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HEARING ON PENDING LEGISLATIVE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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OCTOBER 24, 2007

SENATORS

WITNESSES

HEARING ON PENDING LEGISLATION

WEDNESDAY, OCTOBER 24, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:29 a.m., in room 562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Burr, Craig, and Isakson.

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

Chairman AKAKA. Aloha and good morning, everyone.

Before we begin the formal hearing, I ask for your indulgence for a brief ceremony. Kim Lipsky, will you please stand? Kim has no idea what is about to happen this morning, so you will excuse her for the look of confusion.

[Laughter.]

Chairman AKAKA. Congratulations, Kim, and mahalo. Thank you with warmest aloha for 12 years of outstanding and productive service to the U.S. Senate and to the Veterans' Affairs Committee. I am pleased that the practice of awarding a 12-year service pin and certificate gives me and the Committee the opportunity to recognize and thank you for your vital role you play in helping us to meet our obligations to our veterans on crucial health services issues.

To cite but a few recent examples, largely as a result of your efforts before and during and after our hearings in Hawaii, we have been able to provide the best possible access to quality care to Hawaii veterans as close to home as possible. We did this by improving care, increasing staffing, or both, throughout the Islands, Oahu, Maui, Molokai, Lanai, and the Big Island and Kauai. This is an accomplishment much appreciated by veterans who are now spared not only the inconveniences of going to another island, but also the expenses of traveling and possibly lodging.

I am especially pleased with the results of our hearings in Hawaii this year, for they lend a great deal of credibility to the Committee and the veterans' community and the community at large when we went to listen, and then acted.

Kim, I value your expertise and judgment, particularly on health issues. The force of your logic based on a deep well of knowledge leads to balanced solutions to problems that I find most helpful. I

appreciate your tireless efforts to make this possible and want to express my heartfelt mahalo to you.

Having said that, I also want you to know that I value your friendship on a personal level and I think of you as being a part of the Akaka Office Ohana, which is family. I always think of you as a friend. As we go into this hearing today, I cannot help but observe what a fortuitous coincidence it is that as we recognize your wonderful first 12 years of service, the Committee is taking up two proposals which you developed to improve VA health care in the areas of mental health care and pain management. Thank you for your continuing dedication and efforts for our veterans.

Here is the Senate's formal recognition of your first 12 years of service. Let me just present this to you, Kim.

[Applause.]

Chairman AKAKA. Kim, thank you again, and there is a pin and also a certificate.

Again, aloha and good morning, everyone. I want to welcome you to this hearing on pending legislation.

Today, the Committee will hear testimony on five bills from a number of witnesses. The bills under consideration are largely in response to the needs of the newest generation of veterans, but hold promise for all veterans.

Mental health issues remain an important part of our work in the Committee. Based upon the valuable testimony gathered at our mental health hearing in April, I introduced S. 2162, the Mental Health Improvements Act of 2007. I am pleased that Senator Burr has joined me as a cosponsor and, of course, I am repeating when I say I am so glad to have him here as our Ranking Member. Now, more than ever, VA must make mental health services a priority. New approaches and programs aimed at substance use or disorder, PTSD, and readjustment services are included in this legislation.

Also on the agenda is legislation which recognizes the need for improvements in VA's pain care management program. VA's current pain care efforts are worthwhile, but are unfortunately too inconsistent and are not standardized to adequately meet the needs of our veterans. S. 2160 will enhance VA's pain management program on a national, systemwide level through better clinical practices, research, and professional education.

Senator Murray and Senator Craig have proposed S. 2004, which would require VA to create Epilepsy Centers of Excellence. These centers would focus their attention upon research, education, and clinical care related to epilepsy. Epilepsy is anticipated to be an increasingly prevalent condition among veterans. We have learned that veterans with TBI are at a substantially increased risk to develop Post-Trauma seizures months or even years after their injury.

We also have before us a bill by Senator Brown to clarify how non-VA emergency care needs to work. Senator Brown chaired a field hearing earlier this year which highlighted problems with the reimbursement problems for veterans and private hospitals when emergency care and treatment is needed. Senator Brown's bill would improve the emergency treatment of veterans at non-VA facilities by removing uncertainty through a mandatory reimbursement system and a clarification of transfer procedures.

We will have a Committee mark-up next month. My expectation is that we can move some of this legislation forward to the full Senate.

In closing, I note that the Committee has moved much legislation through its process. Several large authorization bills are on the Senate calendar presently. As Chairman, I am working with our new Ranking Member on time agreements so that we can expedite the path to enactment. I am hopeful that we will be able to reach agreement and get the pending bills to the floor by next week or soon after that.

I would like to yield to our Ranking Member, Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. I want to thank you for holding this hearing on five important bills that we are currently considering in the Committee. I also want to welcome our witnesses. It is always good to see them.

Mr. Chairman, I think the bills before us today are truly deserving of action by this Committee. Certainly the issues addressed by these bills, particularly the issues of mental health and mental health treatment and Traumatic Brain Injury research, are extremely important to our veterans.

I want to especially single out your bill, Mr. Chairman, which seeks to expand treatment and research for substance abuse and Post-Traumatic Stress Disorder. Unfortunately, too many veterans who suffer from PTSD are turning to drugs and alcohol to help them cope with this illness. Thanks to the recent report from the Institute of Medicine, we know that certain treatments work to help improve the lives of those suffering from PTSD. We also know that more research and work needs to be done in the area of treating veterans with co-morbid conditions, such as PTSD and substance abuse. Your bill speaks to the exact issue and I am proud to be a cosponsor of it.

I also want to thank you and your staff for your willingness to work with me and the minority staff in making some minor changes, I hope improvements, to the bill prior to its introduction. You often talk about this Committee's long record of bipartisan cooperation and you have certainly shown that with this bill.

Mr. Chairman, as you know, recent reports to Congress from the Disability Commission and the Institute of Medicine have presented us with a challenge when it comes to the care and treatment of veterans with mental illness, particularly PTSD. Both of these distinguished groups have separately come to the same conclusion, that the VBA and the VHA need to approach compensation, treatment, and rehabilitation of veterans with PTSD and other mental illnesses differently. I think we owe our veterans our best effort to not only compensate them for their injuries and treat their illness, but to improve their overall health and well-being.

I hope that this Committee will take some time to explore these new findings and consider new ways we might be able to improve the VA system to respond to the challenge presented to us. I look forward to working with all of you to do that.

I would also like to compliment the Senator from Ohio, Senator Brown, for his bill on emergency care. I think his legislation is a fine example of what elected representatives do here in Washington. A flaw in the VA's reimbursement policy was brought to his attention. He worked with the administration to explore the source of the problem and now we have legislation that enjoys overwhelming bipartisan support to correct that law.

I would also like to comment for a moment on Senator Domenici's bill, S. 38, by saying that I think any effort to expand the cadre of people who can help our returning war veterans readjust to civilian life is worthy of support.

Finally, Mr. Chairman, I understand that next month you are planning to move forward a few naming provisions at a mark-up of pending legislation. I respectfully would ask of you that you include H.R. 2546, a bill to name the VA Medical Center in Ashville, North Carolina, after Private First Class Charles George.

George was a member of the Eastern Band of the Cherokee Indians from North Carolina. He was awarded the Medal of Honor for his actions on the night of November 30, 1952, when he pushed a fellow soldier out of the way of an exploding grenade. Fully aware of the consequences of his action, he absorbed the full blast of the explosion himself. Charles George is an American hero and all of us in North Carolina are proud to claim him as one of our heroes.

With that, Mr. Chairman, once again, I thank you for holding this hearing. I look forward to working with all the Members as we work toward completion of the legislation that we are here to talk about today, but also the legislation that we have pending. I yield.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator MURRAY?

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman, for holding today's hearing.

Veterans' Day is only a few weeks away and many of us go home to our States and celebrate the day with veterans at remembrance ceremonies and events. But we have to remember that Veterans' Day is not just a ceremony, a holiday. It is also a time that we should be asking if we have done enough for those who have served our country, and that is a very timely question today with so many veterans coming home from places like Iraq and Afghanistan, and with an aging population of veterans who do need more care. When these brave men and women signed up to serve our country, we agreed to take care of them. They kept their part of the bargain. Now it is time for us to keep our part.

Today's hearing is, in essence, about this country keeping its commitment to our veterans and ensuring that we are giving them everything that they need. And importantly, Mr. Chairman, this is the third legislative hearing that has been held by this Committee. The Veterans' Affairs Committee has held two previous legislative hearings several months ago when we considered other benefits and health bills, and many of the bills that were considered during those two hearings were eventually included in the health and ben-

efits omnibus bills that have passed out of this Committee and, as the Chairman indicated, are awaiting floor time.

The fact that we have had to schedule a third legislative hearing is, I think, a real testament to the amount of concern all Members of this Committee have about the way the VA is being run, and near the top of that list is the VA's ability to care for veterans with mental health problems.

Last week, USA Today reported that the number of Iraq and Afghanistan veterans seeking care for Post-Traumatic Stress Disorder at the VA increased by almost 70 percent last year. And unfortunately, that number of returning veterans with PTSD and other mental health ailments is probably too low. Many of our servicemembers and veterans don't seek care because of the stigma surrounding treatment or because they fear that a mental health diagnosis may hurt their career.

Mr. Chairman, as troops are deployed overseas now for the third, fourth, and I am even hearing fifth tour of duty, the likelihood of PTSD and other mental health conditions increases dramatically. We have all heard about the lack of providers across the country and the lengthy delays in getting an appointment. The VA is facing some real challenges on this front.

The two mental health bills that are being considered today provide slightly different approaches to dealing with this challenge and I look forward to hearing from our witnesses about which approach they think is best.

I am also looking forward, Mr. Chairman, to talking about a bill that I introduced earlier this year with Senator Craig which would ensure that the VA is prepared and equipped to deal with what may be one long-term effect of Traumatic Brain Injury, the occurrence of epilepsy. Our bill would establish six Epilepsy Centers of Excellence in the VA system, and it is based on the successful MS Centers of Excellence and Parkinson's Disease Research, Education, and Clinical Centers that are already operated by the VA.

At a May hearing in this Committee, Dr. John Booss, who is a former National Director of Neurology at the VA, testified that VA-funded research done with the Department of Defense found that more than half of veterans who suffered a penetrating TBI in Vietnam developed epilepsy within 15 years. For these veterans, the relative risk for developing epilepsy more than ten to 15 years after their injury was 25 times higher than non-veterans in the same age group. Dr. Booss expressed strong concern that the VA lacks a national program for epilepsy with clear guidelines on when to refer patients for further assessment and treatment of epilepsy. He urged this Committee to create a network of Epilepsy Centers of Excellence.

Now, it is too early to determine the impact of TBI-induced epilepsy created by the Iraq and Afghanistan wars, but we do know from past wars that many injuries associated with service take years or even decades sometimes to develop. So our bill will ensure that the VA is prepared to care for those veterans who need care down the road, and I hope to work with my colleagues to make this important idea a reality soon.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Murray.

Senator CRAIG?

STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Senator CRAIG. Mr. Chairman, I will be brief. Thank you for the hearing and thank, of course, Ranking Member Burr for working with you to produce this legislative hearing.

The reason I will be brief is because both you and Senator Murray have already spoken to S. 2004, a bill that she and I cosponsored to create at least six Epilepsy Centers of Excellence. Now, I understand and realize that the VA generally opposes Congressionally directed research. At the same time, the hearings we have held determine that we really do need to focus much more on this tragic ailment and result of head trauma in a way that attempts to get to the bottom of it, and hopefully through our research and effort can keep men and women out of epilepsy, as Senator Murray has mentioned, as much as 15 years down the road.

We know that one cause is head trauma, or Traumatic Brain Injury, that certainly is related to many combat injury. So that is why we want to focus as we are proposing in this legislation to not only improving the medical treatment of many veterans, but at the same time hopefully deter the emergence of epilepsy later on in life.

We have every reason to be phenomenally proud of the kind of research ongoing at the VA. Across medical science today, VA fingerprints of work done inside its facilities that has gone out into the private sector to not only care for the veterans within its facilities, but citizenry outside. I believe these kinds of Centers of Excellence focused on epilepsy can not only help our veterans, but also help our civilian population at large, and I think it is the right thing to do and I am pleased that we are holding a hearing on it today. Thank you.

Chairman AKAKA. Thank you, Senator Craig.

Senator BROWN?

STATEMENT OF HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you very much, Mr. Chairman.

There are several important pieces of legislation on today's agenda, but in the interest of time, I would like to focus on S. 2142, the Veterans Emergency Care Fairness Act.

Earlier this year, I received a letter from Terry Carson, the CEO of Harrison Community Hospital in rural Southeastern Ohio. Harrison is a 25-bed community hospital in Cadiz. The community of Cadiz is the home of Clark Gable and General Custer, I might add. Terry alerted me to a reimbursement problem with the VA that was taking a financial toll on his hospital.

In late May, Representative Zack Space and I held a joint field hearing on issues facing veterans in rural Appalachia and we invited Terry to be a witness. He spoke of his experience serving veterans coming to the hospital for emergency treatment. Often after the veteran has received the initial urgent care, the hospital encounters problems when they attempt to transfer the veteran to an appropriate VA facility for further treatment. Mr. Carson testified

that the hospital can wait days for transfer approvals, and in some instances, those approvals are withdrawn during the actual transfer of the veteran. Current law does not take this into consideration.

Under current law, non-VA facilities are reimbursed for the cost of stabilizing a veteran who needs emergency care and then they are expected to transfer the patient to a veterans' facility. If no facility is available, no veterans' facility is available, there is a coverage gap. The veteran still needs care, the hospital still provides the care, but the VA is not required to cover any associated costs.

This anomaly in the law is unfair to veterans and hospitals alike. This bill closes the loophole and requires the VA to cover the cost of care provided while a transfer is pending as long as the hospital documents reasonable attempts to complete that transfer. I want to thank Chairman Akaka and Ranking Member Burr and the Veterans Administration for working with me on this legislation.

I thank you, Mr. Chairman. I apologize for having to leave early today. The farm bill is being marked up, so I appreciate the good work you do in this Committee. Thank you.

Chairman AKAKA. Thank you, Senator Brown.

Senator ISAKSON?

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you, Chairman Akaka. Thank you, Ranking Member Burr, for the bill that you have introduced focusing on mental health.

I took the month of August on our break to visit the VA hospitals in Georgia for a couple of reasons: One, to see firsthand what was going on, and second, to lend moral support, if I could, because I understand the tremendous pressure those hospitals are under and the VA is under. And while there are problems with that pressure, I saw some remarkable things happening in those hospitals.

At the Uptown Augusta Medical Center, which is near the Eisenhower Medical Center, I saw a seamless transition from DOD to Veterans Health Care. I had the privilege of meeting a young lady, Sergeant Harris, who on the second day of duty in Iraq was in an IED explosion in her Humvee and suffered a Traumatic Brain Injury. The Department of Defense released her from duty because of her injury. She went to the Uptown Augusta Medical Center where doctors there corrected the damage from the Traumatic Brain Injury and she reenlisted in the United States Army, which is a testimony to what the VA health care is doing at the Uptown Augusta facility in dealing with TBI.

But we have got a long way to go and I think it is very appropriate that we have this hearing today with the focus on mental health, epilepsy, and emergency services. It is very important to see to it that we give the VA not only the direction, but the financial support and the moral support to meet the challenges they will have not just in the months and years ahead, but in the rest of the first half of this century with the results of the injuries coming back from the War in Iraq and the War in Afghanistan.

I look forward to hearing from our witnesses and I thank you for the time, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Isakson.

I want to welcome the first panel from the Department of Veterans Affairs, Dr. Michael Kussman, Under Secretary for Health at VA. This is the first time that you have been before the Committee since our field hearings in Hawaii, and again, I want to thank you so much for your participation in those hearings.

Dr. Kussman is accompanied by Walter Hall. Mr. Hall is the Assistant General Counsel at VA. Dr. Kussman, before you begin your prepared testimony, will you please tell the Committee about the impact the Southern California fires have had on our VA operations.

STATEMENT OF MICHAEL J. KUSSMAN, M.D., M.S., MACP, UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. KUSSMAN. Aloha, Mr. Chairman, and mahalo nui loa. It is a pleasure to be here. If you indulge me for just a second, I would like to thank Kim Lipsky for all her support with us and the collegial working relationship we have had with her over the years. I particularly wanted to thank her for inviting me for the field trip to Hawaii. I know she was responsible for that.

[Laughter.]

Dr. KUSSMAN. Mr. Chairman, you asked for a quick update on the California wildfires. So far, this tragic event that is unfolding, there have been no injuries to employees or veterans in VA facilities, no damage to VA facilities as of the latest report that I have gotten. The Loma Linda Health Care System is fully operational, but there has been some road access and some other things that have been a challenge with the fires.

The VA San Diego Health Care System is operational and has initiated emergency response activities. There have been some challenges with limited staffing because a significant number of members have been required to evacuate their homes and it has been hard for them to get to work, but it hasn't so far denigrated the services that we can provide at the facility. We have housed more than 95 people as a shelter in place and 13 patients, all veterans, have been transferred to us from the local community.

The Greater Los Angeles Health Care System has had no major impacts. Some staff have evacuated their homes and are on standby to evacuate.

If you will bear with me, I will talk a little bit about the VBA and the NCA, too, even though their under secretaries are not here. The San Diego Regional Office Director reports that all employees have been accounted for and has opened with 12 essential personnel. The National Cemetery Administration has continued to cancel burials at the Riverside Cemetery and the Rosencrantz National Cemetery is closed due to road closures related to the fire. But so far, we have been lucky.

There haven't been any, we know of any damage to our facilities as well as no veterans, but we are watching it very closely and we all pray that the winds will calm down and shift and the brave fire

fighters and all the people working on that will be able to get control of these several fires that are going on.

Again, good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here today to present the administration's views on five bills that would affect the Department of Veterans Affairs' programs. With me today, as mentioned, as Walter Hall, the Assistant General Counsel. I would like to request that my written statement be submitted for the record.

Chairman AKAKA. Without objection, it will be.

Dr. KUSSMAN. S. 2142, the Veterans Emergency Care Fairness Act of 2007, would make mandatory enhanced VA authorities to pay for a veteran's receipt of emergency treatment in a non-VA facility. The authorities under which VA may currently pay these claims are discretionary in nature and use different standards to define a medical emergency.

VA strongly supports S. 2142. It would standardize authorities by applying the prudent layperson definition of emergency treatment to all claims and define emergency treatment as continuing until the point in time where the veteran is stabilized and is transferred to a VA or other Federal facility, or until such time as a VA facility or Federal facility agrees to accept the transfer. I am happy to be "Dr. Yes" on that, versus "Dr. No," or "Dr. Maybe."

In regards to S. 38, the Veterans Mental Health Outreach and Access Act of 2007, while we strongly support Section 3, we do not support Section 2. Section 2 would require VA to establish a program to provide OEF/OIF veterans with peer outreach services, peer support services, readjustment counseling services, and mental health services along with related family support services to assist in the veteran's readjustment to civilian life, the veteran's recovery, and the readjustment of the family following return of the veteran. The bill would require VA to contract with community mental health centers and other qualified entities to provide covered services in areas the VA determines are not adequately served.

Mr. Chairman, veterans of OEF/OIF combat operations are already qualified for readjustment counseling services and related mental health services under existing authority. VA's readjustment counseling authority provides for mental health services, consultation, professional counseling, and training for combat veterans, immediate family members as needed for the veteran's effective and successful readjustment back to civilian life. Veterans Centers are also authorized to contract for readjustment counseling services and related mental health services. Veterans Centers routinely rely on contracted services to meet the readjustment needs of veterans residing in rural areas. Also, veterans centers already provide veteran peer outreach and counseling services.

In 2004, VA began an aggressive outreach effort which included the hiring of OEF/OIF combat theater veterans to provide outreach services and peer counseling to their fellow veterans. To date, the veterans center program has hired 100 OEF/OIF outreach workers, and Al Bottras, who runs the program, is in the process of hiring a second 100 OEF/OIF outreach peer counselors. Combat theater veterans who enroll in VA's health care system are also eligible for all needed mental health services as part of VA's medical benefits

package. Family support services are currently available to a veteran's immediate family members as necessary in connection with VA's treatment of the veteran's service-connected disability.

Section 3 of S. 38 would extend from 2 to 5 years combat theater veterans' window of eligibility to enroll without regard to whether they have a service-connected disability or their income level. As the leading researcher in PTSD medicine, VA has known the onset of symptoms or adverse health care effects related to PTSD and even mild to moderate brain injury can often be delayed and not manifested clinically for more than 2 years. VA strongly supports this provision, since it will provide combat theater veterans with an additional 3 years within which they can enroll in VA's health care system.

S. 2004 would require VA to designate at least six VA facilities as Epilepsy Centers of Excellence. VA does not support this bill. As a clinician as well as the Under Secretary of Health, I am concerned about statutory mandates for disease-specific centers have the potential to fragment care in which this otherwise well-designed world class health care integrated system is based. I am increasingly concerned about the proliferation of these disease-specific models and its impact on patient care in VA's integrated health care system. As it relates to a particular disease, I believe it is much more important for VA to be sure to demonstrate the best evidenced practice across the whole system than to establish centers that provide for care of a particular disease. In essence, every one of our centers ought to be a Center of Excellence for these diseases.

