your thoughts with us so that we know how to help VA help you and the rest of Hawaii's veterans. VA officials are here to listen and to respond to the concerns raised by the witnesses on the first panel.

Finally, I note that there are many veterans here today, and I'm happy to see all of you. And many veterans who would like to testify as well. While we cannot possibly accommodate everyone's request to speak, we do want to hear your views.

The Committee is accepting testimony which will be reviewed and made part of the record of today's hearing. If you have brought written testimony with you, please give it to the Committee staff who are located in the back of the room. If you do not have written testimony but would like to submit something, Committee staff will also assist you in that.

In addition, the Committee staff is joined by VA staff who can respond to questions, concerns and comments that you raise. And when I say VA staff, I mean those who are on the Federal level, as well as those who are on the State level here in Hawaii.

Once again, mahalo nui loa to all of you who are in attendance today. And I look forward to hearing from today's witnesses.

Because of the last minute changes in witness availability, we made a slight change in the hearing agenda. The first two panels of individual witnesses have been combined into a single panel. So we have them now in front of us. I want to welcome this first panel to today's hearing. And I want to thank you again, mahalo nui loa for your presence here and for your testimony.

First, I welcome Rogelio Evangelista, President of the Maui Veterans Counsel. I also welcome Clarence Kamai, Jr., a member of the VA Advisory Counsel. I want to welcome Danny Kanahele, another member of the VA Advisory Counsel.

I welcome Mitch Skaggerberg, President of Vietnam Veterans of Maui County.

I welcome Karl Calleon. I understand that it is your la hanau; that is, your birthday. So I want to say hauoli la hanau to you at this time. I also welcome Carl Haupt, a Vietnam Veteran. Next, I welcome Grant Steward, a Veteran of Operation Iraqi Freedom. And finally, welcome William Stroud, a Vietnam Veteran.

Again, I want to thank all of you for being here. Your full statements will be included in the record of the Committee. We would like to move this along as best we can. And because it is important to do that and to keep things moving, please keep your statement to no more than five minutes.

Here in front of me is a time clock. And you will see a green light come on for 4 minutes. Then a yellow light to sum up the last minute. And then a red light to stop.

So again, let me begin by asking Mr. Evangelista to begin with your testimony.

**STATEMENT OF ROGELIO EVANGELISTA,
PRESIDENT, MAUI VETERANS COUNCIL**

Mr. EVANGELISTA. Mr. Chairman, Senator Daniel Akaka, and distinguished Members of the Senate Veterans' Affairs Committee, greetings to you and your staff. And to the veterans here today, thank you for giving me the opportunity to come before you and discuss VA health care here on Maui, home to about 100,000 veterans.

To the excellent efforts the staff of the Maui CBOC and with the support of the (inaudible) and the Tripler Army Medical Center have been extraordinary, especially due to the unique nature of health care within the islands all divided by the Pacific Ocean.

First of all, I would like to commend you and the Committee for all your personal sacrifices and helping us veterans deal with our everyday disabilities in our daily lives. All of you, along with the medical staff in Hawaii that made great strides in our support to overcome our hardship and disabilities.

I was even given the opportunity to address the panel on January 10, 2006. And since then, there have been a lot of new changes. We have lost our primary care doctor to CBOC in the summer of 2006, and the position just got filled the beginning of summer of 2007 by Dr. Chin.

As you know, the State of Hawaii is very unique in that each county is divided by the Pacific Ocean, not like the mainland where the veterans can drive to the clinics or hospitals with his or her family support. And with less than 30 percent of service connected disability and the attending physician at the clinic set you up for an appointment for a condition that could be a plausible cause due to your disability, but part of you must provide your own transportation.

And this happened ever since the millennium, regarding veteran's health care. To travel within the neighbor islands is so costly for veterans because most of us are living with limited income. And when we are referred to a VA doctor to see a private practitioner here on Maui, after two months, we receive a letter saying the visit was not authorized.

This has happened to me a few times. And since it takes so long for VA to eventually get approval and pay the provider, it ends up

to collection agency, which gives you an appropriated report. How many other veterans also have this problem?

Second, there are a lot of veterans here on Maui with chronic health problems. And they just live with it from day-to-day, hoping some day the problem will go away, which will be when they die.

We have a primary care doctor and nurse practitioner that you can get an appointment with. But when you try to call to get an appointment that day, the appointments are usually full. We need to have another doctor here at the CBOC. I think we also need to access VA health care after-hours when the clinic is closed, especially on weekends, so that we don't have to deal the probability of our emergency bill not being paid, especially here on neighbor islands.

On Oahu, they have Tripler Army Medical Center to go to for emergency. They can drive there on weekends. We can't. There's still so much red tape using VA as primary medical care, especially after the clinic closed. And there would be a nurse on-call or doctor on-call 24/7, to authorize emergency care after clinic hours and during clinic hours if the clinic can see you.

Third, our aging veterans are now more in need of acute medical care. We need to provide them with 24/7 access to health care. World War II, Korean and Vietnam Veterans are in their 60's to past 80 years old, with some of them homebound. With a staff of homecare nurses that can visit them at home to provide some sort of respite care. Hopefully, there will be a care home for veterans in the very near future.

There is also no contact with other veterans. Some of them can no longer drive and some of them are without family support. Some veterans are now only realizing their disabilities that might have been caused by military service. And when they apply, they are being asked for collaborating evidence on something that happened over 30 years ago.

Why can't the Veterans' Administration get these records for them? There are a lot of veterans here on Maui and throughout the state and throughout our Nation that don't even know certain benefits that they may be qualified to apply for due to their physical and mental disabilities.

Four, let me share with you my personal experiences with vocational rehab. At age 34, I was very fortunate to be accepted in the VA Chapter 31 rehab program to secure various computer certifications to pursue work as an electronic technician. Somehow, however, I ended up with a shoulder injury that ultimately led to me not being able to complete my employment plan and resulting in my total disability from being able to work.

As a result over time, I found myself to be increasingly stuck at home dependent on others, depressed, frustrated, and feeling useless. When Dr. Richard McDonald, my rehab counselor, noticed my physical, psychological and social functioning was dangerously spiraling downward, he referred me for an independent living evaluation at my home.

Since I was aware that the independent living program has already helped out so many other veterans through my long-standing veteran advocacy, I agreed to undergo the evaluation. Through Mr. McDonald's counseling and the helped of plan development guide-

line, I began to see how I could use the computer knowledge and skills that I gained through my rehab training to help other veterans.

He completed it and we have since initiated my independent living plan. Through this plan, I have received a riding lawn mower so I can once again take care of my lawn. I also received a laptop computer system so I can assist other veterans with updating and operating their computers. It will also enable me to help set up a Veterans Helping Veterans in our communities. Veterans Helping Veterans is comprised of a growing number of veterans who have also been empowered, and their independent living plans are now helping others too disabled, too old, or too poor to help themselves.

These veterans, like myself, are using their independent living equipment skills, interest and time to help these people by fixing their vehicles, repairing their homes, cleaning up their yards, or whatever needs doing.

They're also fixing up their communities: school parks, benches, and so forth. In the process of being empowered to others, these veterans' lives are transforming from depression and isolation to lives of renewed purpose, family, social and community connection.

One of the main reasons this program is so effective with these veterans on Maui, Molokai and Lanai, is because Dr. McDonald works closely with the Maui Community Based Outpatient Clinic staff: Dr. Kathleen McNamara, psychologist; Morey Springer, psychiatrist; Sue Yin Chin, primary physician; and our CBOC and veterans and support professionals throughout our community.

It's disheartening to note, however, that this independent living program is not being utilized in this critically effective manner in many other regions in the Veterans' Administration. This is why I asked Dr. McDonald to provide more information on the independent living program.

The veterans now can be more independent through this program to include full lives within their family and communities.

Members of the Senate Veterans' Committee, we applaud you, all that you do to help us veterans live better and fruitful lives. Through this goal, we all ask that you do what you can to improve both increased support for the use of this independent living program, along with the increased medical services for our most severely disabled veterans in Hawaii and throughout our United Nation.

May God bless America's people and you, the Members of the Senate Veterans' Affairs Committee, the Armed Forces, the Veterans and their families. Thank you and aloha. I think I went over the red light.

Senator AKAKA. Thank you very much, Rogelio. And now we'll hear from Clarence Kamai.

**STATEMENT OF CLARENCE KAMAI, JR.,
MEMBER, VA ADVISORY COUNCIL**

Mr. KAMAI. Good morning, Mr. Senator, staff of Veterans' Affairs, staff of Veterans' Administration, Maui CBOC staff. Hello veterans, male and female.

I concur with what Mr. Roger Evangelista had to say regarding our health care. It is important. It is needed.

We all know that. We all know that some of us have been getting these bills from the collection agencies because of nonpayment from times we've been in the hospital. So I do concur with Mr. Evangelista.

I would also like to point out that maybe we could get back into the system of fee basis. Get back into the fee basis system where I think it would be easier for the staff and the VA. Because what's happening now, as an example, I use myself. Should my wheelchair break down, I have to call Maui CBOC, get permission from the doctor. Now, there's a problem because it's hard to get in touch with the doctor and sometimes it's hard to get through the lines.

So what you have to do is follow the prompts and then just leave your message and hope they'll call back. They do. Whether it's the same day, the next day, it does not matter. But as long as they call back. Now, I need my wheelchair fixed. This is my mode of transportation. Now I'm down stuck in the water until someone calls me back from Maui CBOC to let them know what my situation is. Then there are three to four steps that will follow after that.

First step would be for them to call a service provider. The next step would be for Maui CBOC to get hold of a doctor to get permission. And sometimes I have to get involved to call Honolulu to see if prosthetics—and who knows what's happening and what can happen before me.

The next step is about a week later, everything comes to a head to say, yes, we're going to do this, yes, we're going to do that. The last step is with the service provider. They will give you an appointment. I need a wheelchair, you know, as soon as possible, please. However, I won't get the service until a week or maybe two weeks later.

So I'm saying that if we go with this simple fee basis and we'll get the allocation of funds from our senators, then it can be done. And this would solve a problem of too many veterans going to the VA. This would really lessen the load, I believe. It would take a lot of pressure off the Maui clinic staff and doctors, and would enable them more time to serve other veterans.

This is only one of many, Senator, that I would like to speak about. And I shall let my constituents go ahead. Thank you very much.

Senator AKAKA. Mahalo. Thank you very much. I notice there are some folks standing in the back and on the sides. I see some seats that are empty. So feel free to please move and sit down. Find a seat there and be comfortable.

At this time, I'd like to call on Danny Kanahele for his testimony. Danny.

**STATEMENT OF DANNY KANAHELE,
MEMBER, VA ADVISORY COUNCIL**

Mr. KANAHELE. Good morning. Thank you Mr. Chairman, staff of Maui CBOC, Tripler Hospital, Dr. Hastings. Thanks for being here. Mine is real simple.

Well, actually, what I do is public relation. Go out on the street talk to people, see what's going on. The most important thing I run across is the disability and the percentage that people have. The 100 percenters, not bad.

Sometimes they get hard time, but not bad. But when you're under 50 percent, you've got a real problem. You're either going to be dead or you are not going to make it. People call. All they get is wait, I'll get to you. And they call back.

I see this done many times. I talk to friends. I run across people. They say they are going to call me back.

Why did you not call me back? What is your percent? 30. What's your percent? 50. It seems like anybody under 50 percent, they aren't going any place. I'd like to know who checks on these guys that have been there for like 20 years; I know two guys 20 years ago. Today, they are 50 percent. Who checks on these guys to find out if they're getting any better?

They should get a note about they are not getting better. There's a problem over there. And for myself, well, lucky for me, I can take pain. But as long as you don't take too long, I can be all right. So I hope somebody check on these guys way behind in our percentage and check on why they are not moving their percentage up to the par that they should have. I believe something should be done about it. I think today would be a good time.

Well, that's all I have for today.

Thank you very much, Committee, I appreciate it. Thank you.

Senator AKAKA. Thank you very much Danny Kanahele.

And now we'll hear from Mitch Skaggerberg. Mitch.

**STATEMENT OF MITCH SKAGGERBERG,
PRESIDENT, VIETNAM VETERANS OF MAUI COUNTY**

Mr. SKAGGERBERG. Senator Akaka, good to have you here.

I am proud of the service you and your fellow Senator Daniel Inouye have done for the veterans over the last 20 years here. Twenty years ago, we didn't have any health care clinic in Maui. And now we have a good health care clinic. And thank you for this meeting so that we can even handle some of the big problems that you're going to hear today.

I'd like to thank you for coming to our aid when we called you in March with the problem that we all faced here, our staff, our veterans, we lost both of our doctors and there were no doctors in site. And I can't tell you how much it means to us in what you did personally to make sure that we wouldn't sit another year without doctors. Bless you. Thank you.

With that said, my main focus today is on long-term health care. The veterans that formed a committee—Roger, how long has it been now—to look into a long-term care facility here on Maui. The need for this long-term care is evident in that 70 percent—we figure 70 percent of all the veterans that go into the VA clinic are 60 years or older. 60 years or older, 70 percent. That's a staggering figure.

Now, what does that mean for long-term care? Well, the urgent need for long-term care is already here. Kathy Haas is one of the committee members, as well as Michael Covich, Bill Staton, Roger Evangelista, and me.

Did I miss anybody?

We're proposing, Senator, like we did on the Big Island and like we did on Oahu, that we start planning and generating the funds necessary to build a 60-bed, long-term care facility here. I've talked

to Kathy Haas and some of the other medical providers here in the VA Clinic.

They said that currently, they are handling anywhere from 20 to 35 VA disabled veterans who need long-term care in one form or another. Either hospice care, respite care, where the families are handling the job, but it's so overwhelming, that they need rest. And they need a place to put our fellow veterans for maybe a month or whatever it takes.

We have quite a few veterans with dementia now. And then, of course, we have ambulatory care.

The way we handle that now is, I've seen it personally with two of our close veterans, we put them in the hospital for two months at Maui Memorial. They induce a coma for five or six weeks to see if they can heal because there's no room on this island right now for any long-term care facilities.

The one, Hale Makua, has a problem getting staff, Senator, that their beds are empty right now. They can't even take the veterans over there if we wanted to because there are no qualified nurses right now to handle patients.

So I'm suggesting that on behalf of all the veterans and on behalf of the VA medical staff, we begin to plan and implement and construct a long-term care facility here. Not only for Maui, but for Lanai and Molokai, knowing eventually there may be new technology that allows those veterans from those two islands to have home care at some point, long-term care.

But until that happens, at least they have an alternative there on Oahu. The center for aging in Oahu, as you know, is overbooked. Hilo's a long way to travel for those two veterans and their families from those two islands. So we have started studying possibilities of site locations. We have joined with another group called a "Maui Long-Term Partnership."

We're looking at innovative ways of creating this, such as integrating this long-term care facility for the veterans into an overall community. A new community that is on the drawing board where we would have transitional housing, i.e., a veteran could move into one type of housing where he has, let's say, 50 percent disability, and needs adult care and some long-term nursing care. And if he's not cured, then he can move into the long-term care facility.

There could also be a branch of Kaunoa Senior Center. We'd put a center in there so that they can try to keep many of us more active and engaged. That would help us with our health and perhaps delay the time where we had to go into the long-term care facility.

So these are some of the things that our committee is looking at. And we would be glad to work with you, Senator, and the Veterans' Affairs Committee or anybody on your staff in Honolulu to pursue this. We think the time is now.

So that concludes that.

The other thing I want to say is about the fee basis. You were instrumental in arranging a meeting with Dr. Hastings and Dr. Wiebe in Maui. I think that was in April. And one of the things they had as a proposal was the same thing that Danny and Clarence Kamai, Jr., said that we want to strengthen the fee basis program here. Those were their words (Dr. Wiebe and Dr. Hastings). So we have their support. At least, that's what they told us.

I agree that anybody with 100 percent or 80 percent disability rating, we usually get what we need in a timely manner. But the veterans with 50 percent or lower, have a very tough time. I think one of the bottlenecks for that is VA has a department in Honolulu called the "utilization board." I think that all fee basis requests come from our doctor now, Dr. Chin.

I believe request go through the "utilization board." Then, staff in Honolulu takes sometime to process them because they're overwhelmed with requests from the other islands; then they've got to get back to us. Then they have budgetary requirements. It seems to be a big bottleneck right now.

I know our new doctor is not familiar with this process. I think she was in private practice. So I'm sure she's going to say, well, gee, I'm the doctor, I know what's best. If we have to wait three, four, five weeks for somebody in Honolulu—do you understand what I'm saying, Senator?

Senator AKAKA. Yes.

Mr. SKAGGERBERG. So that might be a key, fee basis 24/7, to have Dr. Wiebe and Dr. Hastings and all our needs met, in looking where the bottlenecks are and expediting the process.

The third item I wanted to bring up is your Internet chat. I'd never done an Internet chat. I said I'd never do an Internet chat until you had one, Senator. I remember I asked you for some help because we really need some help for Dr. Springer and Dr. McNamara. You said, "Mitch, I have good news for you. We're getting a psychologist at the Vet Center." Well, thank you, Daniel. We've been interviewing for quite a while. I understand our team leader has just found somebody that he really likes. But again, we're concerned about the length of time that it might take.

So, Senator, if you can just let same VA management people know, it's not business as usual here. We have critical needs and, you know, things can take forever sometimes. If Tom wants to come here, he's been highly sought after by other people. I think we need to expedite that process so he can be onboard here in the next month or two.

Senator AKAKA. I want to thank you very much, Mitch, for all of this and for the gratitude you expressed.

I want to tell you, it's not only me. I mean, this is teamwork. The VA people have been helpful in bringing this about as well. But I really appreciate hearing from you.

Mr. SKAGGERBERG. Thank you.

Senator AKAKA. Thank you.

Mr. SKAGGERBERG. Mahalo nui loa.

Senator AKAKA. Thank you, Mitch.

Now we'll here from Carl Haupt for your testimony.

STATEMENT OF PRENTISS CARL HAUPT, VIETNAM VETERAN

Mr. HAUPT. Thank you, Senator Akaka, for convening this session. We are proud of our VA facility and staff here on Maui, and grateful for your swift action when our clinic had no doctors, and for the arrangements made for the veterans health care on Lanai. We appreciate this opportunity to testify about health care for veterans here on Maui.

I'd like to talk a little bit about Hawaii State Office of Veterans Services. The State Office of Veterans Services, as our testimony in front of you shows, now has a staff of ten statewide allowed. We now have eight people.

We feel we need 12. Oahu has three counselors and one clerical staff, with 2,275 people visiting last year. We have 2,288 people visiting—over 13 more than Oahu—with one clerical staff and one counselor position, which is not filled yet.

What we're saying now is, the state has 10 people allowed. We now have 8. We feel we need 12. The Maui Office of Veterans Services is a vital part of the infrastructure supporting Maui that is in danger of being overwhelmed. The demand for their services, like the Veterans' Administration, will only increase after our soldiers come home from fighting in conflicts for far too long.

We have two people now that are available for this position that we feel are being—well, we don't know what to say—not hired. Terry Garcia has been with the office for more than 10 years. She has an associate's degree.

The education requirement for the position is graduation from an accredited college or university. Well, she has that. She has 10 years experience. (Inaudible) machine gun in Vietnam. Do I really want to go out with a gunnery sergeant who has 10 years experience, or the new guy who has no experience? Why don't we hire Terry for this position. It needs to get paid right now, and get someone in there. Instead of Cass Russell coming over one day a week. We really need Cass's support and we appreciate all that he does and the time he spent traveling to come to Maui. But we need someone in the office right now, somebody hired in the very near future to take over the position which is now not being filled.

We have someone in there right now who can fill the position, who has the experience, who actually has 15 years experience, not 10 years experience. We really feel that Terry's health is also being affected because of stress at work. Her office handles more patients than the Oahu office which has four staff. We handle it with just one staff right now. Totally unfair. Totally underpaid position. Totally stressed out position.

This Office we feel, as a veterans community, we feel very disenchanted and unable to get just about anything done regarding the health measures that this Office puts out for our veterans. We feel with an old hippie, antiwar protester, antiveteran, by her political agenda and climate against veterans, our Governor makes a bureaucratic nightmare for the veterans to get their earned rights. So basically, that's what I have to say about that issue.

One other issue I'd like to talk about is the DAV Van. The DAV Van is not equipped for handicaps. We do not have the support staff needed to drive patients either to Hana or to the other side. With the traffic and everything, we actually need someone in that van from 6 in the morning to 6 at night.

We wondered if there are any grants or scholarships available, anything to help maybe fund this situation via MEO, or whatever, to get what's needed 12 hours a day, to get the people back and forth in all the tremendous traffic jams we have on Maui so they can have their health care needs taken care of.

[The prepared statement of Mr. Haupt and Mr. Skaggerberg follows:]

PREPARED STATEMENT OF PRENTISS CARL HAUPT AND MITCH SKAGGERBERG, ON
BEHALF OF THE VIETNAM VETERANS OF MAUI COUNTY

Dear Chairman and Members of the Committee:

Thank you, Senator Akaka, for convening this session. We are proud of our VA facilities and staff on Maui, and grateful for your swift action when our clinic had no doctors, and arrangements were made for the veterans' health care on Lanai. We appreciate this opportunity to testify today about health care for veterans on Maui.

VA COMMUNITY BASED OUTPATIENT CLINIC

When Senator Inouye dedicated the Maui CBOC, he said this clinic will be our model clinic for the Nation. Is our clinic still fulfilling Senator Inouye's and Senator Akaka's vision? I don't think so. Two issues, about quality of care have come to our attention. The first is equipment and the second is staffing.

We are now losing our ophthalmologist because he is not provided with even the most basic equipment to do his job. Where is the retina machine Dr. Hastings said was in the warehouse back in March?

A VA cardiologist comes to Maui for examinations. He doesn't have proper equipment at the clinic. Why are we wasting his time and our money?

Why does our clinical staff continue to have to work evenings and Saturdays, with no extra pay, just to get caught up on their paperwork? The *Washington Post* brought attention to the problems with records transfer between the Department of Defense and the Veterans' Administration but VA staff in Hawaii have been coping with it ever since the cooperative agreement with Tripler was signed, even before 9/11. It is contributing heavily to staff burnout and turnover.

There are approximately 600 people on the CBOC waiting list who are not yet able to get VA care. These people are paying as much as \$600-\$800 per month for their maintenance prescriptions; their VA copayment would be about \$35. Many of these veterans are our oldest and most distinguished World War II and Korean veterans.

According to a 2004 study sponsored by the VA Health Services Research and Development Service, "... about one in seven VA pharmacy outpatients fit a definition of having only a small number of outpatient visits annually with a relatively large pharmacy cost. This number was 10 percent of VA patients. The budget impact of this 10 percent was only about 1 percent of medical care appropriations."¹

Many people seem to forget that because of these great men who fought in World War II, Korea and many other conflicts, we have the greatest democracy right now. What can be done right now to alleviate this terrible financial burden on our oldest, most distinguished heroes?

When will we get the necessary staff and equipment to properly fulfill the Maui clinic's promise?

We have heard enough off-the-record comments about the quality of care in Hawaii to believe that outside Congressional-level investigators should interview past and present VA clinicians to get an accurate picture of our veterans' care.

VET CENTER

We need the psychologist we've been promised. So far, no luck on filling this gravely needed position. What can be done about incentives to get the proper staff? We hear the same concerns about money from all the applicants. Even with the 25 percent COLA, our housing, food and gasoline are among the highest priced in the Nation, discouraging many applicants who see themselves going financially backward if they come to Maui.

HAWAII STATE OFFICE OF VETERANS SERVICES

The Office of Veterans Services, although it belongs to the State of Hawaii and not the Federal Government, has long been instrumental in helping our veterans receive the benefits and care to which they are entitled. The Maui office no longer has a counselor and is being covered one day a week by someone from Oahu.

¹Zhu, Gardner and Hendricks, "Just How Many Enrollees Come to VA Just for Pharmacy?" HCFFE Data Brief #2004-10, p. 2, VA Boston Health Care System Research and Development, Health Care Financing and Economics, funded by HSR&D SDR 97-001-01.

As of June 30, 2007 the State councilors' offices had the following number of office visits with the following level of staff:

	Visits	Staff
Oahu	2,275	3 councilors, 1 clerical.
Hawaii	2,202	1 councilor, 1 clerical.
Kauai	1,458	1 councilor, 1 (unfilled) clerical.
Maui	2,288	1 councilor (unfilled), 1 clerical.

Oahu has more telephone and outreach presentation contacts, which of course is due to the large active duty population on the island. The other islands have fewer active duty residents—in the case of Maui, almost none. Their councilors work intensively with their clients on a one-on-one basis, almost always on specific issues involving veteran's benefits or health care.

With the departure of the Maui councilor, Mr. William Staton, and the beginning of the new fiscal year, the office needs a permanent full-time hire right away. We know 2 fine candidates now working full time at other jobs. One of them would probably fill the position but who would quit a permanent job for a temporary position?

The Maui Office of Veterans Services is a vital part of the infrastructure supporting Maui veterans and is in danger of being overwhelmed. The demand for their services, like the Veterans' Administration's, will only increase as our soldiers come home after fighting in conflicts for far too long.

We believe that Maui and the Big island each need 2 councilors and 2 clerical staff instead of a multi-year supply of grave liners for the state cemeteries. How do we get this changed and these very important community positions filled as soon as possible?

DAV VAN

The VA needs to supplement volunteer staff to drive the van. Lack of staff has led to clinic transportation difficulties for handicapped and infirm veterans.

Mr. Chairman, we believe the problems we've recently encountered on Maui are largely logistical and administrative, but magnified by cost and distance. As such, they are a barometer of VA health care efficiency in far flung, rural areas. Our clinicians are very dedicated, but the weather is stormy.

Thank you for this opportunity to testify about veterans' health care in Maui on behalf of the Vietnam Veterans of Maui County. We also thank the Committee for its continuing support of the Nation's veterans.

Senator AKAKA. Is that your statement?

Mr. HAUPT. Yes, sir.

Senator AKAKA. Thank you. Thank you, Carl Haupt.

Now, we'll here from Karl Calleon.

STATEMENT OF KARL CALLEON, VIETNAM VETERAN

Mr. CALLEON. Good morning, Mr. Chairman and Members of the Committee. I'd like to thank you for the opportunity to testify today.

I'll be talking about allowing private practice mental health doctors to assist the veterans.

The VA office has become so thick that many vets are discouraged from getting the mental and physical health care they need. As a result, we have vets killing their families and themselves.

It is a well-known fact that the VA does not have the sufficient mental health resource throughout the system. However, there are many qualified mental health providers who would love to do their patriotic duty and help injured vets. I don't understand why the VA would willingly outsource to medical doctors and dentists, but not to mental health specialists, who we need the most.

The VA does outsource the C&P evaluations to assist the VA to process claims, but they do not outsource to private practice mental health specialist to assist the vets. They only outsource to assist the VA. It would be cost effective to outsource to private practice mental health specialist because they will only be paid on an as-needed basis. No extra money is needed to be spent on facilities or employee benefits, making this approach much more effective than maintaining the high cost of clinics with their administration and maintenance costs.

Now we can only get help during regular office hours. However, most of our problems happen after office hours.

The expensive clinic is useless two-thirds of the time, but the Government pays for it 24/7. I think most suicides occur on non-office hours when the mental help is not available. Lack of immediate attention has directly caused veterans suicides, like it did recently at Tripler.

Maui has maintained a high-cost clinic. And much of the time, there isn't even a doctor there to treat the vets. Please remember, only the doctors provide life-saving treatment, not the facilities which cost the most.

On Maui, after office hours and on weekends, we are told to call 911 and go to the hospital emergency room. This is very expensive and over triples the cost of our health care. And there is no continuity of care. Why can't we just go directly to a private doctor and not wait for clinic hours and face a long waiting period, or go to the ER at extra expense to the Government?

Lastly, we'd like to thank you for your kind consideration and help you have provided us over the years. We are especially impressed at how you jumped in and worked and help us when we asked for help. You have a major role in resolving the problems we were having in the C&P process. We offer our heartfelt gratitude and appreciation.

Senator AKAKA. Well, thank you. Thank you very much. We really appreciate that. And now we'll here from Grant Steward. Grant.

**STATEMENT OF GRANT STEWARD,
OPERATION IRAQI FREEDOM VETERAN**

Mr. STEWARD. Good morning. It is an honor to be allowed to speak here today. After returning from the Middle East, I've been to five different VAs. Although I generally feel completely lost when I go there, the staff is always professional and courteous.

Having spent two and a half years going to VA, here are a few suggestions that may help veterans in the future. When VA realizes that a vet will require counseling, it may benefit the veteran if his or her family could get counselling as well, to let them know what their veteran is going through.

An example would be, after a counseling appointment, the counselor could call the veteran's spouse or family and offer them some help. I find it difficult for myself to open up to what's going on in my head. And, unfortunately, my family is left in the dark.

My wife is very understanding. I do feel guilty for not being able to communicate with her as much as I know I should. Having a counselor that could explain things to her would probably help bring some light to the situation.

There's nothing like being woken up in the middle of the night with an elbow being jabbed into your side. According to my wife, my teeth grinding is keeping her awake. Her elbow is going to keep me awake. I don't have dental coverage because it's only allowed for veterans who have 100 percent disability. What I am having a difficult time understanding is, if I'm going to have two service-connected problems with my head, why can't VA take care of the whole head? So that is the whole thing right there.

The following paragraph comes from a published study released March 2001, where 40 veterans with PTSD and 40 veterans without PTSD had an oral examination to evaluate toothwear.

Results showed significantly increased wear of tooth services in the three dimensions near the gumline—vertical, horizontal and depth—in those with PTSD compared to controls. Erosion vertically was more than three times greater, horizontally more than four times greater, and more than ten times greater in depth than controls.

The only reason I mentioned this is because, while I was in Iraq and even when I came back, I wake up constantly with pain in my jaw. And my dentist thinks it's from all this constant teeth grinding. And I've already lost several teeth since I've been back because of this. And VA can't do anything because of all the red tape. So that's why I mentioned that today.

Lastly, I really hate missing appointments. This is a result of several calls to the VA to make sure of my appointment time, as I have a tendency to lose the paper I write the appointment on. If the VA had a way of e-mailing appointments or appointment cancellations, my memory loss wouldn't cause a lot of overworked VA staff.

