

1 Federal health care workforce, and we will highlight
2 opportunities for collaboration and cost sharing and
3 exploring stronger partnerships between agencies and local
4 providers.

5 As a Montanan and as someone who has worked very
6 closely with the veterans and the Native American
7 population, I am aware of the challenges in rural and
8 frontier areas in accessing quality health care in a timely
9 manner. To address these challenges will certainly require
10 a multifaceted approach. We need to invest in technologies
11 like telemedicine and bring health care closer to home. We
12 need to expand the number of mobile clinics and Vet Centers
13 and improve transportation options for folks that are forced
14 to travel significant distances to receive the health care
15 that they need.

16 But we also need to address chronic health care
17 workforce shortages in rural communities in agencies like
18 the VA and the Indian Health Service. Far too often we have
19 seen new facilities sit idle because we cannot recruit
20 enough mental health professionals to a particular area, or
21 we have seen veterans diverted for care because of nursing
22 shortages of a particular facility.

23 But this is not a VA-specific problem. It is a rural
24 problem, and it is a national problem. We need Government
25 agencies to aggressively and effectively work together to

1 make progress and to ensure they are working in
2 collaboration and not in competition. This collaboration
3 should not only be happening between Federal agencies; it
4 should be happening at the State level, and it needs to be
5 happening in more rural areas.

6 In these communities the Federal health care workforce
7 needs to leverage what limited resources it has and empower
8 local partners to more effectively increase access to care.
9 Just because a veteran lives in a place like Havre, Montana,
10 does not make him or her less deserving of a timely and
11 quality health care.

12 We have some great witnesses with us here today, and as
13 we discuss these critical issues in more detail, I look
14 forward to hearing from each of them.

15 I will now turn it over to Ranking Member Senator
16 Portman for his opening statement.

17 OPENING STATEMENT OF SENATOR PORTMAN

18 Senator Portman. Thank you, Mr. Chairman, and thank
19 you for having the hearing today on an incredibly important
20 issue in Montana, in Ohio, and around the country. It is an
21 important topic, and I think the testimony we are going to
22 get today is going to shed light on some of these issues
23 facing rural health care in particular. Thanks to the
24 witnesses for being here, this panel and the coming panel.

25 One of the most important functions that our Federal

1 Government must fulfill, of course, is the care of our
2 veterans. We need, as we are going to into Memorial Day, to
3 think about that. You know, they are out there defending
4 us, in essence, and their mission continues. When they get
5 home, we have got to be sure we are there with them. And
6 there are acute health care problems right now facing over 6
7 million veterans in rural communities, including a lack of
8 sufficient health care providers and the need to travel, as
9 the Chairman said, significant distances to seek care in
10 many cases.

11 Like our urban veterans, our rural veterans returning
12 from Iraq and Afghanistan are coping every day with both the
13 visible and the invisible wounds of war. But, unfortunately
14 for them in the rural areas, help is not as readily
15 available.

16 I would like to discuss these topics in the context of
17 traumatic brain injury because it is often referred to as
18 the signature wound, unfortunately, of the wars in Iraq and
19 Afghanistan. The Department of Defense now estimates that
20 over 266,000 servicemembers have suffered traumatic brain
21 injuries, or TBIs, from 2000 to 2012. At the same time, the
22 CRS, the Congressional Research Service, has estimated that
23 over 100,000 servicemembers who have served since 2000
24 suffer from post-traumatic stress. So it is one thing to be
25 able to get our rural veterans treatment for an orthopedic

1 issue or even help maybe on a diabetes management program.
2 But often it is another thing entirely to present the full
3 scope of treatment needed for a veteran suffering from the
4 effects of TBI or post-traumatic stress.

5 I know our witnesses recognize the scope of the
6 problem, and each of your departments has embarked on a
7 number of initiatives to address those problems. I look
8 forward to hearing more about that today.

9 I will say I am concerned that we are making internal
10 adjustments and small steps forward, whereas the size of the
11 problem is bigger than that. It is daunting. And the
12 longer we take to address it, the worse it is going to
13 become.

14 I think our treatments that we are now providing for
15 our veterans are not as effective as they could be, and I
16 think the pilot projects and assessments are important. But
17 I think we have a bigger problem that we need to address,
18 and that is what we will talk about today.

19 Tragically, we are now losing, we are told, 22 veterans
20 a day to suicide. Fundamental changes are needed to occur
21 from the way VA interacts with our veterans to the model for
22 providing care, and we will talk about.

23 When I am back home in Ohio, I regularly talk to our
24 veterans about their interactions with the VA. Some are
25 very positive. Some of the stories I hear from our rural

1 veterans are likely similar to what the Chairman hears in
2 Montana: long drives, even longer drives in Montana
3 probably; expensive drives sometimes to get the kind of
4 treatment that they need; uncoordinated appointments;
5 varying customer service. When a TBI patient who may find
6 it difficult to remember his or her appointments, may find
7 it difficult to follow directions or even interact with
8 other people, has to drive a couple hours to an appointment,
9 and when he shows up a little late after driving through a
10 blizzard and has to reschedule his appointment for weeks
11 later, we are not setting that person up for success. And,
12 unfortunately, the stories that I have heard are not
13 isolated, and I know, again, in Montana some of the same
14 stories are out there.

15 So we have got to leverage the resources of our Nation
16 for these men and women who have given so much to us. We
17 have providers throughout our country who stand ready to
18 support this population of over 6 million rural veterans if
19 given the opportunity to do so. And connecting our rural
20 veterans with the right treatment I think is something we
21 ought to be focused on, and we will talk about that today.

22 So, again, thanks to our witnesses. Mr. Chairman, I
23 look forward to the testimony today and discussing these
24 issues.

25 Senator Tester. Well, thank you, Senator Portman. I

1 would just like to say thank you for your opening statement,
2 and as we kick off the first hearing on this Subcommittee, I
3 want to say I look forward to working with you to help
4 improve issues, whether it is health care or something else.
5 This is a pretty broad-based Subcommittee.

6 Senator Portman. Yes, likewise.

7 Senator Tester. So I look forward to working with you
8 to get some good things done.

9 I would like to welcome our first panel of witnesses
10 who have all spent years in public service working to
11 increase access to health care for rural Americans, and they
12 have all dealt extensively with the challenges of recruiting
13 and retaining a quality health care workforce.

14 First of all, I would like to introduce Dr. Robert
15 Petzel. He is the Under Secretary of Health in the
16 Department of Veterans Affairs. He has served in that
17 capacity since February 18, 2010. In this position, he
18 oversees the health care needs of some 8 million veterans
19 currently enrolled in the Veterans Health Administration,
20 the Nation's largest integrated health care system. VHA
21 employs over 272,000 staff members at more than 1,700 sites
22 across this country. Last year, the VA treated 6 million
23 patients during 80 million outpatient visits and 692,000
24 inpatient admissions.

25 Welcome, Dr. Petzel. It is great to see you, and we

1 look forward to your testimony and look forward to getting
2 you back in Montana.

3 Next we have Dr. Yvette Roubideaux, who is the Director
4 of Indian Health Service, IHS, at the U.S. Department of
5 Health and Human Services. She has served in that capacity
6 since 2009. IHS provides a comprehensive health service
7 delivery system for approximately 2.2 million American
8 Indians and Alaska Natives from 566 federally recognized
9 tribes in some 35 States, and they serve a critical role in
10 my State of Montana.