S. 2160, the Veterans Pain Care Act of 2007, would require VA to carry out an initiative on pain care management at each VA health care center. We do not support this bill, as well. Pain management is already a subject of systematic and systemic-wide attention in the VA health care system. In 2003, VHA established a national Pain Management Strategy to provide a systemwide approach to pain management to reduce pain and suffering for veterans. Under that strategy, VA uses a system-wide standard of care for pain management, ensures pain assessment is performed in a consistent manner, and ensures pain treatment is prompt and appropriate, provides for continual monitoring and improvement in outcomes of pain treatment, and ensures VA clinicians are prepared to assess and manage pain effectively. In addition, pain management protocols have been established and implemented in all our settings and VA health care facilities have implemented processes for measuring outcomes in the quality of the pain management.

Title 1 of S. 2162, the Mental Health Improvement Act of 2007, includes multiple provisions related to VA treatment programs for substance abuse disorders and mental health disorders, particularly PTSD. While VA respects the attention this Committee is giving these critical issues, we do not support Title 1. It attempts to mandate the type of treatments to be provided to covered veterans, the treatment settings, and the composition of the treatment teams. Treatment decisions need to be based on professional medical judgments, and experienced health care providers and man-

agers are in the best position to decide how best to deliver needed health care services at the local level.

Title 2 of S. 2162 deals with mental health accessibility enhancements, including the requirements for VA to establish a 3-year pilot program to assess the feasibility and advisability of providing eligible OIF/OEF veterans with peer outreach services, peer support services, and readjustment counseling services, and other mental health services. VA would be required to contract these services with community mental health services and Indian Health Service facilities for veterans residing in rural areas. As we discussed in connection with Section 2 of S. 38, these services are already available to OIF/OEF veterans, including those who served in the National Guard or the Reserves. As such, we don't believe these needs to exist for a pilot program with additional authorities which are duplicative of current existing authorities.

Title 3 of S. 2162 would require that the VA carry out a program of research into co-morbid PTSD and substance abuse disorders and would charge VA's National Center for PTSD with the responsibility for carrying out and overseeing this program. This is overly prescriptive and unnecessary. Therefore, with the exception of the extension of the Special Committee on PTSD through 2012, we are unable to support the provisions of Title 3. VA is a world recognized leader in the care of both PTSD and substance abuse disorders, particularly when these conditions coexist in an individual. The activities required by Title 3 are duplicative of the VHA's ongoing efforts in this area, particularly in research efforts being carried out by the VA's National PTSD Center and the VA's Office of Research and Development. We would be happy to meet with the Committee staff to provide them information on these ongoing efforts.

Title 4 of S. 2162 addresses assistance for families of veterans. However, it is unclear how these readjustment and transition assistance services the bill would require VA to pilot are intended to differ from or interact with the readjustment counseling services and related mental health services already made available to veterans and their families through the veterans centers. In our view, this provision would conflict with many aspects with the VA's existing authorities and lend confusion to what is otherwise a highly successful program. Client satisfaction with the veterans centers is the highest in the VA's program, at 98 percent. The services they provide already include marriage and counseling services to family members as necessary to further the veteran's adjustment.

Second, we do not agree that there is a need for additional study of the merits of using organizations for the provision of these services. Let me again assure you that our veterans centers readily contract with appropriate organizations and providers to ensure veterans and their families receive covered family services when necessary. In sum, we do not believe this provision would enhance current authorities and the veterans center activities. Rather, we see that it has a serious potential to create confusion and disruption for both VA and our beneficiaries.

I appreciate the Committee's continued interest and support in meeting the needs of our veterans. I know we share a common interest in providing the best care to veterans and we would welcome

the opportunity to brief the Committee on VA's ongoing programs and activities in these areas as well as the Office of Mental Health on overseeing PTSD and substance abuse programs.

This concludes my prepared statement and I would be pleased to answer any questions you or other Members of the Committee might have. Mahalo.

[The prepared statement of Dr. Kussman follows:]

PREPARED STATEMENT OF MICHAEL J. KUSSMAN, M.D., MS, MACP, UNDER SECRETARY FOR HEALTH

Good morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. I will address the five bills on today's agenda and then I would be happy to answer any questions you and the Committee Members may have.

S. 2142 "VETERANS' EMERGENCY CARE FAIRNESS ACT OF 2007"

S. 2142 would make mandatory, standardize, and enhance the two existing authorities the Secretary has to pay for expenses incurred in connection with a veteran's receipt of emergency treatment in a non-VA facility. The two authorities under which the Secretary may currently pay these claims are discretionary in nature ("may reimburse" as opposed to "shall reimburse") and cover different veteran populations and use different standards to define a medical emergency.

As background, the Secretary is authorized to pay the reasonable expenses incurred by a veteran for non-VA emergency treatment of a service-connected disability, a non-service-connected disability aggravating a service-connected disability, any disability of a veteran with a permanent and total disability, or for a covered vocational rehabilitation purpose. In these claims, VA medical professionals must determine whether a medical emergency existed (i.e., if there was an actual emergency of such nature that delay in obtaining treatment would have been hazardous to life or health.) Expenses incurred after the medical emergency has ended, that is, after the point in time the veteran could have been transferred safely to VA or another Federal facility, may not be reimbursed.

The Secretary may also reimburse or pay a veteran for expenses incurred for non-VA emergency treatment of a non-service connected disability. In these claims, the law requires use of a prudent layperson standard to determine the need for the non-VA emergency treatment. Thus, if it turns out that the veteran's condition was not an actual medical emergency, VA can still pay the expenses if a prudent layperson would have thought it reasonable for the veteran to seek immediate medical treatment. This happens, for instance, when a veteran goes to the nearest emergency room because of the belief he or she is having a heart attack, but turns out only to have a severe case of heartburn. Similar to claims for service-connected conditions, the Secretary is only authorized to pay for the emergency treatment expenses, and the emergency ends at the point the veteran can be transferred safely to a VA facility or other Federal facility.

S. 2142 would amend both existing authorities by requiring the Secretary to pay the expenses of any veteran who meets eligibility criteria. It would also standardize these programs by applying the prudent layperson definition of "emergency treatment" in both situations. And most importantly it would define "emergency treatment" as continuing until (1) the point in time the veteran can be transferred safely to a VA or other Federal facility, or (2) such time as a VA facility or other Federal facility agrees to accept such transfer if, at the time the veteran could have been transferred safely, the non-VA provider makes and documents reasonable attempts to transfer the veteran to a VA facility or other Federal facility.

VA strongly supports S. 2142; effective emergency room reimbursement has been an issue of concern to the Department. In fact, VA is in the process of drafting regulations to address these concerns within the authority it has under current law.

It is VA's expectation that facilities aggressively work to accept the transfer of a veteran in these situations. We are aware, however, that there have been cases where VA has been unable to find a facility that had the bed, capability, staff, or resources needed to furnish the care required by the veteran. In those cases, which we believe are the exception and not the norm, the non-VA providers ultimately

billed the veterans for those expenses. This can impose a serious monetary hardship for our beneficiaries.

S. 2142 would properly put the financial onus on the Department to provide appropriate care either in the VA or Federal system or at the non-VA facility. Enrolled veterans are eligible for needed hospital or medical care. Good medical practice demands we furnish such care in a manner that advances a seamless continuum of care and reduces fragmentation of such care. Clearly these goals are best achieved by bringing the veteran into the VA health care system as soon as possible. In those rare cases where VA cannot immediately agree to accept the patient transfer, it would be entirely appropriate for VA to be responsible for the expenses related to the veteran's needed continued hospital care in the private facility until the point VA can take over.

When VA initiated drafting regulations for this program choice, it determined funds were available within the FY 2008 President's Budget level for this expanded benefit.

As a final and more technical matter, I would like to clarify that if a veteran currently meets the eligibility criteria on which his or her claim is based, VA invariably pays the claim. Thus, changing the Secretary's authority from "may" to "shall" for purposes of both types of claims would have no practical effect. Nevertheless, we do not object to such a change.

S. 38 "VETERANS' MENTAL HEALTH OUTREACH AND ACCESS ACT OF 2007"

SECTION 2 OF S. 38

Section 2 of S. 38 would require the Secretary to establish, not later than 180 days after enactment of the bill, a program to provide veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) "peer outreach services, peer support services, readjustment counseling services, and mental health services." As part of this program, the Secretary would be required to furnish education, support, counseling, and mental health services to a veteran's immediate family members to assist: in the veteran's readjustment to civilian life, the veteran's recovery, and the readjustment of the family following the return of the veteran.

S. 38 would also require the Secretary to contract with community mental health centers and other qualified entities to provide the peer related, readjustment, and mental health services in areas the Secretary determines are not adequately served by VA health care facilities. Such contracts would require, to the extent practicable, that veterans providing peer related services receive training from a national not-for-profit mental health organization, which contracts with VA for this purpose. In addition, the contractor's clinicians would be required to (1) complete mandated training to ensure the clinicians can provide services in a manner that recognizes factors that are unique to the experience of OEF/OIF veterans and (2) to utilize best practices and technologies.

The centers and entities would have to comply with applicable VA protocols before incurring any liability on behalf of the Department; submit specified reports and certain clinical information to the Secretary; and meet any other requirements established by the Secretary.

VA supports many of the initiatives and certainly the stance of aggressive outreach that underlies this provision. VA does not, however, support section 2 as it is unnecessary and duplicative of current authorities. Veterans of OEF/OIF combat operations already qualify for readjustment counseling services and related mental health services under existing authority. (While limited mental health services are available in the Vet Center program, Vet Centers refer veterans with complex mental health conditions to VA medical centers.) VA's readjustment counseling authority provides for the furnishing of mental health services, consultation, professional counseling, and training to the combat veteran's immediate family members as needed for the veteran's effective and successful readjustment back to civilian life. Vet Centers are also authorized to contract for the provision of readjustment counseling services and related mental health services. Vet Centers routinely rely on contracted services to meet the readjustment needs of veterans residing in rural areas. Hence, the additional authorities related to the provision of readjustment counseling services and related mental health services for OEF/OIF veterans (either through the Vet Centers or by contract) are generally duplicative and simply not needed.

Vet Centers are already providing veteran-peer outreach and counseling services. In 2004, VA began an aggressive outreach effort, which included the hiring of OEF/OIF combat-theater veterans to provide outreach services and peer-counseling to their fellow veterans. To date, the Vet Center program has hired 100 OEF/OIF out-

reach workers. The Vet Center program is also undergoing the largest expansion in its history. This expansion complements the Vet Center peer outreach services initiative. These efforts together enable our Vet Centers to ensure there are sufficient staff and resources to provide the professional readjustment services needed by the new veterans as they return home.

OEF/OIF combat-theater veterans are also already eligible to enroll within 2 years of the date of discharge or release from active duty in VA's health care system and receive VA's comprehensive medical benefits package.

As to family support services, VA is already required to provide immediate family members of a veteran being treated for a service-connected disability with such mental health services, consultation, professional counseling, and training as necessary in connection with that treatment.

If a veteran is being treated for a non-service connected disability, the law currently authorizes the Secretary to provide family services if: the services are initiated during the veteran's hospitalization and the continued provision of these services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

We believe no additional authority is needed as the vast majority of family members of returning OEF/OIF veterans already qualify for these services. However, neither existing authority extends to providing a veteran's family members with mental health services for their individual mental health needs that are separate and apart from the veteran's treatment needs. It is unclear whether S. 38 is intended to authorize individual mental health benefits for family members beyond services needed to assist the veteran's treatment and readjustment. If that is the case, we could not support that provision for the following reasons.

Mental health conditions often manifest with physical symptoms or sequella. In those cases, providing only mental health services to assist in a family member's readjustment could result in fragmented and inadequate treatment. The receipt of other medical care could be equally essential for that member's successful readjustment, and the failure to receive such care could impair the ability of the family as a whole to successfully readjust to the veteran's return. For that reason, we believe it would be more reasonable, from a health care perspective, to continue linking family support services to those that are essential for the veteran's readjustment. Family members should continue to receive needed mental health services from their regular providers who can treat them from a whole-person perspective and concurrently address all of their medical needs.

Also, when VA contracts for services in the community, community health centers may compete for those contracts. The provision to require VA to contact specifically with that entity may reduce the opportunity for the veteran to be cared for by the most highly qualified competent contractor.

We also note that OEF/OIF veterans who are permanently and totally disabled from a service-connected disability are able to sponsor their spouses and children in VA's Civilian Health and Medical Program (commonly referred to as "CHAMPVA"). Once enrolled in that program, their family members will be eligible to receive relatively comprehensive VA medical benefits.

As a final comment on this section, we are uncertain what is meant by the provision requiring centers to comply with VA protocols before incurring any liability on behalf of the Department.

SECTION 3 OF S. 38

Section 3 of S. 38 would extend from 2 to 5 years, combat-theater veterans' window of eligibility to enroll without regard to whether they have a service connected disability or their income level. VA strongly supports section 3. As the leading researcher in PTSD medicine, VA has known that the onset of symptoms or adverse health effects related to PTSD and even Traumatic Brain Injury can often be delayed and not manifest clinically for more than 2 years after a veteran has left active service. As a result, OEF/OIF may not seek VA health care benefits until after their 2-year window of eligibility has already closed. Without that basis of eligibility, they may be ineligible to enroll because of the current bar on enrolling new veterans in Category 8.

We are also aware that many of these veterans are not career military and are less familiar with veterans benefits and the procedures for obtaining them. For that reason they may fail to enroll in a timely fashion.

Providing combat-theater veterans with an additional 3 years within which to enroll in VA's health care system will help ensure that none of them is denied the care they need and deserve for reasons wholly beyond their control. VA estimates the costs associated with enactment of section 3 to be $15.7 million in Fiscal Year

2008, and this expansion can be accommodated within the FY 2008 President's Budget level. This estimate includes both expenditures and lost co-payment revenue.

S. 2004 "EPILEPSY CENTERS OF EXCELLENCE"

S. 2004 would require the Secretary, not later than 120 days after enactment of this provision, to designate at least six Department health-care facilities as epilepsy centers of excellence based on the recommendation of the Under Secretary for Health (USH). The mandate to establish and operate these centers, however, would be subject to the availability of appropriations for this purpose.

The bill defines an "epilepsy center of excellence" as a Department health-care facility that has (or in the foreseeable future can develop) the necessary capacity to function as a center of excellence in research, education, and clinical care activities in the diagnosis and treatment of epilepsy. To qualify as a center, the facility would need:

- An affiliation with an accredited medical school that provides education and training in neurology (or may reasonably be anticipated to develop such an affiliation).
- The ability to attract scientists of ingenuity and creativity.
- An advisory committee composed of veterans and appropriate health-care and research representatives of the facility and of the affiliate.
- The capability to effectively evaluate the activities of the centers.
- The capability to coordinate the centers education, clinical care, and research activities.
- The capability to develop a national consortium of providers with interest in treating epilepsy at VA medical centers; the consortium would have to include a designated epilepsy referral clinical in each Veterans Integrated Service Network.
- The capability to assist in the expansion of VA's use of information systems and databases to improve the quality and delivery of care.
- The capability to assist in the expansion of VA's tele-health program to develop, transmit, monitor, and review neurological diagnostic tests.
- The ability to perform epilepsy research, education, and clinical care activities in collaboration with VA's Poly Trauma Centers.

A number of specific requirements governing the competitive selection of the six facilities are set forth in the bill, including a requirement that the Secretary consider appropriate geographic distribution when making the selections.

S. 2004 would further mandate the designation of an individual in VHA to act as a national coordinator for VHA's epilepsy programs. The bill includes a list of duties for that position, including that such individual report to the VHA official responsible for neurology.

The bill would authorize $6 million for each of fiscal years 2008 through 2012 to establish and operate the centers; such sums as may be necessary for operating the centers for each fiscal year after fiscal year 2012 would also be authorized. For the first 3 years of the centers operation, the bill would require that the centers be designated as a special purpose program in order to avoid funds for the centers being allocated through the Veterans Equitable Resource Allocation system. In addition to those amounts, the USH would be required to allocate such amounts as he deems appropriate from other funds made available to VHA. The bill includes a separate authorization of appropriations to fund the national coordinator position.

VA does not support S. 2004. As I have discussed in the past, I am concerned that statutory mandates for "disease specific" centers have the potential to fragment care in what is otherwise a well-designed, world-class integrated health care system. I am increasingly concerned about the proliferation of this disease-specific model and its impact on patient care and VA's integrated health care model. As it relates to a particular disease, I believe that it is much more important for VA to disseminate the best in evidence-based practices *across* its health care system than to establish centers that provide care for a particular disease.

Treating epilepsy, like every other serious condition, requires an interdisciplinary approach. By mandating new "education, research, and clinical centers" that are disease-specific, flexibility to respond to changing combinations of related conditions is reduced. The centers' mandated collaboration with VA's Poly trauma Centers would not cure this short-coming.

It is also important to note that the "models" on which these Epilepsy Centers are based, the successful Geriatric Research, Education and Clinical Center (GRECC) and Mental Illness Research, Education and Clinical Center (MIRECC)

programs, are not narrowly focused on a disease process but address a wide gamut of issues facing a significant portion of the veteran population.

S. 2160 "VETERANS PAIN CARE ACT OF 2007"

S. 2160 would require the Secretary to carry out an initiative on pain care management at each VA health care facility. Under the initiative, each individual receiving treatment in a VA facility would receive: (1) a pain assessment at the time of admission or initial treatment and periodically thereafter, using a professionally recognized pain assessment tool or process; and (2) appropriate pain care consistent with recognized means for assessment, diagnosis, treatment, and management of acute and chronic pain, including, when appropriate, access to specialty pain management services. The initiative would have to be implemented at all VA health care facilities by not later than January 1, 2008, in the case of inpatient care and by not later than January 1, 2009, in the case of outpatient care.

The bill would further require the Secretary to carry out a program of research and training on acute and chronic pain within VHA's Medical and Prosthetic Research Service. These programs would be directed to meet the purposes specified in the bill. The Secretary would also be required to designate an appropriate number of facilities as cooperative centers for research and education on pain. Each such center would focus on research and training in one or more of the following areas: acute pain; chronic pain, or a research priority identified by VHA. The Secretary would also need to designate at least one of those centers as a lead center for research on pain attributable to central and peripheral nervous system damage commonly associated with the battlefield injuries characteristic of modern warfare. Another center would be the lead for coordinating the pain care research activities conducted by the centers and responsible for carrying out a number of other duties specified in the bill.

The measure would permit these centers to compete for funding from amounts appropriated to the Department each year for medical and prosthetics research. It would also charge the USH with designating an appropriate official to oversee their operation and to evaluate their performance.

VA health care is delivered in accordance with patient-centered medicine. Fundamental to this is effective pain management. In 2003 VHA established a National Pain Management Strategy to provide a system-wide approach to pain management to reduce pain and suffering for veterans experiencing acute and chronic pain associated with a wide range of illnesses. The national strategy uses a system-wide standard of care for pain management; ensures that pain assessment is performed in a consistent manner; ensures that pain treatment is prompt and appropriate; provides for continual monitoring and improvement in outcomes of pain treatment; uses an interdisciplinary, multi-modal approach to pain management; and ensures VA clinicians are prepared to assess and manage pain effectively. The national strategy also called for pain management protocols to be established and implemented in all clinical settings and directed all VHA medical facilities to implement processes for measuring outcomes and quality of pain management.

To oversee implementation of the National Pain Management System, VHA established an interdisciplinary committee. Part of the Committee's charge is to ensure that every veteran in every network has access to pain management services. The committee is also responsible for making certain that national employee education is provided to VHA clinicians so that they have the needed expertise to provide high quality pain assessment and treatment and for identifying research opportunities and priorities in pain management. It also facilitates collaborative research efforts and ensures that VHA pain management standards have been integrated into the curricula and clinical learning experiences of medial students, allied health professional students, interns, and resident trainees.

Because pain management is already a subject of systematic and system-wide attention in the VHA health care system, S. 2160 is superfluous and duplicative of what is already happening in VA healthcare. We would be very happy to meet with the Committee to discuss VA's ongoing pain management program and activities.

S. 2162 "MENTAL HEALTH IMPROVEMENTS ACT OF 2007"

TITLE I. SUBSTANCE USE DISORDERS AND MENTAL HEALTH CARE

Mr. Chairman, title I of this bill focuses on VA treatment programs for substance use disorders and mental health disorders, particularly PTSD. Section 102 would require the Secretary to ensure the provision of the following services for substance use disorders at every VA medical center:

- Short term motivational counseling services.
- Intensive outpatient care services.
- Relapse prevention services.
- Ongoing aftercare and outpatient counseling services.
- Opiate substitution therapy services.
- Pharmacological treatments aimed at reducing cravings for drugs and alcohol.
- Detoxification and stabilization services.
- Such other services as the Secretary deems appropriate.

The Secretary could, however, exempt an individual medical center or Community-Based Outpatient Clinic (CBOC) from providing all of the mandated services. Annually the Department would have to report to Congress on the facilities receiving an exemption under this provision, including the reason for the exemption.

Section 103 would require the Secretary to ensure that VA treatment for a veteran's substance use disorder and a co-morbid mental health disorder is provided concurrently by a team of clinicians with appropriate expertise.