Thank you for your time. And I hope these suggestions benefit everyone who has served and sacrificed for our country. Thank you. [The prepared statement of Mr. Steward follows:]

PREPARED STATEMENT OF GRANT STEWARD, OPERATION IRAQI FREEDOM VETERAN

Good Morning. My name is Grant Steward and I am a U.S. Army veteran. I feel honored to stand here before such prestigious individuals.

Since returning from the Middle East, I've been to five different VA's. Although I generally feel completely lost when I go there, the staff is always professional and courteous. Of the five different centers, the Maui clinic, in my opinion, is the best. The doctors and staff all deserve a pat on the back for how attentive they are to their patients' well being.

Having spent two and a half years going to the VA, here are a few suggestions that may help veterans in the future.

When the VA realizes that a veteran will require counseling, it may benefit the veteran if their family could get counseling as well; if only to let them know what their veteran is going through.

I find it difficult to open up with what's going on in my head, so unfortunately, my family can get left in the dark. My wife has been very understanding, and I do feel guilty for not being able to communicate with her as much as I know I should.

Recently, I had to deal with a rather messy landlord/tenant issue. If the local VA had a list of lawyers who work with veterans, it would have helped with the stress by pointing me in the right direction. While in the Army, whenever a legal issue happened, JAG was full of wonderful answers. These days, I call my counselor and have him tell me to try not to stress out. Unfortunately, with a wife and 3 little children, not having electricity in your house can bring on lots of stress.

There's nothing like being woken up with an elbow jabbing into your side. According to my loving wife, if my bruxism, teeth grinding, is going to keep her awake, her elbow will keep me awake. I even find myself clenching my teeth throughout

the day. I don't have dental coverage, so my teeth get worse every month. I understand the VA wanting to cut costs, but when you have a service connection for two problems with your head, the VA should include care for the whole head.

The following paragraph comes from a published study, released March, 2001, (University at Buffalo, Buffalo VA Medical Center) where 40 veterans with PTSD and 40 patients without PTSD had an oral examination and evaluation of tooth wear.

"Results showed significantly increased wear of tooth surfaces in three dimensions near the gum line—vertical, horizontal and depth—in those with PTSD compared to controls. Erosion vertically was more than three times greater, horizontally more than four times greater and more than 10 times greater in depth than controls."¹

I hate the idea of missing an appointment. This usually results in several calls to the VA to make sure of my appointment times, as I have the tendency to lose the paper I write my appointments on. If the VA had a way of e-mailing appointments and appointment cancellations, my memory loss won't continue to result in an overworked VA staff.

Thank you for your time and I hope these few suggestions benefit all those who have served and sacrificed for our country.

Senator AKAKA. Thank you very much, Grant. And now we'll hear from William Stroud.

Mr. STROUD. Aloha.

Senator AKAKA. Thank you.

**STATEMENT OF WILLIAM FIELDING STROUD,
PAST PRESIDENT, VIETNAM VETERANS OF MAUI COUNTY**

Mr. STROUD. Thank you for inviting me here to speak on behalf of our veterans about health care system. Thanks mainly to a 10-year effort of the Vietnam Veterans of Maui County to obtain a clinic here on Maui for the veterans. There is now a small facility here which has guaranteed a certain level of stamp.

Because this clinic handles the 11,000 veterans here in Maui County, it's crucial that minimum staffing level remain in place. Earlier this year, all of our doctors had quit from overwork and we were left without a staff. When I found this out, I immediately e-mailed you, Senator Akaka, and you took action by going to the VA director and presented him with this information, received a promise of getting one doctor fast, with another one coming up in a few months.

Sir, I applaud you, not only for your words concerning the veterans, but of your willingness to take action. You are a warrior of the highest caliber for taking such good care of your men. In this case, the soldiers of our Nation.

We now have a critical situation of immense proportion. Not only on Maui, but across our whole land.

We have hundreds of thousands of citizen soldier veterans returning from combat and entering immediately back into what can be called their normal lives. But their lives are not longer normal. The reality of war can leave a person an internal wreck.

One may look normal on the outside and try to fit in and do what is right. But believe me, if you've been in combat, you must agree with me that your internal world is forever changed from the experience. Some deal with it. And others fall apart.

Now we hear statistics that 30 percent of the returning combat veterans are seeking PTSD treatment and care. We're talking hun-

¹ <http://www.buffalo.edu/news/fast-execute.cgi/article-page.html?article=50630009>.

dreds of thousands of our men and women whom we sent over there, coupled with the hundreds of thousands of backlogged PTSD cases which we already had from Vietnam and earlier conflicts. We have to admit that the VA is overwhelmed, and very directly speaking, not up to the task. If it was, we wouldn't be in the situation we're in.

VA medical care is among the best. This is not what concerns me personally. I am more concerned that these returning combat veterans get the PTSD care they need immediately so we do not leave these kids and their families hanging in the wind. But if the VA can't give them the care that they need, what can be done, one might ask.

Well, I know from my personal experience that it really takes a combat vet to relate to another combat vet.

For an intellectual person to address the subject of combat without the empathetic or analogical experience themselves is to make a mockery of the word treatment. Our veterans don't need simple therapy. They need lasting positive change, achieved through their experience not just words.

I propose that such a program be funded to be run on Maui for these returning combat vets run by combat vets and professionals who have been in combat situations. And having returned, we're able to shed the negativity of their combat experience and learn from it.

There is such a group here on Maui who can come together, administer and implement an effective two-month program to run combats through on a continual basis. There are such facilities right now which can be rented or purchased if we acted in a timely manner. These men and women returning from war need our help.

Not dealing with PTSD issues is not an issue. With the Army having the highest suicide rate in 26 years, we definitely have a problem. If we fail to act now, we're looking at hundreds of billions of dollars in lifetime care in benefits. And more importantly, the utter failure of taking care of our sons and daughters, whom we voted to put in harm's way.

Now, they say we are we going to pull out. Well, if the war ended tomorrow, we'd have a rush of people who needed treatment and care. Are we ready for this right now? I would say no. We must be ready and get ready for the realities of PTSD in a large way. And who better to deal with these imbalances other than combat vets who know the way out of this internal hell.

Please give our returning combat vets the support they need and do not be afraid to try something new. We don't want to give these returning vets pills. We don't want to treat them on the cheap. We want to give them the experience and the tools they need to fight their internal war, coming out alive, healthy and being a force of good in our lives.

The Maui Vietnam Veterans have proven their worth many times over, both in combat and in peace. We have supported both our country and our community. Our country once again needs help and we're here, willing and able to continue our service. Thank you.

[The prepared statement of Mr. Stroud follows:]

PREPARED STATEMENT OF WILLIAM FIELDING STROUD, PAST PRESIDENT,
VIETNAM VETERANS OF MAUI COUNTY

It has become public knowledge through the National News outlets what Vietnam Veterans and Veterans from other previous wars know from experience: The VA system for dealing with Veterans with PTSD issues is pretty much broken. Our VA professionals really do not know how to deal with these PTSD issues as 99 percent of them have never tasted combat themselves; they can provide pills but are pretty ineffectual/slow/inexperienced in combating active PTSD issues. With a backlog of over 250,000 cases even before the current mid-east crises' arose, and 100's of thousands more current Veterans seeking relief from their PTSD issues, our country is in a crises of unimaginable proportions.

Older Veterans know, from experience, that if PTSD issues are not addressed early upon returning from a combat situation, these internal conflicts will continue to solidify into patterns of behavior which are destructive and can, and do, lead to a downward spiral of damaging personal behavior, many types of family conflicts, large numbers of homelessness and large numbers incarcerated in jails and prisons. And now that there are many women veterans, we are looking at new areas of concern for our society.

This situation is unacceptable to us who have fought in combat in earlier theaters of operation. We cannot sit back and watch as our younger brothers and sisters go through the years of physical, emotional, mental and spiritual anguish which can be reduced and/or eliminated if approached by people of like experience who have gone through the process of re-integration themselves.

This correspondence is to inform you that there is a credible team of peers, professionals and laymen living here on Maui consisting of many combat veterans who have gone through the process of "discharging the negativity of the past" and have the knowledge and expertise to take on these veterans with PTSD issues and teach them how no part of their life is so traumatic that they can't learn from it and become a more mature person; using their experience to become a more balanced person and not a conflicted one.

There is a first-rate facility here on Maui which can easily handle a minimum of 75 PTSD claimants every 3-month cycle which can be obtained (if we act in a timely manner) to provide a place to run this professional operation; and the cost of putting one veteran through this 3-month program is infinitely small compared to a lifetime of 100 percent disability payments. By running traumatized veterans through this program on a continual basis we can pretty much guarantee that our government (and thus our citizens) will save many Billions of Dollars in actual out-of-pocket expenses in taking care of these brave soldiers for the rest of their lives as well as the additional social costs of their resulting behavior. More importantly though is the fact that we will be helping these veterans turn their lives around after having undergone such traumatic experiences in such hostile environments; all at the request of our Country.

We stand ready to act—Now! The PTSD issues being experienced are not so hard to deal with for people who have had similar experience and have made it out through to the other side. Please do not hesitate to act! Our only interest is in helping out our fellow combat veterans and their families; their wars continue on internally.

Senator AKAKA. Thank you, William. Thank you for your kind expressions as well, and for your testimony. I have a few questions here. Let me ask Rogelio Evangelista and Danny Kanahele.

You both testified before this Committee in January of last year, when we held the first series of field hearings across the State. What has changed since then in terms of VA care? Has progress been made on improving access to care on Maui? Rogelio.

Mr. EVANGELISTA. Well, I notice there have been some progress being made. We ended up with more staff at the CBOC to take care of us. One thing that I'd also like to question is, at the last hearing, I think I mentioned that some of the staff there are not full-time VA staff, they're only contract workers. Is it possible to get them also to be on staff and not just contract workers?

Senator AKAKA. I will look into that. Danny?

Mr. KANAHELE. You had some pretty good improvements with health care. I really appreciate that because that was really need-

ed. But I still think that the disability rating of the veterans has to be addressed. I'd like to know how they really go about it and how they rate these people to find out and make sure they get what they need. Because it's been a while. I know a lot—it's been a while and they have never moved yet. They're still there.

Senator AKAKA. Well, thank you for that. And, of course, what I'm reaching for is to find out what else is needed on Maui. Plenty of you have testified to that. So let me call on Carl Haupt.

Mr. HAUPT. When Senator Inouye dedicated the Maui CBOC, he said this clinic will be our model clinic for the Nation. Is our clinic still fulfilling Senator Inouye's and Senator Akaka's vision? I don't think so.

Two issues about quality care have come to our attention. The first is equipment. The second is staffing. We are now losing our ophthalmologist because he is not provided with even the most basic equipment to do his job.

The AUDIENCE MEMBERS. We can't hear you.

Mr. HAUPT. We are now losing our ophthalmologist because he is not provided with even the most basic equipment to do his job. I just went to see him the other day.

His hand was out here and my eyes were over here. And I thought where is the retina machine Dr. Hastings said was in the warehouse back in March?

A VA cardiologist comes for examinations on Maui. He doesn't have the proper equipment at the clinic. Why are we wasting his time and our money? Why does our clinical staff continue to have to work evenings and Saturdays with no extra pay just to get caught up with the paperwork?

The *Washington Post* brought attention to the problems with records transfer between the Department of Defense and the Veterans' Administration, but the VA staff in Hawaii has been coping with it ever since the cooperative agreement with Tripler was signed, even before 9/11. It is contributing heavily to staff burnout and turnover.

As of two months ago, there were approximately 600 people on the CBOC waiting list who were not able to get VA care. Kathy Haas told us the other day that this is not so anymore, that this list has been totally eliminated. We'd like to hear her testimony today to straighten this out.

We can't believe that we have one doctor and one other doctor come onboard on the first of this month, and now all of a sudden, the 600 patients on waiting list are gone. That's unbelievable. But if they said they'd done it, I don't want to say anyone's a liar. I'd just like to hear the testimony on the record to say it was done and how it was done.

These people are paying \$600 to \$800 a month for their maintenance prescriptions. Their VA copayment will be about \$35. Many of these veterans are our oldest and most distinguished World War II and Korean Veterans.

According to a 2004 study sponsored by the VA Health Services Research and Development Service, only about one in seven VA pharmacies fits the definition of having a small number of outpatient visits annually with a relatively large pharmaceutical cost. This number was 10 percent of the VA patients, only 10 percent.

The budget impact of this 10 percent was only about 1 percent of the medical care appropriations.

Many of these people seem to forget that because of these great men who fought in World War I and II and Korea, and many other conflicts, we have the greatest democracy in the world right now. What can be done right now to alleviate the terrible financial burden on our oldest most distinguished heroes? When will we get the necessary staff and equipment to properly fulfill the Maui clinic's promise?

We have heard enough off-the-record comments about the quality of care in Hawaii to believe that outside Congressional-level investigators should interview past and present VA clinicians in order to get an accurate and better picture of our veterans' health care.

We felt these people will tell us off-the-record this, that, and the other thing. But they will not say it to their bosses because they're afraid to lose their job.

If you have an investigation, like we did before, and deposition from people to get the right answers to the right problems, I think a lot of these problems will be alleviated.

Senator AKAKA. Thank you. Let me ask a final question. And this is to all of you. What improvements do you believe could be made to VA health care on Maui and in the State of Hawaii overall?

As you've said, you have had all these experiences as veterans and in dealing with the VA. And as I pointed out, we're looking for what I call challenges that we need to deal with to improve the services here on Maui. So let me give each one of you a chance to respond to what improvements do you believe could be made to VA health care on Maui and in the State of Hawaii overall.

So let me begin with Rogelio.

Mr. EVANGELISTA. Well, Senator, like all other health plans in the State, I'm looking at 7/24 health care center to help the veterans. Because they suffer 7 days, 24 hours. I think that would, hopefully, be something that we could look forward to in the near future.

Senator AKAKA. Thank you. Clarence.

Mr. KAMAI. Again, Senator, I would have to agree with Roger. And I believe again that what Mr. Skaggerberg mentioned about the fee basis as being a problem solver for this island, and possibly for Kauai and the other outside islands. It would solve, I believe, a lot of the problems that is happening now.

Senator AKAKA. Mahalo. Danny.

Mr. KANAHELE. I agree with these two guys, I think we're all going to agree on the same subject. But I think—you've got that equipment in Tripler. I think if we have one here, we'd save a lot of money for our people traveling back and forth. If we can get some equipment here for us—we have Maui, Lanai, Molokai—that would save a lot of money from everybody flying that far. I think that would do it also, sir. Thank you.

Senator AKAKA. Mahalo. Mitch.

Mr. SKAGGERBERG. The mental health professionals we have are some of the best in the country. But they're overwhelmed. And we (those of us with 100 percent PTSD, and have had numerous family problems) have to wait four or five weeks to have follow-up appointments. Much too long!

As Roger and Danny said, a lot of our crisis comes during off-hours, weekends. All of a sudden, our family are exposed to us for three days and we're flashing back or we're about to do harmful things to our families. A lot of it is verbal abuse. But I think we need to look at how we are going to get a 24/7 mental health care.

We have hundreds and hundreds of disabled veterans with PTSD here on Maui and on Kauai and on the Big Island. I don't have answers. I mean, maybe we "fee basis" that too, to start with. I know we need at least four or five full-time mental health professionals right now. And I think we only have two. But we understand that another one at the Vet Center is thinking of accepting the job. But we need more than that, and we need it 24/7.

Most of my episodes happen outside of clinic hours. And it's amazing how a lot of them happen on the weekends, for whatever reason. And we're sitting there for three days just to be able to call the clinic and say we need help.

And then, of course, they want to help us, but they have other critical things going on at the same time. So I would say let's look at some "fee basis." There are some outstanding psychiatrists on the island in private practice that I think we should look at as being able to handle that as well.

Senator AKAKA. Thank you. Thank you very much, Mitch. Carl.

Mr. HAUPT. I agree with Mitch about we need more mental health professionals.

I'd also like to add that we need to offer them higher pay. Money paid to employees on Maui is the number one reason for lack of applicants. Even with 25 percent COLA, housing, food, gasoline, we run the highest price in the Nation, discouraging many applicants who see themselves going financially backward if they come to Maui. Thank you.

Senator AKAKA. Thank you. Karl Calleon.

Mr. CALLEON. Same with me. I agree with everybody with what they're stating. My testimony was about mental health problems. If you cannot get the doctors here at our facilities to help us out, why not attract the private practitioner and have them be, you know—like these guys said, on a fee basis. That was my main concern, too.

Senator AKAKA. Mahalo, Karl.

Grant Steward.

Mr. STEWARD. I think they all hit it right on the head. The 24/7 care would be absolutely wonderful. Because life doesn't exist between 8 to 5 only, Monday through Friday.

Mr. SKAGGERBERG. Can I interject something, Grant.

My understanding of the dental health care policy here is that if you have a common injury or war injury, that even indirectly affects your teeth, there is some time that you should be able to get complete dental health care from the VA system.

I can tell you a lot of our VA providers don't know this. So I would ask you and the Senator to really look into that. Because we have tremendous number of young soldiers coming back and being denied. And yet, I believe— if the last time I read the regulations was if they can prove, you know. So to me, that's a no-brainer, that his teeth should be getting fixed.

I'm sorry about that, Grant. I go crazy too sometimes. I want to help you, and you deserve that. I would ask that whoever is telling you that, ask them to look up the regulations and go to Dr. Hastings, if necessary.

Mr. KANAHELE. That's right.

Senator AKAKA. Grant.

Mr. STEWARD. Every VA I've been to, I believe you have 6 months of care or 3 months of care, after which—until you're 100 percent. And I do believe it's one of the cost-saving measures they have. And I've asked them here again because I needed a dental guard. And they couldn't do it. So maybe if I got a certain ache, they might fix it.

Senator AKAKA. Thank you, Grant.

William. Bill.

Mr. STROUD. I've been using the clinic ever since it was established here. But one thing I realized early on is that it is small with only a few staff dealing with a lot of people. So every time I needed an appointment, whether it's dental or vision or dermatology or arthritis or whatever, I call the specific department over at Oahu, because I know they have a larger staff. I get appointments and I get airplane tickets I need to get over there. And I get referred to a local dentist.

Like last year, I was running for Mayor and I didn't have my false teeth, I lost them. So I needed like partials in a hurry, and I explained this to them. They sent me over to a dentist in Kihei, and I have it taken care of before my first debate. So it was both necessary and very gratifying to get that level of service.

So I would like to recommend that people here don't need to swamp the clinic with their 800 phone calls. As past president of Vietnam Veterans of Maui County, I used to mail out a list of everybody over at Oahu, all the VA staff, the doctors and the offices. And if you contact them directly, they're fast. They get back to you fast. Thus, saving this clinic a little bit of grief and angst for being overloaded with all of this stuff.

I don't know if this defeats the purpose of not having everything here. But I found a way in which I can get treated much faster than try to go in and jam the line in the clinic, which nobody wants to do.

Thank you, sir.

Senator AKAKA. Mahalo nui loa, Bill. William.

Mr. STROUD. Bill is good.

Senator AKAKA. I want to thank all of our witnesses for your testimony, for your response, and for your comments. Without question, it's going to be helpful to all of us, and especially in our work on a different level of Government to continue to help those on the State level, and as well as on the Federal level.

The Committee will keep all of these as records, and we'll be working on it. So I want to say mahalo nui loa to this panel.

(Recess.)

Senator AKAKA. Aloha. I wanted to say aloha to all of you on the second panel. We'll go on with our second panel here. I want to welcome our second panel. I want to welcome Dr. Michael Kussman, who is the VA Under Secretary for Health. We're grateful for you coming and attending our hearings here in Hawaii. He

is our top man for health at the VA. And so we are grateful to have him here. He is accompanied by Dr. Jim Hastings, who's the Director of the VA Pacific Islands Health Care System here in Hawaii; and Dr. Robert Wiebe, who's the Director of VISN 21.

I also want to welcome Mark Moses. He is the Director of Office of Veterans Services for the entire State of Hawaii. He's doing a tremendous job and we're delighted to have him here today.

Finally, I want to welcome Dr. Michael Shepherd, Senior Physician in the Office of Health Care Inspections of the Office of the Inspector General. And we have here Julie Watrous from the VA Inspector General's Office accompanying him. I want to thank each of you for being here today and your full statements will appear in the record of the Committee.

Now I'd like to call on Dr. Kussman. As I said earlier, I can't say enough to welcome him and thank him for being present, and also the others of you on this panel.

Dr. Kussman.

STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., MS., M.A.C.P., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT L. WIEBE, M.D., DIRECTOR, VISN 21, DEPARTMENT OF VETERANS AFFAIRS; JAMES HASTINGS, M.D., F.A.C.P., DIRECTOR, VA PACIFIC ISLANDS HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. KUSSMAN. Mr. Chairman, mahalo nui loa for the opportunity to be here today to testify before you to discuss the state of the VA care here on Maui.

Before I get to my prepared remarks, I'd like to express from the VA in total, from the Secretary to the Deputy Secretary, myself, and all our 230,000 people for the sorrow and sadness of what happened in Iraq for the deaths in the recent helicopter crash of the members of the 25th Infantry Division, to all the members of the 25th Infantry Division, particularly the family members of the deceased. This is particularly poignant for me personally, having been a member the 25th Infantry Division as a division surgeon. We send our condolences and sorrow to all the people involved.

It's a privilege to be here in Maui, the Valley Isle, to speak and answer questions about issues important to the veterans residing in Maui County. Today I will describe our current services and highlight issues of particular interest to veterans residing in Maui, Molokai and Lanai. I would like, as you mentioned already, to have the written testimony submitted for the record. Thank you.

Senator AKAKA. In the record.

Dr. KUSSMAN. The Maui Community Based Outpatient Clinic serves an estimated veteran population of almost 10,000 veterans. In FY 2006, 2,328 Maui veterans were enrolled for care and 1,436 received VA care. The Maui CBOC recorded 9,217 clinic stops, a 46 percent increase from FY 2002. But market penetration rates for enrollees and users suggest additional demand is needed for the veterans' health care services here.

The past year has been difficult for the staff and patients served by the Maui CBOC. That was mentioned already by the previous panel. But the health care system provided coverage with a com-

bination of contract and VA staff traveling from Honolulu. It wasn't what we would have liked, but we did the best we could given the circumstances.

I am pleased to announce we have hired additional staff and shortened waiting times for new patients for first primary care appointments. By next month, the clinic should have two full-time VA primary care physicians and one full-time primary care and nurse practitioner. When the new staff is hired and onboard, we will have sufficient capacity for over 2,000 primary care patients.

There is also significant demand for mental health care services at the Maui Community Based Outpatient Clinic. About 32 percent of all patients currently seen at the clinic have a documented mental health illness. The authorized mental health providers include a psychiatrist, a psychologist, a social worker, a clinical nurse specialist, and a substance abuse counselor. We will soon have a telehealth psychologist and a telehealth technician available as well. The Maui Vet Center is also recruiting for another mental health care clinician.

Specialty care services are also available during scheduled visits from physicians and clinicians from the Honolulu VA Medical Center and other VA facilities in California. If a veterans' needs service is not available at the clinic, the health-care system arranges and pays for care in the local community.

The islands of Molokai and Lanai are part of Maui County. VA provides limited services on these islands, but is accessing options to enhance care and access at both locations. VA estimates that the veteran population on Molokai is 649, and the VA provided care to 148 of them in FY 2006. The VA clinic in Molokai is located in shared space near Molokai General Hospital and operates two half-day primary care clinics per week.

The clinic is staffed with a part-time VA physician and contract support staff. The health care system plans to acquire dedicated space on Molokai, telehealth care equipment, and to add telemental health services when the staff at Maui CBOC is available.

In FY 2006, the VA provided care to more than half of the 58 enrolled veterans on Lanai. We estimated there are approximately 229 veterans on the island. For the past two months, the VA has sent a primary care physician from Honolulu to Lanai once a month to provide needed primary care services. We will reassess the suitability of this monthly visit in about 6 months. The health care system is exploring options with a nearby Straub Clinic, and we hope to relocate our services to this location in the coming months.

In summary, with your support, Mr. Chairman, the VA is providing an unprecedented level of health care service to veterans residing in Hawaii and here on Maui. I am proud of the improvements in VA services in Hawaii, but we recognize our job is not done and there's more to do.

Again, Mr. Chairman and other members, mahalo nui loa for opportunity to testify at this hearing. And my staff and I would be delighted to answer any questions you might have. Mahalo.

Senator AKAKA. Thank you. Thank you, Dr. Kussman.

[The prepared statement of Dr. Kussman follows:]

PREPARED STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., M.S., M.A.C.P.,
 UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, mahalo nui loa for the opportunity to appear before you today to discuss the state of VA care in Maui. It is a privilege to be here in Maui—the Valley Isle—to speak and answer questions about issues important to veterans residing in Maui County.

First, Mr. Chairman, I would like to thank you for your outstanding leadership and advocacy on behalf of our Nation's veterans. During your tenures as Chairman and Ranking Member of this Committee, you have consistently demonstrated your commitment to veterans. As I will highlight later, your vision and support have helped us provide an unprecedented level of health care services for veterans throughout Hawaii and the Pacific Region. In addition, I appreciate your interest in and support of the Department of Veterans Affairs (VA).

Today, I will briefly review the VA Sierra Pacific Network that includes Hawaii and the Pacific Region; provide an overview of the VA Pacific Islands Health Care System (VAPIHCS) and the VA clinic here in Maui; and highlight issues of particular interest to veterans residing in Maui County, including capacity at the VA clinic in Maui and VA services on the nearby islands of Molokai and Lanai. I also look forward to addressing any questions you might have for me and my staff.

VA SIERRA PACIFIC NETWORK (VISN 21)

The VA Sierra Pacific Network (Veterans Integrated Service Network [VISN] 21) is one of 21 integrated health care networks in the Veterans Health Administration (VHA). The VA Sierra Pacific Network provides services to veterans residing in Hawaii and the Pacific Region (including the Philippines, Guam, American Samoa and Commonwealth of the Northern Marianas Islands), northern Nevada and central/northern California. There were an estimated 1.1 million veterans living within the boundaries of the VA Sierra Pacific Network in Fiscal Year 2006 (FY 2006).

The VA Sierra Pacific Network includes six major health care systems based in Honolulu, HI; Palo Alto, CA; San Francisco, CA; Sacramento, CA; Fresno, CA; and Reno, NV. Dr. Robert Wiebe serves as director and oversees clinical and administrative operations throughout the Network. In FY 2006, the Network provided services to 235,000 veterans. There were about 2.9 million clinic stops and 24,500 inpatient discharges. The cumulative full-time employment equivalents (FTEE) level was 8,400 and the operating budget was about \$1.5 billion.

The VA Sierra Pacific Network is remarkable in several ways. In FY 2006, VISN 21 was the highest-ranked Network in overall performance (based on an aggregation of quality, access, patient satisfaction and business metrics). The Network hosts the highest number of Centers of Excellence and also has the most highly funded research programs in VHA. In the most recent all-employee survey, staffs in VISN 21 reported the highest overall job satisfaction in VHA. Finally, VISN 21 operates one of four Polytrauma units in VHA that are dedicated to addressing the clinical needs of the most severely wounded Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans.

VA PACIFIC ISLANDS HEALTH CARE SYSTEM (VAPIHCS)

As noted above, VAPIHCS is one of six major health care systems in VISN 21. Dr. James Hastings is the director and a practicing cardiologist at VAPIHCS. VAPIHCS is unique in several important aspects: its vast catchment area covering 2.6 million square-miles (including Hawaii, Guam, American Samoa and Commonwealth of the Northern Marianas); island topography and the challenges to access it creates; richness of the culture of Pacific Islanders; and the ethnic diversity of patients and staff. In FY 2006, there were an estimated 102,000 veterans living in Hawaii (representing 8 percent of the total population in Hawaii and 9 percent of total veteran population in VISN 21).

VAPIHCS currently provides care in seven locations: the Ambulatory Care Center (ACC) and Center for Aging (CFA) on the campus of the Tripler AMC in Honolulu; and Community Based Outpatient Clinics (CBOCs) in Lihue (Kauai), here in Kahului (Maui), Kailua-Kona (Hawaii), Hilo (Hawaii), Hagatna (Guam) and Pago Pago (American Samoa). VAPIHCS also has outreach clinics in Molokai and Lanai. The inpatient Post Traumatic Stress Disorder (PTSD) unit is now also on the campus of Tripler AMC (the unit was formerly in Hilo). In addition to VAPIHCS, VHA operates five Readjustment Counseling Centers (Vet Centers) in Honolulu, Lihue, Wailuku, Kailua-Kona and Hilo that provide counseling, psychosocial support and outreach.

In FY 2006, VAPIHCS provided services to nearly 22,500 veterans, 19,000 of whom reside in Hawaii. There were 198,000 clinic stops in Hawaii during FY 2006 (7 percent of Network total). The cumulative FTEE in FY 2006 for the health care system was 502 employees. The operating budget for VAPIHCS (i.e., General Purpose allocation from appropriated funds) increased from \$68.0 million in FY 2002 to \$110 million in FY 2007—an increase of 62 percent. For comparison, during this same time period, the operating budgets for VISN 21 increased 48 percent and VHA increased 43 percent. (Please note these amounts do not include Specific Purpose Funds and Medical Care Cost Funds [MCCF].)

VAPIHCS provides or contracts for a comprehensive array of health care services. VAPIHCS directly provides primary care, including preventive services and health screenings, and mental health services at all locations. VAPIHCS does not operate its own acute medical-surgical hospital and consequently, faces challenges in providing specialty services. VAPIHCS recently hired specialists in orthopedics, ophthalmology, nephrology and inpatient medicine (“hospitalist”) and is providing selected specialty care in Honolulu and to a lesser extent, in CBOCs. VAPIHCS is actively recruiting additional specialists (e.g., Urology) and will continue to refer patients to DOD and community facilities.

Inpatient long-term and acute rehabilitation care is available at the CFA. Inpatient mental health services are provided by VA staff on a 20-bed ward within Tripler AMC and at the 16-bed PTSD Residential Rehabilitation Program (PRRP). VAPIHCS contracts for care with DOD (at Tripler AMC and Guam Naval Hospital) and community facilities for inpatient medical-surgical care.