11 Dr. Roubideaux, it is good to see you again. We look
12 forward to your testimony.

13 And last, but certainly not least, we have Tom Morris,
14 who is the Associate Administrator for the Office of Rural
15 Health Policy in the Health Resources and Services
16 Administration, otherwise known as HRSA, an agency within
17 the U.S. Department of Health and Human Services. Tom's
18 office serves as a critical research and policy resource on
19 rural health issues, and it administers a number of critical
20 grant programs that enhance the delivery of rural health
21 care. Additionally, his office works very closely with
22 local partners to increase access and to build capacity
23 within those communities. Tom also happens to serve on the
24 Veterans Rural Health Advisory Committee.

25 Welcome, Tom. It is good to have you here.

1 There she is. We just got going. Before we go to Dr.
2 Petzel for his opening statement, I would--

3 Senator Heitkamp. That is okay.

4 Senator Tester. You can have an opening statement if
5 you would like. It is up to you.

6 Senator Heitkamp. Go ahead.

7 Senator Tester. Okay. We will start with Dr. Petzel.
8 You will have 5 minutes for your oral testimony. Know that
9 your full written testimony will be made a part of the
10 record, so with that, Dr. Petzel, you may proceed.

1 TESTIMONY OF ROBERT A. PETZEL, M.D., UNDER
2 SECRETARY FOR HEALTH, VETERANS HEALTH
3 ADMINISTRATION, U.S. DEPARTMENT OF VETERANS
4 AFFAIRS

5 Dr. Petzel. Chairman Tester, Ranking Member Portman,
6 and members of the Subcommittee, thank you for the
7 opportunity to speak with you today about how VA recruits,
8 retains, and deploys a quality health care workforce to
9 ensure that veterans can access the health care that they
10 have earned and deserve.

11 VA is committed to providing veterans with quality,
12 timely, and accessible health care as close to their home as
13 possible. Veterans' mental health is a top priority for VA.
14 As a part of President Barack Obama's Executive order to
15 improve access to mental health services for veterans,
16 servicemembers, and military families, VA has made
17 significant progress to increase its mental health workforce
18 to meet the needs of veterans.

19 As of May 14, 2013, VA has hired 1,367 new mental
20 health clinical providers. In addition to that, we have
21 hired 2,063 mental health providers to fill existing
22 vacancies, so over the last 10 months, VA has hired almost
23 4,000 additional mental health providers. And in addition
24 to that, we have begun hiring a new group of people called
25 peer specialists, and today 261 of them have been hired.

1 We are aware of the challenges to recruit and retain a
2 quality health care workforce and are implementing a number
3 of creative recruitment strategies to ensure access to care
4 for all veterans. These efforts to increase the awareness
5 of employment opportunities including national
6 advertisements through television commercials, public
7 service announcements. To meet the mental health needs of
8 veterans and their families, VA has also begun to hold
9 facility-based mental health summits with the purpose of
10 building and expanding coalitions with community providers,
11 organizations in the communities, and Federal and State
12 agencies.

13 VA is dedicated to improving access and quality of care
14 for rural veterans by developing innovative practices to
15 support the unique needs of veterans residing in
16 geographically remote areas.

17 VA has used a number of programs, including Project
18 ARCH and Patient-Centered Care, or PC3, in order to provide
19 eligible veterans coordinated and timely access to care
20 through a network of non-VA medical providers who meet VA
21 quality standards.

22 VA will continue to look for and implement new ways to
23 broaden access through innovative approaches to bringing
24 care to veterans.

25 Telehealth enhances health care, especially in rural

1 and geographically remote areas, where it can be difficult
2 to recruit health care professionals and where travel
3 distances are excessive.

4 VA is a national leader in telehealth-based care. In
5 fiscal year 2012, VHA provided care to half a million
6 patients through video clinical conferencing, store-forward
7 technology, telehealth, and tele-home health. This number
8 is set to rise to 830,000 in 2013.

9 Specialty Care Access Network Extensions for Community
10 Health Outcomes, or SCAN-ECHO, is one initiative that VHA is
11 using to ensure the delivery of specialty care services to
12 improve access to specialists. SCAN-ECHO leverages
13 telehealth to allow health care specialists from a regional
14 center to offer expert advice to providers in rural health
15 care settings.

16 Another initiative is MyHealtheVet. This offers
17 veterans online access to the VA health care system, and it
18 is designed to give them greater control over their health
19 and wellness. Features of the system include the ability to
20 communicate with providers, refill prescriptions, and to
21 access their electronic medical record.

22 VA optimizes the delivery of treatments by using
23 technologies and tools such as mobile applications. These
24 mobile applications can help veterans build resilience and
25 manage their daily challenges. The award-winning PTSD Coach

1 mobile app, co-developed with the Department of Defense,
2 provides an opportunity to better understand and manage the
3 symptoms associated with PTSD.

4 PE Coach, or prolonged exposure therapy coach, is a
5 mobile application for patients to use with their therapist
6 during prolonged exposure therapy as a treatment companion.

7 VA maintains partnerships and continuously seeks to
8 foster relationships with Government and nongovernment
9 organizations to bring value to veterans and expand access
10 to the care they have earned and deserve.

11 VA has a strong history of collaborating with community
12 mental health clinics, including federally qualified
13 centers. These locally developed community partnerships
14 provide mental health services to veterans in areas where
15 direct access to VA health care is limited by either
16 geography or workload.

17 In response to President Barack Obama's Executive
18 order, VA, working closely with the Department of Health and
19 Human Services, initiated 15 pilot projects to evaluate how
20 these partnerships can help bring mental health services in
21 areas that are experiencing difficulty in providing direct
22 care. We are committed to building an accessible system
23 that is responsive to the needs of America's veterans. VA
24 continues to implement its rural workforce strategy to
25 recruit locally and utilize the necessary resources,

1 including collaboration, technology, and partnerships, to
2 achieve these goals.

3 I thank the Subcommittee for the opportunity to appear
4 before you to discuss this important issue, and I am
5 prepared to answer any questions you may have.

6 [The prepared statement of Dr. Petzel follows:]

1 Senator Tester. Thank you for your testimony, Dr.

2 Petzel.

3 And we will move to Dr. Roubideaux.

1 TESTIMONY OF YVETTE ROUBIDEAUX, M.D., ACTING
2 DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT
3 OF HEALTH AND HUMAN SERVICES

4 Dr. Roubideaux. Thank you, Chairman Tester, Ranking
5 Member Portman, and members of the Subcommittee. My name is
6 Dr. Yvette Roubideaux, and I am the Acting Director of the
7 Indian Health Service, and I am pleased to provide testimony
8 on our efforts to develop and support the Federal health
9 care workforce.

10 IHS' workforce plays a critical role in supporting the
11 overall mission of the IHS as a rural health care system
12 addressing a population with significant disparities in
13 health and access to care.

14 IHS shares similar challenges faced by rural
15 communities across the Nation. Many of our IHS facilities
16 are in rural and remote locations where recruitment and
17 retention of employees, especially health care providers,
18 present unique challenges.

19 IHS vacancy rates for health professionals have
20 actually improved over the past few years, but they still
21 remain an issue. For example, dental vacancies were greater
22 than 30 percent, but an increased focus on recruitment and
23 retention reduced those vacancies to approximately 10
24 percent. However, continued efforts to improve recruitment,
25 retention, and support of our Federal workforce are

1 critical.