Section 104 would require the Secretary to carry out a program to enhance VA's treatment of veterans suffering from substance use disorders and PTSD through facilities that compete for funds for this purpose. Funding awarded to a facility would be used for the six purposes specified in the bill, in addition to the conduct of peer outreach programs through Vet Centers to re-engage OEF/OIF veterans who miss multiple appointments for PTSD or a substance use disorder. Another specified purpose for the funds would be to establish collaboration between VA's urgent care clinicians and substance use disorder and PTSD professionals to ensure expedited referral of veterans who are diagnosed with these disorders.

Not later than 1 year after the bill's enactment, the Secretary would need to submit a report to Congress on this program and the facilities receiving funding.

S. 2162 would provide for funding by requiring the Secretary to allocate $50 million from appropriated funds available for medical care for each of fiscal years 2008, 2009, and 2010. The bill would require the total expenditure for PTSD and substance use disorder programs to not be less than $50 million in excess of a specified baseline amount. (The bill would define the baseline as the amount of the total expenditures on VA's treatment programs for PTSD and substance use disorders for the most recent fiscal year for which final expenditure amounts are known, as adjusted to reflect any subsequent increase in applicable costs to deliver those programs.)

Section 105 would require the Secretary to establish not less than six national centers of excellence on PTSD and substance use disorders. These centers would provide comprehensive inpatient treatment and recovery services to veterans newly diagnosed with these disorders. Sites for the centers would be limited to VA medical centers that provide inpatient care; that are geographically situated in an area with a high number of veterans that have been diagnosed with both PTSD and substance use disorder; and that are capable of treating PTSD and substance use disorders. This provision would also direct the Secretary to establish a process to refer and aid the transition of veterans receiving treatment in these centers to programs that provide step down rehabilitation treatment.

Section 106 would require the Secretary, acting through the Office of the Medical Inspector (MI), to review all of VA's residential mental health care facilities and to submit to Congress a detailed report on the MI's findings.

Section 107 would provide for title I of this bill to be enacted in tribute to Justin Bailey, an OIF veteran who died while under VA treatment for PTSD and a substance use disorder.

While VA respects the attention this Committee is giving these critical issues, Title I is overly prescriptive and attempts to mandate the type of treatments to be provided to covered veterans, the treatment settings, and the composition of treatment teams. Treatment decisions should be based on professional medical judgments in light of an individual patient's needs, and experienced health care managers are in the best position to decide how best to deliver needed health care services at the local level. With regard to the proposed centers of excellence, we reiterate our concerns about disease-specific treatment centers and models, although we appreciate the Committee's efforts thereby to hasten the eradication of those particular diseases. For all of the above reasons, we do not support this title.

TITLE II. MENTAL HEALTH ACCESSIBILITY ENHANCEMENTS

Section 201 would require the Secretary to establish a 3-year pilot program to assess the feasibility and advisability of providing eligible OEF/OIF veterans with peer outreach services, peer support services, and readjustment counseling services, and other mental health services. This pilot would begin not later than 180 days

after the bill's enactment. Eligible veterans would include those who are enrolled in VA's health care system and who, for purposes of the pilot program, receive a referral from a VHA health professional to a community mental health center or to a facility of the Indian Health Service (IHS).

In providing readjustment counseling services and other mental health services to rural veterans who do not have adequate access to VA services, section 201 would require the Secretary, acting through the Office of Rural Health, to contract for those services with community mental health centers (as defined in 42 CFR § 410.2) and IHS facilities.

Sites for the pilot would need to include at least two Veterans Integrated Service Networks (selected by the Secretary), and at least two of the sites would have to be located in rural areas that lack access to comprehensive VA mental health services.

A center or IHS facility that participates in the pilot program must, to the extent practicable, provide readjustment counseling services and other mental health services to eligible veterans through the use of telehealth services. It would also need to provide the services using best practices and technologies and meet any other requirements established by the Secretary. A participating center or IHS facility would also have to comply with applicable VA protocols before incurring any liability on behalf of the Department and provide clinical information on each veteran to whom it furnishes services.

The Secretary would be required to carry out a national program of training for (1) veterans who would provide peer outreach and peer support services under the pilot program; and (2) clinicians of participating centers or IHS facilities to ensure they can furnish covered services and that such services will be provided in a manner that accounts for factors unique to OEF/OIF veterans. This provision would also establish detailed annual reporting requirements for participating centers and facilities.

As we discussed in connection with section 2 of S. 38, all of these services are already available to OEF/OIF veterans, including those who served in the National Guard or the Reserves. As such, no demonstrated need exists for the pilot program or these additional authorities, which are duplicative of currently existing authorities. And VA is already working with other entities to provide treatment to veterans at the local level if VA is not able to provide the needed care; therefore, the requirement to contract specifically with a community health center or IHS facility would limit the local VA providers' flexibility in finding the most appropriate care for our veterans.

TITLE III. RESEARCH

Section 301 would require the Secretary to carry out a program of research into co-morbid PTSD and substance use disorder. The purpose of this program would be to address co-morbid PTSD and substance use disorder; provide systematic integration of treatment for these two disorders; develop protocols to evaluate VA's care of veterans with these disorders; and, facilitate the cumulative clinical progress of these veterans. This provision would charge VA's National Center for PTSD with responsibility for carrying out and overseeing this program, developing the protocols and goals, and coordinating the research, data collection, and data dissemination.

Section 301 would also authorize $2 million to be appropriated for each of fiscal years 2008 through 2011 to carry out this program and specifically require these funds be allocated to the National PTSD Center. The funds made available to the Center would be in addition to any other amounts made available to it under any other provision of law.

Section 302 would continue the Special Committee on PTSD (which is established within VHA) through 2012; otherwise the Committee's mandate would terminate after 2008.

While well-intended, this title is overly prescriptive and more importantly altogether unnecessary. Therefore, with the exception of the extension of the Special Committee, VA does not support the provisions in title III. VA is a world-recognized leader in the care of both PTSD and substance use disorders, particularly when these conditions co-exist in an individual. The activities required by title III are essentially duplicative of VHA's on-going efforts in this area, particularly the research efforts being carried out by VA's National PTSD Center. We would welcome the opportunity to brief the Committee on VA's achievements and efforts in this area, plus the role of the Office of Mental Health in overseeing the PTSD and substance abuse programs.

TITLE IV. ASSISTANCE FOR FAMILIES OF VETERANS

In connection with the family support services authorized in chapter 17 of title 38, United States Code (i.e., mental health services, consultation, professional counseling, and training), section 401 would amend the statutory definition of "professional counseling" to expressly include marriage and family counseling. This provision would also ease eligibility requirements for these family support services by authorizing the provision of these services when considered appropriate (as opposed to essential) for the effective treatment and rehabilitation of the veteran. Section 401 would further clarify that these services are available to family members in Vet Centers, VA medical centers, CBOCs, or other VA facilities the Secretary considers necessary.

Section 402 would require the Secretary to carry out, through a non-VA entity, a 3-year pilot program to assess the feasibility and advisability of providing "readjustment and transition assistance" to veterans and their families in cooperation with Vet Centers. Readjustment and transition assistance would be defined as readjustment and transition assistance that is preemptive, proactive, and principle-centered. It would also include assistance and training for veterans and their families in coping with the challenges associated with making the transition from military to civilian life.

This provision would require services furnished under the pilot program to be furnished by a for-profit or non-profit organization(s) selected by the Secretary (pursuant to an agreement). To participate in the pilot, a participating organization(s) must have demonstrated expertise and experience in providing those types of services.

The pilot program would have to be carried out in cooperation with 10 geographically distributed Vet Centers, which would be responsible for promoting awareness of the assistance available to veterans and their families through the Vet Centers, the non-VA organization(s) conducting the pilot, and other appropriate mechanisms.

Section 403 would establish detailed reporting requirements and authorize $1 million to be appropriated for each of fiscal years 2008 through 2010 to carry out the pilot program. Such amounts would remain available until expended.

VA does not support title IV. First, it is unclear how these "readjustment and transition assistance" services are intended to differ from, or interact with, the readjustment counseling services and related mental health services already made available to veterans and their families through the Vet Centers. In our view, this provision would conflict in many respects with VA's existing authorities to provide readjustment counseling and related mental health services and lend confusion to what is otherwise a highly successful program (particularly with respect to client outreach). Indeed, client satisfaction with the Vet Centers is the highest of VA's programs (98 percent). The services they provide already include marriage and counseling services to family members as necessary to further the veteran's readjustment.

We also do not understand the perceived need for reliance on non-VA organizations for the provision of these services. Let me again assure you that our Vet Centers readily contract with appropriate organizations and providers to ensure veterans and their families receive covered family support services. In sum, we do not see how this provision would effectively enhance current authorities or Vet Center activities; rather, we see that it has serious potential to create confusion and disruption for both VA and our beneficiaries.

We are currently developing cost estimates on the provisions of these bills, which we will share with the Committee once completed. This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Committee may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY MICHAEL J. KUSSMAN, M.D., TO HON. DANIEL K. AKAKA, CHAIRMAN, SENATE COMMITTEE OF VETERANS' AFFAIRS

Question 1. Please highlight the current VA research programs that are examining how to treat veterans who suffer from both substance use disorder and PTSD.

Response. The Department of Veterans Affairs (VA) continues to be a leader in supporting research related to the mental and physical health consequences of military service, including Post Traumatic Stress Disorder (PTSD). VA researchers and clinicians are working together to understand how co-occurring disorders like substance abuse and PTSD affect a patient's treatment, and are striving to develop the most effective treatments through rigorous research. VA's National Center for PTSD and several of VA's mental illness research education and clinical centers

(MIRECCs) are engaged in studies of PTSD and co-occurring substance use disorders.

Examples of some of the current ongoing research programs sponsored by the Office of Research and Development include:

• VA scientists supported by VA and the Department of Defense (DDD), have collected risk factor and health information from military personnel prior to their deployments to Iraq. Compared to the retrospective studies of past conflicts, this landmark study represents the first time scientists will be able to prospectively examine differences between pre-deployment and post-deployment performance and health outcomes, including PTSD and other health conditions;

• VA's Alcoholism Research Center is recognized as one of the world leaders in understanding genetic contributions to substance abuse. Currently, this center is exploring novel treatments for reducing withdrawal symptoms and drinking;

• VA scientists are exploring the genetic determination of traits related to ethanol withdrawal severity, considered important to reducing relapse events;

• VA scientists are examining the effectiveness of opioid substitution therapy to reduce substance abuse;

• VA's quality enhancement research initiative (QUERI) is sponsoring an initiative to improve the detection and treatment of misuse of psychoactive substances in many co-occurring conditions; and

• VA is supporting research to identify risk factors in subgroups of smokers who are at risk for both increased smoking and difficulty in smoking cessation that could lead to important prevention and intervention efforts.

SOME RECENT ADVANCES BY VA INVESTIGATORS INCLUDE:

• In the largest randomized clinical trial to date involving women veterans with PTSD, VA investigators found that prolonged-exposure therapy—a type of cognitive behavioral therapy—was effective in reducing PTSD symptoms and that such reductions remained stable over time (JAMA, 2007;297(8):820–830).

• Investigators found that prazosin, an inexpensive generic drug already used by millions of Americans for high blood pressure and prostate problems, improves sleep and reduces trauma nightmares for veterans with PTSD (Biological Psychiatry. 2007; 61 (8):928–934). A large, multi-site study is underway to confirm the drug's effectiveness.

• VA researchers found that opioid substitution therapy is as effective at reducing substance use in PTSD patients as it is in patients without PTSD, but additional services are needed for treatment of psychological problems that are largely unchanged by treatment for addiction (J Stud Alcohol. 2006 Mar;67(2):228–35).

Question 2. The Institute of Medicine's report "Treatment of PTSD: An Assessment of the Evidence" released on October 18, 2007 makes a number of observations and recommendations on the need for more research. Accordingly, is VA prepared to assume the leadership role in PTSD research suggested, and does VA have plans to collaborate with the full panoply of Federal and private health organizations focused upon this area to define outcome measures and coordinate future research?

Response. VA, in the continuing role as leader for combat-related PTSD research and treatment, has a well-developed plan to collaborate with other organizations to define outcome measures and coordinate future research. We are particularly proud of the VA scientists who contributed to establishing the evidence supporting the effectiveness of prolonged-exposure therapy which is a psychotherapeutic approach highlighted as the treatment with the highest level of evidence in the Institute of Medicine's (IOM) report. We gratefully acknowledge the veterans who willingly participated in this scientific research.

The IOM report details important research recommendations that will guide future PTSD interventional studies in meeting the highest accepted standards for randomized controlled trials. The recommendations include: (a) standardizing the measures used to determine a modality's effectiveness; and (b) analysis and design improvements that will lead to more solid conclusions about effectiveness of a treatment modality. These issues are best addressed within the scientific and clinical communities. Accordingly, VA has already begun organizing the working group, which will be convened by VA with other Federal research funding agencies early in 2008. Specific outcomes from the working group will be guidance for the scientists developing PTSD interventional studies, as well as for expert peer review panels evaluating research proposals.

Question 3. Clearly, VA and the Committee agree upon the important role families play in providing care for veterans. As VA invests more energy and resources into caring for veterans in their home it is imperative to respond to the needs of

the family members fulfilling the role of care giver. At this time, what services is VHA providing to veterans' families? Do you believe these services are being provided consistently throughout VA?

Response. In areas such as mental health and rehabilitation of veterans with multiple wounds from blast injury, for example, support of families can be essential to the veteran's rehabilitation, Many VA psychologists and social workers are trained and credentialed family therapists. Innovative supports for family members include home health care services and the use of tele-health approaches to make care of wounded or otherwise severely disabled veterans easier for caregivers at home. VA is continuing to explore ways to make these services more "family friendly" in particular for families of severely wounded veterans who bear a heavy burden of care giving.

Family counseling is available at Vet Centers, as needed, in connection with readjustment counseling services furnished to a combat theatre veteran for his or her psychological or social readjustment problems. Providing family counseling services at Vet Centers is not time limited and is available as necessary for the veteran's readjustment throughout the life of the veteran. The Vet Center program has an extensive cadre of licensed clinical social workers, psychologists and nurse psychiatric clinical specialists that provide family assessments, education, preventive health care information, supportive social services, basic counseling and referrals. A number of the program's licensed mental health providers also have the professional expertise to provide marriage and family counseling. The Vet Centers have a cadre of other counselors with master degrees who hold a license in marriage and family counseling.

The polytrauma system of care (PSC) has developed consistent and comprehensive procedures for patients and their families. Families of injured servicemembers require particular assistance in making the transition from the acute medical setting to a rehabilitation setting, including home care. This support encompasses medical care, psychosocial support, and logistical support. For psychosocial support, the proactive case management system provides ongoing support and problem solving in the home community while continually assessing for new and emerging problems. Finally, in terms of logistical support, each polytrauma rehabilitation center (PRC) team carefully assesses the expected needs at discharge for transportation, equipment, home modifications, and other such needs and makes arrangements to provide the needed services to meet the assessed needs.

The Veterans Health Administration's Polytraumal Traumatic Brain Injury (TBI) system of care is designed to assure lifelong care and support for injured soldiers and veterans. As part of this commitment, VA assesses the unique needs of all polytraumal TBl patients and, where indicated, engages the expertise of the private sector. Depending upon the severity of the injury, the needs of veterans with TB] are met either through long-term care for veterans who cannot return home and require institutional care or through extended care support services for veterans who can return to their communities, but not live independently.

The types of non-institutional care that VA currently provides for veterans who can return to their communities, but cannot live independently, include: home based primary care (HBPC); adult day health care (ADHC); respite cam/purchased skilled home health care; homemaker/home health aid (H/HHA); and care coordination/ home tele-health (CC/HT).

Question 4. While I am glad to hear that VA supports S. 2142, I remain concerned over VA's record on emergency treatment. VA's Office of General Counsel (OGC), in a memorandum dated November 16, 2005, concluded that VA may deny reimbursement for care furnished by a non-VA facility when a patient is stabilized, despite the fact that a transfer to a VA facility cannot take place due to the lack of an available bed. What assurance can you provide the Committee that, in the future, VA will take care of all veterans eligible for this benefit?

Response. Although VA makes every effort to accept transfer of a stabilized patient as soon as possible, the Department's current interpretation of regulations, as stated in the November 16, 2005 GGC memorandum, does not allow VA to provide reimbursement or payment for the non-VA hospital care expenses that are incurred while the stabilized patient is awaiting transfer to VA care.

As VA has testified on the Hill, VA fully supports S. 2142, which, in general, would amend VA's statutory authority to reimburse or pay for emergency treatment furnished by a non-VA provider when the veteran is stabilized and awaiting transfer to VA. Prior to this bill's introduction, VA had independently decided to amend current regulations to implement an alternate, valid interpretation of VA's existing statutory authority that would achieve the same overall goal as the pending legislation. Please note, however, that those proposed regulation changes are only in the very early stages of drafting and still subject to all the procedures and requirements

of the Administrative Procedures Act. But this beginning effort should make clear that VA and the Congress are, indeed, of the same mind in attempting to ensure a stabilized veteran in need of continued hospitalization is not penalized (by incurring personal financial liability for the costs of the continued care) due to VA's inability to immediately effect a transfer of the patient to a Department facility.

Question 5. Your prepared testimony described S. 2160 as "superfluous and duplicative" of VA's current efforts on pain care. However, other witnesses at the hearing raised a number of concerns over the adequacy of VA's current efforts. I share in the concern over the lack of uniformity and the apparent variance in the quality of pain care services available at different facilities. Specifically, I question whether all veterans, including those in rural areas, are receiving an adequate level of pain care services?

Response. VA has made pain management a national priority and continues to work aggressively to assure timely access to the highest quality pain care for all veterans seen at VA healthcare facilities, including access in more remote, rural areas. Assuring all veterans (including those returning from Afghanistan and Iraq and those who have experienced polytrauma) are provided immediate and appropriate access to effective pain care, is a top priority for VA.

VA implemented a National Pain Management Strategy in 1998 and published a directive on pain management in 2003 to promote a system-wide approach to pain management. Several publications document the broad successes of this strategy. Of particular note, external peer review data document that routine screening for the presence and intensity of pain, pain plans of care, and reassessment of the effectiveness of the interventions occur with consistency across all VA settings of care.

Extensive educational efforts have been ongoing for the past several years to support the development of provider competency in the area of pain management, including national, Veterans Integrated Service Network (VISN), and facility educational conferences, monthly educational teleconferences, a national pain management website, dissemination of evidence-based information letters and toolkits on pain assessment and management. Practice guidelines have been developed and disseminated to promote safe and effective chronic opioid therapy, post-operative pain care, and management of low back pain. Patient and family educational resources have been developed and disseminated. VA's support for basic science and clinical research on pain and pain management has grown by 500 percent over the past 5 years.

VA remains committed to ensuring that quality pain care services are available to all veterans receiving care through the Department.

Question 6. Regarding S. 2160, does providing a statutory basis for VA's pain initiative cause a problem for the Department?

Response. Because pain management is already a subject of system-wide attention in VA, statutorily mandating a pain initiative is not necessary. Creating fenced research centers and legislatively mandating specific clinical activities will limit the ability of the Department to adjust health care allocations in response to changes in health care needs.

Question 7. Is VA prepared for the anticipated increase in veterans suffering from chronic pain, especially those who are suffering with polytrauama?

Response. Yes. VA is already engaged in numerous new initiatives designed to build on prior successes and to further improve consistency of pain care for veterans. For example, VA now has a revised computerized pain assessment and reassessment polytrauma template/reminder system, which is currently being implemented in two of the four Polytrauma Rehabilitation Centers prior to more widespread dissemination. Also, there are multiple research and clinical programs underway to address pain in patients with PTSD or TBI. Finally, a multi-pronged, multi-disciplinary project to enhance the safe and effective use of opioid medications for pain has recently begun.

Chairman AKAKA. Mahalo. Thank you very much, Dr. Kussman.

Because of time, I am going to try to move this along. I was just notified that we expect a number of votes beginning at 11. So as a result, I am going to ask you just one question and I will ask the other members, as well.

Dr. Kussman, you testified that you do not support the provisions of S. 2162 but that you do support the goals and intentions of this mental health legislation. So to be clear, there is agreement that there is a demonstrated need for changes in mental health

services. However, Congress has yet to receive the draft legislation from VA regarding improvements to mental health. Do you believe that there are no deficiencies in VA mental health services and that you have all the legal tools available to reach all veterans in need?

Dr. KUSSMAN. Mr. Chairman, thank you for the question and let me try to be very clear with this. I never would suggest that we are perfect. I would never suggest that we don't need to improve. That is what we do. That is why we developed our Mental Health Strategic Plan. That is why we have all the programs that we do, and those are viable growing, building programs.

What I was saying is that I believe that we do need to continue to improve. I do not believe that there are any legislative impediments for us to continue to improve and I don't think that the legislation is needed and that is why we haven't put any legislation forward. I believe we already have the ability, legally or otherwise, to provide good care for our veterans.

Chairman AKAKA. Thank you, Dr. Kussman. I will submit my other questions to you and call on Senator Burr for his questions.

Senator BURR. Thank you, Mr. Chairman. I will be brief, as well.

Dr. Kussman, specifically the pain care legislation. Advocates believe, and I think with good reason, that there are inconsistencies within the VA relative to the pain care and how it varies from location to location. In some cases, it is good. In others, it is not as good. Do you agree with the view that the delivery of pain care is inconsistent across the system, and if not this approach, what suggestions do you have to bring that consistency?