The current constellation of VA facilities and services represents a remarkable transformation over the past several years. Previously, the VAPIHCS (formerly known as the VA Medical and Regional Office Center [VAMROC] Honolulu) operated primary care and mental health clinics based in the Prince Kuhio Federal Building in downtown Honolulu and CBOCs on the neighbor islands that were staffed primarily with nurse practitioners. Congress approved \$83 million in Major Construction funds to build a state-of-the-art ambulatory care facility (i.e., ACC) and a long-term care/rehabilitation unit (i.e., CFA) on the Tripler AMC campus and these facilities were activated in 2000 and 1997, respectively. VISN 21 allocated nearly \$17 million from FY 1998–FY 2000 to activate these projects. VISN 21 also provided dedicated funds to enhance care on the neighbor islands by expanding/renovating clinic space and adding additional staff to ensure there are primary care physicians and mental health providers at all CBOCs.

MAUI CBOC

VA operates a CBOC located in Kahului (203 Ho’ohana, Suite 303, Kahului, HI, 96732). In FY 2002, VAPIHCS spent \$208,000 to renovate the clinic. The Maui Vet Center is located in nearby Wailuku.

The Maui CBOC serves an island veteran population estimated in FY 2006 to be 9,900. In FY 2006, 2,382 veterans residing in Maui were enrolled for care and 1,436 veterans received VA care (“users”). The market penetrations for enrollees and “users” are 24 percent and 14 percent, respectively. These are lower than rates elsewhere in Hawaii.

As I will discuss later, the Maui CBOC has recently increased its staffing and currently is authorized to have 19 staff at the clinic. For comparison, at the time of your last hearing here in January 2006, the authorized staffing was 12.4 FTEE. The authorized primary care providers include two physicians, a nurse practitioner and a social worker. The authorized mental health providers include a psychiatrist, psychologist, social worker, clinical nurse specialist and substance abuse counselor. With this staff, the Maui CBOC provides a broad range of primary care and mental health services. In addition, VAPIHCS provides specialty care services at the clinic by sending VA staff from Honolulu and other VA facilities in California. Services provided by clinicians traveling to Maui include cardiology, gastroenterology, geriatrics, nephrology, neurology, optometry, orthopedics and rheumatology. If veterans need services not available at the clinic, VAPIHCS arranges and pays for care in the local community (e.g., Maui Memorial Hospital), Honolulu (including Tripler AMC) or VA facilities in California. In FY 2006, VA spent nearly \$3.6 million for non-VA care in the private sector (i.e., not including costs at other VA or DOD facilities) for residents of Maui.

In FY 2006, the Maui CBOC recorded 9,217 clinic stops, representing a 46 percent increase from FY 2002 (i.e., 6,292 stops). The past year has been difficult for the staff and patients served by the Maui CBOC. Several staff, including a VA and a contract primary care provider, left the clinic for a variety of personal and economic

reasons (e.g., cost of housing on Maui). VAPIHCS provided coverage with a combination of contract and VA staff traveling from Honolulu.

Some patients, like Mr. Richard Bond were pleased with the arrangement. In a letter to an editor, he wrote, "I want to thank the Maui VA clinic. Out of the blue, staff phoned me with a lab appointment and a few days later, a doctor's appointment. Dr. Wong [a VA physician at the ACC in Honolulu] flew over from Honolulu and I received a thorough physical and a flu shot to boot." However, VAPIHCS understands that other patients were dissatisfied because continuity of care was not optimal and waits for appointments lengthened. I am pleased to report that with additional staff, the situation has improved and the clinic currently has short waiting times for new patients with very few veterans waiting more than 30 days for their first primary care appointment.

SPECIAL ISSUES

Capacity at Maui CBOC

As noted earlier, in FY 2006 VA provided health care services to 1,436 veterans who reside in Maui. However, market penetration rates for enrollees and "users" suggest there is additional demand for VA health care. This was corroborated by veterans' advocates during a meeting with Drs. Wiebe and Hastings earlier this year in Maui. Consequently, VAPIHCS has significantly increased the authorized staffing at the Maui CBOC. When the new VA primary care provider arrives next month, the clinic will have two full-time VA primary care physicians and one fulltime primary care nurse practitioner. Based on VA primary care panel size criteria, this would give the clinic a theoretical capacity for over 3,000 primary care patients (i.e., 1,200 patients for each full-time physician and 800 for each full-time nurse practitioner). Even considering the special circumstances at the Maui CBOC (e.g., lack of VA inpatient facility and limited community health care resources on the island), the VA clinic will be able to provide high quality and accessible primary care to more than 2,000 patients.

In addition, the Maui CBOC will soon begin Home Based Primary Care (HBPC) services for veterans residing in Maui. HBPC is currently available in Oahu, Kauai and the Big Island. HBPC is an important component of VA's non-institutional long-term care program designed to provide care in the least restrictive setting for veterans.

There is also a significant demand for mental health services at the Maui CBOC. About 32 percent of all patients currently seen at the clinic have a documented mental health illness (compared to 19 percent for VHA), including a high prevalence of PTSD. In response, VA has substantially increased its authorized mental health capacity at the Maui CBOC. As you know, Mr. Chairman, Congress has provided several hundred million dollars to VA over the past two fiscal years to specifically enhance mental health services. In FY 2006 and FY 2007, VAPIHCS received nearly \$2 million of these funds. These funds are being used to hire about 30 new mental health staff in VA facilities across Hawaii and the Pacific Region, including five staff here at the Maui CBOC. When all of these positions are filled, the Maui CBOC will have a psychiatrist, psychologist, clinical nurse specialist, mental health social worker, substance abuse counselor, telehealth psychologist and telehealth technician. In addition, the Maui Readjustment Counseling Center ("Vet Center") is also recruiting for another mental health clinician (i.e., psychologist or social worker).

The size of the veteran population and number of VA patients in Maui limit the feasibility of having a large cadre of medical and surgical specialists based in the Maui CBOC. Nonetheless, VA recognizes that some veterans in Maui County have needs that go beyond primary care and mental health. VA sends specialists from Honolulu and California to the clinic on a regular basis. As noted earlier, services provided by clinicians traveling to Maui include cardiology, gastroenterology, geriatrics, nephrology, neurology, optometry, orthopedics and rheumatology. VAPIHCS also refers patients to the local community for care at VA expense (when eligibility criteria are met) and transports (also at VA expense, when eligibility criteria are met) to the VA facility in Honolulu. The Maui CBOC also utilizes telehealth technologies to provide specialty services.

Molokai and Lanai

The islands of Molokai and Lanai are part of Maui County. VA provides limited services on these islands with permanent staff (on Molokai) and visiting VA staff (to both islands). However, VA is assessing options to enhance services in both locations.

Molokai

VA estimates the veteran population on Molokai to be 649. In FY 2006, 211 veterans from Molokai were enrolled for VA care and 148 veterans received VA services. VA formerly established an outreach clinic on Molokai in FY 2005. However, Mr. Chairman, with the assistance of you and your staff, VA now has established a more formal presence on the island. The VA clinic on Molokai is located in shared space near Molokai General Hospital and operates two half-day primary care clinics per week. The clinic is staffed with a part-time VA physician and contract support staff. Although VA has not installed its own telehealth equipment in Molokai, VA currently has access to videoconferencing equipment. VAPIHCS is hoping to acquire dedicated space in Molokai to enable the placement of permanent information technology (IT) and telehealth equipment. VA also sends mental health staff from the Maui CBOC to Molokai to provide care. Specifically, the psychologist travels twice a month and the psychiatrist once a month. VAPIHCS is also planning to add telemental health services when staff (at the Maui CBOC) and equipment are on-board. In addition, VA purchases non-VA care in the community (e.g., Molokai General Hospital) for eligible veterans residing in Molokai, at a total cost of \$280,000 in FY 2006. Veterans residing in Molokai also are seen at DOD and VA facilities in other locations. VA pays for travel expenses for those veterans eligible for beneficiary travel.

Lanai

VA estimates the veteran population on Lanai to be 229. In FY 2006, 58 veterans residing on Lanai were enrolled for VA care and 30 veterans received VA services. VA currently sends a primary care physician from Honolulu to Lanai once a month to provide needed primary care services. This began in June 2007, and we will reassess the frequency in about 6 months. VA currently is using space adjacent to the Lanai Community Hospital and is negotiating with the hospital to use its videoconferencing equipment for telehealth. VAPIHCS is exploring options with the nearby local medical clinic (i.e., Straub Clinic) and we hope to relocate our clinic to this space in the next couple of months. In addition, VA purchases non-VA care in the community and pays beneficiary travel for eligible veterans. VA is exploring other options to improve access, including adding an automated pharmacy dispensing device and/or telehealth capabilities. We are also having conversations with local residents in Lanai City about a possible federally Qualified Health Center (FQHC) and how VA might participate in and partner with FQHC.

CONCLUSION

In summary, with your support, Mr. Chairman, and other Members of Congress, VA is providing an unprecedented level of health care services to veterans residing in Hawaii and here in Maui. Although VA struggled earlier this year with staffing at the VA clinic in Maui, we now have a robust cadre of primary care and mental health practitioners. We look forward to a growth of new patients at the Maui CBOC and will meet the expectations of veterans for quality and timeliness.

VAPIHCS still faces several challenges, in part due to the topography of its catchment area, lack of an acute medical-surgical hospital, limited community resources in rural areas and difficulties recruiting staff. VAPIHCS will meet these challenges by utilizing telehealth technologies, hiring specialists, working with community partners and developing new delivery models. I am proud of the improvements in VA services in Hawaii, but recognize that our job is not done.

Again, Mr. Chairman and other Members of the Committee, mahalo nui loa for the opportunity to testify at this hearing. My staff and I would be delighted to address any questions you might have for us.

And now may I call Mr. Moses, representing the State. Mark Moses.

STATEMENT OF MARK MOSES, DIRECTOR, OFFICE OF VETERANS SERVICES, DEPARTMENT OF DEFENSE, STATE OF HAWAII

Mr. MOSES. Thank you, Mr. Chairman. It's a great privilege to testify before your Committee today. I am Mark Moses, Director of the Office of Veterans Services, OVS.

OVS is the state leading agency responsible for the welfare of Hawaii's veterans and family members. We act as the Governor's

liaison to veterans and veterans groups. We serve as an intermediary between the Department of Veterans' Affairs. And we also provide the state services and benefits that our legislature has authorized.

We have provided services and information to nearly 33,000 veterans and survivors this past fiscal year. I've attached the summary sheet describing some of those services and activities made available for your review.

Mr. Chairman, as you understand, the final service we can provide a veteran is interment in a veterans' cemetery with appropriate honors. We take this seriously.

The VA has consistently supported our efforts to expand Hawaii's cemetery plots and columbarium space to keep pace with need. They are deserving of our gratitude.

Makawao Veterans Cemetery has sufficient columbarium space, and we are looking at the need to expand it for burials and plots. It is important to take this opportunity to thank you personally, Senator, for your unwavering support for our veterans' cemetery program.

Thank you very much.

The April 2000 data from the VA Office of Actuary, Office of Policy, Planning and Preparedness estimated that there are 120,000 veterans in Hawaii: about 72 percent on Oahu, 13 percent on the Big Island, 10 percent on one of the Maui County islands, and approximately 5 percent on Kauai.

Our island state represents unique challenges for the Department of Veterans Affairs, but also for our State Offices. You heard the testimony this morning about vacancies. We have had vacancies. We've had two vacancies we could not fill by law because of workers' compensation problems. Both have been resolved, and we're hiring right now as of about the last week. Our island state presents unique challenges in other ways because of our separation.

I want to share with you comments that we have heard from veterans. Now, they speak of the excellence of the VA medical care and how VA staff treats veterans with dignity and respect, and that the services rendered by the dedicated health care professionals are superior to that they received on the mainland. These comments are from local veterans and those visiting from neighbor islands, as well as from out of state. Similar comments are shared about the benefits staff.

Hawaii VA supports National Guard and Reserves prior to deployment and upon their return, as well as all those members ending their active military service. As a disabled veteran, I can attest to the fact that the services provided by the VA locally are among the top in the Nation.

I've had many of my services here by choice when I could have gone to other hospitals. Nevertheless, given the proper resources, they are capable of doing better.

Nearly 30 percent of our veterans live on the neighbor islands. Many of them are referred for surgical services on the mainland in VA medical facilities or civilian medical facilities on Oahu or Tripler Army Medical Center. For neighbor island veterans sent to mainland VA hospitals, this can be very traumatic.

They are booked on flights, sent to a big city where they may not know their way around, and they're told to find the VA facility. They're operated on. And then they're sent back to their homes in Hawaii. We ask that sufficient funding be provided for direct mainland flights from, and whenever possible, back to their neighbor island of residence.

Changes to 38 U.S.C. 1151, *Benefits for persons disabled by treatment of vocational rehabilitation*, means only facilities covered by the law are those over which the VA Secretary has direct jurisdiction or a government facility contracted by him.

Tripler, Straub, Kuakini, Queen's and St. Francis do not qualify. A veteran who suffers any additional disability, or worse, are on their own, and they must sue the medical facility by themselves for damages. It is an overwhelming task for most of our veterans.

We suggest the definitions, as listed in 38 U.S.C. 1701(3) and 38 U.S.C. 1151 be changed, allowing Hawaii veterans the same protection as veterans receiving care in VA facilities on the mainland. At a minimum, veterans must be given the opportunity to make informed consent about the benefits and shortfalls between having medical procedures performed at a mainland VA facility or locally at a non-VA facility.

Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu. Neighbor island Community Based Outpatient Clinics place veterans on a wait list, where they are scheduled for specialty medical care. With the use of telemedicine and more frequent visits, this problem is being addressed. However, a backlog still exists with some veterans waiting months to see a specialist.

VA has a difficult time recruiting and maintaining competent medical staff in these rural areas. VA should be allowed to offer a premium to rural medical service providers and to contract for additional medical care in rural areas, such as the neighbor island.

With our thousands of National Guardsmen and Reservists returning, my desire is that they and those already here receive medical and benefit services in a timely matter. We ask that VA Health and Benefits Administration be adequately funded and staffed to provide medical care and benefits services to all of Hawaii's veterans.

We just received a VA grant to help us with the building and now the opening of the Yukio Okutsu Veterans Home. And it's supposed to open this year. There have been some delays, and we're awaiting the final date of opening. We still don't have eligibility criteria, though, for the hospital. And we're trying to get that information.

Eventually, I envision that we will have several veteran long-term facilities, preferably at least one per county, if not one per island. The need is here. I personally pledge that I will look into making use of the beds in other facilities under the law that you have just passed. Thank you very much for that.

The present per-day veteran reimbursement rate is only \$67.71. And that's very low and insufficient to maintain a veteran without additional payments. We request the reimbursement rate be raised to adequately cover the long-term service provided to assist the

state in meeting the medical care of this very fragile and older group of warriors. The actual cost is approximately \$300 a day.

As these veterans pass, many will utilize our state veterans' cemetery system. Presently, the state and county are reimbursed \$300 for each veteran burial. Less than the cost to open and close the grave and to provide perpetual care. The actual cost is approximately \$1,000 per grave.

This reimbursement rate has not changed in many years. And we ask your Committee to look into increasing it to more closely reflect the true cost of interments.

We must continue to take care of those who served.

They are our sons and daughters. They are Hawaii citizens.

They are our veterans. I thank you and the Committee for this opportunity to testify. And I will respond to any questions.

[The prepared statement of Mr. Moses follows:]

PREPARED STATEMENT OF MARK S. MOSES, DIRECTOR, OFFICE OF VETERANS SERVICES, DEPARTMENT OF DEFENSE, STATE OF HAWAII

Chairman Akaka and Members of the Senate Committee on Veterans' Affairs, I am Mark Moses, Director of the Office of Veterans Services (OVS). The office is the single State lead agency responsible for the welfare of Veterans and their family members. We act as the Governor's liaison to veterans, veterans groups and organizations, and serve as an intermediary between the Department of Veterans Affairs and Hawaii's veterans. The office serves in partnership with the VA to provide state services and benefits. We provided services and information to nearly 33,000 veterans and eligible survivors this past fiscal year. I have attached a summary sheet describing some services and activities made available through the office for your review.

The final service we can provide a veteran is interment in a veteran's cemetery with appropriate honors. The Veterans Administration has consistently supported our efforts to expand Hawaii's cemetery plots and columbarium space to keep pace with need. They are deserving of our gratitude.

Additionally, it is important and proper to take this opportunity to thank you, Senator Akaka for your unwavering support for our veteran's cemetery program. We are particularly grateful for your assistance in obtaining the new grant for the West Hawaii Veterans Cemetery located in Kona. State veterans cemeteries are the only cemeteries accepting full body burials on a consistent basis in Hawaii. This VA grant will assure that West Hawaii will be the cemetery we all have envisioned it to be.

Based on April 2000 data from the Office of the Actuary, Office of Policy, Planning and Preparedness, Department of Veterans Affairs, there are an estimated 120,000 veterans in Hawaii. The majority, about 72 percent live on Oahu, 13 percent reside on the island of Hawaii, 10 percent live on one of the three islands which comprise Maui County, and approximately 5 percent live on Kauai. Hawaii, an island state located in the middle of the Pacific Ocean, presents unique challenges for the Department of Veterans Affairs.

Before I discuss some of these challenges, I want to share with you comments that my staff and I hear from veterans about VA health care and benefit services. These individuals speak to the excellence of VA medical care; that VA's staff treats veterans with dignity and respect, and that the services rendered by the dedicated health care professionals are superior to the care they received on the mainland United States. These comments are expressed by local veterans as well as by veterans who visit Hawaii and have a need to seek services from Spark M. Matsunaga medical staff. Similar types of comments are shared about the VA Benefit staff.

This "new" VA exemplifies the well known phrase of "supporting our troops." Hawaii's VA supports our National Guard members and Reservists prior to deployment and upon their return. They also offer services to military members who are ending their military service. As a disabled veteran, I can attest to the fact that the services provided by the VA locally are top in the Nation. Nevertheless, given the proper resource they are capable of doing better.

As mentioned earlier, Hawaii presents unique challenges to the VA. We are an island state with one large population center on Oahu. Nearly 30 percent of Hawaii's veterans live on the neighbor islands. Presently many of our veterans are re-

ferred for surgical services to mainland VA medical centers, civilian medical centers on Oahu, or to Tripler Army Medical Center. This can be very traumatic for neighbor island veterans who are sent to other VA hospitals. They are booked on flights, sent to a big city to find the VA facility, operated on and sent back to their home in Hawaii. We ask that funding be provided so that those who reside on neighbor islands be provided direct flights to the mainland. We also propose that whenever possible, return flights fly directly to the veteran's island of residence.

Another issue that affects Hawaii and Alaska involves changes that were made to 38 U.S.C. 1151, Benefits for persons disabled by treatment of vocational rehabilitation. With this change the only facilities covered by the law are those over which the Secretary of Veterans Affairs has direct jurisdiction, or Government Facilities contracted by the Secretary. Tripler Army Medical Center and other medical facilities in Hawaii, such as Straub, Kuakini, Queens, and St. Francis do not qualify under the present law. Veterans suffering an unlikely event causing any additional disability or worse are on their own and must sue the medical facility for damages. For most, obtaining an attorney to pursue this option is overwhelming.

We suggest that the definitions as listed in 38 U.S.C. 1701(3) and 38 U.S.C. 1151, be changed so that veterans in Hawaii treated outside VA facilities are afforded the same protection as veterans who receive VA medical care in VA facilities on the mainland. Hawaii's veterans must have the same right to redress as veterans treated at mainland VA facilities. At a minimum, veterans must be given the opportunity to make informed consent about the benefits and shortfalls of choosing between having surgeries or other medical procedures performed at a VA facility on the mainland or in non-VA facilities locally.

Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu. Presently neighbor island Community Based Outreach Clinics place veterans on a wait list where they are scheduled for specialty medical care. With the use of Telemedicine and more frequent visits, this problem is being addressed; however, backlogs still exist. Veterans have been known to wait several months before they see a specialist. Additionally, VA has a difficult time recruiting and maintaining competent medical staff in these rural areas. To address these needs, the VA should be allowed to offer a premium to rural medical service providers and consider contracting for additional medical care in rural areas such as the neighbor islands.

As you are aware, Hawaii has received thousands of its returning National Guardsmen and Reservists. As Director of the Office of Veterans Services, my desire is that these returning military members and those already here be able to access medical and benefit services in a timely manner. We ask that VA Health and Benefits Administrations be adequately funded and staffed to provide medical care and benefit services to all veterans who make Hawaii their home.

Hawaii has received a grant from the VA to build its first Veteran's Home. The Yukio Okutsu Veterans Home is scheduled to open within a few months. Our concern is with the reimbursement rate that the VA pays for veterans who will be residing at the home. The present reimbursement is insufficient to maintain a veteran without payment of additional funds. We in Hawaii are not alone in requesting that the per day reimbursement rate be raised so that it adequately covers long-term care services supplied by the facility. We envision that the Yukio Okutsu Veterans Home will be the first of several veterans' long-term care facilities, preferably at least on per county due to inherent island produced isolation. Adequate per resident reimbursement will assist the state in meeting the medical care needs of this frail group of older warriors.

As these veterans pass, many will utilize our State Veteran's Cemetery system. Presently the state and county are reimbursed \$300 for each veteran burial, but the cost to open and close the grave site and provide perpetual care greatly exceeds this amount. This reimbursement rate has not changed in many years. We ask that your Committee look into increasing the present amount so that it more closely reflects the true cost associated with full body and urn burials.

We must continue to take care of our veterans. We must support our Soldiers, Sailors, Airmen, Marines, and Coast Guard members at home and abroad. They are our veterans, our sons and daughters, our citizens of Hawaii.

I thank the Committee for this opportunity to speak on this matter and I will respond to any questions that you may have.

[The prepared statement of Mr. Moses follows:]

[Note: the following is a summary of services and activities being offered by the Hawaii Office of Veterans Services.]

HAWAII OFFICE OF VETERANS SERVICES

MISSION

The Office of Veterans Services (OVS) is the principal state office responsible for the development and management of policies and programs related to veterans, their dependents, and/or survivors. The OVS acts as a liaison between the Governor and veterans' organizations and also between the Department of Veterans Affairs and individual veterans. Our objectives are to assist veterans in obtaining State and Federal entitlements, to supply the latest information on veterans' issues and to provide advice and support to veterans making the transition back into civilian life.

OVS is the State's primary advocate of veterans applying for and receiving benefits and services. The OVS may take action on behalf of veterans, their families and survivors to secure appropriate rights, benefits and services. This process includes the reception, investigation and resolution of disputes and complaints.

The OVS serves all eligible veterans, Reservists, National Guard members, active-duty military personnel and their dependents (including stepchildren). (See List of Services at end.)

STATE PROVIDED BENEFITS

Special Housing for Disabled Veterans

Payment by the State of up to \$5,000 to each qualified, totally disabled veteran for the purpose of purchasing or remodelling a home to improve handicapped accessibility.

Burials

Burials for qualified veterans (including U.S. war allies) and their dependents in Veterans Cemeteries on Oahu, Hawaii, Kauai, Maui, Molokai, or Lanai.

Vital Statistics

Free certified copies of vital statistics forms when needed for veterans' claims.

License Plates

For the same cost as regular license plates, qualified veterans can acquire distinctive veterans' license plates for their car or motorcycle. Currently available are: "Veteran," "Combat," "Combat Wounded," "Pearl Harbor Survivor," "Former POW," "World War II Veteran," "Korean War Veteran," and Vietnam Veteran."

Tax Exemptions

Applies to real property that is owned and occupied as a home by a totally disabled veteran or their widow(er). Also applies to passenger cars when they are owned by totally disabled veterans and subsidized by the Department of Veterans Affairs.

Employment and Re-employment

Preference is given to veterans, Vietnam-era veterans, service-connected, disabled veterans and their widow(er)s for civil service positions, training programs, job counseling and referrals to civilian jobs by the Workforce Development Division, Department of Labor and Industrial Relations. Re-employment rights for veterans, Reservists or National Guard members who leave a position within State or County government for training or active military service.

We encourage you contact the Office of Veterans Services to have your questions answered. The sooner we begin the process together, the sooner you will see results. Please contact the OVS office nearest you. Walk-ins are welcome, and appointments are recommended. Home, worksite and hospital visits are available if necessary, as are Group presentations.

Office of Veterans Services—Oahu

Office: Tripler Army Medical Center E-Wing
Address: Office of Veterans Services, 459 Patterson Road,
E-Wing, Room 1-A103, Honolulu HI 96819-1522.
Telephone: (808) 433-0420; Fax: (808) 433-0385.
E-mail: OVS@ovs.hawaii.gov.
Hours: Monday-Friday, 7:45 a.m.-4:00 p.m.

Office of Veterans Services—Kauai

Address: 3215 Kapule Hwy., #2, Lihue, HI 96766.
Telephone: (808) 241-3346; Fax: (808) 241-3818.
E-mail: KOVS@ovs.hawaii.gov.

Hours: Monday-Friday, 7:30 a.m.–4:30 p.m.

Office of Veterans Services—Hawaii

Address: 101 Aupuni Street, Room 212, Hilo, HI 96720.

Telephone: (808) 933–0315; Fax: (808) 933–0317.

E-mail: HOVS@ovs.hawaii.gov.

Hours: Monday-Friday, 7:30 a.m.–4:30 p.m.

Office of Veterans Services—Maui

Address: 333 Dairy Road, Suite 201–A, Kahului, HI 96732.

Telephone: (808) 873–3145; Fax: (808) 243–5820.

E-mail: MOVS@ovs.hawaii.gov.

Hours: Monday-Friday, 7:30 a.m.–4:30 p.m.

LIST OF SERVICES FOR VETERANS, ACTIVE MILITARY,
SPOUSES AND DEPENDENTS

Assist in preparation of VA claims.
Help individuals file VA Appeals.
Represent veterans at VA hearings.
Obtain veteran birth, marriage, divorce and death certificates nationwide.
Assist with burial
Provide notary.
Assist indigents.
Maintain DD214s.
Refer individuals not qualified for VA benefits to other agencies.
Legal name change.
Review active service record.
Assist active medical boards.
Hawaii Veterans Newsletter.
Hawaii Veterans Roster.
Hawaii Veterans Website.
Governor's Liaison to veterans.
Legislative Advocate for veterans—State and Federal.
Yukio Okutsu Hilo Veterans Home—development and oversight.
State Veterans cemeteries statewide—grants and expansion.
Grant-in-Aid for all veteran related items—veterans' cemeteries, Arizona Memorial, Aviation Museum, Veterans Centers statewide, etc.
Tri-annual report for State Monuments.
Coordinate veterans organizations to clean the Korean and Vietnam Memorials on Capitol grounds.
Coordinate Memorial and Veterans Day ceremonies annually at Hawaii State Veterans Cemetery.
Assist with Memorial and Veterans Day ceremonies at National Cemetery of the Pacific (Punchbowl).
Coordinate leis for veterans cemeteries on Memorial Day.
Staff the Advisory Board on Veterans Services.
Hawaii Veterans Memorial Fund.
Maintain presence on neighbor islands.
Validate Military Service for Employee Retirement System.

Senator AKAKA. Thank you very much, Mark Moses.

Now we will receive the testimony of Dr. Michael Shepherd.

**STATEMENT OF MICHAEL SHEPHERD, M.D., PHYSICIAN,
OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR
GENERAL, DEPARTMENT OF VETERANS AFFAIRS;
ACCOMPANIED BY JULIE WATROUS, R.N., REGIONAL DIRECTOR,
OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR
GENERAL, DEPARTMENT OF VETERANS AFFAIRS**

Dr. SHEPHERD. Mr. Chairman, mahalo. Thank you for the privilege to testify on access to health care for the veterans on Maui. I'm accompanied by Julie Watrous, Director of the OIG's Office of

Health Care Inspections, Los Angeles office. Today I will briefly discuss challenges and opportunities for providing health care to veterans on the island of Maui.

As have been mentioned by previous speakers, staffing with primary care providers at the Maui CBOC has been a major concern during the past year. Despite efforts at recruitment, the Maui CBOC has been without a full-time VA primary care physician for a 9-month period until May 2007. During this time period, the clinic relied on the informal triage system for scheduling patient appointments. Despite the efforts of remaining staff, waiting lists accrued for nonurgent care leading at times to frustration on the part of veterans and impacting staff morale.

Although part-time contract providers were utilized, continuity of care remained a significant issue. Currently, there is a full-time VA physician day position, as well as a 3-day per week contract position to see patients at the CBOC. In the near term, a second contract physician reportedly will be increasing hours in order to see walk-in patients and OEF/OIF veterans.

A July 2004, VHA directive provides guidance on the maximum number of active patients, or panel size, for whom a provider should provide primary care. On Maui, primary care providers have a greater reliance on fee basis and consult specialty care in the absence of a full service VA, which impacts the real time availability of medical information and may have bearing on the appropriateness of panel size relative to a mainland nonrural location.

Furthermore, replacing providers at rural facilities is generally difficult and may be even more so in light of the real estate market on the island. We found that despite national VA panel size guidelines, the system has responded to a recent gap in primary care continuity by hiring a second full-time primary care physician for the Maui CBOC, who will begin seeing patients within the next month.

During the past year, the Maui clinic has had a full-time psychiatrist and psychologist, but has been experiencing an ongoing increase in the number of patients seen for mental health visits. Approximately 28 percent of visits in the last year were for mental health. The system leadership is presently recruiting for several clinical positions to augment mental health and telemental health services.

In addition to serving veterans on Maui, the CBOC supports veterans on the islands of Molokai and Lanai. Service to veterans on Lanai was also significantly impacted during the 9-month period in which the Maui CBOC was experiencing staffing difficulties. In response, the system began sending providers from Oahu to serve veterans residing on Lanai. System leadership is subsequently considering permanently supporting the VA services on Lanai from Oahu rather than from the Maui CBOC. The system has also begun partnering with the local hospital on the island.

Subsequent to your January 2006 field hearings, a part-time VA physician residing on Molokai is available a few days per week to see patients. The leadership reported having made contractual arrangements for VA to use telehealth equipment that is owned and located at a non-VA clinic on Molokai. Telemental health equip-

ment will be operational when the recruited telehealth staff positions are filled at the Maui CBOC.