2 Over the past few years, IHS has implemented a number
3 of reforms to change and improve the agency, and many of
4 these efforts have contributed to better support and
5 strengthen IHS' workforce since many of our reforms were
6 based on input and recommendations from our employees and
7 our stakeholders.

8 IHS also supports programs such as the American Indians
9 Into Medicine, American Indians Into Psychology, and the
10 Quentin N. Burdick American Indians Into Nursing Programs
11 which help develop students' interest in health professions
12 and encourage them to return to their communities and work
13 for IHS in the future.

14 The IHS Health Professions Scholarship Program is a key
15 strategy for the agency in developing the future American
16 Indian/Alaska Native workforce.

17 The IHS Loan Repayment Program is one of our most
18 effective recruitment and retention tools for the
19 recruitment of a variety of positions in our workforce.

20 The IHS has worked to strengthen our recruitment and
21 retention strategies through gathering input from our
22 workforce and our stakeholders to better understand the
23 needs of our workforce. And another important strategy to
24 improve recruitment and retention is to improve the
25 workplace environment at IHS to better support our

1 workforce.

2 IHS has made improvements in background checks, the
3 hiring process, and credentialing and privileging of
4 providers to ensure that we have a quality Federal
5 workforce.

6 IHS has also worked to make our salaries more
7 competitive with the private sector, which is especially
8 important for health professional improvement.

9 IHS has leveraged many partnerships to help develop and
10 support its Federal workforce with other Federal agencies,
11 academic institutions, and tribal communities.

12 Our partnership with the Health Resources and Services
13 Administration has helped us recruit more health
14 professionals to work in IHS through their National Health
15 Service Corps Scholarship and Loan Repayment Programs.

16 Our partnership with the VA has helped us improve
17 coordination of care for American Indian and Alaska Native
18 veterans through implementation of our 2010 Memorandum of
19 Understanding and our 2012 VA-IHS National Reimbursement
20 Agreement. Those are helping our workforce improve access
21 to quality health care for American Indian and Alaska Native
22 veterans.

23 Our partnerships with academic institutions are
24 extremely important to our recruitment and retention efforts
25 because of the link it provides to students and new

1 graduates seeking places to serve.

2 One of our most powerful recruitment and retention
3 strategies is our partnership with our communities. As more
4 of our Federal workforce feels at home and supported by
5 those communities, the likelihood that they will become a
6 long-term member of that community will increase.

7 In summary, the Federal workforce is essential to the
8 core mission of the Indian Health Service and its delivery
9 of accessible and quality health care services to American
10 Indian and Alaska Native communities. While there is much
11 more to do, we appreciate the opportunity to testify at this
12 hearing to further discuss opportunities for improvement.

13 Mr. Chairman, this concludes my testimony. I am happy
14 to answer questions.

15 [The prepared statement of Dr. Roubideaux follows:]

1 Senator Tester. Thank you, Dr. Roubideaux. We
2 appreciate your testimony.

3 We will go to Mr. Morris.

1 TESTIMONY OF TOM MORRIS, ASSOCIATE ADMINISTRATOR,
2 OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES
3 AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF
4 HEALTH AND HUMAN SERVICES

5 Mr. Morris. Mr. Chairman, Ranking Member Portman, and
6 members of the Committee, thank you for the opportunity to
7 testify today on behalf of the Department of Health and
8 Human Services, the Health Resources and Services
9 Administration, about the Federal Office of Rural Health
10 Policy.

11 For 25 years, the office, which was created by
12 Congress, has served as a focal point for rural health
13 activities within HHS. We are charged with advising the
14 Secretary on the impact of HHS policies, regulations, and
15 programs on rural communities. This includes an ongoing
16 focus on issues related to the training, recruitment, and
17 retention of health care professionals in rural communities.
18 We also administer several grant programs related to
19 capacity building from community-based pilot programs to
20 State programs focused on improving the quality and
21 financial performance of small rural hospitals. We welcome
22 opportunities to discuss ways to help rural communities
23 attract and retain needed health care providers. This is a
24 priority for the office, for the Department, for HRSA, and
25 for the administration.

1 There are nearly 50 million people living in rural
2 areas. That represents about 16 percent of the population
3 spread across 80 percent of the land mass of the United
4 States. The rural health care system is heavily focused on
5 primary care and chronic disease management, relies heavily
6 on safety net providers like small rural hospitals,
7 federally qualified health centers, and rural health
8 clinics, as well as solo providers and small group
9 practices.

10 The Office of Rural Health Policy funds several
11 initiatives that focus on building up that rural capacity.
12 This ranges from our work with the 50 State Offices of Rural
13 Health, which we provide grants to, as well as our work
14 through the Rural Hospital Flexibility Grant Program and the
15 Small Hospital Improvement Grant Program, which works to
16 improve question and financial performance for small rural
17 hospitals.

18 HHS' investment in rural communities, though, goes far
19 beyond the OHRP programs. For example, HRSA administers the
20 National Service Corps, which offers a lifeline to rural
21 communities. They support loan repayment and scholarships
22 for health care providers, and almost half of those
23 providers are in rural areas.

24 HRSA training programs in primary care, behavioral
25 health, dentistry, and nursing play a key role in training

1 the next generation, and we are also heavily focused on
2 investing in community-based residency training for
3 physicians, whether that is through our teaching health
4 center program in which 15 of the 22 grantees serve rural
5 communities or through our work supporting the 23 rural
6 training tracks across the country. Our studies indicate
7 that 70 percent of the graduates of these rural training
8 tracks stay in rural practice, and we are focused on
9 increasing student interest in those programs and also
10 working with communities to start new rural training tracks.

11 Rural areas also benefit greatly from the HHS and State
12 Conrad 30 J-1 visa waiver programs which place foreign-
13 trained physicians in communities that need them the most.
14 Our office also works with each of the States through the
15 National Rural Recruitment and Retention Network, which
16 placed 1,767 clinicians in rural areas in the past year.

17 Telehealth plays a key role in increasing the reach of
18 the health care workforce. We have long supported grants to
19 link urban specialists with rural communities in need, and
20 yet we are seeing through our grant programs new and
21 emerging technologies, such as E-emergency care, E-ICU, as
22 well as tele-home monitoring.

23 Telehealth technology also plays a key role in
24 extending the reach of the limited mental health workforce,
25 particularly in rural areas where psychiatrists and

1 psychologists are often scarce.

2 We also currently are funding a three-State telehealth
3 pilot that includes Montana and Alaska to link rural
4 veterans to telehealth and health information exchange to
5 enhance their care.

6 At HRSA, we are also working within the range of
7 Federal partners through the White House Rural Council to
8 train the workers needed to operate and maintain these
9 health information technology systems, whether we are
10 talking about electronic health records, telemedicine, or
11 health information exchange. We expect this to be a key job
12 growth area in the coming years as these technologies
13 continue to be deployed in health care.

14 Thank you again for providing the opportunity to share
15 HRSA's and the Office of Rural Health Policy's mission with
16 you today and the efforts we have underway to focus on rural
17 working challenges. I am pleased to respond to your
18 questions.