Dr. KUSSMAN. Thank you, Senator Burr. I would never suggest that, whether it is pain care or others, that there isn't potential for inconsistency around our system. We are a large system with 1,400 sites of care. I believe that if we are not providing what we say we are providing and there are inconsistencies or inappropriate or inadequate care, that is my job and the VHA's job to be sure that that is being done, and we would be happy to meet with advocacy groups from wherever or Members of the Committee to determine what those inconsistencies are.

Pain management is a very important thing for us, as you know, and that is why we set up our standard in 2003. We have a Committee that meets regularly to look at what we are doing. We are developing performance standards to ensure that there is consistent delivery of care.

We are reviewed regularly by this. This is one of the tenets of the Joint Commission on Health Care Organizations. They always come and look at whether you are in pain. Every time I go to the doctor, they ask me, "Are you in pain at this time?" It is part of the introductory evaluation. I keep asking, what kind of pain are you talking about, physical, mental, or whatever kind of pain, not to make light of what we are talking about.

But I think that if we are not doing the job and we have inconsistencies or inadequacies in what we are doing, it is my job to fix it and that we will look aggressively on that and work with the advocacy groups. I don't think that the legislation itself will solve that.

Senator BURR. Mr. Chairman, I am going to hold myself to one question, but I also want to make this statement relative to S. 2162, given the nature of your last answer and you will hold yourself to what is proven. The Institute of Medicine found that the literature that existed as it related to the Veterans Affairs process on PTSD and co-morbidity conditions, such as anxiety, substance abuse, and depression along with PTSD, that the literature was uninformative.

So I heard your objection to S. 2162. We have an independent IOM study that suggested there are deficiencies. I will hold you to exactly the answer you gave me on the last one. If that is, in fact, an accurate assessment by IOM, then I would hope you would make the correct changes.

Dr. KUSSMAN. Senator Burr—can I answer that question? Are you asking me something?

Senator BURR. It was not in the form of a question, so I am going to let the Chairman control this.

Dr. KUSSMAN. Can I have the opportunity to respond?

Chairman AKAKA. If it is brief.

Dr. KUSSMAN. I will try to be brief, although everybody says I talk too much. But we chartered the study. It was done by the VHA asking the IOM to look at what we were doing. I believe what the IOM said was that the literature—not just the VHA literature, only 10 of the 50 studies that they have looked at were VHA studies, they looked at the whole country's studies on mental health, particularly PTSD. And what they said was there are gaps in the adequacy and the peer review of these studies, and they didn't suggest that the treatment we were doing was inadequate. They just said that the outcomes of the studies couldn't prove that it was adequate, but they weren't suggesting what we were doing didn't work. The only one that they said that there was good scientific study was a study done by us with the immersion and cognitive therapy. But we are doing studies already to get better results, particularly with drugs and other therapy, on PTSD and substance abuse. So it is already going on. Thank you, sir.

Chairman AKAKA. Thank you. Senator Murray?

Senator MURRAY. Thank you very much, Mr. Chairman.

Dr. Kussman, while you are here, I wanted to ask you, I saw an article from the Charlotte Observer that was out recently that was really disconcerting about wait times for veterans and it said that most VA hospitals showed lags in delivering outpatient care for serious problems. And according to that newspaper's analysis, 24 percent of appointments nationwide for Traumatic Brain Injury care exceeded the 30-day mark last summer. At the Salisbury VA Hospital, 61 percent of appointments for the seriously wounded were scheduled more than 30 days out of the summer, one of the worst records nationwide. And at the Charleston VA in South Carolina, 13 of 14 patients slated to be seen for brain injury waited for more than a month.

I was really discouraged to see this and I was even more discouraged to see that the VA's response to that report was really attacking their own data, saying that the reports can't be used to judge service because they don't show all appointments. So I am com-

pelled to ask you, why is the VA spending money on these reports if that is the case?

Dr. KUSSMAN. Senator Murray, thank you for the question. As you and I have talked before, waiting times is a very important issue to me. I have been concerned for a long time about what the information I get and what is perceived and real out there.

We believe and have responded to the newspaper and had dialogue with them greatly, we believe that their interpretation of the data did not reflect what is going on. But it is a very—complex issue and I will be happy to——

Senator MURRAY. Why doesn't it reflect what is going on?

Dr. KUSSMAN. Because we believe that there were snapshots in time and did not reflect the way that the data is accurately collected and what it reflected in the true waiting times for people. But I will be happy to come and talk to you about that——

Senator MURRAY. Well, let me ask——

Dr. KUSSMAN.—but if I could finish, just for a second, as you know, these are very important things, whether waiting times for TBI or anything else that we are doing. The issue of the electronic wait list, we have pretty much eliminated. Those were things that came up early on about the number of people who couldn't even get an appointment to be seen, and I believe that that number now is around 200 people systemwide.

But because of all these issues related to wait times, I have contracted with a group to look at our whole wait times measure to find out and tell me whether there are inadequacies or breakdowns in how we are collecting the data, because I have no interest, as you know—I am a veteran and a retiree myself—to come up and tell you that data is not accurate.

Senator MURRAY. So you can't tell us right now how long it actually takes veterans to see a doctor, not just schedule an appointment but, actually see a doctor?

Dr. KUSSMAN. Yes, I can, and I don't believe that the numbers that were used by the Charlotte reflect the accurate numbers and we will be happy to get that to you.

Senator MURRAY. What do you think that number is?

Dr. KUSSMAN. I believe that, as we have reported, 95 percent of our patients get their appointment within 30 days of when they want it or was clinically appropriate.

Senator MURRAY. Can you tell this Committee how long wait times are for different generations of veterans, for different priority groups, for different types of injuries or illnesses? Do you have that information?

Dr. KUSSMAN. We do have a breakout, and I will have to get it to you, for OIF/OEF, but I don't think we have it by age group, but I will have to get back to you on that.

Senator MURRAY. OK. Can you give us today what the wait times are?

Dr. KUSSMAN. For?

Senator MURRAY. For all veterans. Can you tell us what the wait time is?

Dr. KUSSMAN. As I reported, we believe on the basis of the data that we have, 95 percent of the 39 million appointments that we see every years are done within the 30-day expectation. These are

not urgent or emergency appointments, but routine appointments and things for veterans within 30 days of when they ask for it.

Senator MURRAY. Can you give me a reason why the Charlotte Observer's information is so different?

Dr. KUSSMAN. I will have to get back to you on that. I think it is a very involved issue of how they interpret the data versus snapshots in time versus continuum, but we have tried to work with the Charlotte and other people to get an accurate assessment.

Senator MURRAY. You can't give me a couple sentences, any view that might make that real for us?

Dr. KUSSMAN. As I said, they used a snapshot in time, not a continuum, and I believe that is a fundamental problem with that. But I will be happy to get the subject matter experts to talk to you about what the differences are.

Senator MURRAY. What I would like you to do is give it to this Committee, because I believe that——

Dr. KUSSMAN. I would be happy to do that.

Senator MURRAY.—We all have a very deep concern about the wait times, and it is not just a newspaper article. We continue to hear that from our veterans. They don't care whether they are a snapshot or a continuum. They actually care that they are waiting a very long time, and it is deeply disconcerting when we——

Dr. KUSSMAN. And as you know——

Senator MURRAY.—continue to hear this and we continue to see it.

Dr. KUSSMAN. It is disconcerting to me, too, and that is why I said we have contracted with somebody to come in and do an objective assessment of how we are trying to collect data on wait times and identify any glitches in how we do our business.

Senator MURRAY. OK. Mr. Chairman, I am compelled to ask, as well. We have been 3 months without a Secretary or even a nominee for the VA. I am beginning to hear from a lot of veterans who are very, very concerned that a lack of a nominee sent to the Senate signals that the administration doesn't have a priority for veterans, at a time when we are at war and we know we have issues with wait times and mental health problems and all the other things this Committee has been discussing. Dr. Kussman, do you have any idea why we have not had a nominee sent over for the Secretary of the VA yet?

Dr. KUSSMAN. No, Senator, I don't, but I can assure you that we are still doing our job to take care of veterans.

Senator MURRAY. I know everybody is working their hardest, but we need somebody at the top that is accountable, and whoever is listening out there, we need an independent, someone who is going to stand up for our veterans when we are at a time of war, and I hope that we get an administration soon that will take this as a priority, Mr. Chairman.

And just really quickly, on the legislation that we are talking about today, I wanted to ask you about Senator Craig's and my bill on the TBI-induced epilepsy. Dr. John Booss, who is a former Director of Neurology at the VA, testified before this Committee in May that there would be a dramatic increase in epilepsy due to TBI and that the VA has no national plan to cover it. Does the VA

anticipate an increase in the number of veterans that develop epilepsy as a result of TBI?

Dr. KUSSMAN. Senator, I know John Booss very well, obviously, and I have not talked to him. I believe that the literature that exists says that 53 percent of people with penetrating wounds of the head, severe TBI, as we would call it, have an increased incidence of—they will develop epilepsy 53 percent of the time after suffering a penetrating wound.

Senator MURRAY. So more than half the time?

Dr. KUSSMAN. With a penetrating wound. I think everybody understands that and we are watching those people very closely. As you know, these are the ones who transfer from the military health system to our polytrauma centers. There have been about 413 of them that have been transferred. Everybody acknowledges and knows that any time there is a penetrating wound to the head, there is an increased incidence of seizure disorder and——

Senator MURRAY. Just so I understand, there are 413 with penetrating wounds?

Dr. KUSSMAN. With severe TBI. I don't know the number of penetrating wounds versus severe non-penetrating wounds.

Senator MURRAY. Do you know how many people have come into the VA with Traumatic Brain Injury at this time?

Dr. KUSSMAN. Well, if you want to talk about the full spectrum of TBI, because it is not all the same, as you know, the mild to moderate TBI is one that is hard to diagnose and we have in place a screening mechanism to try to identify those people because that is very important to us to develop the registries and follow people because it appears with mild to moderate, the incidence of seizure disorder or long-term sequelae is much less than it is for the more severe, the moderate to severe TBI. But the literature doesn't help us with that very much and so we need to put in place research and longitudinal studies, good epidemiologic studies to follow these people.

Senator MURRAY. Is that what you have done?

Dr. KUSSMAN. We are doing that, yes.

Senator MURRAY. And do you know how many people that is?

Dr. KUSSMAN. I would have to—again, we are screening everybody and I don't have the recent data of how many people screened positive.

Senator MURRAY. For any TBI, severe, mild——

Dr. KUSSMAN. Yes, that is correct.

Senator MURRAY. When would we be able to get that?

Dr. KUSSMAN. As soon as I have that data, I will be happy to give it to you.

Senator MURRAY. Thank you so much, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Murray.

Senator ISAKSON?

Senator ISAKSON. I will be very brief. I really have one question. You know, in all my experience on this Committee, my travels to Iraq, and my visits to veterans' hospitals, I can't remember a complaint about the quality of care the physicians render or the facilities do. The complaints generally—not generally, almost always involve accessibility, appointments, and time.

The example I used in my opening remarks about Augusta's Uptown facility and the Eisenhower Medical Center in Augusta, they created a seamless transition which solved a lot of those problems. In fact, Sergeant Harris that I mentioned whose TBI was moderate to mild, as you put it, was actually corrected and she went back into active duty, which is an example of that seamless transition and no skip in quality or accessibility of service.

Now, I know you have veterans all over the country and there are not a lot of cities that have two, a veterans' hospital and a military hospital, but there are a number, San Antonio and others around the country. Are you all working on some of those innovations like what took place in Augusta to replicate them around the country?

Dr. KUSSMAN. Sir, this is one of the most important things for us, is to be sure that both severe and other injured veterans, servicemembers, come to us with a minimum or none, no complications of the bureaucracies. I believe we put in place a very significant infrastructure with VA benefits counselors and social workers at the major military treatment facilities, military people at our facilities, and we are—it will never be perfect because things happen, but I believe the infrastructure is there to do exactly what you are describing in Augusta throughout the country.

Senator ISAKSON. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Isakson.

I want to thank our first panel very much for being here. We will place in the record further questions that we have for you to respond to. I want to thank you for your service. We are looking forward to working together to try to improve it throughout our country. The signs are beginning to show where there is strain and we need to correct these. So we look forward to continuing to work with you. Thank you.

Dr. KUSSMAN. Mahalo, Mr. Chairman.

Chairman AKAKA. Mahalo.

I want to introduce our second panel and extend a warm aloha and welcome to the second panel. I want you to know that I appreciate each of you being here today and look forward to your testimony.

First, I welcome Carl Blake. Mr. Blake is the National Legislative Director for Paralyzed Veterans of America.

I welcome Joy Ilem. Ms. Ilem is the Assistant National Legislative Director for Disabled American Veterans.

I also welcome Brenda Murdough, who is a registered nurse and holds a Masters of Science in Nursing. She is the Coordinator of the Military/Veterans Initiative of the American Pain Foundation.

I also welcome Dr. Brien Smith. Dr. Smith is Director of the Epilepsy Monitoring Unit at Henry Ford Hospital in Detroit, Michigan.

Finally, I welcome Constance Walker. She is a retired Navy Captain and is the President of the Southern Maryland Chapter of the National Alliance on Mental Illness. She also serves on the Maryland Governor's Task Force on Improving State Programs directed at Iraq and Afghanistan veterans and their families.

Each of your statements will appear in the record of today's hearing and I ask that you limit your direct testimony to no more than 5 minutes so that we have time for questions.

Mr. Blake, will you please begin.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Chairman Akaka, Ranking Member Burr, and Members of the Committee. I would like to thank you on behalf of PVA for the opportunity to testify today. In the interest of time, I will keep my statement as short as possible.

PVA supports the provisions of S. 38 that direct the Secretary to establish a program for peer support and counseling, readjustment counseling, and mental health services. We particularly believe in the importance of peer counseling in the rehabilitation and readjustment process. This is something that PVA as an organization does in all of the Spinal Cord Injury Centers around the country. Every PVA chapter designates individual members to pair up with the newly injured veterans to help them get through the early stages of recovery and beyond.

PVA principally supports S. 2004, a bill that would create six Epilepsy Centers of Excellence within the VA health care system. Much like the MS Centers and Parkinson's Disease Centers of Excellence permanently authorized last year, this proposal recognizes the successful strategy of the Veterans Health Administration to focus its systemwide service and research expertise on a critical care segment of the veteran population.

PVA generally supports the provisions of S. 2142, the Veterans Emergency Care Fairness Act, as the legislation is in accordance with the recommendations of the Independent Budget for FY 2008. However, we remain concerned about some of the eligibility criteria that determine what veterans are eligible for this reimbursement. In accordance with the IB for fiscal year 2008, we believe that the requirement that a veteran must have received care within the past 24 months should be eliminated. Furthermore, we believe that the VA should establish a policy allowing all veterans enrolled in the health care system to be eligible for emergency services at any medical facility, whether the VA or private facility, when they exhibit symptoms that a reasonable person would consider a medical emergency.

First, I would like to say that PVA generally supports S. 2162, which improves services provided by the VA to veterans with PTSD and substance use problems. However, PVA does remain concerned with the pilot program outlined in Title 2 of the bill. While we certainly support the emphasis placed on peer counseling and outreach, as expressed in our written statement earlier, we maintain our concerns about contract services with community mental health centers. The VA should be able to provide the services described in this legislation through judicious application of its already existing fee-basis authority.

We do, however, appreciate the emphasis on ensuring that the non-VA facilities are compliant with VA standards, particularly through additional training managed specifically by the VA, a requirement that is also included in S. 38. However, we still believe that at this time, the energy and money that would be expended here could best be used to upgrade the VA system itself.

Mr. Chairman and Members of the Committee, PVA would once again like to thank you for the opportunity to testify and I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Chairman Akaka, Ranking Member Burr, and members of the Committee, on behalf of Paralyzed Veterans of America (PVA) I would like to thank you for the opportunity to testify today on the proposed health care legislation. The scope of issues being considered here today is very broad. We appreciate the Committee taking the time to address these important issues, and we hope that out of this process meaningful legislation will be approved to best benefit veterans.

S. 38, THE "VETERANS MENTAL HEALTH AND OUTREACH ACT"

PVA supports the provisions of this legislation that directs the Secretary to establish a program for peer support and counseling, readjustment counseling, and mental health services. We particularly believe in the importance of peer counseling in the rehabilitation and readjustment process. This is something that PVA as an organization does in all of the Spinal Cord Injury Centers around the country. Every PVA chapter designates individual members to pair up with newly injured veterans to help them get through the early stages of their recovery. I know first hand that being able to talk to someone who has experienced what you have experienced and has dealt with the same problems you are dealing with can help you overcome bouts of depression, sadness, and anger as you first come to grips with your condition. The peer counselor serves as a motivator to get you moving in the right direction. I credit my own peer counselor while I went through spinal cord rehabilitation with driving me to help other veterans.

PVA opposes the provisions of this legislation which would authorize VA to contract with community mental health centers to meet the needs of veterans dealing with mental illnesses. As we testified earlier this year, we oppose any effort to allow the VA to contract out care when it can do a better and more cost effective job in its own system. Furthermore, by allowing the VA to send these veterans out of the system to receive their care, it effectively relieves itself of the obligation it has to these men and women. The VA must be appropriated adequate funding and it must be provided in a timely manner if it is going to have any chance of meeting these veterans' needs.

Moreover, Congress must continue to conduct aggressive oversight to ensure that funding specifically allocated for mental health initiatives is properly spent. As explained in the Government Accountability Office (GAO) report of November 2006, the VA did not allocate all of the funding it planned to commit in fiscal year 2005 for new mental health initiatives, nor did it spend all of the funds planned for fiscal year 2006. VA must be held accountable to ensure that it lives up to the goals established in its National Mental Health Strategic Plan. Until such time as the VA meets these goals, the burden for mental health care should not be shifted to the community.

PVA does support the provision of this legislation which would extend the eligibility for hospital care, medical services, and nursing home care from 2 to 5 years for a veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force after November 11, 1998. This provision has proven especially important to the men and women who have recently served in Iraq and Afghanistan and have exited military service.

S. 2004, EPILEPSY CENTERS OF EXCELLENCE

PVA principally supports S. 2004, a bill that would create six Epilepsy Centers of Excellence within the VA health care system. Much like the Multiple Sclerosis (MS) and Parkinson's disease Centers of Excellence permanently authorized last year, this proposal recognizes the successful strategy of the Veterans Health Administration (VHA) to focus its system-wide service and research expertise on a critical care segment of the veteran population. The designation of these six Centers of Excellence will provide open access to centers engaged in marshaling VA expertise in diagnosis, service delivery, research and education. Furthermore, these programs will be available across the country through the "hub and spokes" approach. We also

hope that this legislation will sow the seeds for broader based research and development into Traumatic Brain Injury (TBI), as we believe the same concept could be crucial for better treatment for veterans in the future.

S. 2142, THE "VETERANS' EMERGENCY CARE FAIRNESS ACT"

PVA generally supports the provisions of S. 2142, the "Veterans' Emergency Care Fairness Act," as the legislation is in accordance with the recommendations of The Independent Budget for FY 2008. However, we remain concerned about some of the eligibility criteria that determine what veterans are eligible for this reimbursement. In accordance with The Independent Budget for FY 2008, we believe that the requirement that a veteran must have received care within the past 24 months should be eliminated. Furthermore, we believe that the VA should establish a policy allowing all veterans enrolled in the health care system to be eligible for emergency services at any medical facility, whether at a VA or private facility, when they exhibit symptoms that a reasonable person would consider a medical emergency.

S. 2162, THE "MENTAL HEALTH IMPROVEMENTS ACT"

First, I would like to say that PVA generally supports this proposed legislation which improves services provided by the VA to veterans with Post-Traumatic Stress Disorder (PTSD) and substance use problems. Current research highlights that Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) combat veterans are at higher risk for PTSD and other mental health problems as a result of their military experiences. In fact, the most recent research indicates that 25 percent of OIF/OEF veterans seen at a VA facility have received mental health diagnoses.

We are pleased with the provisions of Section 102 and 103 of the legislation. In fact, The Independent Budget is set to recommend that VA provide a full continuum of care for substance use disorders including additional screening in all its health care facilities and programs—especially primary care. We also believe outpatient counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics. Furthermore, short-term outpatient counseling including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self help groups, opiate substitution therapies and newer drugs to reduce craving, should be included in VA's overall program for substance abuse and prevention.

Although we support the creation of PTSD Centers of Excellence outlined in Section 105 of the legislation, we wonder whether this step is necessary. The VA already maintains a broad network of PTSD treatment centers. Furthermore, in 1989, the VA established the National Center for Post-Traumatic Stress Disorder as a focal point to promote research into the causes and diagnosis of this disorder, to train health care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The Center offers guidance on the effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat the condition. This center already functions as a center of excellence. At the very least, it should be incorporated into this new network of centers of excellence.

PVA has some concerns with the pilot program outlined in Title II of the bill. While we certainly support the emphasis placed on peer counseling and outreach, as expressed in our statement earlier, we maintain our concerns about contract services with community health centers. The VA should be able to provide the services described in the legislation through judicious application of its already existing fee basis authority. We do, however, appreciate the emphasis on ensuring that the non-VA facilities are compliant with VA standards, particularly through additional training managed specifically by the VA.