The Veterans' Millennium Health Care and Benefits Act of 1999 directed VA to provide certain services to veterans in their homes or in community settings, including the adult day health care, homemaker and home health aids and home based primary care, among others.

In 2006, at your request, the OIG was asked to determine what restrictions placed on noninstitutional care services were appropriate in light of the intent of the Millennium Act. We reported that the system restricted contract adult day health care and homemaker and home health aids to highly service connected veterans, did not provide outpatient respite prior to June 2005, and offered home based primary care only to veterans living within a 50-mile radius to the system.

We specified the need for the VHA to make sure that facilities eliminate local restrictions and where possible and expand coverage to geographic areas that currently do not offer noninstitutional care services. On Maui, VA clinicians reported that homemaker and home health aids and contract adult care services and purchased skilled home health services are presently available to veterans without restrictions on service connection or other non-medical eligibility.

Although there are no restrictions to home based primary care, the system is still in the process of recruiting a nurse practitioner to provide this service.

A gerontologist has resumed coming to the Maui CBOC every other month to perform comprehensive geriatric evaluations and management, and access is not restricted to this service as long as patients have met program criteria. At present, respite care is only available on Oahu and on an inpatient basis.

In summary, Mr. Chairman, over the past year, VA Pacific Islands Healthcare System leadership has taken action to improve access to care for veterans on Maui and to enhance the consistency and continuity of care that will be provided. Although recruitment and programming to enhance future access are presently in progress, some obstacles to access still remain for veterans on Maui.

Mr. Chairman, thank you again for this opportunity to testify. Your leadership and service on behalf of our Nation's veterans is inspiring. And I'm honored to testify before you and the veterans present in this room today.

Thank you again.

[The prepared statement of Dr. Shepherd follows:]

PREPARED STATEMENT OF MICHAEL SHEPHERD, M.D., PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on access to health care for veterans on Maui. I am accompanied by Julie Watrous, R.N., Director, Los Angeles Regional Office, Office of Healthcare Inspections, Office of Inspector General (OIG). Today I will discuss the challenges and opportunities for providing health care to veterans on the island of Maui. These challenges can be viewed as those concerns shared with Veterans Health Administration (VHA) facilities nationwide, those in common with other rural and/or remote areas, and those unique to Maui.

PRIMARY CARE STAFFING ISSUES AT THE MAUI
COMMUNITY BASED OUTPATIENT CLINIC (CBOC)

Staffing at the Maui CBOC has been a major concern since the departure of the full-time nurse practitioner, relocation of the full-time physician to the mainland, and the subsequent departure of a part-time contract primary care provider in 2006. Despite efforts at recruitment, the Maui CBOC was without a full-time VA primary care physician for a 9-month period until May 2007. During this time period, a full-time VA nurse practitioner who was hired in the summer of 2006 was the only consistent provider of primary care at the Maui CBOC.

During this period, the clinic relied on an informal triage system for scheduling patient appointments, based on urgency of medical complaint, service connection, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) service, and lack of veteran financial means to access care elsewhere. Non-service connected veterans with private insurance were encouraged to see providers in the private sector. Some patients were co-managed by VA and non-VA providers depending on the type of service or care needed. Wait lists accrued for non-urgent care such as semiannual or annual physical examinations, leading at times to frustration on the part of veterans and impacting, in turn, staff morale. In the interim, part-time fee basis providers were utilized to provide care that was helpful, though continuity of care remained a significant issue. A fee basis primary care physician was hired as a full-time VA employee at the CBOC in May 2007, and since then the wait list has reportedly been improving. In addition to this now full-time VA physician, a part-time fee basis physician continues to see patients 3 times per week, and a second fee basis physician has been seeing patients twice a month. In the near term, this second fee basis physician reportedly will be working weekly to see walk-in patients and OEF/OIF veterans.

VHA Directive 2004-031, Guidance on Primary Care Panel Size, from July, 6, 2004, provides guidance on the maximum number of active patients (panel size) for whom a provider should deliver primary care with the aim of establishing a primary care system that balances productivity with quality, access, and patient service. The VHA directive recognizes that expected panel sizes will vary from site to site depending upon patient characteristics of the primary care population and the level of system support. The directive also recognizes that panel sizes for specialized panels may need to be smaller than for undifferentiated primary care panels, and adjustments to panel size should be made at a local level, incorporating guidance from national programs where available.

On Maui, primary care providers have a greater reliance on fee basis and consult specialty care in the absence of a full service VA, which impacts the real time availability of medical information and provider efficiency. In addition, the generation of paperwork and arrangement of outside consultation, the absence of an in-house full service pharmacy, and the need for outside referral for certain radiology tests may also have a bearing on the appropriateness of panel size relative to a suburban mainland location.

Replacing providers at rural facilities is generally difficult and may lead to prolonged gaps in continuity. This challenge may be further exacerbated by relative real estate prices on Maui compared to many locations on the mainland. For these reasons, in addition to panel size, in certain locations where there are unique geographic factors that impact access and where a high percentage of complex patients are in need of frequent appointments, expanded full-time primary care provider staffing may be a salient consideration that might assure greater continuity and minimize disruption to care in the event that a full-time provider leaves VA employment. We found that the VA Pacific Islands Health Care System has proactively responded to the recent gap in primary care physician continuity by hiring a second full-time primary care physician for the Maui CBOC. This physician will begin seeing patients at the Maui CBOC within the next month.

ACCESS TO OUTPATIENT MENTAL HEALTH CARE ON MAUI

During the past year, the Maui clinic has had a full-time psychiatrist and psychologist. The psychiatrist reported that the CBOC has been experiencing an ongoing increase in the number of patients seen for mental health visits. The VA Pacific Islands Health Care System is presently recruiting applicants for several new positions at the Maui CBOC including a telehealth clerk, an addictions therapist, a psychology technician, and a psychologist to serve as a telehealth coordinator. In addition, a clinical nurse specialist with a mental health focus, who is presently assigned to the Kona CBOC, will reportedly be assigned to the Maui CBOC to provide patient care.

Cognitive behavioral therapies including prolonged exposure therapy are among the best evidence supported treatments for Post Traumatic Stress Disorder. However, nationally, there is a relative shortage in both the VA and private sector of clinicians trained in specific cognitive behavioral techniques. The VA Pacific Islands Health Care System reported having recently contracted with a psychologist from the University of Pennsylvania to train VA psychologists in prolonged exposure therapy.

ACCESS ON MOLAKAI AND LANAI

In addition to serving veterans on Maui, the CBOC supports veterans on the islands of Molokai and Lanai. A part-time physician and a mental health clinician are available a few days per week to see patients on Molokai. At the U.S. Senate Committee on Veterans' Affairs field hearings in Hawaii in January 2006, VA representatives committed to funding for telehealth capabilities with non-VA providers and announced that Molokai veterans would get telehealth equipment. VA Pacific Islands Health Care System primary care leadership reported having made contractual arrangements for veteran use of telehealth equipment that is owned and located at a non-VA clinic on Molokai. The equipment will be utilized when the telehealth positions are filled, and staff at the non-VA clinic will assist veterans and VA staff with its use. Service to veterans on Lanai was significantly impacted during the 9-month period in which the Maui CBOC was experiencing primary care staffing difficulties. In response, the VA Pacific Islands Health Care System began sending providers from Honolulu to serve the 55 veterans residing on Lanai. System leadership reports that subsequently a primary care physician has been seeing patients in Lanai on a regular basis. System leadership is subsequently considering permanently supporting VA services on Lanai from the medical center in Oahu rather than via the Maui CBOC. The VA Pacific Islands Health Care System has also recently begun partnering with a local hospital.

ACCESS TO NON-INSTITUTIONAL SERVICES PROVIDED TO VETERANS ON MAUI

The Veterans Millennium Health Care and Benefits Act of 1999 clarified requirements for VHA to provide non-institutional care for veterans in response to the changing needs of aging veterans. The Act directed VA to provide veterans eligible for medical services with certain services that are provided to veterans in their own homes or in community settings. VHA implemented policies requiring medical facilities to provide non-institutional care services to all eligible veterans and to include the services in the VHA medical benefits package. These services include: home based primary care; purchased skilled home health care; homemaker and home health aides (H/HHA); adult day health care; geriatric evaluation and management; respite care; and hospice and palliative care. In addition, VHA measures facility use of care coordination and telehealth services (CCHT).

In 2006, at the request of Senator Akaka, the OIG was asked to determine what restrictions were being placed on veterans for access to certain non-institutional care services and whether these restrictions were appropriate or were inconsistent with the intent of the Millennium Act. The OIG report, Review of Access to Care in the Veterans Health Administration, found that the VA Pacific Islands Health Care System restricted contract adult day health care and H/HHA to highly service-connected veterans, provided no outpatient respite prior to June 2005, and offered home based primary care only to veterans living within a 50-mile radius of the VA Pacific Islands Health Care System or the Kona and Hilo clinics. The OIG report specified the need for VHA to make sure that facilities eliminate local restrictions limiting eligible veteran access to non-institutional care and, where possible, expand coverage to geographic areas that currently do not offer non-institutional care services. VA clinicians reported that subsequent to the time of the U.S. Senate Committee on Veterans' Affairs field hearings in January 2006, both homemaker and home health aides and contract adult day health care services no longer have restrictions on service connection, and non-service connected veterans are eligible if they meet the medical qualifications for these programs.

The VA Pacific Islands Health System primary care leadership reported that contract adult day health care is available on Maui, and additional funding has been allocated to bolster H/HHA services. There are no restrictions to home based primary care, however, the VA Pacific Islands Health Care system is presently recruiting for a nurse practitioner to provide the home based primary care to medically eligible veterans. CBOC staff report that purchased skilled home health services are available on Maui. In addition, a gerontologist has resumed working at the Maui CBOC every other month to perform comprehensive geriatric evaluation and man-

agement, and there are no restrictions to access as long as patients meet the program criteria. VA Pacific Islands Health Care System primary care leadership reported that they have begun consideration of “health buddies” and CCHT services for incorporation in future programming once the nurse practitioner to provide home based primary care is on board. At present, respite care is only available on Oahu and on an inpatient basis.

ACCESS FOR VETERANS TO NON-VA SPECIALTY
AND HOSPITAL CARE ON MAUI

Another challenge concerns veteran access to non-VA fee basis specialty or sub-specialty care. Some specialty providers may have full practices and are no longer taking new patients or may not accept the reimbursement rate provided by VA fee basis. Additionally, though the CBOC benefits from indirect access to specialty care through the sharing agreement with the Tripler Army Medical Center, the Maui CBOC does not derive the direct access benefit experienced from physical co-location experienced by veterans at the Matsunaga Medical Center. To address this issue, the VA Pacific Islands Health Care System primary care leadership is examining possible future telehealth alternatives, such as tele-optometry and tele-dermatology to provide certain outpatient specialty care services.

A further challenge facing the VA Pacific Islands Health Care System is the limited medical infrastructure on Maui. Maui Memorial Hospital is presently the only hospital on the island. When veterans are admitted to the hospital, which is a state run facility, they are admitted on a rotational (on-call) basis to the service of local physicians at Maui Memorial Hospital. VA staff reported that some non-VA health care entities have hired hospitalists to care for their patients admitted to Maui Memorial Hospital. A hospitalist is a doctor who specializes in the care of hospitalized patients, whose focus is treating health conditions for which patients are often hospitalized, and whose office is usually located within the hospital. Whether or not the number and medical complexity of veterans admitted to Maui Memorial Hospital would justify hiring or contracting for the services of a hospitalist is a question for further study by the VA Pacific Islands Health Care System leadership.

SUMMARY

Over the past year, the VA Pacific Islands Healthcare System leadership has taken actions to improve access to care for veterans on Maui and to enhance the consistency and continuity of care that will be provided. Although staff recruitment and programming to enhance future access are in process, some obstacles to access remain for veterans on Maui.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer any questions that you or other Members of the Committee may have.

Senator AKAKA. Thank you very much, Dr. Shepherd, for your testimony. And now I have some questions for the witnesses.

Dr. Kussman, in recent years, VA has made significant strides in telemedicine. And telemedicine capabilities in Hawaii already have helped many people. When do you expect to fully implement telemedicine capabilities of the neighbor islands of Molokai and Lanai?

Dr. KUSSMAN. Sir, as we discussed yesterday when we were visiting Lanai, and you'll see tomorrow with Molokai, that this is a work in progress. I think I'd have to refer to Dr. Hastings on this specific dates. But as we're doing here in Maui, the program in hiring the appropriate telemedicine people, this is a very important program for us, as you know. Because it allows us the leverage technology to get the services to the veteran, rather than having to get the veteran to the services.

And the VA has been a leader nationally in the implementation of telemedicine. So we're very proud of what we're doing. And we'll continue working very hard to increase the capability on the island.

Senator AKAKA. Dr. Hastings, will you comment further on that.

Dr. Hastings. Yes. Thank you very much, Senator.

This is clearly an area that we have—that the VA has great interest in, and, I think, is actually leading the country in many areas in developing this technology to improve access and quality care.

Of course, delivering care to more isolated places is the challenge. And I can tell you that we have developed the capability of delivering telemedicine to both of those islands. And the challenge that we face right now is to educate our providers in the best utilization of this technology. We have it set up. We're ready to make the connections. Indeed, we've made the connections. We've had very good cooperation from the state and from Hawaii Health Systems Cooperation in allowing us to work with them and use their equipment.

And so really the challenge that we face now is to have all of our physicians make use of the technology, learn how to use it, learn when to use it. And I think we ought to move ahead smartly on this within the next year or two.

Thank you very much.

Senator AKAKA. Thank you for that, Dr. Hastings.

Dr. Kussman or Dr. Wiebe, staffing at the Maui clinic is an ongoing issue for veterans. While your testimony speaks to the need for an additional providers of the clinic and the addition of a home care program, when can we expect these changes to take effect?

Dr. KUSSMAN. Mr. Chairman, thank you for the question. As was mentioned, the second full-time person will be here on the 7th of September, I believe. But the larger issue of recruiting, as was mentioned by the first panel and ourselves, has been a puzzle to me, actually. And we've had a chance to talk about that.

This is such a wonderful place to live and such a wonderful area that it's been strange that we haven't been able to get people who wanted to come here. And there are a lot of issues related to where you are in your stage of life and the housing, and all of that. But even with offering enticements and things, we've been challenged to do that.

And we're working hard to find out what are the issues that don't allow us to hire people, or they don't want to come here.

This is not unique to Maui. It is a problem throughout the islands. Even getting people to come to Oahu, for the cost of living and things. So we're working they hard on that and looking for innovative ways to encourage people to come.

I don't know. Bob, if you would like to add anything no that.

Dr. WIEBE. I'll just add, in addition to the primary care physician who will join us next month, we're currently recruiting for the home-based primary care nurse. As Dr. Kussman indicated in his testimony, we are recruiting to fill the five mental health care providers that will be at the clinic. And as noted by earlier witnesses, we will be hiring a psychologist, hopefully, at the Vet Center very soon.

Senator AKAKA. Dr. Wiebe, at the field hearing we held last year on Maui, you and I discussed the fact that, in light of network budget constraints, certain types of care were being—let me use the word rationed. You stated at the time that you would look into the situation and work to correct it. Is the full VA benefit's package now available to all veterans on Maui?

Dr. WIEBE. Thank you for the question, Mr. Chairman. As you know, several years ago, the VA faced formidable resource constraints and budget challenges. In response, we implemented referral criteria for non-VA care, including noninstitutional long-term care services.

Fortunately, and thanks to your leadership on this Committee, VA funding has substantially increased since we last met. And as we have noted, we've hired additional staff at the Maui clinic for primary care, mental health and telehealth. In addition, we have increased the number of patients we're referring to the Maui community, and increased the amount of money we're spending in the Maui community.

Specifically, as Dr. Shepherd noted, compared to noninstitutional long-term care services last year, we have increased over 30 percent the average daily census in noninstitutional care in fiscal year 2007. And specifically, we have doubled the average daily census for the homemaker health aids.

So mahalo again for this question. But more importantly, mahalo for your leadership on this Committee, as well as your support for the Department of Veterans Affairs.

Senator AKAKA. Thank you, Dr. Wiebe.

Dr. Shepherd, what is your assessment of the current status of the access to both primary and specialty care on Maui?

Dr. SHEPHERD. Currently, the access to primary care is in a stabilization phase. And hopefully, with Dr. Chin onboard and a new physician coming, hopefully for patients over the next three or four months, the clinic will move from a stabilization phase to a more fluid phase of care.

Some of the veterans on the first panel have brought up some issues, including those related to travel expense for speciality appointments.

When veterans are admitted in Maui Memorial, there is a discontinuity of care because there's not a VA provider caring for them at the hospital. So I think there's still some access to specialty care issues that the system needs to continue to look at and evaluate.

Senator AKAKA. On mental health care on Maui, do you believe that it's up-to-par?

Dr. SHEPHERD. I believe it is with the addition of the five new clinicians coming in. I think in the broader picture, one of the major challenges the VA has is that surprisingly over the past three, four years, about 75 percent of new mental health patients for the system, as a whole, are the aging Vietnam era veterans.

I think one of the challenges the system is going to face as a whole and on Maui is tracking the rates of change in both the returning OIF/OEF population that's going to need mental health services and the aging Vietnam veteran population, and really trying to stay ahead of those rates of change.

Senator AKAKA. Dr. Shepherd, access to long-term care is another issue that is of great concern to me and to many veterans here as overall capacity in Hawaii, as we know, is strained. What is your assessment of the current availability of noninstitutional care on Maui?

Dr. SHEPHERD. Over the past year, access to noninstitutional care has improved.

As mentioned by other panelists, once nurses are onboard to provide a home-based primary care this will also lead to further improvement in access.

Senator AKAKA. Finally, I just want to ask if any of you has any final statements to make before we adjourn.

Dr. Kussman?

Dr. KUSSMAN. Mr. Chairman, again, thank you for the opportunity to be here, to listen and to learn, and to continue to partner with you. We're very fortunate to have you as the Chairman of the Senate Committee on Veterans' Affairs. As you know, we pledge to work with you regularly and the VSOs and anyone who wants better care for veterans.

And again, mahalo.

Senator AKAKA. Thank you. And thank you very much, all of you, for your testimony. It's been very helpful. And we look forward to working together to help the veterans of our country. This hearing is adjourned.

[Whereupon, at 1:05 p.m., the Committee was adjourned.]

A P P E N D I X

AUGUST 22, 2007.

Re: Allowing private mental health doctors to assist veterans.

The VA bureaucracy has become so thick that many Vets are discouraged from getting the mental and physical help they need. As a result we have Vets killing their families and themselves.

It is a well known fact that the VA does not have sufficient mental health resources throughout the system. However, there are many qualified mental health providers who would love to do their patriotic duty and help injured vets. I don't understand why the VA will willingly outsource to medical doctors and dentist but not to mental health specialist, whom they need the most.

The VA does outsource their C&P evaluations to assist the VA to process claims, but they do not out source to private mental health specialist to assist vets, they only outsource to assist the VA.

It would be cost effective because the outsource doctor's will only be paid on an as needed basis. No extra monies need to be spent on facilities or employee benefits making this approach more cost effective than maintaining the high cost of clinics with their administration and maintenance cost.

Now we can only get help during regular office hours, however most of our problems happen in the non-office hours. The expensive clinic is useless 2/3's of the time, but the government pays for it 24/7. I think most suicides occur in non -office hours when the mental help is not available. Lack of immediate attention has directly caused veteran suicides, like it did recently at Tripler.

Maui has maintained a high cost clinic and much of the time there isn't even a doctor there to treat the vets. Please remember only the doctor's provide the life saving treatment, not the facilities that cost the most. On Maui after hours and on weekends we are told to call 911 and go to hospital emergency room. This is very expensive and over triples the cost of our care, and there is no continuity of care. Why can't we go directly to private doctors and not wait for clinic hours and face a long wait period or go to the ER at extra expense to the government.

Lastly, we would like to thank you for your kind consideration and real help you have provided us over the years. We are especially impressed at how you jump in and work to help us when we ask for your help. You had a major role in correcting a problem we were having with our C&P process. We offer our heartfelt gratitude and appreciation.

CONCERNED MAUI DISABLED VETS.

HEARING ON ACCESS TO VA HEALTH CARE AND BENEFITS IN KONA AND OUTREACH TO THE GUARD AND RESERVE IN HAWAII

MONDAY, AUGUST 27, 2007

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

The Committee met, pursuant to notice, at 1:00 p.m., in Sheraton Keauhou Bay, Kailua Kona, Hawaii, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

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

Senator AKAKA. The panel field hearings of Senate Committee on Veterans' Affairs will come to order.

Aloha. Before I make my opening remarks, you've witnessed the presentation of a check, and for those of you who may not know and who may not have heard the news, the VA has approved a grant to make significant improvements to the West Hawaii Vet Center here in Kona. VA Under Secretary Bill Tuerk, who is Gene Castagnetti's boss, advised the Committee of this development during his testimony at our hearing in Honolulu. I could not be more pleased that we're able to get this done for the veterans here on the Big Island.

I'd like to welcome all of you to this hearing. This is our third and final official hearing of the Senate Committee on Veterans' Affairs that I'm chairing here in Hawaii.

We held similar hearings at the beginning of 2006. Much has improved since that time for which I am very, very grateful. However, it is important for the Committee to understand the remaining challenges that we now face.

The focus of this hearing will be on access to VA health care for veterans living in Kona, and on the effectiveness of VA's outreach to redeploying and separating members of the Guard and Reserve in Hawaii.

We are all aware that after Vietnam and other wars some servicemembers who honorably served their Nation were not provided with the care and services that they needed to reintegrate into society. Caring for returning servicemembers must be considered part of the continuing costs of war.

It is important that we look not only at the quality of care that is provided, but also at the outreach process to notify separating servicemembers of what they're entitled to and what VA can do for

them. We must ensure that adequate levels of care and services are available to those that leave the Armed Forces, including members of the Guard and Reserve. We have learned that the earlier a veteran receives care after separation from the military, the lower the risk of him or her developing a long-term problem. An important part of the Dignified Treatment of Wounded Warriors Act, which recently passed the U.S. Senate is my provision to extend the period of eligibility for VA health care for combat veterans of the Persian Gulf War and subsequent wars from 2 years to 5 years after discharge or release.

The Senate bill includes Veterans' Affairs Committee-endorsed provisions that will improve access to mental health care, extend the application period for dental benefits following discharge, and designate the National Guard and Reserves as integral components of VA's outreach program.

The Dignified Treatment of Wounded Warriors Act was truly a collaborative effort between the Senate Veterans' Affairs Committee and the Senate Armed Services Committee. I want to tell you that this is the Hawaiian spirit and Hawaiian style of doing business. I'm so delighted that this collaboration between two Committees made that happen quickly.

Finally, I note that there are many veterans here today who would like to testify. We cannot accommodate everyone's request to speak. However, I do want to hear your views. The Committee is accepting written testimony, which will be reviewed and made part of the record of today's hearing. If you have brought written testimony with you, please give it to Committee staff who are seated at the table back there, or located also in other places in the room, but we have a table on this side. If you do not have written testimony but would like to submit something, Committee staff will assist you. In addition, the Committee staff is joined by VA staff who can respond to the questions, concerns, and comments that you raise.

We are fortunate today that we have top people here from Federal and state government. Coming from the Federal Government we have VA staff. We also have Mark Moses from the state here.

Once again, I want to say mahalo to all of those who are in attendance today, and I look forward to hearing the testimony of our witnesses today. I want to welcome the first panel to today's hearing. Thank you for being here today. First, I want to welcome David Ferreira. David Ferreira is the director of the Hilo Family Assistance Center and retired member of the National Guard. I also welcome First Sergeant Allison T. Yano, who was deployed in Operation Iraqi Freedom. Your full statements will appear in the record of the Committee.

So, Mr. Ferreira, will you begin with your testimony.

**STATEMENT OF DAVID T. FERREIRA, FAMILY ASSISTANCE
SPECIALIST, HAWAII ARMY NATIONAL GUARD**

Mr. FERREIRA. Mr. Chairman, these are my comments based on my experience as a family—

Senator AKAKA. Let me interrupt. Can you folks hear him? You can? Thank you.

Mr. FERREIRA. Through my experiences as a family assistance specialist on the Big Island. It takes too long for VA to determine the disability to receive treatment and compensation. Many Guard and Reserve soldiers that return from deployment are anxious to go home, often do not disclose conditions that would normally be treated during their out processing and delay their return home. Once separated, they realize the condition has worsened or requires treatment. This causes problems with their civilian jobs and prevents them from seeking employment.

Both Hilo and Kona both lack services and specialty care in the remote areas. The Community Based Outpatient Clinics in Hilo and Kona provide much needed services, but at times they lack the staffing or the specialist required. Members are required to either wait for specialists to come in or travel to Oahu.

Although VA has expended their services to families, the Vet Caenters here lack the credentialed or licensed counselors to provide services to family, and when it's available, it's only for a limited time. This has been particularly true of both centers here and in Kona. I've had several servicemembers tell me that they went to the clinic and there were no counselors there at that time, especially for family members.

The VA has done a good job in dealing with traditional problems of active duty veterans, but they're not prepared for the large influx of Guard and Reserve servicemembers that return from deployment.

Our citizen soldiers and family members pose a unique set of problems. Our active duty counterparts return to a relatively stable environment, military environment, whereas Guard and Reserve members deal with returning back to the civilian sector. Returning Guard and Reserve servicemembers have the same stresses of active duty members, but they also have the additional stresses of returning to their civilian jobs. Sometimes they require retraining, requalification. There are different people working there. In some cases they have to go into different positions. They also have to deal with their families that were disrupted.

The families on the outside islands in remote areas become instant military families when the Guard and Reserve members get mobilized. We lack the military infrastructure of places such as Oahu with large military installations. We have to rely on the civilian sector, which is ill prepared to deal with these requirements. Even our schools were unsure of how to deal with children who have parents or family members and in some cases multiple family members deploying.

The VA, the Guard, and Reserves needs to continue to expand its outreach for our servicemembers and encourage them to utilize the services provided. One of the problems in our Guard and Reserve members is overcoming the stigma or perception of going to the VA. Many worry that it will affect their civilian jobs and are reluctant to come in.

On a final note, I feel that in the past several years the VA's greatly improved and expanded its services and it's largely due to the oversight of this Committee. Thank you.

[The prepared statement of Mr. Ferreira follows:]

PREPARED STATEMENT OF DAVID T. FERREIRA,
FAMILY ASSISTANCE SPECIALIST, HAWAII ARMY NATIONAL GUARD

Dear Mr. Chairman:

My name is David T. Ferreira, I am a retired Sergeant First Class with 30 years in the Hawaii Army National Guard, of which I served 24 years on Active Guard (AGR) as a Senior Human Resource Sergeant. I am presently the Family Assistance Specialist, Hawaii Army National Guard for the island of Hawaii. I am also a DEER/RAPIDS administrator and issue I.D. Cards to Military Servicemembers of all branches, DOD Civilians, Retirees, Disabled American Veterans (DAV) and their dependents.

The following are comments/issues:

It takes too long to determine disability, to receive treatment and compensation. Many Guard and Reserve soldiers that return from deployment are anxious to go home, often do not disclosed conditions that would normally be treated during their out-processing and delay their return. Later once separated they realize the condition has worsened, and requires treatment, this causes problems with their civilian jobs or prevents them from seeking employment.

Lack of service and specialty care in remote areas, the Community Based Out-patient Clinics in Hilo and Kona provide much needed services, but many times they lack the staffing or specialist required. Services members are required to either wait for a specialist to come in or travel to Oahu.

Although the VA has expanded services to families, the Vet Centers here lack credentialed/licensed counselors to provide that service to families, and when available it is only for a limited time. This has been particularly true of both Vet Centers here in Hilo, and Kona. I have had several servicemembers and families tell me that they refuse to see the counselor at the Hilo Vet Center, they were very critical of the individual there.

The VA has done a good job in dealing with the traditional problems of active duty veterans, such as physical injuries or PTSD. But they were not prepared for the large influx of Guard and Reserve servicemembers returning from deployments, our citizen soldiers/airmen and family members posed a unique set of problems.

Our active duty counterparts return to a relatively stable military environment versus Guard and Reserve members have to deal with returning to the civilian sector. Returning Guard and Reserve servicemembers have the same stresses as active duty members, but they also have the additional stresses of returning to their civilian jobs (some require retraining, qualification, different personnel, and in some cases different positions), and disrupted families.

Families on the outside islands and remote areas became instant military families, upon the mobilization of their Guard/ Reserve members. They lack the military infrastructure (such as ACS, etc.) of places like Oahu with large military installations. They have to rely on the civilian sector which was ill prepared to deal with the deployments. Even our schools were unsure of how to deal with children that had a parent or other family member (in some cases multiple family members) deploying.

The VA, Guard and Reserve needs to continue to expand its outreach to our servicemembers and encourage them to utilize the services provided. One of the problems with our Guard and Reserve member is overcoming the stigma or perception of going to the VA, many worry it will affect their civilian jobs and are reluctant to come in.

On a final note, I feel that in past several years the VA has greatly improved and expanded its services to our veterans and their families largely due to the oversight and concern by Members of this Committee.

Senator AKAKA. Thank you. Thank you very much, Mr. Ferreira.
And now, Mr. Yano.

**STATEMENT OF FIRST SERGEANT ALLISON T. YANO,
OPERATION IRAQI FREEDOM VETERAN**

1st Sgt. YANO. Mr. Chairman, thank you for this opportunity to appear before you today to present my personal experiences and observations with the VA as a Guardsman returning from Operation Iraqi Freedom.

Streamlined access to VA health care benefits must get to all combat veterans. The Iraq-Afghanistan Post-Deployment Screen was initiated throughout the Department of Veterans' Affairs in

2004 to identify OEF/OIF veterans who may have had the need or clinical intervention for conditions such as PTSD, depression, alcohol abuse, chronic and infectious diseases. Early intervention was a goal to identify those who screened positive for these conditions.

The inability to complete the post deployment survey with the VA soon after their war experience hampered the opportunity to prevent a quality transition and readjustment to civilian life, as well as identify those with possible PTSD, depression, alcohol/substance abuse, or other psychological issues as a result of our National Guard service within the combat zone.