19 [The prepared statement of Mr. Morris follows:]

1 Senator Tester. Well, thank you, Mr. Morris, for your
2 testimony.

3 Around 10:30 there will be a vote called, and what we
4 are going to do is we will just kind of stagger it out, so
5 we are not going to adjourn. We will just stagger out, and
6 then when Rob comes back, he can do it; otherwise, if we
7 both have to be gone, we will kick it over to either Senator
8 Begich or Senator Heitkamp. All right? Thank you. Could
9 we put 7 minutes on the clock, please.

10 Dr. Petzel, the VA has made a commitment to hire I
11 think 1,600 new mental health care professionals--"health
12 clinicians," I guess we will call them--and I think about
13 300 support staff. You correct me if my numbers are wrong.
14 Where are we at on those hirings both for the clinicians and
15 for the support staff?

16 Dr. Petzel. The numbers are correct, Mr. Chairman. In
17 terms of the clinical providers, we have two ways that we
18 look at this. One is the actual positions that were
19 identified that have been filled, and as of the 14th of May,
20 we have filled about 1,356 of that 1,600 clinical mental
21 health providers.

22 Another way that we look at this is that every quarter
23 we are able to assess the number of clinical providers
24 providing direct care that we actually have on board. So we
25 went back and looked at what we had on board in May of 2012

1 when we began this effort, and now I have the most recent
2 data from March of 2013, and that indicates that we have got
3 an additional 1,556 people on board providing mental health
4 care than we did back in May. So we believe that we are
5 well on our way to meeting that goal. And we have basically
6 hired almost all within a few short of the administrative
7 personnel that were part of the 1,900.

8 Senator Tester. What are the totals, the 1,556
9 additional from what they were, what are your total number
10 of mental health--

11 Dr. Petzel. The total mental health that we have--let
12 me just take a quick look so I make sure I get this number
13 correct. But I believe that the total mental health that we
14 have on board providing direct patient care is about 18,600.
15 So that would include psychiatrists, psychologists, mental
16 health nurse, clinical mental health specialist nurses,
17 psychiatric social workers, the master's trained counselors
18 and master's trained family therapists.

19 Senator Tester. As you well know, in Montana--and I
20 think this could be said for all of rural/frontier America--
21 we have struggled to overcome shortages in mental health
22 professionals for years. So unless we are getting a healthy
23 portion of new hires, which you have indicated we have, it
24 is unable to make up the ground with the impacts of PTSD and
25 TBI and the issues of the unseen--we will just call them the

1 "unseen injuries" coming back from war.

2 You talked about where we are today. Moving into the
3 future are there long-term efforts for assessment? And if
4 so, are there long-term efforts for recruitment that go with
5 those assessments as we move forward to help bring in more--
6 I will just say more young folks into the eye of rural
7 America?

8 Dr. Petzel. Well, first of all, Mr. Chairman, there
9 are ongoing recruitment efforts, and these will continue
10 because we have continuing developing vacancies. I am
11 pleased to say that the vacancy rate has actually dropped
12 from slightly over 13 percent amongst clinical mental health
13 providers to a little bit below 11 percent, and that is a
14 significant number when you are talking about almost 20,000
15 mental health professionals.

16 We are assessing and will assess actually continuously
17 whether or not we are meeting the access needs and the
18 access standards that we have described. And if we discover
19 that we are not able to do that because we do not have the
20 personnel available, we will continue to add to the mental
21 health workforce.

22 But I think that it would be useful if I could take 1
23 minute--

24 Senator Tester. Sure.

25 Dr. Petzel. --to describe the other things that we are

1 doing that are relatively new efforts, the most important of
2 which is the use of telehealth and telemental health to deal
3 with the shortage of psychiatrists, which we and everybody
4 has difficulty recruiting into rural areas. I know you are
5 very familiar with that.

6 We have set up regional centers of psychiatry that
7 communicate with our community-based outpatient clinics and
8 provide consultation and therapy by a telemental health from
9 remote areas such as Spokane, Washington, where we are
10 having difficulty recruiting psychiatrists, into one of
11 these centers in an urban area where we are able to recruit
12 psychiatrists. We have no difficulty recruiting
13 psychiatrists to New York or Minneapolis or Houston or San
14 Francisco. And these regional centers are proving to be
15 very effective.

16 The telemental health therapy is very well received by
17 veterans. They like the idea that they do not have to
18 travel great distances. They are not befuddled and
19 frustrated by a 45-minute drive, even across town in an
20 urban area. And that is going to be a major effort in the
21 next 2 years to help us provide the psychiatrist services in
22 remote areas.

23 Senator Tester. Well, thank you, and thank you for
24 your work.

25 Dr. Roubideaux, I want to talk about some of the

1 challenges that may be unique to Indian country as you seek
2 to recruit and to train and to retain quality health care
3 folks. Time and again we hear about administrators who must
4 bring in folks from outside the area as primary care docs,
5 as specialists, as nurses. These are highly skilled but
6 high-paying jobs, especially in Indian country.

7 I had a group of eighth graders in my office yesterday
8 from down at Crow, and one of the questions they asked me
9 was: How do we get more doctors and nurses from Crow
10 country in the Crow hospital? These are eighth graders,
11 these are 12-, 13-year-old kids that understand what is
12 going on.

13 Can you talk about the challenges of recruiting in
14 Indian country?

15 Dr. Roubideaux. Well, our challenges are significant,
16 and we certainly would like to recruit more individuals from
17 our tribal communities to work in our facilities and to be
18 health professionals, the challenges of social and economic
19 issues in the communities, schools, and things like that,
20 and then they have to travel far away for their education,
21 and sometimes they do not come back.

22 So our health professions programs help us recruit and
23 retain American Indians and Alaska Natives to work in our
24 system.

25 The Indian preference law helps us a lot because about,

1 I would say, approximately three-quarters of our employees
2 right now are American Indian/Alaska Native. The place
3 where we have a difficulty recruiting American Indians and
4 Alaska Natives in some of the health professions that
5 require training at a distance from the Indian reservation
6 and so recruiting them back to work is a challenge, but our
7 loan repayment programs really help with that.

8 Senator Tester. Okay. I am going to kick it over to
9 Senator Portman.

10 Senator Portman. [Presiding.] Thank you, Mr.
11 Chairman,

12 Dr. Petzel, I wanted to ask a little about using non-VA
13 providers for rural veterans. I know that you have got
14 capacity issues--we just talked about that--despite hiring
15 over 1,500 new positions in the last year or so on the
16 mental health side.

17 Beyond capacity issues, where sometimes you do have to
18 use a private or a fee service, what is the threshold? How
19 far do you require a veteran to go to seek services? How do
20 you define "geographic inaccessibility?" Which I know is
21 one of your criteria.

22 Dr. Petzel. Thank you, Senator Portman. We have
23 definitions of rurality that involve both distances--60
24 miles would be an example--and time--60 minutes--to
25 services. But those are not really used in any great sense

1 when we are evaluating whether somebody should be "fee'd" as
2 we call it, or cared for in the community. Much of it has
3 to do with the convenience of them being--or inconvenience
4 of them being able to travel. If you have an 81-year-old
5 gentleman who lives even 60 miles from a medical center, it
6 is a burden to ask that individual to travel for a routine
7 clinic appointment. And even for some individuals who are
8 much closer but have to travel across an urban area, that
9 can be a daunting task for somebody who is 81 years old.