While we also support Title III of the legislation regarding research into comorbid PTSD and substance use disorder, we wonder if this is duplicative with activities already taking place at the National Center for PTSD. However, PVA has long supported research initiatives into various types of conditions and the treatments associated with them.

Finally, we recognize the unique challenge associated with providing mental health services to families of veterans. This is an area that the VA has had little experience with in the past. Likewise, we see no problem with the VA examining the feasibility of providing readjustment and transition assistance to veterans and their families. It is certainly an issue that has become more apparent as more men and women return from conflicts abroad broken and scarred. The impact that this has on the veteran and his or her family cannot be overstated.

PVA supports the draft legislation that would establish a system-wide pain care initiative within the VA. We agree with the finding that comprehensive pain care in not consistently provided across the entire system. We have seen firsthand the benefits of pain care programs as each VA facility that supports a Spinal Cord Injury (SCI) unit also maintains a pain care program. Veterans with Spinal Cord Injury know all to well the impact that pain, including phantom pain, can have on their daily life. The pain care programs that SCI veterans have access to have greatly enhanced their rehabilitation and improved their quality of life.

The one concern we have is the expectation that every facility in the VA should have a pain care program. Does this suggest that every community-based outpatient clinic (CBOC) should have a similar program? This might be an unreasonable expectation. We do support the idea of cooperative centers for research and education on pain. The work done at these locations can only benefit the provision of pain care services throughout the system.

Mr. Chairman and Members of the Committee, PVA once again thanks you for the opportunity to testify. We look forward to working with you to ensure that veterans continue to have access to the best health care services in America.

I would be happy to answer any questions that you might have.

William Carl Blake National Legislative Director Paralyzed Veterans of America at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's relations with the U.S. Congress and Federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues. He also represents PVA to Federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute operation.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.

Chairman AKAKA. Thank you very much.

Ms. ILEM?

STATEMENT OF JOY J. ILEM, ASSISTANT, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. ILEM. Mr. Chairman and Members of the Committee, thank you for inviting the DAV to testify today at this legislative hearing. In the interest of brevity, I will focus my oral remarks on two mental health bills being considered by the Committee.

S. 38, the Veterans Mental Health Outreach and Access Act of 2007, would require VA to establish a VA-contracted peer outreach, peer counseling, and mental health program for veterans who served in Operations Iraqi and Enduring Freedom who are not adequately served by VA. The bill would also authorize members of the immediate families of such veterans to receive mental health services to assist in the readjustment of the veteran and their family. The final provision in the bill would extend eligibility for VA health care services from 2 to 5 years for this group.

We appreciate the bill's intent to better serve veterans in rural areas, which has historically been a challenge for VA. Although DAV believes that VA contract care is an essential tool in providing timely access to medical services, we feel strongly that VA should use this authority judiciously.

Our main concern with this bill is that VA over the past several years has received a significant amount of new funding targeted to providing better access to mental health services to enrolled veterans. Over the past few years, VA has hired 3,500 new mental health providers and established a significant number of new initiatives and programs within the system to address the mental health needs of enrolled veterans, including OEF/OIF veterans. Before Congress authorizes a program such as the one envisioned in S. 38, we recommend VA determine a degree of unmet need after it has done as much as practical to meet that need directly. Additionally, we point out that VA's Office of Rural Health has already been charged with evaluating and presenting solutions to address the needs of this population.

For these reasons, with the exception of the extension of eligibility for health care for combat veterans from 2 to 5 years, we cannot support this measure at this time.

We have also been asked to comment on S. 2162, the Mental Health Care Improvements Act of 2007, a comprehensive bill that focuses on programs for treatment of veterans who suffer from both PTSD and substance use disorders. This measure would require VA to offer a complete package of services for substance use disorders at all VA facilities unless specifically exempted. It would also establish six new national Centers of Excellence on PTSD and substance use disorders to provide a comprehensive inpatient treatment and recovery services, as well as a targeted research program in co-morbid PTSD and substance use disorders, and a ten-site pilot program for providing specialized mental health transition assistance in coordination with veterans centers to veterans and their families.

Title 2, Section 201 of the measure would authorize a pilot program of peer readjustment counseling and other mental health services at non-VA community mental health centers for OEF/OIF veterans not adequately served by VA. While we support the peer counseling concept, we continue to have concerns about contracting with non-VA mental health providers for specialized PTSD. While we appreciate the Chairman's efforts to address unmet needs of veterans in underserved areas, we have the same concerns about this provision that we expressed regarding contract care in S. 38.

Mr. Chairman, like you, we are concerned that over the past decade, VA has drastically reduced its substance use treatment and related rehabilitation services and has made little progress in restoring them, even in the fact of increased demand for such services from veterans returning from current conflicts. There are multiple indications that PTSD and readjustment issues in conjunction with the misuse of substances will continue to be a significant problem for our newest generation of combat veterans, and therefore we agree VA should adopt new programs and services to meet these unique needs.

We are especially pleased about the provisions in the bill expanding mental health services for family members at VA facilities. These families of these veterans are suffering, too, and are the core support for veterans struggling to rehabilitate and overcome readjustment issues related to their military service. We hope at the same time previous generations of veterans and their families can also benefit from these expanded programs and services.

Thus, with the exception of the sections in the bill dealing with contracted care, we believe these are very timely provisions and we fully support them.

For the record, we believe the remaining measures being considered by the Committee today would also be beneficial to sick and disabled veterans and, therefore, have no objection to their passage, specifically S. 2004, which seeks to establish six Epilepsy Centers of Excellence within VA, S. 2142, the Veterans Emergency Care Fairness Act of 2007, and S. 2160, the Veterans Pain Care Act of 2007. We refer the Committee to our written statement for DAV's complete analysis of these bills.

Mr. Chairman, again, DAV appreciates the opportunity to appear before you today to give our testimony and view on these bills and we are pleased to answer any questions you may have. Thank you.

[The prepared statement of Ms. Ilem follows:]

PREPARED STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE, DIRECTOR OF THE DISABLED AMERICAN VETERANS

Mr. Chairman, Ranking Member Burr and other Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important legislative hearing of the Committee on Veterans Affairs. DAV is an organization of 1.3 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

You have requested testimony today on five bills primarily focused on health care services for veterans under the jurisdiction of the Veterans Health Administration, Department of Veterans Affairs (VA). This statement submitted for the record reviews our positions on all of the proposals before you today. The comments are expressed in numerical sequence of the bills, and we offer them for your consideration.

S. 38—THE VETERANS' MENTAL HEALTH OUTREACH AND ACCESS ACT OF 2007

S. 38 would require the VA Secretary to establish a VA-contracted peer outreach, peer counseling and mental health care program to provide readjustment and certain mental health services to veterans who served in Operations Iraqi and Enduring Freedom (OIF/OEF), and are not adequately served by VA. It would also require VA to train peer counselors and professional providers to ensure their cultural competency to care for veterans of OIF/OEF, and specifically those who live remotely from VA facilities in circumstances in which they have no access to direct VA programs.

The bill would also authorize, for a 3-year period immediately following combat deployment to Iraq and Afghanistan, members of the immediate families of such veterans to receive VA services, such as orientation and education, support, counseling and mental health services, to assist in the readjustment of veterans and their families, especially in the case of a veteran who sustained injury or illness during military deployment.

We appreciate the intent of the bill in serving veterans in rural areas, which has historically been a challenge for VA. On a positive note, this bill would be consistent with VA's principles to use coordinated contract care only when services are unavailable in the VA—a firm position that DAV holds. At the same time, the legislation would address the needs of the veteran's immediate family as it relates to his or her recovery and would build on the tested concept of having peers with similar personal military experiences from which they have recovered, to provide outreach and support—an approach that probably would increase the likelihood of engaging

veterans in readjustment and treatment and may provide new vocational rehabilitation options for some veterans who provide this counseling.

Although DAV believes that VA contract care is an essential tool in providing timely access to quality medical care, we feel strongly that VA should use this authority judiciously. Current law limits the use of VA purchased care to specific instances [1] so as not to endanger VA facilities' ability to maintain a full range of specialized services for enrolled veterans and to promote effective, high quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, spinal cord injury or chronic mental health conditions.

Unfortunately, in most cases where VA authorizes care to veterans by contract providers, VA has not established a systematic approach to monitor that care, consider any alternatives to its high cost, analyze patient care outcomes, or even establish patient satisfaction measures. In fact, VA knows very little about the care for which it now contracts.

Any bill that would authorize contract care by VA without addressing these concerns would essentially shift medical resources and veterans from VA to the private sector, to the detriment of the VA health care system and eventually would be deleterious to the interests of sick and disabled veterans themselves. DAV could not support this or any similar bill without such protections. It is unclear how the services that would be authorized by this bill would be triggered and controlled by an accountable VA health care professional. Typically, a veteran is authorized contract care after VA establishes that it cannot provide a particular service or that the veteran is geographically or otherwise hampered from access to VA services. A VA health care professional makes this determination. Also, legal eligibility determination is a necessity to ensure an individual veteran is eligible for VA care.

Our main concern with this bill is that VA, over the past several years, has received significant new funds targeted to providing better mental health services to all veterans. VA has been especially concerned about ensuring services to OIF/OEF veterans, particularly those who live in rural and remote areas without good access to care. VA has developed a national mental health strategic plan, to deploy several new programs within all the normal strictures in which the system is required to operate. DAV believes VA should rapidly deploy those plans and exhaust those program possibilities, and then determine the degree of unmet need in rural areas—rather than being required to contract out these services before those programs are given a chance to materialize. Before Congress authorizes a program such as the one envisioned here for rural veterans, we recommend VA determine the degree of unmet need after it has done as much as practicable to meet that need directly. Since Congress recently enacted legislation that established VA's new Office of Rural Health, we believe that office should be charged with implementing and managing these matters in conjunction with VA's Office of Mental Health Services.

S. 2004—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO ESTABLISH NOT LESS THAN SIX EPILEPSY CENTERS OF EXCELLENCE IN THE VETERANS HEALTH ADMINISTRATION OF THE DEPARTMENT OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES.

These Centers are intended to function as centers of excellence in research, education, and clinical care activities in the diagnosis and treatment of epilepsy and include training of medical residents and other VA providers to ensure better access to state-of-the art treatments throughout the VA health care system. Provisions in the bill also include a peer review panel, consisting of experts on epilepsy, complex multi-trauma associated with combat injuries, including Post-Traumatic Epilepsy, to assess the scientific and clinical merit of research and treatment proposals that are submitted to the Centers.

While DAV has no adopted resolution from our membership on this matter, we have been briefed by professional associations concerned about the decline of availability of epilepsy services in the VA. Also, literature is emerging to suggest co-morbid epilepsy in veterans with Traumatic Brain Injury. Therefore, this is timely legislation to fill a real need, and DAV would have no objection to its passage.

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[1] (1) When VA facilities are incapable of providing necessary care to a veteran. (2) When VA facilities are geographically inaccessible to a veteran for necessary care. (3) When medical emergency prevents a veteran from receiving care in a VA facility. (4) To complete an episode of VA care. (5) For certain specialty examinations to assist VA in adjudicating disability claims. (6) For the services in VA facilities of scarce medical specialists.

S. 2142—THE VETERANS EMERGENCY CARE FAIRNESS ACT OF 2007

The intent of S. 2142 is to amend Sections 1725 and 1728 of title 38, U.S.C., to require the Secretary of Veterans Affairs to reimburse veterans receiving emergency treatment in non-VA facilities. In addition to applying the prudent layperson definition of "emergency treatment" under both Sections, the bill intends to clarify the current VA practice of denying payment for emergency care provided to a veteran by a private facility for any period beyond the date on which VA determines the veteran can be safely transferred. Specifically, it would amend the definition of reimbursable emergency treatment to include the time when VA or other Federal facility does not agree to accept a stabilized veteran who is ready for transfer from a non-VA facility and the non-VA provider has made reasonable attempts (with documentation) to make such transfer.

The DAV supports the intent of this bill as outlined above in accord with the mandate from our membership and with the recommendations in the Independent Budget for Fiscal Year 2008 to improve the reimbursement policies for non-VA emergency health care services for enrolled veterans. Having consulted with the author of this important measure and with pertinent parties, it is our understanding that the current language may require additional modification. The DAV thanks those involved for their efforts to ensure the improvements to this essential benefit as contemplated by this bill is properly implemented.

S. 2160—THE VETERANS PAIN CARE ACT OF 2007

This measure would amend title 38, U.S.C., to establish a pain care initiative in all VA health care facilities. Specifically, it would require the Secretary to ensure that all patients receiving treatment be assessed for pain at the time of admission or initial treatment and periodically thereafter, and that pain care management and treatment, including specialty pain management services, are provided as deemed clinically appropriate. Pain care initiatives in this measure would be required to be established by January 2008 for inpatient care and January 2009 for outpatient care service lines. The bill would also require the establishment of research centers and training of healthcare professionals in assessment, diagnosis, treatment and management of acute and chronic pain.

There is increasing interest by healthcare providers in the specialized field of pain management, and a number of advances in medicine and technologies from that interest are benefiting severely wounded service personnel and veterans. A recent study of OIF/OEF servicemembers receiving treatment in VA Polytrauma Centers found that pain is highly prevalent among this group. It also noted in its clinical implications that pain should be consistently assessed, treated, and regularly documented. The report concluded that polytrauma patients are at potential risk for development of chronic pain, and that aggressive and multidisciplinary pain management (including medical and behavioral specialists) is necessary. The report suggested the phenomenon of pain is a new opportunity for VA research in evaluating long term outcomes; developing and evaluating valid pain assessment measures for the cognitively impaired; and, developing and evaluating education or policy initiatives designed to improve the consistency of assessment and treatment across the VA continuum of care.

VA has been a leader in assessment and treatment of pain management; having issued a National Pain Management Strategy in 1998 (its current iteration is VHA Directive 2003–021). We understand that the overall objective of VA's national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering for veterans experiencing acute and chronic pain associated with a wide range of illnesses, including terminal illness. However, we are concerned that implementation of pain management programs has not been consistent throughout VA's nationwide health care system.

DAV does not have a specific resolution adopted in support of establishing a legislated system-wide pain initiative at all VA medical facilities, but we believe the goals of the bill are in accord with providing high quality, comprehensive health care services to sick and disabled veterans and thus, would be strongly supported by our membership; therefore; we have no objection to this measure and look forward to its enactment.

S. 2162—THE MENTAL HEALTH IMPROVEMENTS ACT OF 2007

This measure would establish new program requirements and new emphases on programs for treatment of Post-Traumatic Stress Disorder (PTSD) and substance

use disorder—with special regard for the treatment of veterans who suffer from co-morbid associations of these disorders.

Sections 102–104 of the bill would require VA to offer a complete package of continuous services for substance use disorders, including: counseling; intensive outpatient care; relapse prevention services; aftercare; opiate substitution and other pharmaceutical therapies and treatments; detoxification and stabilization services; and any other services the Secretary deemed necessary, at all VA medical centers and community-based outpatient clinics unless specifically exempted. The measure would require that treatment is provided concurrently for such disorders by a team of providers with appropriate expertise. This section describes allocation funding to facilities for these new programs, as well as how facilities would apply for such funding.

Sections 105 and 106 would require establishment of not less than six new National Centers of Excellence on Post-Traumatic Stress Disorder and Substance Use Disorder, that provide comprehensive inpatient treatment and recovery services for veterans newly diagnosed with both PTSD and a substance use disorder. The bill would require the Secretary to establish a process of referral to step-down rehabilitation programs at other VA locations from a center of excellence, and to conduct a review and report on all of VA's residential mental health care facilities, with guidance on required data elements in the report.

Title II—Section 201 of the measure seeks to make mental health accessibility enhancements. This provision would require the establishment of a pilot program of peer outreach, peer support, readjustment counseling and other mental health services for OIF/OEF veterans who reside in rural areas and do not have adequate access through VA. Services would be provided using community mental health centers (grantee organizations of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services), and facilities of the Indian Health Service, through cooperative agreements or contracts. This pilot program would be carried out in a minimum of two Veterans Integrated Service Networks (VISNs) for a 3-year period. Provisions would require the Secretary to carry out a training program for contracted mental health personnel and peer counselors charged to carry out these services for OIF/OEF veterans. All contractors would be required to comply with applicable protocols of the Department and provide, on an annual basis, specified clinical and demographic information including the number of veterans served.

Title III—Section 301 of the bill would establish a new, targeted research program in co-morbid PTSD and substance use disorders, and would authorize $2 million annually to carry out this program, through VA's National Center for PTSD.

Title IV—Sections 401 and 402 of the measure seek to clarify authority for VA to provide mental health services to families of veterans coping with readjustment issues. The bill would establish a ten-site pilot program for providing specialized transition assistance in Vet Centers to veterans and their families, and would authorize $3 million to be used for this purpose. The bill would require a number of reports on all these new authorities.

Current research highlights that OEF/OIF combat veterans are at higher risk for PTSD and other mental health problems, including substance use disorder, as a result of their military experiences. Mr. Chairman, like you, we are concerned that over the past decade VA has drastically reduced its substance abuse treatment and related rehabilitation services, and has made little progress in restoring them—even in the face of increased demand from veterans returning from these current conflicts. There are multiple indications that PTSD and readjustment issues, in conjunction with the misuse of substances will continue to be a significant problem for our newest generation of combat veterans and therefore; we need to adapt new programs and services to meet their unique needs. We are especially pleased with the provisions pertaining to mental health services for family members. The families of these veterans are suffering too and are the core support for veterans struggling to rehabilitate and overcome readjustment issues related to their military service. We hope at the same time previous generations of veterans and their families can also benefit from these newly proposed programs and services.

Although DAV has no approved resolution calling for a joint treatment program for PTSD and substance use disorders from our membership, we believe the overall goals of the bill are in accord with providing high quality, comprehensive health care services to sick and disabled veterans. Thus, with only two exceptions, stated below, we believe these are very timely provisions, and we fully support them.

It is our understanding that the National Center for PTSD is focused primarily on research in PTSD, while your intentions for these six new centers would focus them on direct clinical care, as regional referral specialty centers in the care of these co-morbid conditions. Should this bill be enacted, we hope that the seven fa-

cilities would work in tandem to advance both the clinical and research fields associated with PTSD and substance use disorders. An additional concern relates to Title II Section 201 of the bill—while we support the peer counseling concept we continue to have concerns about contracting with non-VA providers for specialized PTSD treatment. While we appreciate the Chairman's efforts to address unmet needs in underserved areas we refer you to the comments we provided on S. 38, the Veterans' Mental Health Outreach and Access Act of 2007. We would value the opportunity to work with the Committee staff to make further adjustments to the provisions in this section of the bill so that we can fully support this well-intended measure.

Mr. Chairman, again, DAV appreciates the opportunity to appear before you today and present our views these bills. I will be pleased to respond to any questions you or other Committee Members may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY JOY ILEM, ASSISTANT, NATIONAL LEGISLATIVE DIRECTOR OF THE DISABLED AMERICAN VETERANS TO THE COMMITTEE ON VETERANS' AFFAIRS

Question. During our hearing DAV expressed concern about section 201 of S. 2162, related to a proposed pilot program to develop peer support and outreach for OEF/OIF veterans living in rural areas and for readjustment counseling at community mental health centers and the Indian Health Service. You indicated in your statement that DAV is not opposed to contracting for mental health services when such services are not available from VA, and that VA already has sufficient authority to contract for care. You also expressed concern about maintaining the quality of care that would be provided by non-VA providers under this new authority. Our bill includes a provision to ensure VA would provide training to qualify contractors to address this challenge.

Given these provisions of the bill, why do you believe that quality of care would not be protected for these rural veterans?

Response. Mr. Chairman, we appreciate the opportunity to clarify our position on your bill. First and foremost, DAV believes that veterans deserve the highest quality health care available to them—whether provided by VA, purchased on a fee basis, or through contractors under VA auspices. Because of its long history in providing effective readjustment counseling services that are culturally sensitive to veterans and their unique military combat experiences, unquestionably VA is the optimum source for readjustment services for our newest veterans. However, when VA is not able to meet demand for services for legitimate reasons, it is clear that VA must use other options. As DAV testified, VA already has ample authority to provide services through fee basis and contract care programs. The question is how VA should provide that contract care.

There have been disturbing reports that some private mental health providers are not only insensitive to the veteran culture but have attempted to assign blame to veterans for having been a part of the military establishment, and thus are culpable for their own mental health problems induced by combat exposure during that service. The Committee bill would require that participating community mental health clinics (CMHC) and the Indian Health Service (IHS) receive VA provided culturally sensitive, relevant clinical training in order to deliver effective post deployment readjustment counseling and treatment for Post Traumatic Stress Disorder (PTSD); thus, we believe the Committee is acknowledging there may be deficits in the private mental health community and the IHS in treating veterans for military-related readjustment disorders.

As stated in our testimony, DAV wants to ensure that all veterans receiving care from VA or through its fee basis or contract programs are treated in accordance with VA's standards. In its 2001 report, "Crossing the Quality Chasm: A New Health Care System for the 21st Century," the Institute of Medicine (IOM) put forward six aims that now underpin the standard of care for U.S. providers. The IOM aims are that health care will be safe (avoiding errors and injury), effective (based on the best scientific knowledge), patient-centered (respectful of, and responsive to patient preferences, needs and values), timely (reduced waiting time and harmful delay), efficient (avoiding waste), and equitable (unvarying, based on race, ethnicity, gender, geography, or socioeconomic status). VA embraces the IOM aims and therefore should manage rural veterans' health care issues in a way that addresses all of the aims collectively.