The screening is conducted only with OEF/OIF veterans who have enrolled with the VA. As of two months ago, not all soldiers who returned from our deployment enrolled, and only a small number of combat veterans who signed up for VA benefits were contacted and received the screening. A vast majority of combat veterans failed to receive early intervention. We're only now getting our soldiers enrolled.

This was due to a recent incident involving a fellow soldier and the failure of qualitative counseling by the VA after returning from a combat zone. Coupled with this is a lack of streamline process of continued care with the VA, as well as stressing the importance to the soldier in following up with their recommended care. Only after this incident were we able to put into perspective the importance in enrolling and utilizing the services of the VA health care system.

Additionally, we had to make our own coordination for readjustment counseling, educational briefings with the VA, which should have been completed during the demobilization process. Furthermore, the insufficient number of social workers available to handle the large number of OEF/OIF veterans prevented the screenings from being conducted.

A recommendation would be to make the enrollment to VA health care system mandatory and part of our demobilization process. This would allow VA to administer the Iraq-Afghanistan Post-Deployment Screen to a greater number of returning veterans at an earlier point after deployment.

Also, the lack of medical specialists in our geographical location is another concern. The islands of Hawaii, Maui, Molokai, Lanai, and Kauai do not have the same resources of medical specialists as on Oahu; therefore, veterans who reside on these islands are referred to see specialists on the island of Oahu and are asked to pay for our transportation costs. This is a deterrent to having soldiers get the necessary examinations we need.

A recommendation is to have referred visits to specialists paid for by the VA, or to have specialists flown to the outer islands on a periodic schedule. I would like to acknowledge the efforts of the staff of the VA Hilo Community Based Outpatient Clinic in assisting myself and fellow combat veterans in providing the best service they can with the minimal staffing they have.

In closing, there are needed adjustment to ensure that access to VA health care and benefits get to all combat veterans. Although there are other concerns that are in the minds of my fellow combat veterans, what is provided in this testimony is of the greatest con-

cern. It is hoped that this testimony, along with others being given today, will expedite necessary changes.

Mr. Chairman, this concludes my statement. I would be pleased to answer any of your questions.

[The prepared statement of 1st Sgt. Yano follows:]

PREPARED STATEMENT OF FIRST SERGEANT ALLISON T. YANO,
OPERATION IRAQI FREEDOM VETERAN

Mr. Chairman, thank you for the opportunity to appear before you today to present my personal experiences and observations with the VA as a Hawaii Army National Guardsman returning from Operation Iraqi Freedom III.

Streamlined access to VA health care and benefits must get to all combat veterans. The Iraq-Afghanistan Post-Deployment Screen was initiated throughout the Department of Veterans Affairs in 2004 to identify OEF/OIF veterans who may have had the need for clinical intervention for conditions such as PTSD, depression, alcohol abuse, chronic and infectious diseases (ID). Early intervention was the goal to identify those who screened positive for mental health conditions and to refer others to specialty care for ID or chronic medical conditions. The inability to complete the post deployment survey with the VA, soon after their war experience hampered the opportunity to prevent a quality transition and readjustment to civilian life as well as identify those with possible PTSD, depression, alcohol/substance abuse or other psychological issues as a result of our National Guardsmen's and women's service within a combat zone. The screening is conducted only with OEF/OIF veterans who have enrolled with the VA. As of two months ago, not all soldiers who returned from our deployment enrolled and only a small number of combat veterans who signed up for VA benefits were contacted and received the screening. A vast majority of combat veterans failed to receive early intervention. We are only now getting our soldiers enrolled. This was due to the recent incident involving a fellow soldier and the failure of qualitative counseling by the VA after returning from a combat zone. Coupled with this is the lack of a streamlined process of continued care with the VA as well as stressing the importance to the soldier in following up with their recommended care. Only after this incident were we able to put in perspective the importance in enrolling and utilizing the services of the VA health care system. Additionally, we had to make our own coordination for readjustment counseling and educational briefings with the VA, which should have been completed during the demobilization process. Furthermore, the insufficient number of Social Workers available to handle the large number of OEF/OIF veterans prevented the screenings to be conducted.

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The lack of medical specialists and our geographical location is another concern. The islands of Hawaii, Maui, Molokai, Lanai, and Kauai do not have the same resources of medical specialist as on Oahu, therefore, veterans who reside on these islands and referred to see specialists on the island of Oahu, are asked to pay for their transportation cost. This is a deterrent to having soldiers get the necessary examinations and help.

A recommendation is to have referred visits to specialist paid for by the VA or to have specialist flown to the outer islands on a periodic schedule.

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In closing, there are needed adjustments to ensure that access to VA health care and benefits get to all combat veterans. Although there are other concerns that are in the minds of my fellow combat veterans, what is provided in this testimony is of the greatest concern. It is hoped that this testimony along with others being given today will expedite necessary changes.

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

Senator AKAKA. Thank you, Allison Yano, for your testimony.

I do have some questions for both of you. I'm so glad to hear some of your concerns that will help us try to continue to improve whatever has been improved already. My question to both of you

has to do with servicemembers and their families. I want you to tell us what the challenge is, and if you have a solution in mind, also mention that, because we are looking for solutions.

So here is the question: Do you believe that servicemembers and families are sufficiently informed about VA benefits and services? Mr. Ferreira.

Mr. FERREIRA. We try to make sure they're informed, both families and soldiers. But like I said, a lot of them are reluctant to go to the VA because they still have to go back to their civilian jobs, and a lot of times I guess it's basically a perception problem that, oh, you went to see the VA, that you have some kind of disability, you know, where it may or may not affect his job, but it's just a perception that it will.

On the family side, VA was not ready for families with problems. We had instant military families, and when they went to VA, the counselors there were more geared to deal with soldiers with physical injuries and maybe PTSD-type problems, not marital problems, separation anxiety problems, or even children with problems dealing with the deployment of their parents.

In some cases both parents were deployed. We've had several people with both parents deployed and the kids were with the grandparents or aunts and uncles and there really were not enough counselors qualified to deal with them.

How would we fix the problem? That part I really don't know, other than providing more trained counselors that would be a great help.

Senator AKAKA. Thank you very much, David.

Allison Yano.

1st Sgt. YANO. Sir, we did receive some briefings after deployment, post-deployment process, and at that time I don't think the briefings were standardized to all the different units, and I don't think it was conducted at a time that was right.

Everyone—again, like Mr. Ferreira stated in his testimony, everyone is in a rush to get back to their families, so hearing some of this information at that time was not a priority. What I found in my experiences dealing with the VA is that the perfect briefing I think was already there. The VA's orientation briefing that you receive when you register with VA would have been the ideal briefing to receive. However, again, a lot of people just put registering with the VA on the side, in the back of their minds because all they wanted to do is get back into their civilian life.

Recently we held some briefings that brought out these points and we had help from Helping Hands Hawaii, a nonprofit association, that conducted briefing for us, and with those briefings we were able to get a number of our combat veterans registered with the VA. We're still in the process of increasing the numbers, and also bringing that out to the families.

So we're working with the FRGs to make this information available to them as well, and that is our work toward the solution to this problem. I think it's just a matter of getting the right information out at the right time.

Senator AKAKA. Thank you very much. You're not the first to tell us that when a person is being separated, their priority is to get home and get back to their family. This is something we have to

take into consideration. And as David mentioned, the word reluctance, some of them are reluctant to seek the help. I'm hoping these sessions that we have here, and with your help and others, and Helping Hands' help, that we'll be able to get veterans to feel easy enough to know that VA is there to help them, and that they should be able to contact VA.

Here's another question to both of you, and this has to do with families. And as you pointed out, VA really has not had a focus on family, because they focus on veterans and not veterans' families. But with this war and also with deployments, and also with the fact that more veterans are now married, about 38 percent of servicemembers have families. We know how important families are to the troops, so we need to help take care of families as well. We hope that in the future programs we'll be able to put more focus on helping families.

You are aware that the well-being of families plays an important role in the well-being of veterans. How can families be more effectively included in the transition process and in caring for veterans? David?

Mr. FERREIRA. I guess both the VA, Guard, and Reserve would have to, when they do their out processing, we actually have—when the soldiers return back to their home islands, rather than—you know, all the out process is done in a military installation, and families are not physically present there. They may have visited but they're not physically there, so they don't really hear anything about the benefits available. I know I myself is guilty of—a lot of times I get told stuff and I would never go tell my wife, oh, yeah, we need to do this. So maybe if they have a briefing back here again—we had briefings, but, again, not with the family around, the soldier is there. If part of out processing is at their home station, that might help get the word out better.

Senator AKAKA. Thank you. Allison.

1st Sgt. YANO. I think that's a good suggestion. A lot of families were not even told about a lot of this from their soldiers returning. Even ego issues or embarrassment issues, those play a little part of it. But I think somewhere along the line of the post employment period that we can have a period where the families can come in and receive this briefing, that will help the situation.

Senator AKAKA. As I mentioned, improvements have been made in services, but I repeat again, we are here to try to learn more about what further improvements can be made. Helping servicemembers adjust may take more than VA can provide. You mentioned Helping Hands—I'm so glad that we're finding veterans organizing to help themselves and their families, which is really great here in Hawaii.

Are you aware of local groups partnering with VA and military to enhance access to services for returning veterans?

David?

Mr. FERREIRA. The National Guard have a retirees group that work kind of closely with the VA, but that's the only group that I know of that works closely with the VA. Part of their members are part of the VA, the DAV, and they're both retired Guardsmen and belong to the DAV, so they work pretty closely with the VA to do outreach type of work.

Senator AKAKA. Yes.

1st Sgt. YANO. I've been aware just recently with Mr. Park, with Helping Hands Hawaii, and through working with him, along with the VA, we've been able to get the education and information out to the soldiers. But, again, this is just a small amount.

We worked on a unit, because the individual that I mentioned was within my unit as a co-worker, so it was a big issue for us. But working with these other organizations helped to get the information out, and I think if we can continue to do this, you'll see greater improvements and involvement by our families and so forth.

Senator AKAKA. My final question to both of you. I am aware that the Family Assistance Centers of the Hawaii Department of Defense provide a broad range of services to families of the Hawaii National Guard. What services do you offer to families transitioning from active duty to civilian life, and which services have been most important to families? David.

Mr. FERREIRA. I normally provide a referral service. Although I belong to the Hawaii Army Guard, we deal with all services, even Coast Guard people come in. I also issue ID cards for servicemembers and their dependants, also 100 percent disabled veterans, and I normally do a referral service. If they need legal-type counseling, we refer them to people we have on the list, or specifically a lot of times we refer them to the Military Family Life Consultants for counseling services. They've been a real good resource on this island. And we've recently lost that individual. For whatever reason, his contract was terminated. I'm not really sure why. He was here and he was willing to do counseling for the entire island. He's actually out of—he actually works up in Waimea, but somehow he lost the contract.

I'm not sure why he was taken off. A lot of the families really liked that individual as far as going to see him for counseling. He dealt with families and their children a lot of times. And that was kind of a great loss for this island, I know that.

Senator AKAKA. Thank you. Mr. Yano.

1st Sgt. YANO. The big service that we've been using lately is the Vet Center, which was instrumental in getting a lot of other soldiers that we identified as having some issues, resolution to the issues and helping them readjust and get back into the civilian life and their families. Some family members also took place in that conference, and that was key for us. Other than that, Military OneSource was another route that we sent people to.

Senator AKAKA. Well, you know, I want to thank you so much for your testimony and also your responses to the questions I've asked. I want to tell you that you've been helpful to what we're trying to do, and together we can continue to improve services to veterans. So, again, I want to thank our first panel very much.

[Applause.]

Senator AKAKA. Now, I want to welcome our second panel of witnesses. First, I welcome Brigadier General Gary Ishikawa, who is the Deputy Adjutant General, Hawaii Army National Guard. I also welcome Colonel Gerald Gibbons, Chief of Staff of the 9th Regional Readiness Command, he is accompanied by Colonel Floresita Quarto. I want to thank both of you for being here. Your full statement

will appear in the record of this Committee. We look forward to your testimony.

So will you please begin with your testimony, General Ishikawa.

**STATEMENT OF BRIGADIER GENERAL GARY ISHIKAWA,
DEPUTY ADJUTANT GENERAL, HAWAII ARMY NATIONAL
GUARD**

General ISHIKAWA. General Akaka, Members of the Committee, aloha. Good afternoon.

Senator AKAKA. Aloha.

General ISHIKAWA. Thank you for having us here. I have to profess upfront that in my mad rush to get here, I have misplaced my written testimony.

Fortunately, I've read it three or four times and I remember the salient points, so I will forward to your staff my official written testimony.

Senator AKAKA. We'll make that part of the record.

General ISHIKAWA. Thank you, Senator Akaka.

I'm here on behalf of Major General Bob Lee, the Adjutant General for the State of Hawaii, and he testified on August 21 on Oahu. And it's my distinct pleasure and honor to be here in Kona representing the State Department of Defense.

I'm Gary Ishikawa. I'm the Deputy Adjutant General for the State of Hawaii. Let me start off by saying the Department of Defense is broken down or organized into four major divisions, that's the Hawaii Army and the Hawaii Air National Guard, State Civil Defense, and most important and relevant to these hearings is the Office of Veterans Services, the State of Hawaii office. Now, our new head person there is a retired Major, Mark Moses. I believe he'll be testifying also as part of the panels to follow. So I won't go into some of the areas he's scheduled to talk about.

I will add that since the State Office of Veterans Services is part of the State Department of Defense, it's been really my privilege and honor to really work hard with that agency to create a very effective newsletter, and that's something funded by the State legislature and is growing more and more. I'm not naive enough to believe that that's the only mechanism to communicate, but I think it's a very important mechanism besides, of course, the State Department of Defense web site, has some important links with information. Again, it's not only going to be one or two methodologies. It has to be many, many efforts to communicate to our veterans the benefits as they are available to them and the newer benefits that's becoming—thanks to your great help becoming—made a state of law.

At this point in time, nine out of ten reservists, and I include the Army Reserves and the Army National Guard, have deployed to Iraq or Afghanistan. At one point in time part of our total veterans population was decreasing, and that's because a lot of them in large numbers were passing away each day, especially from the Second World War and on into Korea. But because of the recent deployments, we're staying fairly level as far as the total number of veterans that we have, the newest veterans being, of course, the recent deployments.

I bring two concerns, and, again, I'd like to in short form capture what General Lee has shared. The two concerns I bring to the table, you've heard it before and you're going to hear it continuously, is access in remote areas, access to help.

I do want to share with the Chairman that last year I had the honor of serving with the Chief of Staff of the Army for funeral for a fallen warrior in American Samoa. I did have a chance to go and visit with the 100th Battalion who deploys with the 29th to Iraq, and in that time they were having a lot of problems.

I want to thank VA for opening up a clinic in American Samoa, and I think that will go a long way in at least identifying some of the problems.

There are, however, other small islands in the Pacific that probably need a good, strong look at, and at a minimum some visiting teams to conduct assessments for some of the soldiers of the 100th Battalion that deployed. I think this is going to be a huge challenge, but I think that we as a Nation, it's something that we can overcome if we put our minds to it.

The other issue that was brought up that I'd like to go over real quickly is the classic need for paperwork, and the recertification of some of our combat veterans when they already were certified for combat awards or badges, and I refer to it as a big check when they get awarded the CIB, the CAB, Purple Heart, and things like that. It seems like you really don't have to go through the paperwork again to recertify something that's already been certified.

In a small way, when I look at this, it tells me that we have some resources that perhaps would be better focused to some of the harder problems that we face, especially in the areas of mental health or brain damage.

That basically summarizes my testimony, and, Senator, I see my testimony right there. I put it behind me when I received the check, so I will be filing it with your Committee. Thank you again very much for being here. I appreciate the opportunity to testify.

STATEMENT OF BRIGADIER GENERAL GARY M. ISHIKAWA, DEPUTY ADJUTANT GENERAL OF THE STATE OF HAWAII BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS, RELATING TO STATE OF VA HEALTH CARE IN HAWAII

Chairman Akaka, Senator Craig and Members of the Senate Committee on Veterans' Affairs, I am Brigadier General Gary Ishikawa, The Deputy Adjutant General for the State of Hawaii.

Within the State Department of Defense, there are four major divisions: the Hawaii Army and Air National Guard, State Civil Defense and the Office of Veterans' Services (OVS). The Director of Office of Veterans Service is Mr. Mark Moses, a retired Marine major and a former state legislator.

The Office of Veterans' Services is the single office in the State government responsible for the welfare of our veterans and their families. OVS serves as the liaison between Governor Linda Lingle and the veterans groups and organizations. They also act as an intermediary between the Department of Veterans Affairs and Hawaii's veterans.

Veterans make up more than ten percent of Hawaii's total population. The majority of them—about 72%—live on the island of Oahu. About 13% reside on the island of Hawaii, 10% live on one of the three islands that comprise Maui County, and about 5% live on the island of Kauai.

Within this large veteran population are many World War II veterans, many members of the famed 100th Battalion and the 442nd Regimental Combat Team. Hawaii's overall numbers were declining because many veterans of this era, most in their 80s, are passing on in large numbers.

But since September 11, 2001, mobilizations have involved nine of every ten Army National Guard and Reserve soldiers. They served honorably in Iraq, Afghanistan

and other locations; and have returned to Hawaii after their 12–15 month activations. Air National Guard members supported Operations Iraqi Freedom and Hawaii's overall veteran population has increased.

We must insure these new veterans return to their civilian lives in good health. The Office of Veterans Services partners with the Veterans Administration here during the soldiers demobilization process. This partnership works to insure no one or no benefit falls through the crack.

The United States government has an obligation to our military members from enlistment, through their service years, to veterans' benefits and finally, death benefits. We must insure that all veterans receive all entitled benefits now and in the years to come.

The National Guard Bureau recently issued a memorandum authorizing both the Army and Air National Guard to release medical records to the Department Veterans Affairs without the veteran's signature. This new procedure speeds the Department of Veterans Affairs adjudication of veterans' claims and provides medical care to Guard members.

I come to you with two concerns.

My first and most important concern is the Veterans Affairs services to all our veterans, especially, on our neighbor islands and our Pacific Islander veterans from Tinian, Rota and Saipan. In July 2007, a VA clinic opened in American Samoa that supports our veterans there. However, veterans from other Pacific islands must pay the high cost of airline and hotel accommodations to receive follow-on VA medical treatment. In Hawaii, a similar situation occurs when neighbor island veterans must come in to Tripler Army Medical Center or the Matsunaga VA Hospital in Honolulu for treatment. We must work to find a solution to this situation.

My next concern deals with the certification of a disability by the Department of Veterans Affairs. Often a servicemember is awarded a decoration recognizing the specific incident that is associated with an injury or disability. However, when filing for a disability, the VA requires a complete recertification of the incident causing the injury or disability. Approval and certification of this letter of determination is required prior to providing any services.

My final concern is the staff of VA hospitals. For example, the Post Deployment Health Reassessment Program (PDHRA) requires an initial appointment within 30 days of VA registration. On average, the VA hospital schedules initial appointments as much as 90–120 days from the registration date. Our local VA hospital staff has been doing their best to provide services to all our veterans. They have stretched their limited health care provider resources to their support mission requirement to all the veterans in the Pacific Basin.

In closing, I want to thank the Committee for their continuing support of our veterans. Thank you for coming to Hawaii to conduct these hearings.

Are there any questions?

Senator AKAKA. Thank you very much, General Ishikawa, for your testimony.

Now we'll look to Colonel Gerald Gibbons.

STATEMENT OF COLONEL GERALD GIBBONS, CHIEF OF STAFF, 9TH REGIONAL READINESS COMMAND, U.S. ARMY RESERVE

Colonel GIBBONS. My name is Colonel Gerry Gibbons, and I'm Chief of Staff for the 9th Regional Readiness Command. I'm here representing Brigadier General Alexander Kozlov, Commander, 9th Regional Readiness Command, who is off island. I have submitted a copy of my written testimony for the record.

Senator AKAKA. It will be included in the record.

Colonel GIBBONS. This afternoon I'll limit my comments to issues of returning 9th Regional Readiness Command Army Reserve veterans and the necessity for collaboration between the Department of Defense and the Veterans Health Administration to prepare for and care for their future needs.

As you are probably aware, the 9th Regional Readiness Command is responsible for Army Reserve units in American Samoa, Guam, Saipan, Alaska, and Hawaii. Since 9/11, approximately

2,400 9th Regional Readiness Command soldiers have answered the call to duty and were mobilized in support of Operation Iraqi Freedom and Operation Enduring Freedom. Within the past two years over two-thirds of the Pacific based 9th Regional Readiness Command soldiers will have served on active duty in support of the Global War on Terrorism. Currently there are 460 soldiers of the 9th Regional Readiness Command still mobilized and deployed. Deployed soldiers are serving in Iraq, Kuwait, and the Philippines.

As soldiers return from theater, they complete a Post-Deployment Health Assessment before being released from active duty. At 3 to 6 months after coming home from theater they are then given a Post-Deployment Health Reassessment. Our findings from these health reassessments show that 62 percent of the soldiers are referred for additional assessment or care and treatment. Almost without exception these referrals are all evaluated by the VA.

If a soldier requires evaluation and/or treatment of mental health or behavioral health problems, which have significant impact on the performance of their duty, they may be brought back on active duty status and assigned to an Army warrior transition unit.

Currently, we have 23 Army Reserve soldiers in the warrior transition unit at Tripler Army Medical Center. Initial assignment to the warrior transition unit is for 179 days, but that assignment can be extended until the soldier is found fit for duty.

Soldiers diagnosed with Post Traumatic Stress Disorder requiring inpatient care are enrolled in a 7-week VA PTSD residential recovery program. In the last year, we have had 43 soldiers complete the program, and I should emphasize this primarily happened because of the VA's constant support. Currently, we have 12 soldiers programmed for the next PRRP session scheduled to begin this week.

On July 21, 2007, the VA Pacific Islands Health Care System held a dedication ceremony for a new Community Based Outpatient Clinic in Pago-Pago, American Samoa. The opening of this clinic is largely the result of a successful partnership between the Army Reserve and the VA. With the opening of this clinic, we know there will be an increase in efficiencies and more timely access to health care and treatment for veterans in American Samoa.

While it may not be possible to predict the specific number of Army Reserve soldiers who will need to access Veterans Health Administration Services in the future, it's critical that we continue to work with the VA to ensure that we understand the processes and procedures to enable our returning soldiers to receive care through the current VA system in the 9th Regional Readiness Command's area of operations.

Thank you. I would be pleased to answer any questions you have.
[The prepared statement of Colonel Gibbons follows:]

PREPARED STATEMENT OF COLONEL GERALD GIBBONS, CHIEF OF STAFF,
9TH REGIONAL READINESS COMMAND, U.S. ARMY RESERVE

Good Morning. I appreciate being given the opportunity to speak before the Senate Committee on Veterans' Affairs. I am Colonel Gerald Gibbons and I am the Chief of Staff with the 9th Regional Readiness Command (RRC). As you are probably aware, the 9th RRC is responsible for Army Reserve units in American Samoa, Guam, Saipan, Alaska, and Hawaii. Additionally, many of our members live and work in Japan, Korea, other Pacific Rim countries, and CONUS. We are responsible for 3,400 soldiers serving proudly in the Pacific and other parts of the world.

This morning I will limit my comments to the issues of returning 9th RRC Army Reserve veterans and the necessity for collaboration between the Department of Defense and the Veterans Health Administration to prepare and take care of their future needs.

Since 9/11, 9th RRC Reserve soldiers have answered the call and were mobilized and deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

There have been approximately 2,440 9th RRC Soldiers returned from active duty and there are approximately 460 9th RRC Soldiers still mobilized and deployed. Within the past 2 years, over $\frac{2}{3}$ of the Pacific based 9th RRC Soldiers will have served on active duty in support of the Global War on Terrorism.

As Soldiers returned from theater, they completed the Post Deployment Health Assessment (PDHA) before being Release From Active Duty (REFRAD) and approximately 838 soldiers have completed the required Post Deployment Health Reassessment (PDHRA) at 3–6 months after coming home from theater.

There are currently 23 Army Reserve Soldiers in the Warrior Transition Unit (WTU) at Tripler Army Medical Center (TAMC). These Soldiers are being continued or brought back on Active Duty status for evaluation and/or treatment for medical, mental health or behavioral health problems which have significant impact on their performance of duty. Assignment to the WTU is for 179 days with a possibility of extensions until they are found fit for duty.

Soldiers diagnosed with Post Traumatic Stress Disorder (PTSD) requiring in-patient care are enrolled in the PTSD Residential Recovery Program (PRRP), a VA Pacific Health Care System, at the TAMC Campus. There are currently 6 Soldiers in the program.

The VA Pacific Islands Health Care System Community Based Outpatient Clinic was recently dedicated on July 21, 2007 in Pago Pago, American Samoa and is scheduled to be fully activated in the very near future.

While it may not be possible to predict the specific number of Army Reserve Soldiers who will need to access VHA services in the future, it is critical that we continue to work with the VA to ensure that we understand the processes and procedures to enable our returning Soldiers to receive care through the current VHS system in the 9th RRC's area of operations.

Thank you. I would be pleased to answer any questions you may have.

Senator AKAKA. Thank you very much, Colonel. I do have questions for both of you, but before I continue with the questions, I just want to remind our veterans in the room that if you have anything that you want to talk about that is a problem for you and you need to talk to our staff, I just want to remind you that they're seated in the back of the room. Even as we talk here you should feel free to get up and seek their help.

So to our witnesses, do you believe that there is a stigma associated with seeking care for mental health disorders? If a servicemember did come forward with mental health concerns, how would his or her career be impacted? General.

General ISHIKAWA. There is a perceptual reality about mental health. This is something not only in the military, but in society overall, and we've done a lot of good things as far as education. From my perspective, it should not impact a soldier's career whatsoever, as long as they can get the proper treatment, but there is that perception.

Senator AKAKA. Thank you very much, Colonel.

Colonel GIBBONS. I agree with General Ishikawa. There is a perceived stigma associated with PTSD; however, our soldiers are coming forward by somewhat significant numbers to attend the VA's PTSD residential recovery program.

Additionally, we hear a consistent message from our soldiers in remote areas that they would like greater access to mental health practitioners. The point I would like to make is that regardless if there is a stigma associated with PTSD, our soldiers are seeking help.

Senator AKAKA. General and Colonel, what is your best estimate of number of Guard and Reserve members here on the Big Island who have served in Iraq and Afghanistan? Your best estimate.

General ISHIKAWA. Not to make light of it, Senator, but over 90 percent of the Hawaii Army National Guard has deployed to either Iraq or Afghanistan. The small percentage that did not is on Oahu, and as once in a while we say, actually the band is the only element or unit that is not. So all of the soldiers or a huge majority of the Army National Guard on the Big Island has in fact deployed.

Senator AKAKA. Colonel Gibbons.

Colonel GIBBONS. I would say the same thing. Both units we have on this island, elements of the 411th Engineer Battalion and the 100/442nd Infantry Battalion, have deployed. For numbers I would estimate 20, 25 Infantry soldiers and approximately 75 engineers have deployed. So, with the exception of a few stay-behind folks, all USAR soldiers from this island have deployed.

Senator AKAKA. To both of you, last year DOD expanded the post-deployment health assessment by including a breathing assessment. How is the Hawaii National Guard conducting the required post-deployment health assessments and reassessment? Has this been an effective program, and does it reach all members of the Guard in Hawaii as well? General?

General ISHIKAWA. Just overall it's three to six months, and it's normally conducted on a unit level, and a lot of it is done by our family support organizations. And keeping in mind my original statements about perceptions of the stigma attached, I think that it has, in fact, contributed to sharing of information and the end result is more and more of the soldiers are coming forward.

Senator AKAKA. This is a follow-up question. Have the soldiers experienced difficulty in getting follow-up medical appointments?

General ISHIKAWA. Yes, that's still a huge problem. I think when you made an employment it's supposed to be 30 days that you're supposed to get. We're averaging anywhere from 90 to 120. I think there's going to be some testimony, I hope, today with a lot of vacancies, and some of the ideas that may be when you serve in a remote location there might be a premium attached to that. I think when you look at rural medicine overall that's a true statement.

Senator AKAKA. Colonel.

Colonel GIBBONS. I think the Post-Deployment Health Reassessment has been a success story for the Army Reserve. At the national level they have contracted with a medical organization to come out and assist us in conducting these reassessments. I know on Oahu the VA also participates, and sometimes we get immediate care. On the remote islands, we do get medical practitioners that come with this contracted assessment team from the mainland. So, the PDHRA has been helpful for us. And, as I mentioned in my opening remarks, 62 percent of the soldiers surveyed have been referred to VA for further assessment and treatment.

Senator AKAKA. To both of you, DOD recently launched a Turbo TAP, a web-based program intended to assist separating servicemembers with the transition process. Do you believe this website meets the needs of transitioning servicemembers? What can be done to improve the transition process? General Ishikawa.

General ISHIKAWA. I need to pass on that one, Senator. I'm not really familiar with that web site, so I'll pass.

Senator AKAKA. Colonel.

Colonel GIBBONS. I think that's an interesting question, and I don't have the answer to that either. So I would like to get back to the organization and we'll follow up on that.

Senator AKAKA. Fine. Thank you. We'd like to have your responses shortly.

General ISHIKAWA. We will respond.

Senator AKAKA. General Ishikawa, as a result of problems at Walter Reed Army Medical Center, much has been written about care for members of the Guard and Reserves and medical holdover detachments. Are you satisfied with the care for wounded warriors from your units who are assigned to the Tripler Medical holdover detachment and what improvements would you recommend?

General ISHIKAWA. I think because of the incident at Walter Reed it's been improved mightily, and I haven't had any recent complaints, coming to me anyway, as far as the medical holdover. I normally don't like to bring up problems where I do have some idea of solutions, but let me just put it on the table. In active duty you can return to your units and it's kind of like a home. On our medical hold units, especially if they're not from Oahu, it becomes a challenge. I think that—and, again, I'm not sure how this can be solved, but if there's a way where we can perhaps bring the families periodically.

We have Air National Guard aircraft, but I believe there's regulations that won't let us do that. I think things like that could help us get the families more involved. Short of that, they have to go through this process to be cured, so I think maybe some help getting the families there would be appreciated.

Thank you.