10 So we try to do two things. Number one, an option is
11 fee'ing that care, that is, providing the care in the local
12 community, and we have got two pilots that are running right
13 now looking at that option. But another one that we are
14 doing using in increasing numbers is what we call tele-home
15 health, a video camera in the patient's home, instruments to
16 monitor the patient's weight, EKG, blood pressure, and
17 regular contacts with their primary care provider at their
18 clinic or their medical center. It has proven very
19 effective in taking care of patients with multiple chronic
20 diseases, and in not--providing them with the opportunity to
21 not travel to a clinic. We reduce emergency room visits by
22 40 percent in patients where we have done this and studied
23 it. We have reduced clinic visits by 38 percent. And we
24 have reduced hospitalizations by almost a third by providing
25 this care in the home with constant communication.

1 Senator Portman. For mental health treatment, is that
2 as effective as it is for other kinds of treatment? We
3 talked earlier about the fact that we have so many of our
4 veterans with PTSD or TBI, and so maybe for somebody who is,
5 again, recovering from an orthopedic procedure or somebody
6 who is on dialysis, maybe you can work through some of these
7 issues using some of the telemedicine you are talking about.
8 But how about for mental health? Is it more of a challenge?

9 Dr. Petzel. Telemental health is remarkably well
10 accepted. It began actually in the VA on an Indian
11 reservation, on the Rosebud Indian Reservation in South
12 Dakota, almost 10 years ago now, as a study, treating PTSD
13 by telemental health, by a researcher at the University of
14 Colorado. It proved to be very successful and was really
15 the impetus for spreading telemental health around the
16 country. The acceptance rate by this and the satisfaction
17 rate by this is over 90 percent for the patients that use
18 it.

19 I will tell you an anecdote very quickly. A man lives
20 in New Jersey, has to travel 45 minutes to get to his
21 psychiatrist who works in one of the medical centers there,
22 and he described live on the video camera the experience, 45
23 minutes through traffic, he is frustrated, he is angry, and
24 he is not the same kind of person that he normally is by the
25 time he shows up for that appointment.

1 When he does a telemental health therapy episode, he is
2 sitting in his own home. He is comfortable. He has not
3 driven across urban traffic. He is relaxed, and he is an
4 entirely different person. And the therapy session has a
5 dramatically better effect.

6 It works. It works very well, and we are going to be
7 exploiting this to the maximum over the next several years.

8 Senator Portman. Do you think that using non-VA
9 providers, particularly for mental health and TBI, is
10 something that you are doing adequately? I notice in the
11 data that you provided the Committee that about 2 percent of
12 VA mental health patients are seen by non-VA providers every
13 year. DOD, as you know, has a policy with TRICARE that is a
14 little different where they use non-DOD mental health
15 providers for TRICARE recipients on a more regular basis.
16 What is your policy? And, again, is only allowing 2 percent
17 of our veterans to seek treatment by the many providers
18 outside of the VA system appropriate?

19 Dr. Petzel. Well, I think that that should be
20 expanded, Senator. I have no doubt that 2 percent is not as
21 much as is needed and as could be, and we are, in fact,
22 doing it. The new non-VA care arrangement called PC3 is
23 going to have in it a mental health component, and we will
24 be expanding that.

25 The issues are making sure that those non-VA providers

1 are facile with PTSD, particularly traumatic brain injury
2 and depression and the things that we see as a result of
3 combat. But we are expanding and we intend to expand our
4 use of non-VA providers.

5 The pilot that we are doing with the federally
6 qualified health centers I think is an example of that. We
7 have committed to piloting in 15 locations how this works
8 when we have a contract with a federally qualified health
9 care provider. Those are up and running, 15 of them. Five
10 more are going to be added relatively shortly, and I have no
11 doubt that that network is going to expand.

12 Senator Portman. I notice the data you provided us
13 goes up to 2010, and it does show an increase from 2007 to
14 2009, actually a decrease in 2010 from 2009. But are you
15 suggesting that your data for 2011 and 2012 and 2013 would
16 show an increase?

17 Dr. Petzel. Certainly, Senator, 2012 will show an
18 increase. I do not know about 2011 looks like, but it
19 should show--2012 should certainly show an increase.

20 Senator Portman. On telehealth or telemedicine, you
21 have given us some important information in your testimony
22 and then in answer to my earlier question, and I appreciate
23 that. By your own count, you are seeing over a million
24 mental health patients a year now. Clearly a lot more of
25 our veterans need this service. If we assume these patients

1 are dispersed like the veteran population as a whole, that
2 is at least 300,000 mental health patients will be in rural
3 areas or highly rural areas already seeking treatment and
4 likely just as many who need treatment who are not seeking
5 it. Through these health programs that are telemedicine,
6 telemental health programs, how many patients have been
7 connected?

8 Dr. Petzel. That is a very good question. Presently
9 it is about 83,000 patients that we have delivered
10 telemental health services to.

11 Senator Portman. And how many of those 83,000 have to
12 go to a CBOC or to one of your community-based outpatient
13 clinics in order to get that service?

14 Dr. Petzel. Almost all of them, Senator, would be
15 going to some location where we have telemental health
16 services. There have been a few, but not many, that we
17 have--as the gentleman I described in New Jersey, where we
18 have set this up in their home. That is with the shrinking
19 of--

20 Senator Portman. That is a pilot program that you
21 think should be expanded?

22 Dr. Petzel. It is not a pilot. It is just in its
23 infancy, and yes, it will be expanded. I think that we have
24 demonstrated--these patients have demonstrated the fact that
25 they are better therapy sessions, better therapy patients

1 when we see them in the context of their home.

2 Senator Portman. Anything we can do to help you expand
3 that capacity into the home?

4 Dr. Petzel. I think we have the resources, Senator.
5 We have the money to buy the equipment. The price has
6 shrunk dramatically, and it is basically just a Web cam now,
7 a high-quality Web cam on a computer. The thing that we
8 need help with around the country, all of us do, is
9 psychiatrists. There just are not enough psychiatrists in
10 this country to meet the country's mental health needs, much
11 less meet the needs of rural veterans, people that are being
12 treated by the Indian Health Service. That is probably one
13 of our largest issues.

14 Senator Portman. Thank you, Dr. Petzel. I appreciate
15 your testimony.

16 Senator Begich?

17 Senator Begich. [Presiding.] Thank you very much.
18 And, Dr. Petzel, thank you very much for your work and your
19 times to Alaska and other work your agency has done,
20 especially around--we call it the "Heroes Card," but the
21 work you have been doing with Indian Health Services and
22 delivering health care services to rural veterans,
23 especially in roadless areas in Alaska where it is very,
24 very difficult, as you know, to get access.

25 I want to ask you a general question, but first I again

1 want to commend you for moving forward. I know our tribes
2 have been very motivated, and hopefully--I have given them
3 the task, after a period of time, to be working with us on
4 any issues that may come up to make sure we continue that
5 process so that a veteran, no matter where they live in
6 rural Alaska, will have access to health care and not worry
7 about having to fly all the way to Anchorage or Seattle,
8 depending on the service they need.

9 Can you just give me a quick update on how that is
10 working and how you feel the success of that is?

11 Dr. Petzel. Thank you, Senator Begich. I want to just
12 mention that I had dinner last night with Katherine Gottlieb
13 from the Southcentral, and I mentioned we were having the
14 hearing, and she said to send her regards.