DAV believes that while section 201 of S. 2162 would address timeliness and equity of mental health services, two important IOM aims, it would do so to the potential detriment of the others. In fact, without evidence that CMHCs have relevant capacity, it is questionable whether even the timeliness or access goals of this legis-

lation can be achieved. DAV understands that several years ago VA tried to explore a partnership with these clinics, but it appeared that most CMHCs had no excess capacity. In addition, it is unclear if these clinics would be able to provide the range of post-deployment mental health services that new veterans may require. Specifically, these veterans may need services for depression; stress and anxiety reactions, including PTSD; individual or group counseling; specialized intensive outpatient treatment for severe PTSD—including cognitive behavioral best practices; services for relationship problems (including marital and family counseling); psychopharmacology services; and, substance-use disorder interventions and treatment, including initial assessment and referral, brief intervention and/or motivational counseling, traditional outpatient counseling and intensive outpatient substance-use disorder care. DAV is not confident they will be able to rise to such a formidable challenge, given the small population that would be assigned to each CMHC and the amount of training and other resources that would be required to prepare them for this patient care workload.

VA holds itself out to veterans to be their health care system, a direct provider of care. DAV observes, like the Committee, that VA currently lacks an integrated approach to address the unique health care challenges of OEF/OIF veterans living in rural, remote and frontier areas. To remedy this gap, VA should identify an effective and creative approach to make health care—including mental health care—available to our newest generation of wartime veterans irrespective of their locations of residence. Many of these veterans have co-morbid physical and mental health conditions related to military service therefore; we want VA to address the veteran's needs in a holistic manner. Additionally, VA needs to develop performance measures and quality standards to assess the care that is provided through contract or fee-basis arrangements. VA should also be held accountable by Congress to provide a continuum of services for these veterans whether provided directly or through contracts.

DAV believes that reform in rural, remote and frontier VA care can be achieved with the same overarching principles that have accompanied the transformation of the Veterans Health Administration (VHA) over the past decade. Necessary actions to achieve this reform would include:

- Issuance of clear VHA policy that local facilities and Networks, through their mental health leadership, are responsible for creating a VHA-sponsored system that provides a stipulated array of services reasonably accessible to as many OEF/OIF veterans as possible who need these services.
- Provision of direct services wherever VHA has a large enough concentration of veterans needing such services, and has an existing VHA site of care. This would require VA to upgrade access to marital counseling and develop brief interventions for substance abuse—services that VHA does not make easily accessible in even some of its largest facilities.
- Contracting for care where there is not a large enough concentration of veterans needing readjustment counseling services, after local and Network leadership assess the availability and quality of alternative service providers (e.g. Vet Centers, State veterans services), including the availability and quality of services which could be purchased in the community, and assuring that a full array of services is made readily available.
- Oversight by Congress of this policy, with evidence that it is coordinated with the VHA Office of Mental Health Services and the newly established Office of Rural Health.

A critical aspect of health care quality is patient-centered care that is respectful of veterans' preferences, values and culture but is also holistic and provides care coordination. Coordination of the full range of services for every enrolled veteran should be a key characteristic of VA care. This will not occur unless VA remains integrally involved in the veterans overall health care.

Additionally, VA should make available to all its health care contractors gateways to VA's computerized patient record system (CPRS) so that they can provide clinical information on the care of patients assigned to them and so that they are aware of the veterans' entire medical history, diagnoses, and prescribed medications. VA must develop a strategic plan to achieve true continuity of care for its contract care patients.

Any organization that wants to partner or contract with VA in providing health services, including mental health services, should be willing to provide performance measurement data on each IOM quality aim and other requirements that VA may need to validate quality. They would need to develop the ability to collect, track and submit data on the technical quality process and outcome measures, patient satis-

faction, and wait times, as well as clinical data. This information should be collected and reported publicly on a quarterly basis.

Finally, Mr. Chairman, we appreciate the Committee's efforts in attempting to address this difficult issue, and this opportunity to further expand on our thoughts regarding mental health care options for rural, remote and frontier veterans. During your hearing on October 24th one Member suggested by his question that DAV and others would prefer veterans to remain unserved rather than having care provided by private contractors. To the contrary, DAV members—all service-disabled veterans—are the prime users of VA's fee-basis and contract health care programs. We want for our members, and for our newest generation of combat wounded veterans, the very best care VA can provide or obtain whether from another Federal agency or grantee, or from private providers through contracts. We believe our policy, and our thoughts expressed here, are consistent with that goal.

Chairman AKAKA. Thank you very much.

Ms. MURDOUGH?

STATEMENT OF BRENDA MURDOUGH, MSN, RN–C, MILITARY/ VETERANS INITIATIVE COORDINATOR, AMERICAN PAIN FOUNDATION

Ms. MURDOUGH. Good morning. My name is Brenda Murdough. Mr. Chairman, Ranking Member Burr, Members of the Committee on Veterans Affairs, I am here to provide testimony to support the Veterans Pain Care Act of 2007, S. 2160, on behalf of the American Pain Foundation and our Military/Veterans Pain Initiative.

I would like to thank Chairman Daniel Akaka and his dedicated staff for their leadership in introducing this important legislation.

I am the Coordinator of this initiative for the American Pain Foundation, and I am a certified nurse specialist in pain management. I am also a member of the American Society for Pain Management Nursing, having worked in the field of pain management for the last 7½ years.

I am also here on behalf of the more than one million families who have members currently serving or who have served in the Armed Forces on active duty or in the National Guard and Reserve. My husband retired from active duty in the Army after 23 years of active service. His father is a World War II veteran. We have had family members serve in almost every armed conflict in the United States back to the Revolution, with the most recent being our son, who served 15 months in the Army in Iraq, returning last December. He is still on active duty.

My sister's two daughters serve on active duty in the Army, with one currently serving in Afghanistan, the other scheduled for deployment to Iraq most likely in February with her husband of 4 months, who also serves. My oldest brother's son is also currently serving in the Army in Iraq. My brother served for 30 years on active duty and retired last year, after having served in the First Gulf War. My younger brother served in the Army in the early 1980's, and my husband's brother is on active duty in the Air Force. I could go on, but I think my point is clear.

Military service has been an important and influential part of my life and I care deeply for the members of the Armed Services and their families, particularly those who have suffered the horrors of battlefield injury. I am proud of their service and I am honored to know so many individuals personally.

But it is for all military personnel, active and retired, and all veterans from all armed conflicts that this important legislation for ef-

fective pain management must be enacted. The Veterans Pain Care Act of 2007 is designed to ensure improvement in pain care services, research, education, and training for the benefit of the veteran population. It is the least we can do for those who have given so much for the service of their country.

Founded in 1997, the American Pain Foundation is the Nation's leading independent nonprofit organization serving people with pain. Several years ago, with support from the Disabled American Veterans Charitable Service Trust, APF began reaching out to veterans with pain. The goal of APF's Military/Veterans Pain Initiative is to improve the quality of life of military veterans who suffer from pain by collaboratively working with other organizations to provide resources, information, and support to veterans with pain, their loved ones and caregivers, and to advocate for quality acute chronic pain care and increased research.

I know firsthand the importance of early and effective pain management in acute pain care to prevent the development of chronic painful conditions. Newsweek recently had an article highlighting this. Our men and women serving in Iraq and Afghanistan are surviving battlefield injuries that previously would have been fatal, thanks to improvements in battlefield medicine and evacuation. The most recent complete study of soldiers enrolled in VA polytrauma centers show that more than 90 percent have chronic pain. Most have pain from more than one part of the body, and that pain is the most common symptom in returning soldiers.

Advances in neuroscience, such as neuroimaging, now demonstrate that unrelieved pain, regardless of its initial cause, can be an aggressive disease that damages the nervous system, causing permanent pathological changes in sensory neurons and in the tissues of the spinal cord and brain. We need to be sure these painful shrapnel wounds, traumatic amputations, closed head traumas, and other battlefield injuries are receiving the most immediate and effective pain management at the time of acute injury to prevent chronic painful conditions from developing, and we need to make sure that all veterans that have developed chronic pain are receiving proper comprehensive, multi-modal pain care.

Perhaps more than any other Federal agency, the VA has been a leader in focusing institutional resources on the assessment and treatment of pain. The Veterans Health Administration has made pain management a national priority. However, although many of our military and veterans' treatment facilities offer the highest level of skilled expertise in treating these painful conditions suffered by our wounded Armed Servicemen and women, we need to ensure that all of our veterans' facilities are consistently providing the highest level of comprehensive pain management to prevent long-term suffering and disability.

We know the high multi-dimensional costs of untreated or undertreated pain on individuals and on families. Chronic pain conditions, such as those that can come from Traumatic Brain Injury, multiple fractures, traumatic amputation, crush injuries, and other battlefield injuries can be devastating to individuals and their families as they try to cope with the impact physically, mentally, socially, psychologically, and economically.

Pain can be acute and effectively treated by short-term interventions, or it can be chronic, often without effective cures, and sometimes without consistent and effective means of alleviation. Chronic pain symptoms and Post-Traumatic Stress Disorder frequently co-occur and may intensify individuals' experience of both conditions. Those who suffer severe chronic pain see their daily lives disrupted, sometimes forever. Their pain and their constant search for relief affects their function, their relationships, and those they love, their ability to do their work effectively, and often their self-esteem. Chronic pain is often accompanied by or leads to sleep disorders, emotional distress, anxiety, depression, and even suicide. We need to provide our Armed Servicemen and women with the resources necessary to provide effective pain relief within the Veterans Administration Health Care System.

The APF has recently developed "Treatment Options: A Guide for Living With Pain" for people living with pain, written and reviewed by leading pain specialists. Our guide provides credible, comprehensive information about many options for care. Pain is complex and unique to each individual and is usually best managed by a combination of treatments, such as medication, psychological assistance, physical rehabilitation, injection infusion therapies, implanted devices, such as spinal cord stimulators, or continuous infusion catheters and complementary alternative medicines.

I recently had the privilege and honor of meeting and speaking with soldiers at Walter Reed Medical Center on the regional anesthesia acute pain care team rounds and words cannot do justice to the courage and determination I witnessed. All were amputees. All were injured in the conflicts in Iraq and Afghanistan. And all will be veterans with painful, lifelong consequences of their battlefield injuries. They fought for others. Now it is our time to fight for them. They deserve freedom from pain.

With this in mind, I ask you to pass the Veterans Pain Care Act of 2007, S. 2160, so that all——

Chairman AKAKA. Ms. Murdough, will you please summarize your statement?

Ms. MURDOUGH. Thank you. All veterans, all of our men and women who have served, past, present, and future, who have suffered wounds of battle deserve consistent, high-quality pain management, deserve freedom from pain, and it is our obligation to provide it to them. It is the least we can do.

Thank you. I apologize.

[The prepared statement of Ms. Murdough follows:]

PREPARED STATEMENT OF BRENDA MURDOUGH, MSN RN–C, MILITARY/VETERANS INITIATIVE COORDINATOR, AMERICAN PAIN FOUNDATION

Mr. Chairman and Members of the Committee on Veteran's Affairs, my name is Brenda Murdough, MSN RN–C. I am here to provide testimony to support the Veterans Pain Care Act of 2007, on behalf of the American Pain Foundation and our Military/Veterans Pain Initiative. I am the Coordinator of this Initiative for the American Pain Foundation and I am a certified nurse specialist in pain management. I am also a member of the American Society for Pain Management Nursing, having worked in the field of pain management for the last seven and a half years.

I am also here on behalf of the more than one million families who have members currently serving or who have served in the armed forces on active duty or in the National Guard and Reserve. My husband retired from active duty in the Army after 23 years of service. His father is a WWII veteran. We have had family members serve in almost every armed conflict in the United States back to the Revolu-

tion, with the most recent being our son, who served 15 months in the Army in Iraq, returning last December. He is still on active duty. My sister's two daughters serve on active duty in the Army with one currently in Afghanistan and the other scheduled for deployment to Iraq most likely in February with her husband of 4 months, who also serves. My oldest brother's son is also currently serving in the Army in Iraq. My brother served for 30 years on active duty and retired last year after having served in the first Gulf War. My younger brother served in the Army in the early 80's and my husbands' brother is on active duty in the Air Force. I could go on, but I think my point is clear. Military service has been an important and influential part of my life and I care deeply for the members of our armed services and their families, particularly those who have suffered the horrors of battlefield injury. I am proud of their service and honored to know so many individuals personally. But it is for all military personnel, active and retired, and all veterans from all armed conflicts that this important legislation for effective pain management must be enacted. The Veterans Pain Care Act of 2007 is designed to ensure improvement in pain care services, research, education, and training for the benefit of the veteran population. It's the least we can do for those who have given so much in the service of their country.

Founded in 1997, the American Pain Foundation (APF) is the Nation's leading independent nonprofit organization serving people with pain. Three years ago, with support from the Disabled American Veterans Charitable Service Trust, APF began reaching out to veterans with pain. The goal of APF's Military/Veterans Pain Initiative is to improve the quality of life of military/veterans who suffer from pain by collaboratively working with other organizations to provide resources, information and support to veterans with pain, their loved ones and caregivers; and to advocate for quality acute and chronic pain care and increased research.

I know first hand the importance of early and effective pain management in acute pain care to prevent the development of chronic pain conditions. Our men and women serving in Iraq and Afghanistan are surviving battlefield injuries that previously would have been fatal, thanks to improvements in battlefield medicine and evacuation. The most recent complete study of soldiers enrolled in VA Polytrauma Centers show that more than 90 percent have chronic pain, that most have pain from more than one part of the body, and that pain is the most common symptom in returning soldiers. Advances in neuroscience, such as neuroimaging, now demonstrate that unrelieved pain, regardless of its initial cause, can be an aggressive disease that damages the nervous system, causing permanent pathological changes in sensory neurons and in the tissues of the spinal cord and brain. We need to be sure that these painful shrapnel wounds, traumatic amputations, closed head traumas and other battlefield injuries are receiving the most immediate and effective pain management at the time of acute injury to prevent *chronic* painful conditions from developing. And we need to make sure that all veterans that have developed chronic pain are receiving proper, comprehensive, multi-modal pain care.

Perhaps more than any other Federal agency, the VA has been a leader in focusing institutional resources on the assessment and treatment of pain. The Veterans Health Administration has made pain management a national priority. However, although many of our military and veterans treatment facilities offer the highest level of skill and expertise in treating these painful conditions suffered by our wounded armed service men and women, we need to ensure that all of our veterans' facilities are consistently providing the highest level of effective, comprehensive pain management to prevent long term suffering and disability.

We also know the high, multidimensional costs of untreated or under treated pain on individuals and their families. Chronic pain conditions such as those that can come from Traumatic Brain Injury, multiple fractures, traumatic amputation, crush injuries and other battlefield injuries can be devastating to individuals and their families as they try to cope with the impact physically, mentally, socially, psychologically and economically. Pain can be acute and effectively treated by short term interventions, or it can be chronic, often without effective "cures" and sometimes without consistent and effective means of alleviation. Chronic pain symptoms and Post Traumatic Stress Disorder frequently co-occur and may intensify an individual's experience of both conditions. Those who suffer severe chronic pain see their daily lives disrupted—sometimes forever. Their pain and their constant search for relief affects their function, their relationships with those they love, their ability to do their work effectively, and often their self esteem. Chronic pain is often accompanied by or leads to sleep disorders, emotional distress, anxiety, depression, and even suicide. We need to provide our armed service men and women with the resources necessary to provide effective pain relief within the Veterans Administration Health Care system.

The APF has recently developed *Treatment Options: A Guide for People Living with Pain.* Written and reviewed by leading pain specialists, our guide provides credible, comprehensive information about many options for care. Pain is complex and unique to each individual and is usually best managed using a combination of treatments such as medication, psychological assistance, physical rehabilitation, injection and infusion therapies, implantable devices such as spinal cord stimulators or continuous infusion catheters, and complementary and alternative medicine.

I recently had the privilege and honor of meeting and speaking with soldiers at Walter Reed Medical Center on the Regional Anesthesia Acute Pain Care team rounds and words cannot do justice to the courage and determination I witnessed. All were amputees, all were injured in the conflicts in Iraq and Afghanistan and all will be veterans with painful, lifelong consequences of their battlefield injuries. They fought for others rights and now it's our time to fight for theirs. Freedom from pain is their right.

It is with this in mind that I ask you to pass the Veterans Pain Care Act of 2007. This bill requires that all facilities within the Department of Veterans Affairs are held accountable for the adequacy and consistency of pain treatment across programs and geographic regions; that pain assessment, diagnosis and treatment be prompt and integral to veterans health care; and that the VA increase its research into the areas of acute and chronic pain. Our veterans, all of our men and women who have served, past, present and future, who have suffered the wounds of battle, have earned the right to consistent high quality pain management—have earned the right to freedom from pain—and it is our obligation to them to provide it. It is the least we can do.

Additional information is available at American Pain Foundation, 201 N. Charles Street, Suite 710 Baltimore, MD 21201–4111 P: 410–783–7292 *www.painfoundation.org*

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO BRENDA MURDOUGH, MSN, RN–C, MILITARY/VETERANS INITIATIVE COORDINATOR, AMERICAN PAIN FOUNDATION

1. In your testimony, you raised concerns over the implementation of VA's pain management program, in that it has not been consistent across the entire system. Can you comment further on this, and discuss the areas most urgently in need of improvement?

There are VA facilities that have excellent pain care programs—an example is the Tampa Florida center, which was recently highlighted in the news. Unfortunately, this high quality, multidiscipline, comprehensive approach to pain management is not available to those who must travel long distances, only to find that the person treating them has had no training in Pain Management, is not educated in prescribing the medications necessary to manage pain effectively, or that the resources necessary are not available in the area. Consequently, the areas most urgently in need of attention are ensuring available, consistent, high quality, multimodal pain care treatment and an increase in individuals who are appropriately educated and trained in the specialty of Pain Management. We hear from Veterans often about the disparity of Pain Management across the VA system.

2. As you have testified, pain is complex and unique to each individual. How can VA most effectively prioritize their research to address the array of acute and chronic pain conditions veterans face? How much focus should there be upon treatment versus other priorities?

Research opportunities should focus on two main categories: improved acute pain management either in the battlefield or at the time of injury to prevent the possible development of chronic pain conditions, and the improvement in treatment options for chronic pain conditions, including the pain specific to Traumatic Brain Injury, traumatic amputation, shrapnel wounds, and other concussive injuries which may have long term pain associated with them. Research should focus on the most effective means of decreasing pain and improving quality of life, including the most effective multi modal approaches for accomplishing these goals. Research should also explore the high co-prevalence of psychiatric disorders (such as PTSD and depression) with pain.

Chairman AKAKA. Thank you.

Dr. SMITH?

STATEMENT OF BRIEN J. SMITH, M.D., MEDICAL DIRECTOR, COMPREHENSIVE EPILEPSY PROGRAM, HENRY FORD HOSPITAL

Dr. SMITH. Mr. Chairman and distinguished Members of the Committee, thank you very much for the opportunity to be here today. My name is Brien Smith and I am the Medical Director of the Comprehensive Epilepsy Program at Henry Ford Hospital in Detroit, Michigan. I am pleased to speak today in support of S. 2004, the VA Epilepsy Centers of Excellence Act of 2007.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. The seizure happens when a brief strong surge of electrical activity affects part or all of the brain. When a person has two or more seizures, the condition is then considered epilepsy. Epilepsy affects 1 percent of the U.S. population, or three million people.

One of my first experiences with Post-Traumatic Epilepsy as a clinician is when I met George Bussell in 1994. Mr. Bussell's Traumatic Brain Injury occurred in 1944 while he served as a combat engineer during World War II and he was taking up a mine field between France and Germany. A fragment from a shell struck him in the frontal region, blowing off his helmet and leading to hospitalization. He seemed to recover fully, but subsequently developed seizures 16 years later arising from the area of injury. Despite multiple attempts to control his seizures, his life was dramatically altered by daily seizures until he was presented to my clinic in 1994, 34 years later, for surgical evaluation. Fortunately, we were able to help him with surgery and he gained a new sense of independence for the last 10 years of his life.

Mr. Bussell is one of many similar stories. We know that trauma to the brain, whether mild or severe, is clearly a defined risk factor for epilepsy. Studies from the Vietnam War and from the Iran-Iraq War show that 32 to 50 percent or more of service-related TBI victims develop epilepsy within 1 to 15 years Post-Trauma. Let me clarify that this statistic is for penetrating injuries which occur when a foreign object or piece of fractured skull enters the brain.

Today's story is a bit different. The common head trauma in Iraq is the result of the shockwave effect of high pressure that reverberates through the body and head from an explosion like those from an improvised explosive device, or IED. Researchers fear that incidence of Post-Traumatic Epilepsy could increase exponentially given this mechanism of injury.

The 2003 data from Walter Reed Army Medical Center found evidence of brain injury in 61 percent of returning soldiers who had been exposed to IED blasts according to the Defense and Veterans Brain Injury Center, a partnership between the VA and Department of Defense. It is because of such alarming statistics that the Epilepsy Foundation and epileptologists like me believe that S. 2004 is critically needed.