Senator AKAKA. To both of you, it has been recommended that DOD and VA develop a joint separation physical. From your perspectives, do you believe that all servicemembers separated from active duty should receive a physical examination? Do you believe it makes sense to combine VA and DOD separation exams?

General Ishikawa?

General ISHIKAWA. I would go one step further besides just join. I know that Tripler use a lot of contract professional doctors within the community. I think that all military leaving the service should get a very thorough physical, and I think that joint combined type of organization is very appropriate. It's a matter of best resources doing the job.

Colonel GIBBONS. Senator, during deployment, when soldiers come off active duty, a physical is included as part of the out processing procedures. I don't know the detail of the medical review or how it differs from what VA provides. But, it would seem to me that there is added value in a more detailed composite physical.

Senator AKAKA. General Ishikawa, we know the activated members of the Guard and Reserve do not have access to TRICARE, and in some cases have nowhere to turn for health cares besides VA. What other issues do the Guard and Reserve face that are not shared by their active duty counterparts?

General ISHIKAWA. That question is not overall Guard differences, so I guess it's more in reference to benefits and access. I think the Guard, by its nature, being a community-based organization that really is in rural areas, I think that adds a special challenge, as opposed to having a big military base like Schofield where you have the capability of putting more resources on base. I think our remoteness and the way we're situated is the biggest difference as far as access to support.

Senator AKAKA. Colonel?

Colonel GIBBONS. Another challenge for Guard and Reserve soldiers is the transition back to their civilian job. We've got the Employer's Support of the Guard and Reserve (ESGR), who actively support our Guard and Reserve members when they get off active duty. But, to list on issue in addition to the change in the health care that is provided, I would add return to civilian employment.

Senator AKAKA. Well, you know with what we're doing today we're very concerned about the Guard and the Reserves, because there are so many things that we need to look at and try to improve on what has been there, and part of that is they've been deployed so many times. So there are some differences as to how we need to deal with the National Guard and the Reserve units. We look forward to any resolutions that you think might help us.

I want to thank you so much Brigadier General Gary Ishikawa and Colonel Gerald Gibbons, and Colonel Floresita Quarto also. Thank you for being here with us. Thank you.

General ISHIKAWA. Thank you, Mr. Chairman.

[Applause.]

Senator AKAKA. I want our audience to know that we have a third panel that may be able to respond to some of the challenges that were mentioned. I want to welcome a third panel of witnesses, and the panel consists of representatives from VA.

First, I welcome Dr. James Hastings. Dr. Hastings is the Director VA Pacific Islands Health Care System. He is accompanied by Felipe Sales, team leader of the Kona and Hilo Vet Centers. I also welcome Mark Moses, who is the Hawaii State Director of Office of Veterans Services. Finally, I want to welcome Gregory Reed, Director of the Honolulu Regional Office of the Veterans Benefits Administration.

I want to thank all the witnesses for being here today. Your full statements will be included in the record of the Committee.

Dr. Hastings, will you please begin with your testimony.

**STATEMENT OF JAMES E. HASTINGS, M.D., F.A.C.P., DIRECTOR,
VA PACIFIC ISLANDS HEALTH CARE SYSTEM, VETERANS
HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS
AFFAIRS**

Dr. HASTINGS. Yes, thank you very much, Mr. Chairman. Mahalo nui loa for the opportunity to appear before you today to discuss the state of VA care in Hawaii. It is a privilege to be here on the island of Hawaii, the Big Island, to speak and answer questions about issues important to veterans residing in Hawaii. I would like to request my written statement be submitted for the record.

Senator AKAKA. Without objection, it will be included in the record.

Dr. HASTINGS. Thank you, sir. Before I begin, Mr. Chairman, I would like to thank you personally for your leadership and assistance in helping VA care for Hawaii veterans. Your vision and commitment are truly noteworthy and deeply appreciated.

The VA operates CBOCs, Community Based Outpatient Clinics, and Vet Centers in both Kailua-Kona and Hilo. The Big Island CBOCs served an estimated island veteran population in fiscal year 2006 of 14,291. Of these, 5,081 were enrolled for care, and 2,936 received care. Since our last hearings in Hawaii, the VA relocated the clinic here to Kailua-Kona. In fiscal year 2006 the Kailua-Kona CBOCs treated 1,055 patients and recorded 6,779 clinic stops.

The VAPIHCS, VA Pacific Islands Health Care System, now leases about 5,000 square feet for the new clinic and spent approximately \$500,000 to renovate the existing facility. Although the current configuration and size is a vast improvement over the prior clinic location, parking at the new clinic is very limited. Currently, we are working with an outside firm to provide an additional 15 to 20 parking spaces.

Kailua-Kona CBOCs is actively recruiting for a psychiatry position. In the interim, mental health coverage is provided by a mental health clinical nurse specialist from the Maui CBOC and a visiting psychiatrist and nurse from the Hilo CBOC. Our clinics spent approximately \$100,000 in fiscal year 2001 to remodel the Hilo CBOC and further renovated it in fiscal year 2006. In fiscal year 2006 the Hilo CBOC treated 1,683 veterans and recorded 8,843 clinic stops. The VA estimates that up to 15,000 Hawaiians have been deployed to serve in Operation Enduring Freedom and Operation Iraqi Freedom as active duty personnel, Reservists, or members of the Hawaii National Guard.

The VA Pacific Islands Health Care System has an active outreach program to inform OIF and OEF veterans about the availability and scope of VA health care services. A team of clinical and non-clinical staff from our health care system attend all Post-Deployment Health Reassessment events. Those are the PDHRAs. At these events the VA staff answers questions, enrolls veterans, and schedules appointments for those who are interested.

The VA Pacific Islands Health Care System has a dedicated OIF/OEF program manager who helps veterans receive the services they need, and an OIF/OEF case manager. OIF/OEF veterans requiring inpatient treatment for PTSD will be admitted to the PTSD residential rehabilitation program in Honolulu.

In fiscal year 2006 the VA Pacific Islands Health Care System provided care and services to 1,137 OIF/OEF veterans. This group has special needs. For example, about 18 percent have a diagnosis of PTSD, and women comprise a larger segment of the population. A significant proportion of OIF/OEF veterans have been exposed to blasts, placing them at risk for Traumatic Brain Injury.

VA aggressively screens patients for TBI, Traumatic Brain Injury, PTSD, and other conditions. We also are training staff and hiring additional specialists to ensure we exceed the expectations of these brave warriors.

The VA Pacific Islands Health Care System and the veterans we proudly serve benefit from our relationship with academic institu-

tions. One of our most important partnerships is with the John A. Burns School of Medicine, University of Hawaii. Prior to my appointment as Director of VA Pacific Islands Health Care System, I served as Chairman of the Department of Medicine at the medical school. I've seen both sides of this relationship and truly appreciate its value.

In summary, with support, Mr. Chairman, the VA is providing an unprecedented level of health care services to veterans residing in Hawaii and here on the Big Island. I am proud of the improvements in VA services in Hawaii, but recognize that our job is not done. We must continue providing exemplary care to all veterans, including the brave soldiers of the Guard and Reserve who proudly served in OIF and OEF.

Again, Mr. President, Mr. Chairman, mahalo nui loa for the opportunity to testify at this hearing. I will be delighted to address any questions you may have.

PREPARED STATEMENT OF JAMES E. HASTINGS, M.D., F.A.C.P., DIRECTOR,
VA PACIFIC ISLANDS HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION,
DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, mahalo nui loa for the opportunity to appear before you today to discuss the state of VA care in the Hawaii. It is a privilege to be here on the Island of Hawaii—The Big Island—to speak and answer questions about issues important to veterans residing in Hawaii.

First, Mr. Chairman, I would like to thank you for your outstanding leadership and advocacy on behalf of our Nation's veterans. During your tenures as Chairman and Ranking Member of this Committee, you have consistently demonstrated your commitment to veterans. As I will highlight later, your vision and support have helped us provide an unprecedented level of health care services for veterans throughout Hawaii and the Pacific Region. In addition, I appreciate your interest in and support of the Department of Veterans Affairs (VA).

Today, I will briefly review the VA Sierra Pacific Network that includes Hawaii and the Pacific Region; provide an overview of the VA Pacific Islands Health Care System (VAPIHCS) and the VA clinics here on the Big Island; highlight issues of particular interest to veterans residing in Hawaii, including outreach to the National Guard and Reserves, Compensation and Pension examinations, new State Veterans' Home in Hilo and our important affiliations with our academic partners. I also look forward to addressing any questions you might have for me.

VA SIERRA PACIFIC NETWORK (VISN 21)

The VA Sierra Pacific Network (Veterans Integrated Service Network [VISN] 21) is one of 21 integrated health care networks in the Veterans Health Administration (VHA). The VA Sierra Pacific Network provides services to veterans residing in Hawaii and the Pacific Region (including the Philippines, Guam, American Samoa and Commonwealth of the Northern Mariana Islands), northern Nevada and central/northern California. There were an estimated 1.1 million veterans living within the boundaries of the VA Sierra Pacific Network in Fiscal Year 2006 (FY 2006).

The VA Sierra Pacific Network includes six major health care systems based in Honolulu, HI; Palo Alto, CA; San Francisco, CA; Sacramento, CA; Fresno, CA; and Reno, NV. Dr. Robert Wiebe serves as director and oversees clinical and administrative operations throughout the Network. In FY 2006, the Network provided services to 235,000 veterans. There were about 2.9 million clinic stops and 24,500 inpatient discharges. The cumulative full-time employment equivalents (FTEE) level was 8,400 and the operating budget was about \$1.5 billion.

The VA Sierra Pacific Network is remarkable in several ways. In FY 2006, VISN 21 was the highest-ranked Network in overall performance (based on an aggregation of quality, access, patient satisfaction and business metrics). The Network hosts the highest number of Centers of Excellence and also has the most highly funded research programs in VHA. In the most recent all-employee survey, staffs in VISN 21 reported the highest overall job satisfaction in VHA. Finally, VISN 21 operates one of four Polytrauma units in VHA that are dedicated to addressing the clinical needs of the most severely wounded Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans.

VA PACIFIC ISLANDS HEALTH CARE SYSTEM (VAPIHCS)

As noted above, VAPIHCS is one of six major health care systems in VISN 21. I am the director and a practicing cardiologist at VAPIHCS. VAPIHCS is unique in several important aspects: its vast catchment area covering 2.6 million square-miles (including Hawaii, Guam, American Samoa and Commonwealth of the Northern Marianas); island topography and the challenges to access it creates; richness of the culture of Pacific Islanders; and the ethnic diversity of patients and staff. In FY 2006, there were an estimated 102,000 veterans living in Hawaii (representing 8 percent of the total population in Hawaii and 9 percent of total veteran population in VISN 21).

VAPIHCS currently provides care in seven locations: the Ambulatory Care Center (ACC) and Center for Aging (CFA) on the campus of the Tripler AMC in Honolulu; and Community Based Outpatient Clinics (CBOCs) in Lihue (Kauai), here in Kahului (Maui), Kailua-Kona (Hawaii), Hilo (Hawaii), Hagatna (Guam) and Pago Pago (American Samoa). VAPIHCS also has outreach clinics in Molokai and Lanai. The inpatient Post-Traumatic Stress Disorder (PTSD) unit is now also on the campus of Tripler AMC (the unit was formerly in Hilo). In addition to VAPIHCS, VHA operates five Readjustment Counseling Centers (Vet Centers) in Honolulu, Lihue, Wailuku, Kailua-Kona and Hilo that provide counseling, psychosocial support and outreach.

In FY 2006, VAPIHCS provided services to nearly 22,500 veterans, 19,000 of whom reside in Hawaii. There were 198,000 clinic stops in Hawaii during FY 2006 (7 percent of Network total). The cumulative FTEE in FY 2006 for the health care system was 502 employees. The operating budget for VAPIHCS (i.e., General Purpose allocation from appropriated funds) increased from \$68.0 million in FY 2002 to \$110 million in FY 2007—an increase of 62 percent. For comparison, during this same time period, the operating budgets for VISN 21 increased 48 percent and VHA increased 43 percent. (Please note these amounts do not include Specific Purpose Funds and Medical Care Cost Funds [MCCF].)

VAPIHCS provides or contracts for a comprehensive array of health care services. VAPIHCS directly provides primary care, including preventive services and health screenings, and mental health services at all locations. VAPIHCS does not operate its own acute medical-surgical hospital and consequently, faces challenges in providing specialty services. VAPIHCS recently hired additional specialists in Orthopedics, Ophthalmology, Nephrology and inpatient Medicine (“hospitalist”) and is providing selected specialty care in Honolulu and to a lesser extent, CBOCs. VAPIHCS is actively recruiting additional specialists (e.g., Urology) and will continue to refer patients to DOD and community facilities.

Inpatient long-term and acute rehabilitation care is available at the CFA. Inpatient mental health services are provided by VA staff on a 20-bed ward within Tripler AMC and at the 16-bed PTSD Residential Rehabilitation Program (PRRP). VAPIHCS contracts for care with DOD (at Tripler AMC and Guam Naval Hospital) and community facilities for inpatient medical-surgical care.

The current constellation of VA facilities and services represents a remarkable transformation over the past several years. Previously, the VAPIHCS (formerly known as the VA Medical and Regional Office Center [VAMROC] Honolulu) operated primary care and mental health clinics based in the Prince Kuhio Federal Building in downtown Honolulu and CBOCs on the neighbor islands that were staffed primarily with nurse practitioners. Congress approved \$83 million in Major Construction funds to build a state-of-the-art ambulatory care facility (i.e., ACC) and a long-term care/rehabilitation unit (i.e., CFA) on the Tripler AMC campus and these facilities were activated in 2000 and 1997, respectively. VISN 21 allocated nearly \$17 million from FY 1998–FY 2000 to activate these projects. VISN 21 also provided dedicated funds to enhance care on the neighbor islands by expanding/renovating clinic space and adding additional staff to ensure there are primary care physicians and mental health providers at all CBOCs.

BIG ISLAND CBOCS

VA operates CBOCs in both Kailua-Kona (75–377 Hualalai Road, Kailua-Kona, HI 96740) and Hilo (1285 Waianuenue Avenue, Suite 211, Hilo, HI 96720). VHA also operates Readjustment Counseling Centers (“Vet Centers”) in Kailua-Kona (73–4976 Kamanu Street, Suite 207, Kailua-Kona, HI 96740) and Hilo (126 Pu‘uhonu Way, Suite 2, Hilo, HI 96720).

The Big Island CBOCs serve an estimated island veteran population in FY 2006 of 14,291. In FY 2006, 5,081 veterans were enrolled for care on the island and 2,936 received care (“users”) at Big Island VA facilities. The market penetrations for en-

rollees and “users” are 36 percent and 21percent, respectively, and compare favorably with rates within VISN 21 and VHA.

Kailua-Kona CBOC

Since the last time this Committee held hearings on the Big Island (i.e., January 2006), VA relocated the clinic here in Kailua-Kona. VAPIHCS now leases about 5,000 square-feet for the new clinic and spent about \$500,000 to renovate the existing facility. Although the current configuration and size is a vast improvement over the prior clinic location, parking at the new clinic is very limited. VAPIHCS is currently working with an architect/engineering firm to provide an additional 15–20 new parking spaces.

The current authorized FTEE level at the Kailua-Kona CBOC is 12.0, including a full-time primary care physician, psychiatrist and nurse practitioner. Currently, the psychiatry position is vacant and we are actively recruiting to fill it. In the interim, mental health coverage is provided by a mental health clinical nurse specialist (on “loan” from the Maui CBOC) and visiting psychiatrist for the Hilo CBOC. With this staff, the Kailua-Kona CBOC provides a wide array of primary care and mental health services. The Kailua-Kona CBOC also has a formal home-based primary care (HBPC) program that provides clinical services in the homes of veterans.

VAPIHCS provides specialty care services at the clinic by sending VA staff to Kailua-Kona from Honolulu and other VA facilities in California. Services provided by clinicians traveling to Kailua-Kona include cardiology, gastroenterology, nephrology, neurology, optometry, orthopedics and rheumatology. If veterans need services not available at the clinic, VAPIHCS arranges and pays for care in the local community (e.g., Kona Community Hospital) and Honolulu (including Tripler AMC). In FY 2006, VA spent more than \$7.8 million in non-VA care in the private sector (i.e., not including costs at other VA or DOD facilities) for residents of the Big Island.

In FY 2006, the Kailua-Kona CBOC treated 1,055 patients and recorded 6,779 clinic stops. The clinic has short waiting times for new patients with very few veterans waiting more than 30 days for their first primary care appointment. The Kailua-Kona HBPC program recorded 598 clinic stops for providing home care to veterans residing on the west side of the island.

Hilo CBOC

VAPIHCS spent about \$100,000 in FY 2001 to remodel the Hilo CBOC and spent additional funds in FY 2006 to further renovate the clinic. The current authorized FTEE level at the Hilo CBOC is 15.0, including two full-time primary care physicians and a psychiatrist. This is an increase of four staff since January 2006 and reflects the reassignment of staff from the PRRP that was relocated from Hilo to Honolulu. With this staff, the Hilo CBOC provides a broad range of primary care and mental health services. The Hilo CBOC also has a formal HBPC program that provides clinical services in the homes of veterans.

VAPIHCS provides specialty care services at the clinic by sending VA staff to Hilo from Honolulu and other VA facilities in California. Services provided by clinicians traveling to Hilo include cardiology, gastroenterology, nephrology, neurology, optometry, orthopedics and rheumatology. If veterans need services not available at the clinic, VAPIHCS arranges and pays for care in the local community (e.g., Hilo Medical Center), Honolulu (including Tripler AMC) or VA facilities in California. As noted before, in FY 2006, VA spent more than \$7.8 million in non-VA care in the private sector (i.e., not including costs at other VA or DOD facilities) for residents of the Big Island.

In FY 2006, the Hilo CBOC treated 1,683 veterans and recorded 8,843 clinic stops. The clinic has short waiting times for new patients with very few veterans waiting more than 30 days for their first primary care appointment. The Hilo HBPC program recorded 641 clinic stops for providing home care to veterans residing on the east side of the island.

SPECIAL ISSUES

OIF/OEF outreach

VA estimates up to 15,000 residents of Hawaii have been deployed to Afghanistan and Iraq as active duty personnel, Reservists or Hawaii National Guard. All VAPIHCS sites of care, including CBOCs, are authorized to provide care to DOD beneficiaries as TRICARE providers under the national “Seamless Transition” initiative between VA and DOD.

VAPIHCS has an active outreach program to inform OIF/OEF veterans about the availability and scope of VA health care services. As an example, a team of clinical and non-clinical staff from VAPIHCS attend all Post Deployment Health Reassessment (PDHRA) events. PDHRA is a program managed by DOD and is designed to

provide education, screening, assessment and access to care for military personnel who have returned from deployment. The assessment generally occurs 3 to 6 months after returning from deployment. At the PDHRA events, VA staff is available to answer questions and to enroll and make appointments for interested veterans.

All VA health care systems, including VAPIHCS, have dedicated OIF/OEF program managers, who help OIF/OEF veterans receive the services they need. VAPIHCS also has an OIF/OEF case manager and support from a Transition Patient Advocate in VISN 21. OIF/OEF veterans who need inpatient treatment for PTSD will be admitted to the PRRP program in Honolulu. Veterans residing in Hawaii also have access to the Polytrauma Unit at the VA Palo Alto Health Care System. This is one of four specialized units designed to meet the needs of the most severely injured OIF/OEF veterans and active duty personnel.

The total number of OIF/OEF veterans seen in VA health care facilities is a relatively small proportion of the total "user" population; however, the number is increasing. In FY 2002, VAPIHCS treated 225 OIF/OEF veterans; in FY 2006, the number of OIF/OEF veterans seen at VAPIHCS facilities increased to 1,137. Very few OIF/OEF veterans are waiting more than 30 days for an appointment.

VA recognizes that our newest group of veterans has special needs. About 18 percent of OIF/OEF veterans seen in VHA have a diagnosis of PTSD. There are more women veterans in the OIF/OEF cohort than the general veteran population. A significant proportion of OIF/OEF veterans has been exposed to blasts and might suffer from Traumatic Brain Injury (TBI). Musculo-skeletal problems (e.g., low back pain) are common and constitute the most prevalent reason for seeking VA health care. In response, VA is aggressively screening patients (e.g., for TBI), training staff and hiring additional specialists (e.g., mental health, rehabilitation) to ensure we will meet the needs and expectations of these brave warriors.

Compensation and Pension (C&P) examinations

Veterans Benefits Administration (VBA) relies heavily on the medical evidence and expert opinion provided by C&P examinations to adjudicate veterans' claims. Consequently, the quality and timeliness of C&P examination results provided by VHA is very important. The quality of C&P examinations performed at VAPIHCS is very good, as measured by Compensation and Pension Examination Program scores (an external review of examination completeness and quality), insufficiency rates and remand rates.

Regrettably, for the past several months, there is a backlog of examination requests and the timeliness of examinations has not met VHA standards of 35 days. The underlying causes of the delays include a surge of requests from VBA, staffing vacancies coupled with recruitment challenges (especially, in more remote locations such as Guam), and space constraints in the ACC.

VAPIHCS is highly motivated to resolve these barriers and has developed a credible plan. VAPIHCS now has made additional examiners available to the C&P unit by reassigning staff, "borrowing" VA physicians from mainland facilities and hiring contract staff. VAPIHCS is also conducting C&P clinics on some Saturdays and has plans to renovate the ACC to relieve space constraints. Assuming the number of requests from VBA remains stable (i.e., about 500 requests each month), VAPIHCS is confident it can eliminate the backlog and maintain timeliness standards by fall 2007.

State Veterans Home

The State of Hawaii is planning to open its first State Home in Hilo later this year. This will be the first State of Hawaii facility to provide nursing home and domiciliary care to eligible veterans. The 95-bed facility is on the site of the former Hilo Hospital on the Hilo Medical Center campus. VA awarded a grant of about \$20 million for the project to complement state funding. VA is excited about this project and looks forward to our continuing collaboration with the State of Hawaii. I commend the State Advisory Board on Veterans Services for the recommendation to name the facility in honor of Mr. Yukio Okutsu. As you know, Mr. Chairman, Mr. Okutsu was a resident of Hilo and a recipient of our Nation's highest award for valor, the Medal of Honor, for his heroism during World War II.

Academic affiliations

VAPIHCS and the veterans we proudly serve benefit from an array of balanced relationships with academic institutions. One of our most important partnerships is with the John A. Burns School of Medicine, University of Hawaii. Prior to my appointment as Director, VAPIHCS, I was fortunate to have served as Chairman, Department of Medicine at the Medical School. I have seen from both "sides" the value of a strong relationship between VA and academic medicine. VAPIHCS serves as a training site for medical students, post-graduate housestaff (i.e., interns, residents

and fellows), dentists, nurses, pharmacists, psychologists and social workers. We also work with the Medical School in recruiting physicians and research investigators. Our patients and staff also benefit from the training programs and other academic programs at Tripler AMC.

CONCLUSION

In summary, with your support, Mr. Chairman, and other Members of Congress, VA is providing an unprecedented level of health care services to veterans residing in Hawaii and here on the Big Island. Our goal is to provide safe, effective, efficient and compassionate care to all veterans. We are committed to and active in our outreach efforts to veterans, including the brave soldiers in the Guard and Reserve, who proudly served in OIF/OEF.

However, VAPIHCS still faces several challenges, in part due to the topography of its catchment area, lack of an acute medical-surgical hospital, limited community resources in rural areas and difficulties recruiting staff. VAPIHCS will meet these challenges by utilizing telehealth technologies, hiring specialists, working with community partners and developing new delivery models. I am proud of the improvements in VA services in Hawaii, but recognize that our job is not done.

Again, Mr. Chairman and other Members of the Committee, mahalo nui loa for the opportunity to testify at this hearing. I would be delighted to address any questions you might have for me.

Thank you.

Senator AKAKA. Thank you very much, Dr. Hastings.

And now I call on Mark Moses for his testimony.

STATEMENT OF MARK MOSES, DIRECTOR, OFFICE OF VETERANS SERVICES, DEPARTMENT OF DEFENSE, STATE OF HAWAII

Mr. MOSES. Thank you, Mr. Chairman. I'm very privileged to testify before your Committee today. I am Mark Moses, the Director of the Office of Veterans Services, OVS. OVS is the State lead agency responsible for the welfare of veterans and family members. We have a counselor stationed in each county and we touch each island. We have counselors that have regular appointments on every island in the state.

As the Governor's liaison to veterans and veteran groups we serve as an intermediary between the Department of Veterans Affairs and provide access to state services and benefits. We have provided services and information to nearly 33,000 veterans and survivors this past fiscal year. I've attached a summary sheet providing some services and activities made available for your review.

The final service we can provide a veteran is interment in a veteran cemetery with appropriate honors. The VA has consistently supported our efforts to expand Hawaii's cemetery plots and columbariums in order to keep pace with need. They're deserving of our gratitude.

It is important and proper to take this opportunity to personally thank you for your support of our veterans in general and our cemetery system in particular. We are very grateful for your assistance in obtaining a new grant for the West Hawaii Veterans Cemetery. This VA grant ensures the cemetery will have all that we have envisioned. The West Hawaii Veterans Cemetery will be known as the most expensive cemetery in the Nation, even with the personal sacrifices made by veterans and community volunteers of time and energy. My special thanks go to John Grogan and the West Hawaii Veterans Cemetery Association. Thank you, gentlemen.

The effort of the volunteers were greatly enhanced through material and financial support of the local business community. Nurs-

eries, construction firms, hotels, and the Carpenters Union. Particularly noteworthy is our good neighbor Kukio. Their individual contributions ensure the cemetery is the oasis that it is today, and their commitment of water supply, which, I understand, they have tripled, Mr. Chairman, ensure the further expansion of the cemetery, as well as the ability to have restroom facilities.

To all of you, thank you. We look forward to your continuing participation as we work to expand the West Hawaii Veterans Cemetery.

Mr. Chairman, the April 2000 data from the VA Office of the Actuary Office of Policy, Planning, and Preparedness estimated 120,000 veterans in Hawaii. About 72 percent are on Oahu, 13 percent on the Big Island, 10 percent on one of the Maui County islands, and approximately 5 percent on Kauai. Our island state presents unique challenges for the Department of Veterans Affairs. Despite these challenges, I want to share with you comments that we hear from veterans.

They speak of the excellence of VA medical care, how VA staff treats veterans with dignity and respect, and that the services rendered by the dedicated health care professionals are superior to that that they received on the mainland. These comments are from local veterans and those visiting Hawaii that seek care in the Spark M. Matsunaga Medical Center.

Similar comments are heard about the VA benefits staff. Hawaii's VA supports the Guard and Reserve prior to deployment, and upon their return, as well as their family members while they're in military service. As a disabled veteran, I can attest to the fact that the services provided here by the VA are top in the Nation. Nevertheless, given the proper resources, they're capable of doing better.

Recall that nearly 30 percent of the veterans live on the neighbor islands. Many of them are referred for surgical services to mainland VA medical centers, civilian medical facilities on Oahu, or to Tripler Army Medical Center. For neighbor island veterans sent to mainland VA hospitals, this can be very traumatic. They're booked on flights, sent to a big city, and they're told find a VA facility. They're operated on and then they're sent back to their homes in Hawaii. We ask that sufficient funding be provided for direct mainland flights from and, whenever possible, return flights to the veteran's island of residence.

Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu. Neighbor Island Community Based Outreach Centers place veterans on a wait list where they are scheduled for specialty medical care. With the use of telemedicine and more frequent visits, this program is being addressed. However, backlogs still exist. With some veterans waiting several months to see a specialist.

VA has a difficult time recruiting and maintaining competent medical staff in these rural areas. VA should be allowed to offer a premium to rural medical service providers and to contract for additional medical care in rural areas such as the neighborhood islands.

Thousands of National Guard and Reservists have returned. My desire is that they, and those already here, receive medical and

benefit services in a timely manner. We ask that VA Health Administration and VA Benefits Administration be adequately funded and staffed to provide medical care and benefit services to all Hawaii's veterans.

Hawaii received a VA grant to help build the Yukio Okutsu Veterans Home, opening this year. I envision that eventually we'll have several veterans long-term care facilities, preferably at least one per county. This need is here now, and I understand that you have legislation which offers bed spaces in other hospitals, and that's greatly appreciated.

The present per day veteran reimbursement rate, however, in the VA care home is \$67.71 per day. It's insufficient to maintain a veteran without additional payment. We request the reimbursement rate be raised to adequately cover long-term care services provided to assist the State in meeting the medical care needs of this frail group of our older warriors. The actual cost is approximately \$300 per day.

As many veterans pass, many will utilize our State veterans' cemetery system. Presently the State and County are reimbursed \$300 for each veteran burial, less than the cost to open and close the grave site.

This reimbursement rate has not changed in many years, and we ask your Committee look into increasing it to more closely reflect the true cost of interments, which is approximately \$1,000. We must continue to care for those who served. They are our sons and our daughters, our Hawaii citizens, our veterans. I thank the Committee and you for this opportunity to testify, and I'll respond to any questions.

[The prepared statement of Mr. Mark Moses follows:]

PREPARED STATEMENT OF MARK S. MOSES, DIRECTOR, OFFICE OF VETERANS SERVICES, DEPARTMENT OF DEFENSE, STATE OF HAWAII

Chairman Akaka and Members of the Senate Committee on Veterans' Affairs, I am Mark Moses, Director of the Office of Veterans Services (OVS). The office is the single State lead agency responsible for the welfare of Veterans and their family members. We act as the Governor's liaison to veterans, veterans groups and organizations, and serve as an intermediary between the Department of Veterans Affairs and Hawaii's veterans. The office serves in partnership with the VA to provide state services and benefits. We provided services and information to nearly 33,000 veterans and eligible survivors this past fiscal year. I have attached a summary sheet describing some services and activities made available through the office for your review.

The final service we can provide a veteran is interment in a veteran's cemetery with appropriate honors. The Veterans Administration has consistently supported our efforts to expand Hawaii's cemetery plots and columbarium space to keep pace with need. They are deserving of our gratitude.

Additionally, it is important and proper to take this opportunity to thank you, Senator Akaka for your unwavering support for our veteran's cemetery program. We are particularly grateful for your assistance in obtaining the new grant for the West Hawaii Veterans Cemetery located in Kona. State veterans cemeteries are the only cemeteries accepting full body burials on a consistent basis in Hawaii. This VA grant will assure that West Hawaii will be the cemetery we all have envisioned it to be.