15 Senator Begich. Very good. Thank you.

16 Dr. Petzel. We have had great success, I think, in
17 working with Southcentral and the other tribes in Alaska.
18 The contract that we have for sharing services with
19 Southcentral has been very effective in providing specialty
20 services. We also have some instances where in more remote
21 areas veteran patients are being seen in tribal facilities,
22 obviating the need to travel back to either Fairbanks or to
23 Anchorage.

24 So the number--and then the second issue, the number of
25 people that are having to travel out of Alaska down to

1 Seattle or to Portland for services has shrunk dramatically,
2 and I would say that with very few exceptions we are going
3 to eliminate that need in the not too distant future. I
4 mean, there are some quaternary things such as bone marrow
5 transplants, et cetera, which Seattle is the obvious place
6 to go.

7 Senator Begich. Right, sure.

8 Dr. Petzel. But, otherwise, our goal is to not have
9 veterans in Alaska traveling out of Alaska in order to
10 receive care. I think we are making progress, sir.

11 Senator Begich. Fantastic. Let me ask you on the
12 mental health, because, you know, since I have been here,
13 that has been an issue, and I appreciate I think the
14 regulatory change you made to eliminate copays on mental
15 health providers on mental health services. Alaska has
16 been--and you know this, and so it is kind of repeating the
17 obvious--that we have been on the forefront of telehealth
18 and many different avenues from health care to mental health
19 to delivery of just about everything you can imagine through
20 telehealth.

21 If, let us say, I am an Alaskan who needs services
22 through telemedicine, and my doctor is in Idaho, does that
23 doctor that I am doing telemedicine have to be licensed in
24 Alaska?

25 Dr. Petzel. The short answer is no.

1 Senator Begich. Okay.

2 Dr. Petzel. First of all, in the VA, as in I think
3 every Federal health care entity, you need to have a license
4 in a State, but you do not have to have a license in the
5 State in which you are practicing. So the licensure issue
6 is really not a problem. What you need--the problem, if it
7 arises, is not the credentialing, which is what licensing is
8 about.

9 Senator Begich. Right.

10 Dr. Petzel. It is the privileging. You need to have
11 that individual have the right kind of privileges in the
12 right organization. So if a doctor in Boise was doing
13 specialty care for somebody at the Anchorage facility, they
14 would have to be privileged at both Anchorage and at Boise.

15 We are working to try and smooth out this process of
16 privileging.

17 Senator Begich. Good.

18 Dr. Petzel. Credentialing is not an issue. It is--

19 Senator Begich. Thank you for kind of splitting the
20 two issues. I knew there was an issue here, and it is on
21 the privileging situation.

22 Dr. Petzel. Correct.

23 Senator Begich. Is there anything legislatively we
24 need to do. I know we did some stuff with DOD on their end,
25 on active, that Senator Kelly Ayotte and I did in an

1 authorization bill a couple of years ago to fix that
2 problem. There were a few more issues they had, but to make
3 sure no matter where an active military member would go,
4 they could get their mental health services delivered from
5 whatever doctor they had at any time. Is there anything
6 legislatively we need to do?

7 Dr. Petzel. Senator Begich, I do not know.

8 Senator Begich. Okay.

9 Dr. Petzel. The privileging issue is something that
10 has to do with the regulating bodies in medical care, the
11 Joint Commission. So the Joint Commission requires that an
12 individual be privileged at the point where they are
13 delivering the care. There is no law, there is not even a
14 Federal regulation that has anything to do with privileging.
15 It is basically a requirement that the Joint Commission has,
16 and we have been working with them to try and find ways to
17 make it easier to have people privileged at various places.
18 But right now privileged is the right of the medical center
19 or the clinic that is delivering the care.

20 Senator Begich. Okay. Very good. Let me again say
21 thank you for all the work that you guys have done in
22 regards to getting what I called the "Heroes Card," but
23 really delivery for health care for veterans no matter where
24 they live, the services they have earned and deserve. So
25 thank you for that.

1 Dr. Petzel. I would like to also just comment on the
2 fact that working with the IHS and tribes in Alaska has just
3 been wonderful. That has been a very, very good example of
4 Federal collaboration. Thank you.

5 Senator Begich. They are a great group up there.

6 Let me ask you, Dr. Roubideaux, if I can--again, Dr.
7 Petzel, thank you very much for that.

8 As you know, we have a significant problem--and, again,
9 I want to echo what Dr. Petzel said. I think our Indian
10 Health Services tribes are doing fantastic work in the
11 delivery of health care. I would argue that we have the
12 best, if not, you know, the top in the country when it comes
13 to delivery in the most harsh climates, conditions, and
14 situations. So I agree that we have some incredible and
15 very innovative approaches that we are making headway in.

16 But one of the issues--and you have heard me talk about
17 this before, and that is this consistent problem of staffing
18 packages and how do you make sure that--you know, you have a
19 vacancy rate of 30 percent in some of your categories, as
20 you described. But the bigger issue is we have, as you
21 know, a hospital in Barrow, one being developed in Kenai,
22 Nome is completed, Matsu--Matsu, a beautiful facility, the
23 whole top floor is empty because they do not have a staffing
24 package. They cannot deliver the services that the Federal
25 Government contracted with them to do.

1 You got about \$53 million last year in the CR
2 nationwide. Just the one in Fairbanks TCC will take \$8
3 million of that.

4 How are we going to solve this? Because, you know, it
5 is one thing to have a clinic in an urban area, but to get
6 someone hired in a rural area like in Alaska, you cannot do
7 it the day they are open. It does not make any sense.

8 How are we going to solve this? Because this is
9 honestly unacceptable. We have invested--"we"--lots of
10 money in these facilities, and then we do not staff them.
11 What is the answer here? Because these are in rural areas.

12 Dr. Roubideaux. Well, the answer is for us to work
13 together on the appropriations that will help us get the
14 staffing packages, and I am pleased to report that the
15 President's budget for 2014 in terms of staffing packages
16 for new and replacement facilities, including joint venture
17 facilities and Federal facilities in Alaska and in Oklahoma,
18 helps us catch up to the amounts that we need to catch up.
19 It has been a difficult budget climate over the past few
20 years, but fortunately through our colleague and through our
21 working with the tribes, our proposal for \$77 million in new
22 staffing really helps us catch up.

23 Senator Begich. Is that enough?

24 Dr. Roubideaux. That is enough to catch up with the
25 need for the facilities that are planned to be open in 2014.

1 And so right now we are doing our 2015 budget formulation
2 and trying to estimate which ones will be open then as well.

3 Senator Begich. Okay. Let me ask one last question,
4 and then I have got to go vote. This one, I will use the
5 Matsu facility. They have a top floor that is available.
6 They are going to fill it up. VA has a clinic down the
7 street that is at capacity. It does not have full service,
8 but it is a clinic. Why don't we just take the clinic that
9 the VA has, take the space that is beautiful space, put it
10 in there and have a collaborative effort? It is all Federal
11 money.

12 Dr. Roubideaux. Well, the great thing about our--

13 Senator Begich. Is that a good idea?

14 Dr. Roubideaux. Because the VA-IHS MOU allows us to do
15 that through sharing of facilities and staff, we have
16 started to do that, and we hope to do more.

17 Senator Begich. VA, good idea?

18 Dr. Petzel. Absolutely. We would be delighted if that
19 kind of arrangement worked for both parties.

20 Senator Begich. Fantastic. We want to work with you
21 specifically on that project, so I think that is a huge
22 opportunity to create a great model.