We have to make sure that VA is prepared for the influx of Post-Traumatic Epilepsy. In essence, that is what S. 2004 is all about. The VA currently lacks a national program for epilepsy with clear guidelines on when to refer patients for further assessment and treatment of epilepsy. What the VA does have is a great model. Centers of Excellence have been developed over the years to ad-

dress other disabling and chronic diseases in the veteran population such as Parkinson's disease and multiple sclerosis. Through such Centers of Excellence, the VA has been able to address many of the other common consequences of TBI, such as psychological changes and vision problems, but not Post-Traumatic Epilepsy.

The VA did establish epilepsy centers in the 1970's, but they have languished with few staff and no national budget, leaving veterans with Post-Traumatic Epilepsy, like Mr. Bussell, at the mercy of an inadequate system. Many veterans are denied services in locations without the necessary epilepsy facilities and the centers are not linked together. Sadly, the potential of these centers to be the backbone of a national epilepsy program never materialized.

The new centers created by S. 2004 would be linked with prestigious medical schools and research centers, thus attracting outstanding clinicians and scientists capable of driving innovation in the prevention and treatment of Post-Traumatic Epilepsy. A highlight of this legislation is that it contains a telemedicine component whereby the review of neurologic diagnostic tests, such as EEGs and MRIs, will be able to take place through transmission of the tests from the veteran's local care facility to one of the six centers. Thus, the centers would provide a nationwide monitoring program to improve the quality of life for veterans who live in rural areas that are far from a center.

Mr. Chairman, I strongly believe that we must strike while the iron is hot. As a Nation, we became more aware of TBI as a consequence of war when news anchor Bob Woodruff shared his personal story with the Nation. But while we now have people understanding that TBI is occurring at high rates, most people do not understand the high probability of epilepsy as a consequence of TBI or that epilepsy may manifest many years later.

Congress has the opportunity right now to make a difference for our veterans and for their future. Without proper diagnosis and care, their lives and livelihoods are affected forever. By enacting S. 2004, we will be finally putting into place a national network of centers to address the effects of TBI and epilepsy for the war heroes of today who will be citizens living in your towns tomorrow.

Thank you for this opportunity today.

[The prepared statement of Dr. Smith follows:]

PREPARED STATEMENT OF BRIEN J. SMITH, MD, MEDICAL DIRECTOR, COMPREHENSIVE EPILEPSY PROGRAM HENRY FORD HOSPITAL

Mr. Chairman and Distinguished Members of the Committee:

Thank you very much for the opportunity to be here today. My name is Brien Smith and I am Medical Director of the Comprehensive Epilepsy Program at the Henry Ford Hospital in Detroit, Michigan. I am pleased to speak in support of S. 2004, the VA Epilepsy Centers of Excellence Act of 2007 and to share with you some thoughts about why these Centers are critically needed.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. A seizure happens when a brief, strong surge of electrical activity affects part or all of the brain. When a person has two or more seizures the condition is then considered epilepsy. Epilepsy affects about 1 percent of the U.S. population or 3 million people.

Nearly half a million people are involved in some kind of accidental brain injury each year—typically through a car accident or a fall—and 80,000 of them require hospitalization due to moderate or severe Traumatic Brain Injury. Mortality and morbidity as a consequence of TBI are a major public health problem and Post-

Traumatic Epilepsy is linked to psychosocial disability and is probably a contributing factor to premature death after penetrating head injury.

One of my first experiences with Post-Traumatic Epilepsy as a clinician is when I met George Bussell in 1994. Mr. Bussell's Traumatic Brain Injury occurred in 1944 when he served as a combat engineer during World War II and he was taking up a mine field between France and Germany. A fragment from a shell struck him in the frontal region blowing off his helmet and leading to hospitalization. He seemed to recover fully, but subsequently developed seizures 16 years later arising from the area of injury. His wife recalls witnessing the first event with him screaming out, becoming confused, strange movements of his arms and legs, clicking of his tongue and undressing himself. Despite multiple attempts to control his seizures his life was altered by these recurrent, almost daily events until he presented to our clinic in 1994 for surgical evaluation. With good fortune, surgical intervention at age 69 provided him with a new sense of independence for the last 10 years of his life.

Mr. Bussell is one of many similar stories. We know that the risk for our service men and women is very real—even if we cannot predict the exact number of soldiers who will be harmed, we know that trauma to the brain, whether mild or severe, is a clearly defined risk factor for epilepsy. Past studies from the Vietnam War referenced in my written testimony, show that more than 50 percent of service related TBI becomes epilepsy within 1–15 years Post Trauma. This statistic is for penetrating injuries which occur when a foreign object or piece of fractured skull enters the brain. Another study conducted between 1980 and 1988 in Iran looking at soldiers in the Iran-Iraq war showed 32 percent of penetrating head injury TBI became epilepsy within 6 months to 2 years.

Today's story is a bit different. The common head trauma in Iraq is the result of a "shock wave' effect of high pressure that reverberates through the body and head from an explosion like those from the Improvised Explosive Devices or IEDs. Researchers fear that incidence of Post-Traumatic Epilepsy could increase exponentially given the shock wave effect from IEDs.

2003 data from Walter Reed Army Medical Center found evidence of brain injury in 61 percent of returning soldiers who had been exposed to blasts according to the Defense and Veterans Brain Injury Center (DVBIC), a partnership between the VA and Department of Defense. It is because of such alarming statistics that the Epilepsy Foundation and epileptologists like me believe that S. 2004 is critically needed.

The legislation has three major goals:

1. (re)Establish 6 Centers to specialize in Post Traumatic Epilepsy and make them part of a national network of Centers that can serve veterans;
2. Conduct research that will lead to an ability to prevent epilepsy as an outcome of TBI as well as research for better seizure control and an eventual cure for all epilepsy;
3. Allow veterans living in rural communities or far from VA hospitals access to the care they need.

Given the high rate of Post-Traumatic Epilepsy that veterans with TBI are likely to endure, the Epilepsy Foundation and the American Academy of Neurology believes that Congress should take a strong role in veterans' health care by authorizing this bill that would direct the VA to establish a strong national epilepsy program with research, education, and clinical centers that will provide state-of-the-art care for our brave soldiers.

As this Committee heard in May from Dr. John Booss, a former national director of neurology for the VA, the VA lacks a national program for epilepsy with clear guidelines on when to refer patients for further assessment and treatment of epilepsy. VA Centers of Excellence have been the model of innovation in the delivery of highly specialized health care and research for other disabling and chronic diseases in the veteran population such as Parkinson's disease and Multiple Sclerosis. The VA has the infrastructure to address many of the other common consequences of TBI such as psychosocial changes and vision problems but not Post-Traumatic Epilepsy.

The VA established Epilepsy Centers as early as 1972, but these Centers have languished over the years with few staff and no national budget. The net result of allowing these Centers to fall by the wayside is that veterans with post TBI epilepsy are at the variable mercy of a system with markedly uneven distribution of epilepsy services. This often results in denial of services in locations without the necessary epilepsy facilities and in which administrators are hard pressed to meet their budget. Sadly, the potential of these Centers to be the backbone of a national epilepsy program never materialized.

Under this bill, the VA would designate six new Centers that would be linked with prestigious medical schools and research centers thus attracting outstanding clinicians and scientists capable of driving innovation in the prevention and treatment of Post-Traumatic Epilepsy. State-of-the-art care is what our veterans deserve. Research is the key to discovering ways to better predict when TBI victims will develop epilepsy.

To date, research has been focused primarily on the seizures themselves and what drugs might control or eliminate them. My colleague Marc Dichter, M.D., Ph.D. professor of neurology and pharmacology at the University of Pennsylvania says, "We basically wait for epilepsy to happen and then see if we can treat it, which is in stark contrast to how we tackle other public health problems such as cancer or heart disease where we identify risk factors and try to prevent disease from occurring."

Another grave concern we have is that many returning veterans live in rural areas or far from a VA Center. S. 2004 contains a component on telemedicine whereby the review of neurological diagnostic tests such as EEG's and MRI's will be able to take place through transmission of such tests from the veteran's local care facility to one of the 6 ECoEs. Thus, the ECoEs would provide a nationwide monitoring program to improve the quality of life for veterans with Post-Traumatic Epilepsy who live in rural areas.

Mr. Chairman, I strongly believe that we must strike while the iron is hot. As a Nation we became more aware of TBI as a consequence of war when news anchor Bob Woodruff shared his story of experiencing TBI with the Nation. But while we now have people understanding that TBI is occurring at high rates, most people do not understand the high probability of epilepsy as a consequence of the TBI or that the epilepsy may manifest many years later. Congress has the opportunity right now to make a difference for our veterans and for their future. Without proper diagnosis and care, their lives and livelihoods are affected forever. By enacting the VA Epilepsy Centers of Excellence Act of 2007, we will be putting into place a national network of Centers to address the affects of TBI and epilepsy for the war heroes of today who will be the citizens living in your towns tomorrow.

Thank you for this opportunity today.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DR. BRIEN SMITH, M.D., MEDICAL DIRECTOR, COMPREHENSIVE EPILEPSY PROGRAM, HENRY FORD HOSPITAL

1. Your prepared testimony noted that epilepsy is unlike most other medical conditions, in that despite known risk factors, a wait-and-see approach is used in lieu of aggressive preventive care. Recognizing that there is a large population of veterans who may be at risk for developing epilepsy, what types of preventive practices can be implemented?

Presently, there are no preventive practices from a medical perspective available. Aggressive preventative care would be ideal, if there was any data to suggest what that is. Completing controlled trials on acute Traumatic Brain Injury is very difficult and costly in the civilian population. Unfortunately, combat arenas, like Iraq, is one of the few scenarios where research trials could be performed to identify potentially profitable treatments.

A number of compounds have been tested either in animal models and a few in human civilian studies which were hoped to demonstrate neuroprotective or antiepileptogenic properties without disturbing the normal features of the healing process. No agents have been identified thus far which demonstrate positive results. In fact, a recently published study on the use of magnesium in humans with head trauma appeared to actually have a negative effect versus placebo, after animal studies had suggested potential neuroprotective properties.

Attempts are being made to optimize the care in the acute Post-Traumatic Period (first 2 weeks), but there has been no data to suggest that this has had any significant impact in reducing the subsequent development of epilepsy.

2. What role would the creation of epilepsy centers of excellence play in the development of preventative medicine and the early diagnosis of epilepsy?

Epilepsy Centers of Excellence would serve as a model to develop patient care practices designed to assist in recognizing the development of Post-Traumatic Epilepsy and rapidly initiate evaluation and treatment. All soldiers with a history of head trauma, and at risk for the development of epilepsy, would undergo baseline testing including EEG, MRI, and Neuropsychological testing. Vigilant outpatient monitoring followed by scheduled testing with a prolonged follow-up period would provide significant data to identify soldiers at highest risk to develop the condition and enable reduction of secondary morbidity from unrecognized seizures.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO DR. BRIEN SMITH, MEDICAL DIRECTOR, COMPREHENSIVE EPILEPSY PROGRAM, HENRY FORD HOSPITAL

Dr. Smith, in your testimony you spoke about a former patient, Mr. Bussell. He was injured in WWII, and began having seizures 16 years later, and yet he didn't enter your clinic and get proper care to treat his seizures until 1994.

Can you please share with us where he was in the interim and whether he sought medical care from the VA?

Mr. Bussell did seek care from the VA shortly after the onset of his seizures in 1960. He was informed that the seizures were unrelated to his previous head trauma, and that his problem was a separate issue. Due to the limited options offered to him, Mrs. Bussell felt she was running into a "dead end" with the VA and therefore pursued evaluations at outside centers. Mr. Bussell was evaluated at the University of Michigan for epilepsy surgery, but since he was considered a complicated extratemporal case, the surgical option was not offered, and he was entered into a number of experimental drug trials. After those attempts failed, he was subsequently seen in my clinic at Henry Ford Hospital where the surgical treatment option was offered.

Do you think veterans of this generation will meet the same fate as Mr. Bussell if we fail to develop a national program for epilepsy care?

Yes. The VA system is presently ill-prepared to handle the numbers of returning soldiers who are at risk of developing Post-Traumatic Epilepsy. Not only do they have only a limited number of centers that have the equipment to manage these patients, the specialty personnel to complete these evaluations, and provide cutting edge treatment is lacking. The VA has a very limited perspective on the problem of Post-Traumatic Epilepsy. When you review their 180 page Traumatic Brain Injury manual, there is only one-half of a page that addresses epilepsy, and none of the listed authors are considered epilepsy specialists.

Chairman AKAKA. Thank you very much, Doctor.

Captain WALKER?

STATEMENT OF CAPT. CONSTANCE A. WALKER, USN (RET.), NATIONAL ALLIANCE ON MENTAL ILLNESS MEMBER, NAMI VETERANS COUNCIL; PRESIDENT, NAMI SOUTHERN MARYLAND

Capt. WALKER. Good morning, Chairman Akaka and Members of the Committee. My name is Connie Walker. Thank you for your invitation to provide testimony as you consider this very important legislation related to mental health programs in the Department of Veterans Affairs.

This is a particularly important session for me, not only as a veteran and as a member of the National Alliance on Mental Illness, but as the parent of an Operation Iraqi Freedom 100 percent disabled veteran. Having said that, sir, I would ask the Committee's indulgence for two additional minutes, if I may.

My son asked if he could come today, but I said no. Mike is six-foot-seven and very handsome and I was afraid that people would pay more attention to him than to what I have to say.

He enlisted in the Army as a motor transport operator in June 2001, Associate's Degree in hand, basketball trophies and varsity letters in the attic, and more impressed by a chance to see the world and a very large enlistment bonus than by the idea of two more years of college. He had a good service in the Army and particularly enjoyed his deployment to Germany.

In January 2003, his unit deployed to Northern Kuwait in support of the first phase of the war and our advance into Baghdad. They returned about 7 months later. I was deeply concerned with what I saw on that homecoming weekend. He would wake up screaming and was very subdued. The Army assured me he would be seen by a counselor at Fort Eustis, but in the coming months, his physical and mental decline became even more apparent.

In December 2003, at my insistence, after an aborted attempt by the Army to administratively separate him, my son received a full physical and mental evaluation. In January 2004, Michael was diagnosed with PTSD, major depression, and schizophrenia. He was hospitalized, and later that year medically retired. Today, he lives with my husband and I in rural Southern Maryland. After using every resource available to us where we live and coordinating with the VA whenever we can, we are encouraging him to accept residential mental health care at the VA Medical Center in Perry Point, Maryland. The issue is not that my son cannot be helped. The issue is one of availability and quality of care where we live.

I have been and remain my son's primary advocate and have worked with military, VA, and civilian mental health care, insurance, and disability benefits systems. Navigating these waters is always a difficult job. At times, it is debilitating, even to someone with my skill sets: a 20-year career in recruitment, accession, retention, and retiree policy and program management; strong supporters within the VA, TRICARE, and other Federal and State agencies; and access to a local resource network that spans three Maryland counties. My experiences, my advocacy on behalf of OIF and OEF veterans and families in St. Mary's County and other parts of Maryland, North Carolina, Georgia, and California's rural areas, and connections to veteran advocates across the country have led me to this conclusion.

Mr. Chairman, it is impossible to overstate the stressors that rural and frontier family caregivers are bearing on a daily basis as they search for limited treatment and rehabilitative services, and work to support a loved one whose cognitive abilities have been severely and sometimes permanently impaired by the invisible injuries of PTSD, other mental health issues, or the aftermath of Traumatic Brain Injury.

From a mental health care perspective, a single bottom line looms over everything in mental health treatment and rehabilitation for our veterans in rural areas. The likelihood of obtaining effective services is slim to none for those who live beyond a reasonable commute from a VA medical center or do not have access to an appropriately and consistently staffed VA Community-Based Outpatient Clinic.

This is a painful realization for families of these veterans, especially in light of this truth about recovery: Early intervention and regular access to treatment and rehabilitation services are as vital to a disabled veteran's recovery from serious mental illness as they are to a physically injured veteran's recovery from serious physical injury.

Mr. Chairman, you asked me to limit my remarks to your mental health bill, S. 2162, the Mental Health Care Improvements Act. My formal statement submitted earlier this week also discusses the other legislation under your consideration. Your proposed mental health bill would establish new requirements in the VA for the treatment of PTSD and substance use disorder, with special procedures to address the treatment of veterans who suffer from co-occurring disorders. VA emphasis on concurrent treatment for veterans who have PTSD or other mental illness and are self-medicating with alcohol or drugs would be a welcome step forward in these veterans' journey to recovery.

That said, for OIF and OEF veterans who need these services in rural areas, I think the only practical avenue for VA care for this core of veterans would be through the CBOCs. The Substance Abuse and Mental Health Services Administration reports that rural substance abuse is a large and growing problem in America with insufficient resources in place to meet that challenge. So to reach rural veterans, rural CBOCs would need to be fully and consistently staffed, not staffed by rotating mental health professionals among multiple sites, in order to offer consistent treatment capabilities when these veterans need them—not on the day of the week that the physician happens to be there. I am afraid that even under these circumstances, veterans in need of mental health treatment who are self-medicating in our frontier areas are likely to be beyond reach.

To continue, the legislation would require a VA review of its residential mental health care facilities, including the domiciliaries. The deliverable would be a report on availability and quality of care at these sites for this Committee and the House Committee on Veterans Affairs. Mr. Chairman, this is an extremely important assessment of VA residential and long-term mental health care facilities and it cannot wait.

I was an Inspector General in my last Navy assignment. A legislative mandate is not necessary to initiate a fact-finding review of this nature. There are inspection and audit agencies that can be tasked to take this for action right now, for example, the VA's Office of Inspector General or the GAO.

Mr. Chairman, your legislation would require the VA to establish a pilot program in two VA networks for peer outreach and support, readjustment counseling, and other mental health services for OIF and OEF veterans in partnership with community mental health services and the Indian Health Service. Sir, this aspect of your legislation discusses a vital need for families like mine in rural America: increased access to mental health care programs and rehabilitation services for veterans who are coming home to places where VA resources are very limited or do not exist.

There are several issues of concern, not with your legislation's correct and critically important intent, but with the assumption of

a capability of existing rural resources to achieve that goal, VA training notwithstanding. The overarching challenge is a national issue. There are too few mental health care specialists, programs, and services in rural areas to meet the needs of the existing population. Sixty percent of rural Americans live in federally designated mental health professional shortage areas. Sixty-five percent get their mental health care from their primary care doctor. In Southern Maryland, where I live, individuals seeking psychiatric care can wait up to 4 months for their first appointment.

Related concerns go to community mental health centers, where programs are funded primarily through grants from the Department of Health and Human Services. There are very few centers in rural areas, and sustained mental health workforce shortages have reached crisis levels in many areas of this country. Clinics most often operate at capacity, and many of their clients have lived with chronic mental illness for years.

My son received services through our county's only community-based residential treatment program after his return to Southern Maryland. Mike has had an independent full life and although he wanted to come home, certainly, after his medical retirement—coming home to live with Mom was not something he was excited about doing...would it be for any young man or woman? We arranged for residential treatment at the only agency available and found the gap between slick marketing and reality to be more than disillusioning.

We know that 56% of OIF and OEF veterans utilizing VA health care are under 29 years old, just like my son. This demographic, these veterans' distinct psychiatric treatment and rehabilitation needs, and what they want and we all hope for, for their futures—will make the requirement for VA training of community mental health center clinicians, at a minimum, even more important.

Mr. Chairman, if this legislation will increase mental health staffing and resources in rural areas, then it can ensure access to care for OIF and OEF veterans who need it and it must be supported. My fear is that the current state of our country's rural mental health infrastructure will keep it from achieving its intent and more precious time will be lost, and that clock is ticking.

Mr. Chairman, Senior Ranking Member Burr, like you, I believe the solution is achievable and that a collaboration of care is what it will take. Local mental and physical health care providers must receive some VA training in mental and physical health issues for this generation of combat veterans so they know what to look for. A continuum of partnered care that keeps an assigned VA case manager informed on a regular basis, an approach that will take input from family caregivers into account and give them some training——

Chairman AKAKA. Captain Walker, will you please summarize your statement?

Capt. WALKER. Sure. VA and Health and Human Services must actively partner and perhaps even combine resources for a treatment venue in rural areas that works for this population of veterans and their families. It cannot be business as usual, and in rural areas, right now, it is definitely business as usual.

Thank you for considering my views on this legislation, sir.

[The prepared statement of Capt. Walker follows:]

PREPARED STATEMENT OF CONSTANCE A. WALKER, CAPT, USN (RET.) NATIONAL ALLIANCE ON MENTAL ILLNESS MEMBER, VETERANS' COUNCIL, PRESIDENT, NAMI SOUTHERN MARYLAND

Chairman Akaka and Members of the Committee—

As a member of the Veterans Council of the National Alliance on Mental Illness (NAMI), I appreciate your invitation to provide testimony for your consideration of several legislative proposals related to mental health programs in the Department of Veterans Affairs (VA). On behalf of NAMI's Executive Director, Mr. Michael Fitzpatrick, and our Veterans Council Chairman, Ms. Sally Miller, of Bozeman, Montana, please accept our thanks for this opportunity to speak with you today.