Based on April 2000 data from the Office of the Actuary, Office of Policy, Planning and Preparedness, Department of Veterans Affairs, there are an estimated 120,000 veterans in Hawaii. The majority, about 72 percent live on Oahu, 13 percent reside on the island of Hawaii, 10 percent live on one of the three islands which comprise Maui County, and approximately 5 percent live on Kauai. Hawaii, an island state located in the middle of the Pacific Ocean, presents unique challenges for the Department of Veterans Affairs.

Before I discuss some of these challenges, I want to share with you comments that my staff and I hear from veterans about VA health care and benefit services. These individuals speak to the excellence of VA medical care; that VA's staff treats veterans with dignity and respect, and that the services rendered by the dedicated health care professionals are superior to the care they received on the mainland United States. These comments are expressed by local veterans as well as by veterans who visit Hawaii and have a need to seek services from Spark M. Matsunaga medical staff. Similar types of comments are shared about the VA Benefit staff.

This "new" VA exemplifies the well known phrase of "supporting our troops." Hawaii's VA supports our National Guard members and Reservists prior to deployment and upon their return. They also offer services to military members who are ending their military service. As a disabled veteran, I can attest to the fact that the services provided by the VA locally are top in the Nation. Nevertheless, given the proper resource they are capable of doing better.

As mentioned earlier, Hawaii presents unique challenges to the VA. We are an island state with one large population center on Oahu. Nearly 30 percent of Hawaii's veterans live on the neighbor islands. Presently many of our veterans are referred for surgical services to mainland VA medical centers, civilian medical centers on Oahu, or to Tripler Army Medical Center. This can be very traumatic for neighbor island veterans who are sent to other VA hospitals. They are booked on flights, sent to a big city to find the VA facility, operated on and sent back to their home in Hawaii. We ask that funding be provided so that those who reside on neighbor islands be provided direct flights to the mainland. We also propose that whenever possible, return flights fly directly to the veteran's island of residence.

Another issue that affects Hawaii and Alaska involves changes that were made to 38 U.S.C. 1151, Benefits for persons disabled by treatment of vocational rehabilitation. With this change the only facilities covered by the law are those over which the Secretary of Veterans Affairs has direct jurisdiction, or Government Facilities contracted by the Secretary. Tripler Army Medical Center and other medical facilities in Hawaii, such as Straub, Kuakini, Queens, and St. Francis do not qualify under the present law. Veterans suffering an unlikely event causing any additional disability or worse are on their own and must sue the medical facility for damages. For most, obtaining an attorney to pursue this option is overwhelming.

We suggest that the definitions as listed in 38 U.S.C. 1701(3) and 38 U.S.C. 1151, be changed so that veterans in Hawaii treated outside VA facilities are afforded the same protection as veterans who receive VA medical care in VA facilities on the mainland. Hawaii's veterans must have the same right to redress as veterans treated at mainland VA facilities. At a minimum, veterans must be given the opportunity to make informed consent about the benefits and shortfalls of choosing between having surgeries or other medical procedures performed at a VA facility on the mainland or in non-VA facilities locally.

Hawaii's neighbor islands must be offered the same level of medical care and services as veterans located on Oahu. Presently neighbor island Community Based Outreach Clinics place veterans on a wait list where they are scheduled for specialty medical care. With the use of Telemedicine and more frequent visits, this problem is being addressed; however, backlogs still exist. Veterans have been known to wait several months before they see a specialist. Additionally, VA has a difficult time recruiting and maintaining competent medical staff in these rural areas. To address these needs, the VA should be allowed to offer a premium to rural medical service providers and consider contracting for additional medical care in rural areas such as the neighbor islands.

As you are aware, Hawaii has received thousands of its returning National Guardsmen and Reservists. As Director of the Office of Veterans Services, my desire is that these returning military members and those already here be able to access medical and benefit services in a timely manner. We ask that VA Health and Benefits Administrations be adequately funded and staffed to provide medical care and benefit services to all veterans who make Hawaii their home.

Hawaii has received a grant from the VA to build its first Veteran's Home. The Yukio Okutsu Veterans Home is scheduled to open within a few months. Our concern is with the reimbursement rate that the VA pays for veterans who will be residing at the home. The present reimbursement is insufficient to maintain a veteran without payment of additional funds. We in Hawaii are not alone in requesting that the per day reimbursement rate be raised so that it adequately covers long-term care services supplied by the facility. We envision that the Yukio Okutsu Veterans Home will be the first of several veterans' long-term care facilities, preferably at least on per county due to inherent island produced isolation. Adequate per resident reimbursement will assist the state in meeting the medical care needs of this frail group of older warriors.

As these veterans pass, many will utilize our State Veteran's Cemetery system. Presently the state and county are reimbursed \$300 for each veteran burial, but the cost to open and close the grave site and provide perpetual care greatly exceeds this amount. This reimbursement rate has not changed in many years. We ask that your Committee look into increasing the present amount so that it more closely reflects the true cost associated with full body and urn burials.

We must continue to take care of our veterans. We must support our Soldiers, Sailors, Airmen, Marines, and Coast Guard members at home and abroad. They are our veterans, our sons and daughters, our citizens of Hawaii.

I thank the Committee for this opportunity to speak on this matter and I will respond to any questions that you may have.

[Note: the following is a summary of services and activities being offered by the Hawaii Office of Veterans Services.]

HAWAII OFFICE OF VETERANS SERVICES

MISSION

The Office of Veterans Services (OVS) is the principal state office responsible for the development and management of policies and programs related to veterans, their dependents, and/or survivors. The OVS acts as a liaison between the Governor and veterans' organizations and also between the Department of Veterans Affairs and individual veterans. Our objectives are to assist veterans in obtaining State and Federal entitlements, to supply the latest information on veterans' issues and to provide advice and support to veterans making the transition back into civilian life.

OVS is the State's primary advocate of veterans applying for and receiving benefits and services. The OVS may take action on behalf of veterans, their families and survivors to secure appropriate rights, benefits and services. This process includes the reception, investigation and resolution of disputes and complaints.

The OVS serves all eligible veterans, Reservists, National Guard members, active-duty military personnel and their dependents (including stepchildren). (See List of Services at end.)

STATE PROVIDED BENEFITS

Special Housing for Disabled Veterans

Payment by the State of up to \$5,000 to each qualified, totally disabled veteran for the purpose of purchasing or remodelling a home to improve handicapped accessibility.

Burials

Burials for qualified veterans (including U.S. war allies) and their dependents in Veterans Cemeteries on Oahu, Hawaii, Kauai, Maui, Molokai, or Lanai.

Vital Statistics

Free certified copies of vital statistics forms when needed for veterans' claims.

License Plates

For the same cost as regular license plates, qualified veterans can acquire distinctive veterans' license plates for their car or motorcycle. Currently available are: "Veteran," "Combat," "Combat Wounded," "Pearl Harbor Survivor," "Former POW," "World War II Veteran," "Korean War Veteran," and "Vietnam Veteran."

Tax Exemptions

Applies to real property that is owned and occupied as a home by a totally disabled veteran or their widow(er). Also applies to passenger cars when they are owned by totally disabled veterans and subsidized by the Department of Veterans Affairs.

Employment and Re-employment

Preference is given to veterans, Vietnam-era veterans, service-connected, disabled veterans and their widow(er)s for civil service positions, training programs, job counseling and referrals to civilian jobs by the Workforce Development Division, Department of Labor and Industrial Relations. Re-employment rights for veterans, Reservists or National Guard members who leave a position within State or County government for training or active military service.

We encourage you contact the Office of Veterans Services to have your questions answered. The sooner we begin the process together, the sooner you will see results.

Please contact the OVS office nearest you. Walk-ins are welcome, and appointments are recommended. Home, worksite and hospital visits are available if necessary, as are Group presentations.

Office of Veterans Services—Oahu

Office: Tripler Army Medical Center E-Wing
 Address: Office of Veterans Services, 459 Patterson Road,
 E-Wing, Room 1–A103, Honolulu HI 96819–1522.
 Telephone: (808) 433–0420; Fax: (808) 433–0385.
 E-mail: OVS@ovs.hawaii.gov.
 Hours: Monday-Friday, 7:45 a.m.–4:00 p.m.

Office of Veterans Services—Kauai

Address: 3215 Kapule Hwy., #2, Lihue, HI 96766.
 Telephone: (808) 241–3346; Fax: (808) 241–3818.
 E-mail: KOVS@ovs.hawaii.gov.
 Hours: Monday-Friday, 7:30 a.m.–4:30 p.m.

Office of Veterans Services—Hawaii

Address: 101 Aupuni Street, Room 212, Hilo, HI 96720.
 Telephone: (808) 933–0315; Fax: (808) 933–0317.
 E-mail: HOVS@ovs.hawaii.gov.
 Hours: Monday-Friday, 7:30 a.m.–4:30 p.m.

Office of Veterans Services—Maui

Address: 333 Dairy Road, Suite 201–A, Kahului, HI 96732.
 Telephone: (808) 873–3145; Fax: (808) 243–5820.
 E-mail: MOVS@ovs.hawaii.gov.
 Hours: Monday-Friday, 7:30 a.m.–4:30 p.m.

LIST OF SERVICES FOR VETERANS, ACTIVE MILITARY,
 SPOUSES AND DEPENDENTS

Assist in preparation of VA claims.
 Help individuals file VA Appeals.
 Represent veterans at VA hearings.
 Obtain veteran birth, marriage, divorce and death certificates nationwide.
 Assist with burial.
 Provide notary.
 Assist indigents.
 Maintain DD214s.
 Refer individuals not qualified for VA benefits to other agencies.
 Legal name change.
 Review active service record.
 Assist active medical boards.
 Hawaii Veterans Newsletter.
 Hawaii Veterans Roster.
 Hawaii Veterans Website.
 Governor's Liaison to veterans.
 Legislative Advocate for veterans—State and Federal.
 Yukio Okutsu Hilo Veterans Home—development and oversight.
 State Veterans cemeteries statewide—grants and expansion.
 Grant-in-Aid for all veteran related items—veterans' cemeteries, Arizona Memorial, Aviation Museum, Veterans Centers statewide, etc.
 Tri-annual report for State Monuments.
 Coordinate veterans organizations to clean the Korean and Vietnam Memorials on Capitol grounds.
 Coordinate Memorial and Veterans Day ceremonies annually at Hawaii State Veterans Cemetery.
 Assist with Memorial and Veterans Day ceremonies at National Cemetery of the Pacific (Punchbowl).
 Coordinate leis for veterans cemeteries on Memorial Day.
 Staff the Advisory Board on Veterans Services.
 Hawaii Veterans Memorial Fund.
 Maintain presence on neighbor islands.
 Validate Military Service for Employee Retirement System.

Senator AKAKA. Thank you very much, Mr. Moses. Now we'll receive testimony of Gregory Reed.

STATEMENT OF GREGORY REED, DIRECTOR, HONOLULU REGIONAL OFFICE, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. REED. Chairman Akaka, it is my pleasure to be here today to discuss our efforts to meet the needs of veterans residing in the Pacific Region. The Veterans Benefits Administration, VBA, is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors.

Today I will discuss the important services we provide at the Honolulu Regional Office. I will also discuss actions VA is taking to expedite the processing of claims from our Operations Iraqi and Enduring Freedom veterans and VBA's national hiring initiative that will improve Honolulu's ability to provide more timely, accurate, and consistent determinations on veterans' claims.

The Honolulu Regional Office is responsible for delivering VA benefits and services to veterans residing in the Pacific Region, including Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Marianas. We provide disability compensation, dependency and indemnity compensation, disability and death pension, and burial benefits to eligible veterans, dependents, and survivors. In addition, we offer vocational rehabilitation employment services, home loan guarantees, and Native American direct loans.

The Regional Office also provides extensive outreach to veterans and dependents throughout the Pacific Region. One of our most successful benefit packages is the Native American Direct Loan Program. Initially a pilot program, which you, Senator, helped to make permanent in 2006 by way of Public Law 109-233, the Native American Direct Loan Program. This has effectively provided quality homes in the U.S. territories and Hawaii homelands. At present, the Honolulu Regional Office holds 75 percent of all Native American direct loans nationwide.

More than 107,000 veterans are served by the dedicated employees of the Honolulu Regional Office. Approximately 16,700 of these veterans are receiving disability compensation. This fiscal year, through July, the Honolulu Regional Office provided approximately 4,314 veterans with decisions on their disability claims. Through aggressive outreach and public contact activities, Regional Office employees have conducted nearly 9,000 personal interviews and over 2,300 telephone interviews, and briefed 850 separating servicemembers so far this year.

We recently extended telephone service, benefits counseling, and other interisland itinerate services to the South Pacific area encompassing the Federated States of Micronesia. Telephone service is also provided to veterans residing in the Republic of Palau and the Marshall Islands. Our Veterans Service Center at the RO has a designated Military Service Coordinator, who performs many of the outreach functions provided to returning servicemembers. The Military Service Coordinator conducts regular briefings covering the full range of VA benefits as part of the Military Transition Assistance Program, better known as TAP. A Veterans Service Representative is also out based in Guam to provide TAP briefings

there. In addition, the Military Service Coordinator conducts briefings for members of the Army or Navy being discharged for medical disabilities.

Our Vocational Rehabilitation and Employment employees work very closely with military facilities in Hawaii to ensure that outreach is extended to as many returning servicemembers as possible. A VA employment specialist from the Honolulu Regional Office is staffed at the Tripler Army Medical Center's Deployment Health Center to assist returning Reservists and National Guard members.

In addition to providing information about VA services, the employment specialist sometimes refers recuperating soldiers to the local Disabled Veteran Outreach person for employment briefings offered by the Department of Labor.

We also provide monthly briefings at the TAP sessions at Pearl Harbor Naval Hospital and Schofield Barracks. Our vocation rehabilitation division also provides over 1,000 servicemembers and recently discharged veterans vocational and educational counseling. We are the third highest in the country providing that service.

The Honolulu Regional Office has been a major player in the success of the Native American Direct Loan Program. Since 1993 VA has made almost 600 loans to Native American veterans for the purchase, construction, or improvement of homes on Federal trust land under this program. Over 75 percent of all loans made in this program have been to Native American veterans living on the homeland territories of American Samoa, Guam, Hawaii, and the Commonwealth of the Northern Marianas. Much of the credit for this achievement is due to our ongoing partnerships with the Department of Hawaiian Homelands, the Community Development Bank of American Samoa, the Territorial Government of Guam, and the Commonwealth of the Northern Marianas Cultural Affairs Office.

With the ongoing activation of Reserves and National Guard members in support of the military operation in Iraq and Afghanistan, servicemembers are becoming eligible for VA home loan benefits faster and in greater numbers. Instead of the time and service requirement of 6 years for members of the Reserves or National Guard, eligibility is established under the loan guarantee and Native American Veteran Direct Loan Program after 90 days or more of active wartime service.

Further, as a result of Public Law 108-454, veterans are eligible for VA guaranteed and direct loans equal to the Freddie Mac conforming loan limit. As of January 2006, that rate increased to 625,000 for high cost areas such as Hawaii and Guam.

Mr. Chairman, I will now discuss two VA-wide initiatives which the Honolulu Regional Office is actively participating. The first of these is priority processing of claims submitted by veterans of Operation Iraqi Freedom and Operation Enduring Freedom.

Since the onset of the combat operations in Afghanistan and Iraq, VA has provided expedited and case management services for all seriously injured OIF and OEF veterans and their families. Records show that the Honolulu staff has assisted a total of 57 OIF/OEF seriously injured veterans. This individualized service begins at the military medical facilities where the injured

servicemembers, separating under the VA medical care and benefit system, are streamlined into our benefits system overall, as well as the VA health care system.

Beginning in February 2007, VA has provided priority processing for all OIF/OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OIF/OEF theaters or in support of these combat operations, as identified by the Department of Defense, DOD. As a result, all the brave men and women returning from the OIF/OEF theaters who were not seriously injured in combat, but who, nevertheless, have a disability incurred or aggravated during their military service enter the VA system and begin receiving disability benefits as soon as possible after separation.

I am especially pleased today to be able to discuss VA's national hiring initiative. VA has already added more than 800 new employees since April, and plans call for adding a total of 3,100 new employees by the end of next year. These employees will be placed in critically needed positions in VA regional offices throughout our Nation. In order to have these new employees online and productive within a few months, VA is providing them with accelerated training that focuses on specialized areas of claims processing. This initial training will be followed by ongoing, carefully structured, and progressively complex training until full journeymen expertise is achieved.

The Honolulu Regional Office been authorized to increase its staffing level by over 10 percent as a result of this hiring initiative. A number of the new employees are already on board, and the regional office is in the process of filling another five vacancies. The training of our new employees is going well. We sought the assistance of the San Diego Regional Office and temporarily detailed one of their senior specialists for about 6 weeks to assist with training in forming a nucleus of expertise. Our employees were tremendously helped by this expertise and continue to thrive on it. These additional resources will enable Honolulu Regional Office employees to make great strides in improving the delivery of benefits and conducting more outreach in the Pacific Region.

We thank you for your assistance, and with your continued support we intend to deliver best service possible to veterans who reside in the Pacific Region.

Mr. Chairman, this concludes my testimony. I greatly appreciate being invited to testify here today and look forward to any questions you may have, sir.

[The prepared statement of Mr. Reed follows:]

PREPARED STATEMENT OF GREGORY C. REED, DIRECTOR, HONOLULU REGIONAL OFFICE, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Chairman Akaka, it is my pleasure to be here today to discuss our efforts to meet the needs of veterans residing in the Pacific Region.

The Veterans Benefits Administration (VBA) is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors. Today I will discuss the important services we provide at the Honolulu Regional Office. I will also discuss actions VA is taking to expedite the processing of claims from Operations Iraqi and Enduring Freedom (OIF/OEF) veterans and VBA's national hiring initiative that will improve Honolulu's ability to provide more timely, accurate, and consistent determinations on veterans' claims.

HONOLULU REGIONAL OFFICE

The Honolulu Regional Office is responsible for delivering VA benefits and services to veterans residing in the Pacific Region, including Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Marianas. We provide disability compensation, dependency and Indemnity compensation, disability and death pension, and burial benefits to eligible veterans, dependents, and survivors. In addition, we offer vocational rehabilitation and employment assistance, home loan guaranties, and Native American direct home loans. The regional office also provides extensive outreach to veterans and dependents throughout the Pacific Region.

One of our most successful benefit packages is the Native American Direct Loan Program. Initially a pilot program, which you helped to make permanent in 2006 by way of Public Law 109-233, the Native American Direct Loan Program has effectively provided quality homes on in the U.S. Territories and Hawaiian Home Lands. Currently, the Regional Office has closed 315 loans, and refinanced 161 loans, totaling \$30,557,365 and \$13,716,700, respectively. Our Loan Guaranty division has an additional 33 homes under construction with loan obligations totaling \$6,686,919. At present, Honolulu holds 95 percent of all Native American Direct Loans, nationwide.

More than 107,000 veterans are served by the dedicated employees of the Honolulu Regional Office. Approximately 16,700 of these veterans are receiving disability compensation. This fiscal year through July, the Honolulu Regional Office provided approximately 4,314 veterans with decisions on their disability claims.

OUTREACH AND COMMUNICATION

Through aggressive outreach and public contact activities, regional office employees have conducted nearly 1,350 personal interviews and 2,250 telephone interviews, and briefed approximately 850 separating servicemembers so far this year. We recently extended telephone service, benefits counseling, and other inter-island itinerant services to the South Pacific area encompassing the Federated States of Micronesia. Telephone service is also provided to veterans residing in the Republic of Palau and the Marshall Islands.

The Veterans Service Center at the RO has a designated Military Services Coordinator who performs many of the outreach functions provided to returning servicemembers. The Military Services Coordinator conducts regular briefings, covering the full range of VA benefits, as part of the military Transition Assistance Program (TAP) at various military installations in Hawaii. A Veterans Service Representative is also outbased in Guam to provide TAP briefings there. In addition, the Military Services Coordinator conducts briefings for members of the Army or Navy being discharged for medical disabilities. These briefings, which are part of the Physical Evaluation Board orientations, are conducted at Pearl Harbor Naval Regional Medical Center and Tripler Army Medical Center.

VOCATIONAL REHABILITATION AND EMPLOYMENT ACTIVITIES

Our Vocational Rehabilitation and Employment (VR&E) employees work very closely with military facilities in Hawaii to ensure that outreach is extended to as many returning servicemembers as possible. A VA Employment Specialist from the Honolulu Regional Office is staffed to the Tripler Army Medical Center's Deployment Health Center to assist returning Reservists and National Guard members. In addition to providing information about VA services, the Employment Specialist sometimes refers recuperating soldiers to the local Disabled Veteran Outreach Program for employment briefings offered by the Department of Labor. VR&E employees participate in a program at the Schofield Barracks Army Base's Soldier and Family Assistance Center, which provides one-stop service for returning servicemembers and their families. We also provide monthly briefings at Disabled Transition Assistance Program (DTAP) sessions at Pearl Harbor Naval Base and Schofield Barracks.

Our Vocational Rehabilitation Division also provides over 1,000 servicemen and recently discharged veterans vocational/educational counseling, the third highest in the country.

HOME LOAN GUARANTY SERVICES

The Honolulu Regional Office has been a major player in the success of the Native American Veteran Direct Loan Program. Since 1993 VA has made almost 600 loans to Native American veterans for the purchase, construction, or improvement of homes on Federal Trust lands under this program. Over 75 percent of all loans made under this program have been to Native American veterans living on the

homeland territories of American Samoa, Guam, Hawaii, and the Commonwealth of the Northern Marianas.

Much of the credit for this achievement is due to our ongoing partnerships with the Department of Hawaiian Homelands, the Community Development Bank of American Samoa, the Territorial Government of Guam, the Commonwealth of the Northern Marianas (CNMI), the CNMI Department of Community and Cultural Affairs Veterans Affairs Office, and the Mariana Islands Housing Authority. These offices have played crucial roles in assisting with outreach and delivery of the VA home loan benefit to veterans located throughout the South Pacific. They have acted as our partners in assisting with loan packaging, appraisals, and construction-related inspections, and have provided crucial communication links between our staff and the veterans we serve.

With the ongoing activation of Reserve and National Guard members in support of the military operations in Iraq and Afghanistan, servicemembers are becoming eligible for VA home loan benefits faster and in greater numbers. Instead of the time-in-service requirement of 6 years for members of the Reserves or National Guard, eligibility is established under the Loan Guaranty and Native American Veteran Direct Loan Programs after 90 days or more of active wartime service. Further, as a result of P.L. 108-454, veterans are eligible for VA-guaranteed and direct loans equal to the Freddie Mac conforming loan limit. As of January 2006, that rate increased to \$625,500 for high cost areas such as Hawaii and Guam. We think this will make VA guaranteed home loans much more attractive to veterans served by the Honolulu Regional Office, and we anticipate continued growth in the Loan Guaranty Program and Native American Direct Loan Program in the Pacific Region as a result.

PRIORITY PROCESSING FOR OIF/OEF VETERANS

Mr. Chairman, I will now discuss two VA-wide initiatives in which the Honolulu Regional Office actively participates. The first of these is priority processing of claims submitted by veterans of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

Since the onset of the combat operations in Afghanistan and Iraq, VA has provided expedited and case-managed services for all seriously injured OIF/OEF veterans and their families. Records show the Honolulu staff has assisted a total of 57 OEF/OIF seriously injured veterans. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment, and continues as these servicemembers are medically separated and enter the VA medical care and benefits systems. VA assigns special benefits counselors, social workers, and case-managers to work with these servicemembers and their families throughout the transition to VA care and benefits systems, and to ensure expedited delivery of all benefits.

Beginning in February 2007, VA has provided priority processing for all OIF/OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OIF/OEF theatres or in support of these combat operations, as identified by the Department of Defense (DOD). As a result, all the brave men and women returning from the OIF/OEF theaters who were not seriously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, enter the VA system and begin receiving disability benefits as soon as possible after separation.

The Honolulu Regional Office is currently processing 74 OEF/OIF veteran claims. None are designated as seriously injured. Currently, our average time to process these claims is less than 180 days. On occasion, specialty exams or add on conditions will necessarily extend the time required to process a claim.

VA expanded outreach programs for National Guard and Reserve components and its participation in OIF/OEF community events and other information dissemination activities. An OIF/OEF team at VBA Headquarters addresses OIF/OEF operational and outreach issues at the national level and provides support to the newly designated OIF/OEF managers at each regional office, including Honolulu.

To ensure that VA benefits information is provided to all separating servicemembers, including Reserve and Guard members, VA works with DOD to expand its role in DOD's military pre-separation process. Specifically, VA now provides "Claims Workshops" in conjunction with many VA benefits briefings for separating servicemembers. At these workshops, groups of servicemembers are instructed on how to complete the VA application forms. Personal interviews are also conducted with those applying for VA disability benefits.

In addition to providing ongoing TAP/DTAP briefings at the major military bases on Oahu, the Regional Office OIF/OEF Manager collaborates with the Veterans

Health Administration on special outreach events. Most recently, on August 7, 2007, a multi-disciplinary "New Patient Orientation" was conducted for OEF/OIF veterans. Approximately 30 veterans participated and our staff reported it was a very successful event. Our OEF/OIF Coordinator and Manager are working on sponsoring "Claims Workshops" in collaboration with the Warrior Transition Units at TAMC, Schofield, and MCBH. I would also like to point out that our out based satellite office in Guam is also actively engaged in services such as these, serving the veterans who reside on Guam and the Commonwealth of the Northern Marianas Islands. Our Guam staff has also been responsible for providing benefits counseling services to veterans in Micronesia, at the special "request of the Ambassador of the Federated States of Micronesia."

NATIONAL HIRING INITIATIVE

I am especially pleased today to be able to discuss VA's national hiring initiative, VA has already added more than 800 new employees since April, and plans call for adding a total of 3,100 new employees by the end of next year. These employees will be placed in critically needed positions in VA regional offices throughout the Nation.

In order to have these new employees "on-line" and productive within a few months, VA is providing them with accelerated training that focuses on specialized areas of claims processing. This initial training will be followed by ongoing, carefully structured, and progressively complex training until full journey expertise is achieved.

The Honolulu Regional Office has been authorized to increase its staffing level by over ten percent as a result of this hiring initiative. A number of the new employees are already on board, and the regional office is in the process of filling another five vacancies. The training of our new employees is going well. We sought the assistance of the San Diego Regional Office and temporarily detailed one of their senior specialists for about six weeks to assist with training and forming a nucleus of expertise. Our employees were tremendously helped and have ongoing access to this expertise.

These additional resources will enable Honolulu Regional Office employees to make great strides in improving the delivery of benefits and conducting more outreach in the Pacific Region. We thank you for your assistance, and with your continued support, we intend to deliver the best service Possible to Veterans who reside in the Pacific Region.

Mr. Chairman, this concludes my testimony. I greatly appreciate being invited to testify here today and look forward to answering your questions.

Senator AKAKA. Thank you very much, Director Reed.

Again, I want to remind you, if you have any messages to pass on, any written statements, please take it to the staff who are here, even as we talk. Before I ask questions of the witnesses, I'd like to ask Felipe Sales, who is accompanying Dr. Hastings, if he wants to say something about the Vet Centers?

Mr. SALES. Thank you, Mr. Chairman, for allowing me to be here. Yes, I need to, in a sense, clarify some of the things that I think often get misconstrued in terms of what we do at the Vet Centers. The Vet Center is the outreach center of the VA. We do outreach, where the VA usually doesn't go out and talk to or get to veterans, especially those from the combat theater. We are mandated to provide counseling to combat veterans and their families. And in the instance of the units on the Big Island that were deployed, we in fact went to and their units and talked to them prior to deployment, explaining to them and letting them know what were the benefits and resources available for them and their families who were remaining behind, and then what may be available to them on their return.

Also, on their return, we also went and made contact with the units, letting them know what was available in terms of counseling for the veteran and their families. There's also a family support group that the Guard units and the Reservists have. We have gone

out to them and talked to their families in terms of the resources and benefits that are available for them. Hilo Vet Center was involved with both the deployment health survey, and we conducted—I think we saw about 135 veterans that came back. And since then, the follow up we've done in terms of counseling—veterans that have come in for counseling and their families—we've seen approximately 20 families now.

So we let them know that we're available. We even had extended hours for those that work. The only thing we ask is that they call. I don't think we've turned down any one of them that have applied or called for counseling. Thank you.

Senator AKAKA. Thank you very much, Felipe. Now, questions to each one of the panelists. It has been recommended, and you've heard this question before today, that DOD and VA develop a joint separation physical. From your perspective, do you believe that it makes sense to combine VA and DOD separation exams?

Dr. Hastings.

Dr. HASTINGS. Thank you, Mr. Chairman. I saw this one coming when you had asked the previous group.

It's a complicated question because the DOD and the VA are looking at different things when those exams are done. But as I think about it, to have one very complete and comprehensive evaluation done on somebody that's separating from the military, I think would be a good thing.

The DOD separation physical is traditionally quite brief. The VA physical examination for rating purposes is extraordinarily detailed. And we need to train our people extensively in order to meet the high standards that the VA maintains for those physical exams.

So this would be a significant investment, I think, for the system, combined DOD/VA system, in order to meet this requirement. It's an investment in the future. If you look, as I do, at the VA as being the health care provider for these people who are separating for the rest of their lives, I think to have a benchmark as to what their issues were is a worthwhile investment for the country. Thank you.

Senator AKAKA. Thank you, Dr. Hastings. Mr. Moses.

Mr. MOSES. Thank you, Mr. Chairman. Of course I'm not in the medical field myself. I think it would be beneficial to have some of the issues identified at the time of discharge, but I know out of just observations and personal history all the issues don't show themselves immediately upon discharge.

Post Traumatic Stress Disorder is one that might not appear for a few years. That doesn't mean you can't at the time of discharge try to indicate the types of combat or other situations that you were involved with. I don't know if we can get those listed, though, at the time of a medical examination. They should more appropriately be in the active duty records. If they could come up, that would be good.