23 Thank you. I have to go vote.

24 Senator Tester. [Presiding.] Yes, you do.

25 Senator Heitkamp?

1 Senator Heitkamp. Thank you, Mr. Chairman, and thanks
2 to all the members of the panel. Lest you think that this
3 is an unimportant issue to North Dakota, I want to point out
4 that the two Senators whose names were invoked in the
5 testimony were Senator Conrad and Senator Burdick, both from
6 North Dakota and both deeply concerned over a long, long
7 period of time about the issue of rural health delivery.
8 Whether it is veterans, whether it is our Native Americans,
9 or whether it is just mom and dad on the farm, this is a
10 critical issue for us, and it is a critical infrastructure
11 issue for the development and the continued viability of
12 rural America.

13 And so I thank the Chairman for bringing this very
14 important issue to the forefront, and I have got obviously
15 more questions than what I have time for, and so I would ask
16 for an opportunity to submit some additional questions going
17 forward.

18 But I want to first make a point. We have heard every
19 bit of your testimony across the board, talking about
20 telemedicine, talking about the need to do things a little
21 differently, expand your capacity by using the technology.
22 Are you so convinced that the technology is available in
23 Indian country or in rural America? You know, the kinds of
24 things that you think you can do in Washington, D.C., do you
25 really believe you can do in Hoople, North Dakota? Is there

1 the infrastructure backbone, the amount of technology? And
2 have you looked at those issues going forward when you are
3 promoting telemedicine as a solution?

4 Dr. Petzel. Senator, I will take a crack at that
5 first. Ten years ago, the technology was clunky. It
6 required special telephone lines that were often difficult
7 to get into in terms of remote areas. But that whole
8 technology landscape is changing dramatically.

9 Number one is that we can now use a high-resolution Web
10 camera to provide the same kind of fidelity of image, et
11 cetera, that we--

12 Senator Heitkamp. I do not mean to interrupt, but is
13 that true in every remote location in the United States?

14 Dr. Petzel. Well, we can put that technology anyplace,
15 and we can then use the Internet in order to--

16 Senator Heitkamp. What happens if the Internet is
17 intermittent and dial-up?

18 Dr. Petzel. If it is dial-up, it works. We have not
19 run into those kinds of difficulties really any place. We
20 have been on Rosebud. We have been providing services of
21 this nature on Pine Ridge. We are going to be providing
22 those services in Devils Lake in North Dakota. And every
23 place we have used it, it has been, number one, reliable but
24 I think more importantly it is very well accepted by the
25 patients. When they see that as an alternative to driving

1 100 miles to Fargo, they will take it in a minute. And they
2 like it, and they get good care with it.

3 So, yes, I am convinced that this is going to be the
4 wave of the future.

5 Senator Heitkamp. Mr. Morris, I would like to hear
6 your response to that, because you are beyond--I mean, your
7 umbrella is a little broader.

8 Mr. Morris. Yes, ma'am. You know, I think there are
9 some challenges in terms of broadband access, which I think
10 is what you are trying to get at, is there enough capacity
11 to use the full extent of the technology that I agree with
12 Dr. Petzel works very well. And we can get back to you for
13 the record with some--I know there has been some analysis of
14 where there are some broadband gaps.

15 The FCC has done some revisions to its universal
16 service program for rural health care that we think is going
17 to be a key tool in sort of that last mile and expanded
18 capacity for those areas, and that was just announced I
19 think within the last couple months.

20 In addition to that, some of the investments in the
21 Recovery Act through both the Department of Commerce and the
22 Department of Agriculture helped close some of that gap, but
23 there are areas still that are not accessible.

24 Senator Heitkamp. I do not think there is any doubt
25 there is still a digital divide in this country, and that is

1 my point. My point is we cannot offer a solution to the
2 remoteness in rural health care and say we are going to
3 solve it with telemedicine, and then not have the highway
4 that is going to take you there. And so I will pledge this.
5 I am chairing on the Ag Committee the Rural Development
6 Subcommittee, and this is an area that goes beyond
7 telemedicine, but this is obviously an absolute critical
8 component of rural development in my opinion.

9 I have a question for Dr. Roubideaux as well. You
10 know, obviously Senator Begich and the work that has been
11 done in Alaska is very intriguing to us in North Dakota. We
12 think we have remote locations. We think that we have a
13 great deal of difficulty. And I would tell you that where
14 you hear a lot of praise from him in terms of Indian Health
15 Service, that is not what I hear in my State. What I hear
16 is intermittent services. I hear about clinics shutting
17 down because they do not have the capacity and do not have
18 the staff to even open up on a Friday. That overflow goes
19 to other hospitals.

20 And so I am very concerned about the long-term
21 commitment and appreciation that you have about the concern
22 that Native Americans in my State have about the quality of
23 their health care.

24 Dr. Roubideaux. I want to reassure you that we are
25 absolutely committed to providing health care services to

1 the best of our ability to the American Indians and Alaska
2 Natives throughout the country, including in different
3 areas. And you are absolutely right. There are differences
4 among areas. It tends to track around the difference
5 between the proportion of more direct service programs
6 versus more tribally managed programs. And there are
7 flexibilities around tribal management that are really
8 helping Alaska do some really innovative things. But we
9 still have the Federal trust responsibility and our
10 commitment to the direct service programs in North Dakota
11 and throughout the regions in the country. And so we are
12 still working very hard to try to get these same types of
13 improvements in those programs.

14 Senator Heitkamp. And not to prolong it, but I will
15 tell you this: that there are concerns about squashing
16 innovation, especially in the mental health area, within the
17 Indian Health Service because it does not fit with what
18 people may see as traditional models. And I would like to
19 have a longer conversation with you about that going into
20 the future. But we need to be innovative in Indian country
21 in order to provide these services. We need to continue to
22 develop the workforce and the technical expertise of anyone
23 who wants to offer their services, but particularly the
24 programs that we have at UND to train Indian doctors and
25 Indian nurses.

1 And if I can just indulge just one additional question
2 on Heroes, I am very interested in looking at modeling the
3 Heroes Health Card program that Senator Begich has been able
4 to get a pilot on. I am very interested in modeling that in
5 North Dakota, and particularly as it relates to Native
6 American veterans. You know, I think anyone who understands
7 Indian country knows that very many Native Americans in
8 terms of a percentage of their population serve in really
9 double, triple, quadruple numbers in the armed services.
10 When they come home, they have access to Indian Health, they
11 have access to Veterans, but neither one seems to work for
12 them.

13 And so we do not want people who have chemotherapy who
14 are entitled to veterans services to have to get on a bus
15 and drive 10 hours and literally wait in Fargo another 8
16 hours while the other patients on the bus get their
17 services. You know, as somebody who understands
18 chemotherapy, that is not a healthy thing to do to people.

19 And so we really believe that North Dakota would be a
20 great additional site, Dr. Petzel, for modeling a Heroes
21 Health Card in the Lower 48.

22 Dr. Petzel. We would be delighted to talk with you
23 about that.

24 Senator Heitkamp. Terrific.

25 Dr. Petzel. And I would just make a comment. In North

1 Dakota and South Dakota, which is where I used to work, 50
2 percent of the Native American adult males are veterans.
3 That is a huge number.