NAMI is the Nation's largest non-profit organization representing and advocating on behalf of persons living with chronic mental health challenges. Through our 1,200 chapters and affiliates in all 50 states, NAMI supports education, outreach, advocacy and biomedical research on behalf of persons with schizophrenia, bipolar disorder, major depression, severe anxiety disorders, Post-Traumatic Stress Disorder (PTSD), and other chronic mental illnesses that affect children and adults.

NAMI and its Veteran Members established the Veterans Council in 2004 to assure close attention is paid to mental health issues in the VA and within each Veterans Integrated Service Network (VISN). We advocate for an improved VA continuum of care for veterans with severe mental illness. The council includes members from each of VA's 21 VISNs. These members serve as NAMI liaisons with their VISNs; provide outreach to national Veterans Service Organizations; increase Congressional awareness of the special circumstances and challenges of serious mental illness in the veteran population; and work closely with NAMI State and affiliate offices on issues affecting veterans and their families. Council membership includes veterans who live with serious mental illness, family members of this population of veterans, and NAMI supporters with an involvement and interest in the issues that affect veterans living with mental illness. The Council's monthly meetings are conducted via teleconference and often feature guest speakers who provide updates on developments in treatment, research, program initiatives, and service delivery for veterans, active duty servicemembers, and family members with serious mental illness. We also use these opportunities to stay current on developments in Congress and the Executive Branch that have the potential to affect mental healthcare for veterans.

Mr. Chairman, as you indicated in my introduction, my name is Constance "Connie" Walker. I am a retired Navy Captain with over 22 years of active duty service; a member of NAMI's Veterans Council; and, the President of a regional, rural NAMI affiliate in southern Maryland. My son, Michael, is a disabled veteran of Operation Iraqi Freedom (OIF). He enlisted in the Army as a Motor Transport Operator in June 2001, associate's degree in hand, but Mike was more impressed by an enlistment bonus and a chance to see the world than the idea of two more years of college.

In January 2003, Mike's unit deployed to northern Kuwait in support of the first phase of OIF and our advance into Baghdad. That deployment ended in July. In December of that year—at my insistence, after a season of observable physical and mental decline in him, and an aborted effort by the Army to administratively separate him—my son received a full mental and physical evaluation. In January 2004, Mike was diagnosed with PTSD, major depression, and schizophrenia; he was hospitalized, and medically retired later that year. Today my son lives with my husband and me in southern Maryland.

Throughout that period and since my son's medical retirement, I have been his primary advocate in working with military, VA, and civilian mental healthcare, insurance, and disability benefit systems. Navigating these waters is always challenging and sometimes debilitating—even to someone like me, with over 20 years of experience in recruitment, accession, retention, and retiree policy and program management; having strong supporters within the VA, TRICARE, and other Federal and State agencies; and professional involvement in a local resource network that spans three Maryland counties. My family's experiences; my advocacy work on behalf of OIF and Operation Enduring Freedom (OEF) veterans and families in rural areas of Maryland, North Carolina, Georgia, and California; and, connections to veteran advocates across the country, have led me to this conclusion:

It is impossible to overstate the stressors that rural and frontier family caregivers are bearing on a daily basis as they search for limited treatment and rehabilitative services, and work to support a loved one whose cognitive abilities have been se-

verely and sometimes permanently impaired by the invisible injuries of PTSD or other serious mental illness.

There is a looming reality over all discussions about recovery-based treatment and rehabilitation services for rural OIF and OEF veterans living with PTSD or other serious mental illness. The likelihood of obtaining those specialized services on a consistent basis is very small for veterans living in rural and frontier areas beyond a reasonable commute to a VA Medical Center (VAMC) or without access to an appropriately and consistently staffed VA Community Based Outpatient Clinic (CBOC).

This is a sobering fact, Mr. Chairman. Early intervention and regular access to appropriate treatment, rehabilitation, and support services are as vital to a disabled veteran's prospects for recovery from serious mental illness as they are for recovery from serious physical injury.

Mr. Chairman, with that background, I offer the following comments on the legislation before the Committee today, as requested in your invitation letter:

S. 2162 MENTAL HEALTH BILL

Title I—PTSD and Substance Use Disorder

This bill would establish new VA requirements and re-emphasize existing VA programs for the treatment of PTSD and substance use disorder (SUD), with special procedures for VA to address the treatment of veterans who suffer from co-morbid association of these disorders. It would require VA to expand its offering of services for SUD, including counseling, outpatient care, prevention, aftercare, opiate substitution and other pharmaceutical treatments, detoxification and stabilization services, and other services the Secretary deems necessary, at every VAMC and CBOC. It would create a joint program of care for veterans with PTSD and a SUD, and authorize VA to spend $50 million a year in FY08, FY09, and FY10 on this program. VA would also designate six "National Centers of Excellence on Post-Traumatic Stress Disorder and Substance Use Disorder."

Following orthopedic problems, mental health is the second largest area of illness for which OIF and OEF veterans are seeking treatment at VA medical centers and clinics, and the demand for mental health services is increasing at a faster rate than orthopedic care. If this trend continues, we can expect to see mental health care at the top of the VA's treatment list in the future. Within the range of mental health issues that OIF and OEF veterans are experiencing, PTSD tops the list. PTSD is a special emphasis area for NAMI in its work to support veterans in the VA health care system.

The requirement in this legislation to emphasize concurrent treatment for veterans who have PTSD or other mental illness and a SUD is an important step forward in the treatment and recovery of veterans with PTSD or other mental illness who self-medicate with alcohol and/or drugs. Expanded VA efforts to treat co-occurring disorders would be welcome, and is long overdue. That said, for OIF and OEF veterans who need these services in rural and frontier areas, the only practical avenue to VA care for co-occurring disorders would be through VA's CBOCs. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that substance abuse is a large and growing problem in rural America. There would need to be a sense of urgency in ensuring CBOCs in rural areas have a fully staffed and consistent treatment capability for this population of veterans. Even under those circumstances, veterans who need mental health treatment and are self-medicating in America's frontier areas are likely to be beyond reach.

This legislation would also require a review of all VA residential mental health care facilities, including domiciliary facilities. The results of the review would produce a report to Senate and House Committees on Veterans' Affairs that addresses the availability of care and provides, for each one, an assessment of supervision and support; staff-to-patient ratio, assessment of rules and procedures for medication management; description of protocols for handling missed appointments, and recommendations for improvements to residents' care and the facilities themselves.

This is an issue of extreme significance but I am personally puzzled by the need for legislation to conduct this review. Unless there are legal constraints to doing so, it should be possible to avoid delays inherent to the legislative process by requesting GAO or any of the audit or inspection agencies available for tasking by Congress (to include the VA's Inspector General) to conduct this review and deliver the report.

TITLE II—MENTAL HEALTH ACCESSIBILITY ENHANCEMENTS

This legislation would require the establishment of a 3-year pilot program in two VA networks to provide peer outreach, peer support, readjustment counseling and other mental health services to OIF and OEF veterans, particularly National Guard and Reserve veterans, who live in rural areas and are unable to routinely access comprehensive mental health services through the VA. These services would instead be provided through community mental health centers or facilities of the Indian Health Service participating in the pilot as VA's partners. Clinicians at these facilities would receive VA training to help them address mental health concerns unique to the experiences of OIF and OEF veterans. These facilities would be required to annually report the following information to the VA: number of veterans served; courses of treatment provided; and demographic information for services, diagnoses, and courses of that treatment.

Mr. Chairman, the goal of this legislation is vitally important: increasing access to mental healthcare programs and rehabilitation services for veterans returning to rural and frontier areas where VA resources are limited or do not exist. It is similar in its proposals to S.38, but downsized. In an effort to address this need using in-house resources, the VA recently launched a program at selected test sites to provide Mental Health Intensive Case Management (MHICM) services in some rural areas, but this program is in its infancy.

If legislation can increase mental health resources for veterans and families who live in rural areas, it should be supported. However, there are concerns that cause NAMI to question whether legislation alone can achieve this goal.

The lack of availability of mental healthcare specialists, programs and services in rural areas is a national issue. Most rural areas do not have the mental health resources in place to meet the needs of the existing population. More than 60% of rural Americans live in mental health professional shortage areas. 65% percent get their mental health care from their primary care physicians. St. Mary's County, Maryland received its federal designation as a psychiatric services shortage area in 2005. Individuals seeking psychiatric care often wait 3 or 4 months for their first appointment.

Community Mental Health Center programs are funded primarily through grants from the Department of Health and Human Services. There are very few centers in rural areas. Those there are tend to operate at capacity, and many of their clients have lived with chronic mental illness for years. These centers would be attempting to assimilate a very different client population in terms of OIF and OEF veterans' average age, psychiatric treatment, and rehabilitative needs. Given these considerations, the legislation's requirement for VA training of clinical staff takes on even more significance.

These considerations raise a question as to whether legislation alone will be able to create an acceptable solution for OIF and OEF veterans in rural areas, who need timely and regular access to recovery-based mental healthcare treatment and rehabilitative services.

S. 38

This legislation would establish a 3-year program of services for members of the immediate families of new veterans diagnosed with PTSD or other serious mental illness. Services would include education, support, counseling and other programs for families to increase their understanding of their veteran's illness, enabling them to more effectively support their veteran's journey to recovery. These programs would also improve the family's coping skills and ability to more effectively manage the stressors that family caregivers deal with every day. VA would have to develop a program based on these requirements—but these families are in desperate need of help. There is an equally important subject this bill does not address: compensation for family caregivers. Their role, in advocating for a seriously disabled veterans' physical and mental healthcare and supporting their recoveries, is a fulltime job. My circumstances are unusual. I draw retired O–6 pay from the United States Navy and have a supportive spouse who is willing and able to work past retirement eligibility age. We can support my son. The vast majority of family caregivers supporting a seriously disabled veteran's recovery do not enjoy these luxuries. In many cases, family caregivers have had to quit their jobs to take on fulltime caregiving responsibilities—placing the family under even more stress as it struggles to deal with the loss of income.

S. 2142

This bill would require the Secretary of Veterans Affairs to reimburse veterans with service-connected disabilities for costs incurred as a result of emergency treatment in civilian hospitals, for the period of inpatient care needed before they can be transported to VA facilities.

It is a fact that a percentage of OIF and OEF veterans with PTSD or other mental illness, TBI, and other injuries not visible to the eye, go undiagnosed until symptoms become obvious. A VA facility is not always within commuting distance when the veteran with a service connected disability needs emergency inpatient care. NAMI supports legislation that broadens the entitlement of service-disabled veterans to emergency inpatient care covered by the VA, certainly until the veteran can be safely transported to a VA facility. Therefore, since this bill clarifies that VA responsibility, NAMI supports it.

S. 2004 AND S. 2160

Mr. Chairman, these two bills do not deal with mental illness, so NAMI takes no position on them.

CONCLUSION

The National Alliance on Mental Illness is committed to supporting VA efforts to improve and expand mental healthcare programs and services for veterans living with serious mental illness. Our members directly see the effects of what the national Veterans Service Organizations have reported through the Independent Budget for years: chronic under-funding of veterans' health care has eroded the VA's ability to quickly and effectively respond to present-day and projected requirements, even with the infusion of new funds it now is receiving. Forward motion has been stalled for 3 years on VA's "National Mental Health Strategic Plan," to reform its mental health programs—a plan that NAMI helped develop and fully endorses. A Government Accountability Office (GAO) report released in September 2006 noted that the VA had failed to spend all of a promised $300 million in 2005 that was allocated towards improved awareness of mental illness treatment services in the VA; improved access to mental health services for Veterans returning from Iraq and Afghanistan, as well as others diagnosed with serious mental illness—all important initiatives within the VA strategic plan. NAMI hopes the Committee will agree that oversight of VA's implementation of its National Mental Health Strategic Plan would be beneficial to ensuring its progress toward full implementation, to provide help to OIF–OEF veterans and all veterans who live with mental illness.

Chairman Akaka and Members of the Committee, thank you for your invitation for NAMI to offer testimony as you consider this legislation. I would be pleased to respond to any questions you may have.

Chairman AKAKA. Thank you very much, Captain. I really appreciate that.

Let me just ask one question and then I will pass it on to other Members. Ms. Ilem, in your testimony, you raised concerns about increasing contract care at VA. What safeguards do you feel are necessary to ensure that veterans get the best care available when they are treated for mental health issues or other conditions by outside care providers?

Ms. ILEM. Well, I think the provisions in the bill, in your bill, try to—attempt to make sure that there is cultural competence. If VA has to provide that care outside VA, I think that is critical. When they have to use contracted care, we hope that it would be more consistent with VA's care that those folks have access to, evidence-based treatments that VA had found effective in treating these very unique PTSD and readjustment issue problems, substance abuse issues, and that veterans are going to have the full benefit of good quality care. I mean, that is, I guess, our main issue with that.

We would like to see VA provide as much of that care as possible in-house, and hopefully through the Office of Rural Care that is

just newly stood up that they have been charged to address these issues, and we are hoping that they can really get a handle on what the unmet need is out there and how VA can really help provide that care and not just contract it out with not having a good handle on who those veterans are and that they have access to VA evidence-based programs for the treatment.

Chairman AKAKA. Mr. Blake, you indicated that PVA remains concerned about the eligibility criteria that determines which veterans are eligible for reimbursements for certain emergency care. Can you please expand upon your concerns?

Mr. BLAKE. Well, Mr. Chairman, I think that my statement kind of speaks for itself. There are a couple of—I guess the 24-month requirement is something that we didn't see as being addressed by the legislation that we feel is a critical component to addressing the emergent care requirement. And again, our bottom-line point about allowing for emergent care for any veteran who is currently eligible for VA health care within the system to be reimbursed if they get that care outside of the VA or within the VA.

I mean, I don't know that I could expand on any more than that. I would certainly refer you to our section in the Independent Budget for fiscal year 2008, but most of that is also addressed by my statement, as well.

Chairman AKAKA. Thank you. I will yield now to Senator Burr.

Senator BURR. Mr. Chairman, thank you.

Captain Walker, thank you for that very personal testimony that I think sheds a lot of light on the challenge that Senator Akaka and I and VA deal with, and that is that, and I quote your numbers and they were very consistent with the numbers I found, that 60% of rural Americans live in an area where mental health professionals don't exist. So it implores me to turn to you, Mr. Blake, and you, Ms. Ilem, because I went back to read your testimony, Mr. Blake. Let me just read it. PVA opposes the provisions of this legislation that would authorize VA to contract with community mental health centers to meet the needs of veterans dealing with mental health.

I represent North Carolina. Sixty percent of North Carolina is rural. I think today in the private health care system, finding the specialists that we need to provide services to the entire population, much less the challenges it presents within the VA system to find how to reach some of the rural markets.

Let me give you an opportunity. Are you opposed to contracting under any condition, or are you opposed to contracting under some conditions?

Mr. BLAKE. Well, Senator Burr, I think our statement speaks for itself in that we believe that the authority exists within the VA to contract care, particularly in the rural setting, already. As we have testified on the broader rural health care issue, which we feel is probably maybe one of the leading issues that VHA is facing, our concern has always been that maybe the VA has not applied its fee basis authority in the appropriate manner anyway and it would also affect these individuals.

To qualify my statement that you read from a little bit further, our sense has always been that the VA can provide better care and more cost-effective care within its own system. That is why we

voice our concerns about broader contract care with this in mind, being particularly the mental health aspect.

I think the point that Captain Walker made can't be lost, that it is not just a problem for the VA, it is a problem nationally. I mean, if the access and the professionals are not there, I can certainly see where this legislation gets the VA in the door, and we appreciate the provisions about training——

Senator BURR. All this simply does is create some options where there are no options today, options that the VA in charge of delivering health care to veterans—if, in fact, a veteran lives in an area that there is no VA services because, quite frankly, there are no mental health professionals, we are challenged. That may mean the only option for that veteran outside of driving an hour and a half, hoping that they are on their scheduled appointment, and we know the consistency of their visits and the access at difficult times is absolutely crucial, maybe they turn to some company that is specifically designed to cover rural areas. Would you object to that?

Mr. BLAKE. Absolutely not, Senator. In fact, I would suggest that the Spinal Cord Injury Service uses a similar method for individuals that we have, particularly PVA members who live in extremely rural areas, because they make those choices, as well. And they have fee basis as an availability.

Senator BURR. My attempt here is to find out exactly, when you say we oppose any effort, I mean, that is a pretty strong thing.

Ms. Ilem, let me turn to you. In your testimony, you said the VA should be given time to fully implement and deploy new programs and strategies that are not yet fully deployed, then we should reassess the situation and see about the possibility of contracting opportunities. How do I look at Captain Walker and her son and suggest that she wait until they complete an assessment of the deployment of new programs and strategies? Is that fair?

Ms. ILEM. Well, I think my point I was trying to make is that all of this money and effort has been put into, from Congress, making sure that VA has the opportunity to provide this care and the new law——

Senator BURR. Should this Committee be focused on process or outcome?

Ms. ILEM. Well, certainly outcome, but it does take time for VA to get those services in place. But if VA doesn't have it right now when that veteran needs it, obviously they have the authority to provide that care on a contracted basis. But do you want them to provide that care or authorize that care through somebody who may not fully understand or have the cultural competence to provide PTSD or readjustment issue care? I mean, we want that veteran to have, you know, if they have to drive in to get it because that is the best care available, you know, what is in the best interest of that veteran?

Obviously, getting it close to their home is important, especially if it is a situation where they don't have good transportation to and from the medical center. But at the same time, we want to make sure there is the cultural competence out there on behalf of that provider providing that care. And if VA can't do it, and we would expect them to do it, if they do not have their services up and running for that veteran, that should be made available to them.

Senator BURR. How many veterans are you willing to let fall through the crack while VA completes their assessment of new programs——

Ms. ILEM. We don't want any veterans to fall through the cracks.

Senator BURR. But they are. They are today. We wouldn't be doing this legislation. Captain Walker wouldn't be here testifying. And this is no reflection on the position of both of your groups or a reflection on the VA.

Dr. Smith, let me just turn to you because the vote has started and I know the Chairman has been very gracious, but I didn't see any other Members, so I thought I would take the opportunity.

[Laughter.]

Senator BURR. You clearly drew a distinction between Shockwaves and Direct Blows, not penetrations but blows. Can you sort it out for me? Is epilepsy, Post-Traumatic Epilepsy, more likely in Shockwave Injuries versus Direct Blow Injuries, or do we know?

Dr. SMITH. Senator, we don't know exactly the answer to that question right now. Most of the data that we have from in the past, for example, in Vietnam, you have missile injuries that penetrate the brain and create blood. Blood is something that is very irritative to the brain. But remember that a lot of head injuries that we see are closed head injuries where you have acceleration-deceleration injuries and it is a diffuse process where there can be the development of partial epilepsy which has nothing to do with penetration.

This is a whole new world we are looking at with these IEDs and the type of injury. In talking to a couple neurologists who have actually been there, when they talk about the type of injuries they are seeing, a bullet injury is directly in and can be directly out where these IEDs are smashing areas and there is debris in a number of areas that is creating a completely different picture that we are not used to seeing.

Senator BURR. Thank you for that, and there is a reason I went in the order that I did. You are dealing with it today, Captain. I know you guys have to take the position that you do. You bring a new element that we don't talk about enough. It is the servicemen and women today who are coming back with injuries that we haven't experienced, that if we are not focused on the technological progressions in prosthetics, if we are not focused on how we treat the mental health issues that arise from this current operation, if, in fact, we don't transition Traumatic Brain Injury from one of penetration to one of shockwaves and possibly some direct blows, then we have done an injustice to the personnel that we have asked to serve.

Part of our ability to address these is that we have to act quickly, and it doesn't mean that we always have all the information. It doesn't mean that we have all the programs out. Clearly, I think we could all find consensus that there are areas of the country that even in the private sector, it is very difficult to find the services that cover the scope that are needed and that it shouldn't be unusual for VA to have a problem there like the private sector does, and when we hit those, that we ought not wait for programs to be fully vetted, that we ought to contract with somebody if, in fact, there is somebody that is qualified to deliver that service.

Right now, the single most important thing we have to do is to drop the concerns we have with process. We will sort out process and focus on outcome, and that is how many of these men and women that go into the system for whatever need come out as quickly as they can, but with a life in front of them that is as productive as we can possibly make it and they can possibly enjoy.

I thank you for letting me ask you some very pointed questions. Again, I thank all of you for your testimony, and Mr. Chairman, I thank you for your indulgence.

Chairman AKAKA. Thank you very much, Senator Burr.

A vote has been called. I want to thank our panelists here. We have questions that we will submit for your responses.

I also want to thank Dr. Kussman, who has remained here to listen to the testimony of our second panel. I want you to know I appreciate that, Dr. Kussman.

Again, I appreciate all of you and your testimonies as well as your responses. The reason I am going to adjourn is that we have a series of votes, and instead of keeping you here waiting until we are done, I want you to know that we appreciate your coming. We have heard from you and this will, without question, help us in dealing with these issues in the Department of Veterans Affairs. This is all for the sake of trying to find the best ways of helping our veterans, and I thank you for contributing to that.

Captain Blake, I had questions about families and your family, as well, but we will hear from you on that in your responses.

I want to thank all of you again for appearing here and wish you well in all that you do.

This hearing is adjourned.

[Whereupon, at 11:12 a.m., the Committee was adjourned.]

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