I can see one other problem. We have the luxury here in Hawaii with having the VA and Tripler co-located. You don't have that in all instances in other states, but also we have Makalapa and we have facilities at the Marine Corps Base Kaneohe. We don't have that co-located with VA. So I can see a lot of logistics problems in just getting everybody together at the appropriate time. When a

VA doctor travels to one of these other facilities, he's not serving VA patients. This is a complicated issue.

Senator AKAKA. Gregory Reed, I know you're not a doctor, but you're the director of the Regional Office. Let me ask you for your comments on this.

Mr. REED. No, Senator. I believe it would help us expedite the claims if we could do this. As Mark pointed out, it may not, you know, pick up PTSD and things of that nature, but as far as physical, I think it would be very beneficial for us.

Senator AKAKA. As I mentioned earlier, this has been recommended. I'm just asking our witnesses to comment on this. And this is part of a whole move to try to have seamless transition between active and civilian life. We are thinking seriously about this and looking for comments from all of you.

Mr. Moses, what is the State of Hawaii doing to assist members of the Guard and Reserves as they transition to civilian life?

Mr. MOSES. Well, briefly, Mr. Chairman, I have to go a step further. We help active duty while they're still active duty. We have active duty veterans coming in regularly into the office from all branches of the service, but that includes the Guard and the Reserve. We try to attend the returning ceremonies, the post-deployment gatherings of all the veterans, we try to have a counselor available. We also are getting more involved in actually providing the information, as you've seen attached to the testimony, the list of the services that we provide, we find that not all members understand that those services are available.

And I can go back to my own history. When I was active duty, I never thought of going to a state Office of Veterans Services for anything, let alone the VA. There was active and there was my command and that's who took care of me. We're trying to break through that, and this goes toward your seamless idea, to make them understand that we are there. We're there for many things that can be done while they're still in service, and at the time of their discharge or release we need to get out to them more and more and tell them what's available.

We do try this through newsletter, web site, and, as I said, we have counselors go to their post-deployment gatherings, whether it's formal or informal, there are debriefings and there are regular—I don't know what word to use for it other than gatherings, but the National Guard and the Reserves do talk to all of their returning soldiers and airmen about what's going on and what they should expect. We're trying to be there as part of it.

I think it's fortunate that we are part of the National Guard. We're directly under the National Guard in this state, and that helps us because we know the events that are happening and we know when units are returning, and even as individuals return we have access to that information and we can be there.

Senator AKAKA. Thank you, Mark Moses.

Mr. Reed, VA's timely access to veteran's DD-214 and medical records continues to be a serious problem.

Please explain the process by which the Veterans Benefits Administration obtains these records. And does delayed access slow claims processing at the Honolulu Regional Office?

Mr. REED. In reference to that accessing the DD-214s, are you speaking about from the Records Maintenance Center in St. Louis? That's where we normally access the 214s from. Is that what you're referring to?

Senator AKAKA. No.

Mr. REED. I'm unaware of younger veterans having difficulty obtaining their 214s for VA.

Senator AKAKA. Let me rephrase my question. Are they bringing in their DD-214s to you as they come in?

Mr. REED. Yes, they are, sir, when they're filing original claims.

Senator AKAKA. One of the things that we're going with this idea of seamless transition is to try to eliminate some of the problems that develop into problems of access and getting records—

Mr. REED. Yes.

Senator AKAKA [continuing].—from the active duty.

Mr. REED. Sir, we've had a problem or a challenge in getting records from the National Guard, but we have recently become signatories, or I have, and I believe everybody else on this panel has with the Hawaii National Guard. We had one of the representatives come over and meet with Susan Bauman, and we signed off on that and we looked to that to be improved greatly.

Senator AKAKA. Dr. Hastings, a key provision of the Senate's Dignified Treatment of Wounded Warriors Act is the extension of automatic access to care for separating combat veterans from two to five years after separation. How will this affect health care for veterans in Hawaii?

Dr. HASTINGS. Senator, first of all, I applaud this idea, because as we are identifying problems with the individuals that are coming back, some of them are not picked up initially. The classic one of course that you've heard about is the PTSD, but this is also true of the TBI, and there are others as well. So it's very clear to us that there are problems that are not being identified initially, and also it's taking us a while to work through the natural history of these diseases in carrying for these veterans. I applaud the efforts of the Senate to extend that eligibility for a period of three more years.

My organization is growing. We have been growing at 5 to 6 percent per year, and as a result we're improving access, we're adding staff, we're improving specialty care, and of course adding—this is an additional workload to us. My guess is that this will increase our workload by probably 6 or 7 percent, which on the aggregate would increase my growth rate probably the equivalent of 1 or 2 percent per year, which is in line with the growth that we're sustaining right now.

I think this is something that we will handle in the normal course of events, as long as we continue on the growth curve that we have experienced in the past few years, and I don't see any reason why we shouldn't. You have provided and the Senate has provided increased resources to us, and we are offering more care today to the veterans in our area of operation. I would expect that will—or I hope that ends up continuing, with your support. Thank you, sir.

Senator AKAKA. Thank you, Dr. Hastings.

Dr. Hastings and Mr. Reed, what measures have you undertaken to educate separating servicemembers about the VA benefits and services available to them? Let me call on Mr. Reed first.

Mr. REED. Senator, as I mentioned in my testimony, we are actively engaged with separating the servicemembers at all the military facilities on Oahu, as well as out on Guam, in getting them TAP sessions and also we're involved in the DTAP sessions. I think we're doing a very good job there.

Dr. HASTINGS. Senator, we're involved also at the TAP sessions and at the DTAP sessions, and in addition, we are actively involved with the PDHRAs.

Of course, the other thing we have done is once we have veterans that have signed up with us, we have begun inviting them in to orient them again. Now, the issue there is if they didn't sign up with us at one of these original events, then they may not be picked up. But when we have gone out to advertise with these sessions where we sort of have an orientation for them once they've signed up, we sort of open it up and say, please bring your friends, it's not an exclusive thing, and indeed when we've done that—we actually signed up some more veterans that we had missed in our first rounds. But there's no doubt that outreach for us is a continuing effort, and it's going on both here and on Oahu.

It's going on at our CBOCs. It's going on throughout our—you know, throughout our organization, and of course we're getting help from the Vet Centers. A lot of veterans are coming in through the Vet Centers, and we have very good close working relationships between our Vet Centers and our CBOCs, and so they will refer back patients—or refer back and forth when they identify individuals.

Senator AKAKA. I have one more question to ask Dr. Hastings. Before I do that, I just want to tell the panelists that following that question I'm going to ask each member of the panel to make any final comments.

I want also those of you who are here to know that although we continue to talk about challenges and looking for improvements. We all know that many improvements have been made over the few years back, but we still want to improve what is happening. We still have people that have concerns as well. This is what we're trying to do with these hearings and meetings that we're holding. As I asked the first panel, as you remember, if they had any solutions or recommendations, to mention it.

We are looking, because you folks are the ones that have these concerns and we may have a simple answer to whatever your concern is. You can leave it with some of the staff that are in the back of the room. I just want to mention it because I was talking to Jim Asing, who is sitting in the first row here, who is a Vietnam veteran and a musician who set up a foundation. And this is, again, about people who are trying to help veterans. He set up a foundation, and their approach is to help veterans through music therapy. That's the kind of solution that we may be able to use in the future.

I'd like for you to think about these innovative ideas, and if you have any, we would be glad to hear them. And of course if we can

work it in the system, you know, we certainly would like to look at that.

Dr. Hastings, I am aware that members of the National Guard and Reserve are not eligible for TRICARE, and if I'm wrong, correct me, must turn to VA for health care. Are members of the Guard and Reserve who come to be soldiers in Hawaii receiving the care they need?

Dr. HASTINGS. You're talking about the OIF/OEF veterans, is that it? I believe that the OIF and OEF veterans that are coming to us, once they've been identified, are being seen, are being taken care of. We monitor this. We monitor the waiting times. We try to keep them under 30 days, and I think we're succeeding in that the majority of the time.

We are challenged when we're dealing with some of the outer islands and some of the more distant locations in the Pacific. There's no doubt about that. That's a continual challenge for us, and that has been mentioned by some of the earlier testimony today, and that's the challenge that we face in building a health care system in an area of the world that is the geographically separated by oceans. And so that's—that's our challenge. It's what we're doing.

We have been able to improve using all the tools available to us. We have been able to improve specialty consultation to our—to our beneficiaries. So am I totally satisfied with how well we're doing today? No, I'm not. Do I think we can do better? Yes, I do. Is it a matter of money and resources? No. You have provided for me the money necessary.

The problem is building complex systems, and that's the challenge that I face is building complex health care systems to work in this kind of harsh environment we live in.

Senator AKAKA. Thank you, Dr. Hastings. I would like to ask Felipe about the Vet Centers.

Are Vet Centers staff meeting regularly with demobilized Guard and Reserve members as they come together for drills or otherwise get together? And do you have sufficient resources to do such outreach?

Mr. SALES. No, we don't do it regularly. It's been offered. We've talked to the point of contacts at the Guard units, letting them know of our availability and our willingness to go in and talk with them. Our regular hours are 8 to 4:30, with extended hours in the evening to take care of anyone who works, but we have gone down to the Guard units on the weekends also to do talks for them. Like the previous incident that occurred with one of their members, we went down and helped debrief and talked with them and got some of them to come in for counseling services. So we're readily available.

We'll go there, or if they call, more than willing to see them in the office.

Senator AKAKA. Felipe, what is your assessment of how the Guard and Reserve members and their families are learning about their benefits?

Mr. SALES. Aside from the briefings, just from how they either call either our office or the CBOC or the visit, we have a benefits counselor that now comes into our office once a month, and we take sign-ups and if they have questions they can ask there, but we've

gone out to them and talked to them about the benefits that are available and allow them to know that.

We're a resource, and we're a resource that can attach them to other resources in the VA that can help them with any other problems that they might be having.

Senator AKAKA. Well, thank you very much. I'm asking all of this because you know that I feel that Vet Centers are important to veterans. I thank you so much for what you're doing.

Let me ask for each of the witnesses to make their final comments and for any responses they may have. I'm going to start Greg Reed, the Director of the Regional Office.

Mr. REED. Thank you, Senator. I just wanted to once again thank you for all the support you've given the Honolulu VA Region Office. You know, sir, without your intervention, without your support, we would not be where we are today with the additional hires, as well as doing the itinerate visits to the outer islands. That was put on hold because of travel fund constraints, and we also an opportunity to go out to Micronesia and do two town hall meetings out there, which were very successful. We have a representative that works for us in Guam. He went to the islands of Micronesia, and he has also has done briefings for National Guard units on Saipan and also on Guam.

Thank you very much.

Senator AKAKA. Thank you. Mark Moses.

Mr. MOSES. Thank you, Mr. Chairman. Some of the problems I heard at the beginning , was lack of outreach, lack of outreach, lack of knowledge and where to get help. We do outreach, as I mentioned, in the newsletter. There's 8 veterans organizations registered with us. We send them regular briefings.

We send them newsletters, what's going on. We have the website. As I said, we have counselors located in each county and they make trips to each of the islands within the county, or like on the Big Island, my counselor Keith there makes trips over to Kona regularly. We also attend all the transition assistance programs.

And more than just outreach, we try to tell them to come into us we'll help you prepare documents. We'll help brief you in detail on your particular case, and we do help prepare their actual documents before they submit them to the VA. I think we do a very good job of getting it right the first time, which helps the VA, because it cuts down on repeats. And if they do have an appeal, we represent the veterans at the appeal.

The question about the DD-214s, as each veteran separates, he's asked what state are you going to, and the DD-214 is sent to that state. And the state offices are called various things, but in Hawaii it's the Office of Veterans Services. The DD-214s are sent to us. And if the veteran comes in, of course he has one, but if he needs another one, he can come to us and we'll give him a copy. And the veteran service organizations, we can do the same thing. So we can provide that DD-214. If he didn't put down Hawaii, put down some other state, we will get it from the other state and we'll provide them with a certified copy that can be used by the VA.

Senator AKAKA. Thank you very much, Mr. Moses.

Dr. Hastings.

Dr. HASTINGS. Thank you, Mr. Chairman. We are faced with many challenges, and I mentioned to you the obvious one that you know very well, and that is that we live in this very challenging geographic area. My area of interest covers million square miles and encompasses a number of different cultures that we must figure out how to deliver health care in.

At the same time, we're faced with an evolving system that's evolving very, very fast. Health care is changing. The science of health care is changing. The sociology of health care is changing. And then the very nature of warfare is changing, and so the new veterans that we are seeing today have different challenges from the veterans we saw from each of the encounters that our country has had to deal with in the past 50 or 75 years, and the VA must change in order to meet those challenges.

An example is women veterans. We recently, as you know, had the opportunities to open a new clinic in American Samoa, and we've heard about that today. And I was at a town hall down there and a woman came up to me and asked me what are you providing for women veterans in American Samoa? I must admit, I was a little embarrassed. I didn't realize how many we had. And I asked her, how many women veterans do we have down here? And she said between 300 and 400. I didn't know that. And that's a challenge for me. How do I build a system to take care of that group of veterans that I didn't even really recognize I had responsibility for.

This whole area of Traumatic Brain Injury, this is the signature illness of this war. We are just learning about it. We really are. I'm actually a little embarrassed to tell you that also. And in saying that, I'm reflecting on the science of medicine and where we stand and how much information we have.

And we are rapidly trying to understand this and integrate it into our health care system. What are the long-term implications of this—of this traumatic process that our soldiers are coming back with. And it's hard for us to know exactly how to do this. So we're building the system to do these things.

We're living in a rapidly evolving system on many realms. I think—I think we're doing pretty well, all things considered, but there's no doubt that we have a lot of challenges ahead of us in the next few years to build a health care system that's going to meet the needs of our veterans into the future. We're going to continue to need to be resourced and supported as we go forward from this point on. And I want to thank you very much for the support that you've given to our veterans with your leadership and support over the past several years, and I look forward to working with you into the future.

Senator AKAKA. Thank you very much, Dr. Hastings.

You've heard from our person in charge of benefits for Hawaii. And you've heard from the person who represents the State of Hawaii, Office of Veterans Services. I want to tell you that the State of Hawaii has really been instrumental in helping veterans. Mark Moses now is in charge of the veterans affairs for Hawaii, so remember him. As he was pointing out, they want to do all they can to help Hawaii's veterans. And, of course, Dr. Hastings is our health person, and Felipe is our Vet Center person.

In closing, I again want to thank all of our witnesses for appearing today. I'm always so pleased to hear directly from Hawaii's veterans on issues affecting the veterans of this State. I truly appreciate your taking the time to share your perspectives on the issues that our service men and service women are facing, and on ways to support them. My hope is that today's hearing will promote more thoughtful and focused assistance for the veterans of our State.

I'm so happy to have all of you here. I want to wish you well, and thank you so much for your service to our great country. And of course we are grateful for all of those who are now serving us in harm's way, and we have so much aloha for those families who have lost loved ones who were serving our country.

And so with that, I want to say aloha to all of you. God bless you. God bless America. This hearing is adjourned.

[Whereupon, at 3:05 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF MICHAEL KILPATRICK, M.D., DEPUTY DIRECTOR, FORCE HEALTH PROTECTION AND READINESS, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Thank you, Mr. Chairman, for the opportunity to speak to you today on behalf of the Assistant Secretary of Defense for Health Affairs regarding the health care needs of returning Servicemembers and new veterans.

The satisfaction with medical care that a Servicemember has after becoming ill or injured in the combat theater will be the measure of success of cooperation between the Department of Defense (DOD) and the Department of Veterans Affairs (VA) in providing facilities, treatment, rehabilitation and support for Servicemembers and their families.

Today I will highlight some of the significant programs that our two Departments have together put in place to provide the world-class medical care that our men and women in uniform deserve. The medical innovations such as body armor, buddy care, far-forward surgical care, and medical air transportation with intensive care in the air have saved American lives. However, the severity of wounds, the rapidity of movement between medical care locations, and the necessity for long-term rehabilitation have created new challenges for the medical systems and for the systems that support our Servicemembers and veterans when they have medical problems. As needed changes are instituted to meet these challenges, we must always keep the focus on the patient and the family.

DOD and VA have had many independent and internal groups evaluate our abilities to support and care for our ill and injured Servicemembers and veterans, culminating in almost 400 recommendations. Even as these groups were preparing those recommendations, the Secretary of Defense and the Secretary of Veterans Affairs chartered a Senior Oversight Committee (SOC) to systematically address concerns about the treatment of wounded, ill, and injured Servicemembers and veterans. DOD and VA are already working toward the prompt implementation of the recommendations of the President's Commission on Care for America's Returning Wounded Warriors. In addition, the SOC will ensure that the recommendations of the Secretary of Defense's Independent Review Group, DOD's Mental Health Task Force, and the VA's Task Force on Returning Global War on Terror Heroes, and others, are promptly consolidated and properly aligned, integrated, coordinated, resourced, and implemented.

To do this, the SOC will collect all recommendations, evaluate feasibility, break down the recommendations into actionable parts, associate those actionable parts with timelines and milestones, establish priorities, and apply resources to support rapid implementation. The Deputy Secretary of Defense and the Deputy Secretary of Veterans Affairs chair the SOC. Reporting to the SOC is an Overarching Integrated Product Team (OIPT), chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the Principal Under Secretary for Benefits (VA). The OIPT has chartered eight discrete lines of action (LoA), each tasked with analysis and improvement of a specific part of both Departments' integrated programs for treatment and support of wounded, ill, or injured Servicemembers, veterans, and their families.

DOD's collective focus is centered on LoAs that leverage the experience and capabilities of both the DOD and the VA to enable each to more effectively serve its beneficiary populations. We are convinced the continued cooperation of both Departments will greatly improve the quality of health care provided to all beneficiaries.

LoA 1 has DOD and VA working closely to provide a seamless and transparent disability process that is jointly administered by both organizations. The Departments will support one Disability Evaluation System that will be flexible enough to evolve as trends in injuries and supporting medical documentation and treatment necessitate.

For LoA 2, DOD and VA are working together to respond to a myriad of recommendations about the identification, treatment, recovery, and follow-up for Traumatic Brain Injury (TBI) and post-traumatic stress disorder (PTSD) and other psychological health (PH) issues. A group of DOD and VA subject matter experts were temporarily assigned to a "Red Cell" to develop a comprehensive program to address all aspects of recommendations and concerns about these issues, including establishing Centers of Excellence for both PH and TBI. Through this collaborative effort, we are focusing on clinical research, prevention, education and patient/family support. The Red Cell will involve the Services in assessing their TBI and PH/PTSD plans and programs for responsiveness to the SOC-approved planned and prioritized actions of LoA 2.

LoA 3 addresses recommendations to improve coordination and collaboration of DOD/VA health care delivery and support to all Servicemembers and their families through the continuum of care. The LoA 3 team is assessing optimal approaches for delivery of an integrated, comprehensive DOD/VA case management program that will provide timely, proactive, longitudinal, seamless, collaborative coordination of quality health care and social services to the individual Servicemembers and their families in a manner that promotes positive outcomes and quality of life throughout the continuum from active duty to veteran status.

The goal of this program is to provide individualized, integrated, interagency and intergovernmental support for the wounded, injured, or ill Servicemember and his/her family throughout the process of treatment, rehabilitation, and renewal. These efforts will strive to minimize fragmentation of Federal services, improve coordination of medical and rehabilitative care provided by DOD and VA and enhance access to needed support.

LoA 4 focuses on the DOD and VA commitment to full, bidirectional exchange of each Department's electronic medical records. The goal is to ensure the Departments' vast array of shared beneficiary data, medical records, and other health care information is visible, accessible, and readily understandable through secure and interoperable information systems, essential in supporting a seamless continuum of care.

Our current focus is building a common inpatient application for both Departments to further enhance patient-centric health care delivery. DOD and VA have recently contracted a study to identify common processes and requirements for a joint inpatient electronic health record. Currently, the requirements are being assessed and a recommendation will be made on how to create a joint inpatient system. In the meantime, further integration of the current systems is taking place.

LoA 5 addresses concerns and recommendations associated with adequacy of facilities to support medical hold and holdover Servicemembers at DOD installations.

LoA 6 will provide Departmental leadership recommendations for a redesign of policies, regulations and laws, processes, and course directions. The philosophy behind this LoA is holistic, beginning with a blank sheet of paper, and setting aside all limitations presented by existing public law, departmental policy and organizational lines to deliver and implement a seamless continuum of care for Servicemembers and their families from the battlefield to return to productive life.

LoA 7 develops the public affairs strategies necessary to successfully implement changes through legislative proposals approved by the Administration and submitted to Congress. The primary goal is to ensure that the Departments have the authority and capability to provide the world's best medical care for our Servicemembers, veterans, and their families.

LoA 8 seeks to provide solutions to ensure compassionate, timely, accurate and standardized personnel, pay, and financial support practices for wounded, injured, or ill personnel. Ensuring appropriate data sharing, quality control, and support benefits will further support these objectives. Together with the Small Business Administration, we are working to provide more timely and accurate personnel and fiscal support at all critical patient flow locations and points of Service support to include reintegration.

OVERALL DOD-VA SHARING EFFORTS

Over the last several years, the DOD and VA have made significant strides in coordinating and developing common health care and support services along the entire continuum of care. Both agencies are making concerted efforts to work closely to maintain and foster a more effective, aligned Federal health care partnership.

In April 2003, a DOD/VA Joint Executive Council (JEC), chaired by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of the Department of Veterans Affairs, was established to jointly set strategies, goals and plans to better align and coordinate the health and benefit services of the two De-

partments. The JEC meets quarterly to review progress against the mutually developed plans.

The VA/DOD Joint Strategic Plan reflects common goals from both the VA Strategic Plan and the Military Health System (MHS) Strategic Plan—and specifically articulates the shared goals and objectives developed and ratified by DOD/VA leadership. Progress on the Joint Strategic Plan objectives is tracked on a monthly basis and reported to the co-chairs of the JEC, and the plan is revised annually.

The spectrum of DOD/VA collaboration and sharing activities encompasses clinical services, education and training, research and development, patient administration, and information/data technology sharing.

Section 721 of the National Defense Authorization Act for FY 2003, required the Departments to establish, and fund on an annual basis, an account in the Treasury referred to as the Joint Incentive Fund (JIF). The JIF provides a means to eliminate budgetary constraints as a possible deterrent to sharing initiatives by providing designated funding to cover the startup costs associated with innovative and unique sharing agreements. There are now 48 JIF projects underway or completed, accounting for \$88.9 million of the \$90 million in the fund. The 2006 projects cover such diverse areas of medical care as mental health counseling, Web-based training for pharmacy technicians, cardio-thoracic surgery, neurosurgery, and increased physical therapy services for both DOD and VA beneficiaries.

We also are jointly staffing a number of Federal health facilities. These include:

- The Center for the Intrepid—opened in January 2007, provides a state-of-the-art facility in San Antonio, Texas, explicitly to rehabilitate wounded warriors.
- Augusta—coordinated staffing and assignment to hire, train, and share staff.
- Integrated DOD/VA operations at eight locations: North Chicago (Great Lakes Naval Station); New Mexico (Kirtland AFB); Nevada (Nellis AFB); Texas (Fort Bliss); Alaska (Elmendorf AFB); Florida (NAS Key West); Hawaii (Tripler AMC); and California (Travis AFB).
- At the end of FY 2006, DOD military treatment facilities and Reserve Units were involved in sharing agreements with 157 VA Medical Centers, enabling improved visibility of medical needs in the VA for reservists entitled to VA care after returning from combat operations.

This year, both Departments plan to integrate services within market areas, not just facility operations, in major population centers.

COORDINATED TRANSITION

For Servicemembers who transition directly from DOD military treatment facilities to VA medical centers (436 individuals as of June 2007), DOD and the VA implemented the Army Liaison/VA Polytrauma Rehabilitation Center Collaboration program—also called “Boots on the Ground”—in March 2005. This program ensures that severely injured Servicemembers who are transferred directly from a military medical treatment facility to one of the four VA Polytrauma Centers—in Richmond, Tampa, Minneapolis, and Palo Alto—are met by a familiar face and a uniform. A staff officer or non-commissioned officer assigned to the Army Office of the Surgeon General is detailed to each of the four locations, to provide support to the family through assistance and coordination with a broad array of such issues as travel, housing, and military pay. This coordination process has been working exceptionally well. However, this transition has not worked as well when Servicemembers were transferred to other locations around the country.

In response, the VA opened 17 additional Polytrauma Network Sites to improve continuity of care to injured Servicemembers. The Department deeply values the sacrifices that these veterans and their families have made. Through the efforts of the LoAs, we are actively doing all we can to improve the coordination and care management plan for Servicemembers transitioning to any VA facility.

The VA also is placing personnel in our medical facilities. The Joint Seamless Transition Program, established by the VA in coordination with the military Services, facilitates more timely receipt of benefits for severely injured Servicemembers while they are still on active duty. There are 12 VA social workers and counselors assigned at 10 military treatment facilities, including Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda. These social workers ensure the seamless transition of healthcare, including a comprehensive plan for treatment. Veterans Benefits Administration counselors visit all severely injured patients and inform them of the full range of VA services, including readjustment programs, educational and housing benefits. As of June 29, 2007, VA social worker liaisons had processed 7,760 new patient transfers to the Veterans Health Administration from participating military hospitals.

Finally, the VA has placed liaisons in each of our three TRICARE Regional Offices in Washington, DC, San Antonio, TX, and San Diego, CA, providing an important communications and coordination link between the DOD and VA to better support our shared beneficiaries.

Mental Health

Although the Mental Health Task Force's findings indicate that we have work to do in expanding our Mental Health programs, we have in place several programs that already make a difference. Mental health services are available for all Servicemembers and their families before, during, and after deployment. Servicemembers are trained to recognize sources of stress and the symptoms of distress in themselves and others that might be associated with deployment. Combat stress control and mental health care are available in-theater. In addition, before they return home, we brief Servicemembers on how to manage their reintegration into their families, including managing expectations, the importance of communication, and the need to control alcohol use.

After returning home, Servicemembers are provided easy and direct access to mental healthcare services following a continuum of care model. Same-day appointments and daily walk-in appointments are available in military mental health clinics, and behavioral healthcare providers are integrated into primary care clinics in both the DOD and the VA. TRICARE also is available for 6 months after return for Reserve and Guard members and TRICARE Reserve Select programs are available for continuing health insurance coverage for Reserve and Guard members and their families after the 6-month transition period. To facilitate access for all Servicemembers and family members, especially Reserve Component personnel, the Military OneSource Program—a 24/7 referral and assistance service—is available by telephone and on the Internet. In addition, we provide face-to-face counseling in the local community for all Servicemembers and family members. DOD provides this non-medical counseling at no charge to the member, and it is completely confidential. For clinical care, family members can access mental health services directly in the TRICARE network. Up to eight sessions are available without a referral from a primary care manager and without pre-authorization requirements from TRICARE.

The Periodic Health Assessment (PHA) was added to the continuum of assessments in February 2006. This annual requirement for all deployable members of the Department includes a robust mental health section that complements the deployment health assessment process, allowing the opportunity for assessment, referral to care, and treatment outside the deployment cycle.

To supplement mental health screening and education resources, we added the Mental Health Self-Assessment Program (MHSAP) in 2006. This program provides Web-based, phone-based, and in-person screening for common mental health conditions and customized referrals to appropriate local treatment resources. The program also includes parental screening instruments to assess depression and risk for self-injurious behavior in their children, along with suicide prevention programs in DOD schools. Spanish versions of the screening tools are available, as well.

Traumatic Brain Injury (TBI)

The Department is working on a number of measures to evaluate and treat Servicemembers affected or possibly affected by Traumatic Brain Injury (TBI). For example, in August 2006, a clinical practice guideline for management of mild TBI in-theater was developed and fielded for the Services. Detailed guidance was provided to Army and Marine Corps line medical personnel in the field to advise them on ways to assess, diagnose, and treat TBI. The clinical practice guideline includes a standard Military Acute Concussion Evaluation (MACE) tool to assess and document TBI for the medical record. TBI research in the inpatient medical area is also underway.

As part of the LoA 2 effort, DOD has modified the questions asked during the Post-Deployment Health Assessment, the Post-deployment Health Reassessment, and the Periodic Health Assessment to help identify individuals who may have suffered a TBI. In April, VA began TBI screening of OEF/OIF veterans seeking care in the VA. While there is no currently validated clinical screening instrument for TBI, the VA is screening for events that increase risk for TBI, immediate symptoms at the time, new or worsening symptoms after the event, and current symptoms.

HEALTH INFORMATION TECHNOLOGY AND DATA SHARING

Although LoA 4 actions will improve DOD and VA data sharing, we have already engaged in a number of important efforts to share essential clinical and manage-

ment information in support of health care services to our wounded servicemembers and all eligible former military members who seek care from the VA.

The work of capturing and sharing relevant clinical information between the DOD and VA begins on the battlefield. Data is being captured and sent to the DOD electronic health record, AHLTA. By December 2007, theater clinical data will be accessible by VA providers for patients presenting to VA for care.

In September 2005, DOD began monthly transmission of the electronic Pre- and Post-Deployment Health Assessment information to the VA, followed in November 2006 with monthly transmission of Post-Deployment Health Reassessments (PDHRAs) for separated Servicemembers and demobilized National Guard and Reserve members. Weekly transmission of PDHRAs for individuals to be referred to the VA for care or evaluation started in December 2006. As of June 2007, VA has access to more than 1.7 million assessment forms on more than 706,000 separated Servicemembers and demobilized Reserve and National Guard members.

The Bidirectional Health Information Exchange (BHIE) enables the real-time sharing of allergy, outpatient pharmacy, demographic, laboratory, and radiology data between all DOD and all VA treatment facilities for patients treated in both DOD and VA facilities. Today, all DOD sites and all VA sites can view allergy information, outpatient pharmacy data, radiology reports, and laboratory results (chemistry and hematology) on shared patients, as well as computable data in the Clinical Data Repository/Health Data Repository.

Supporting all of these collaborative efforts, we will continue to grow, enhance, align, and integrate the technology infrastructure that supports both systems, enabling greater access to clinical and administrative information for the benefit of the people we serve. Our greatest mission is to honor our Servicemembers by providing the best quality care and ensuring a compassionate, fair, and timely disability adjudication process to enable them to return to the fullest, most productive and complete quality of life possible.