4 Senator Heitkamp. Yes.

5 Senator Tester. Thank you, Senator.

6 I have a question for Tom Morris. Tom, you are
7 Administrator of the Office of Rural Health Policy, and you
8 are a member of the Veterans Rural Health Advisory
9 Committee. You have a very unique informed perspective on a
10 lot of the issues we have talked about today. Could you
11 tell me what the biggest challenges to greater collaboration
12 between agencies like the VA and HHS might be?

13 Mr. Morris. Well, we have had a good partnership with
14 the VA, and their Office of Rural Health I think was created
15 in 2007, and they reached out to us very early on to sort of
16 learn the lessons we learned over the last 25 years about
17 what it is like to sort of be a voice for rural within a
18 large organization. And that collaboration has continued,
19 as you mentioned. I am on the VA Rural Advisory Committee.
20 And I think it has taken a little time for us to understand
21 the unique challenges that the VA has and how that
22 intersection takes place between the VA providers and
23 private providers. But, you know, I think the fact remains
24 that so often veterans who are returning from the previous
25 two wars especially are predominantly rural, and they are

1 coming back to their towns, and they are seeing care both
2 from their local providers and then they may also be going
3 to the VA for some more specialized care.

4 And so the challenge but also I think the opportunity
5 is how we can both, the private sector and the VA, dually
6 care for those patients, and part of it involves, you know,
7 making sure that, as you share patient information or you do
8 telehealth, you meet the privacy and security challenges of
9 the VA's firewall. But I think there is progress being made
10 there through an initiative they have around Blue Button,
11 which is a form of health information exchange.

12 We have a veterans pilot program right now--and one of
13 the grantees is in your State of Montana, and also Alaska
14 and Virginia--in which we are putting money in to put
15 telehealth equipment into hospitals and clinics, and then
16 reaching out to the VA so that, for instance, a veteran
17 might be able to get their PTSD treatment from a VA provider
18 without having to leave their home community, even if there
19 is not a CBOC or a veterans clinic in that location. And so
20 that program is really still in its infancy. We are
21 recompeting it right now to award another 3 years of grants.
22 And our hope is that that can serve as a pilot for ways that
23 the private providers that care for veterans can also reach
24 out to the VA in their regions and dually care for those
25 patients as effectively as possible.

1 And then we are in conversations with the VA Office of
2 Rural Health about looking at a number of pilot sites really
3 to focus on this whole notion of health information exchange
4 so that as the veteran sees care in both places, the patient
5 information, the medical record, goes back and forth between
6 both groups.

7 Senator Tester. Very good. I would be remiss if I did
8 not ask this question that Senator Begich alluded to,
9 because I have got Dr. Roubideaux here and Dr. Petzel here,
10 and it is the collaboration between the VA and the IHS. I
11 would expect you both, since you are sitting side by side,
12 to say it is working great. But what are the challenges
13 that you faced with the collaboration that you have done
14 together? That is the first question to each of you.

15 And the second question is: Do you have all the policy
16 flexibility you need to be able to do collaboration? You
17 are basically--in many, many cases you are serving the same
18 group of people. So if you could talk about what the
19 challenges have been and then talk about if, in fact, from a
20 policy standpoint if you have the flexibility you need.
21 Whoever wants to go first, go ahead.

22 Dr. Roubideaux. Well, I think that we really
23 appreciate our partnership with the VA and their willingness
24 to try to dig in and deal with some of the challenges we
25 face. We are two different systems with two different

1 authorities, and sometimes we have to work through those
2 issues.

3 There is also the enormous need and the distances that
4 really challenge us as we work together, but I have been
5 requiring my area directors and my CEOs to work with the VA
6 over the past 2 years and meet with them, and that is
7 actually going really well. So we are starting to have the
8 conversations we need to have to work through some of the
9 challenging issues. So that relates to the policy issues,
10 and I think the reimbursement agreement was a great
11 opportunity for us to understand each other's authorities
12 and understand some of the innovative ways that we could
13 collaborate and innovative things that we could do. And so
14 I really appreciate our partnership with the VA because they
15 are willing to dig at some of the hardest challenges we are
16 facing.

17 Senator Tester. From your perspective, Dr. Petzel?

18 Dr. Petzel. I would say that in terms of Washington,
19 and here the collaboration is excellent, the attitude, the
20 desire to make this work for both of us, the desire
21 particularly from our perspective to serve veterans wherever
22 they might be is unparalleled.

23 The issue for me is generally how this is executed
24 locally, and on both sides. I am not saying it is either
25 the VA or the IHS or the tribes. But it works better in

1 some areas than it does in others. Alaska I think is an
2 example of where it works wonderfully. We have sharing
3 agreements with every tribal organization in Alaska. We are
4 going to have reimbursement pilots in almost all of the
5 State.

6 In other parts of the country, we have difficulty with
7 our people getting together with the IHS people, and I think
8 that my responsibility is to be sure that the attitude that
9 we evince in Washington is transmitted down to the level
10 where the work is being done.

11 But I would also agree with Dr. Roubideaux. It is, as
12 I would look at it in the main, working very well. We have
13 a number of places around the country where we do do
14 sharing. We have got clinics located from the VA's
15 perspective on tribal grounds. The reimbursement agreement
16 I think was a huge step forward, ten pilots piloting that
17 reimbursement agreement to work out the kinks in terms of
18 charges and how bills are paid and patients move back and
19 forth.

20 There is always room for improvement, Mr. Chairman, and
21 that is in my mind at the local level where we need to be
22 sure that people are doing everything they can do to develop
23 these cooperative relationships in places like Devils Lake,
24 in places like the Crow Reservation, in the Billings clinic,
25 et cetera.

1 Senator Tester. Right. Okay. Thank you all very
2 much.

3 Did you have any further questions, Senator Heitkamp?

4 [No response.]

5 Senator Tester. Okay. I just wanted to thank you all
6 for your testimony and thank you for the question-and-answer
7 session we have had. This record is going to be open for 15
8 days, so if there are additional questions--and I know there
9 will be because I will have some myself, and I am sure the
10 others will, too--or additional comments that you want to be
11 put in the record, you certainly can do it over the next 15
12 days. Thank you all for your service, and thanks for being
13 here this morning.

14 [The questions follow:]

15 / SUBCOMMITTEE INSERT

1 Senator Tester. Now we will go to the second panel,
2 so, Matt Kuntz and Ralph Ibson, if you would come up, and we
3 will get the name tags changed.

4 I would like to welcome our second panel of witnesses
5 who both have worked tirelessly over the years to advocate
6 on behalf of policies that improve health outcomes and
7 increase access to care for more folks.

8 We have, first of all, Mr. Matt Kuntz. I have known
9 Matt for a while now. He is from the great State of Montana
10 and represents the best of Montana. Born and raised in
11 Helena, Matt graduated from West Point, served with
12 distinction as an Army infantry officer. Matt's advocacy on
13 behalf of our veterans, which is spurred by personal loss,
14 has been recognized by President Obama. Currently he
15 practices law and serves as executive director of the
16 National Alliance on Mental Illness for Montana. Matt took
17 on this role to support, educate, and advocate for all
18 Montanans suffering from serious mental illness and their
19 families. He has done a tremendous job in that capacity,
20 and I am proud of his work and the work of the National
21 Alliance on Mental Illness. Welcome, Matt.

22 Next we have Ralph Ibson. Ralph is the national policy
23 director of the Wounded Warriors Project. In that capacity,
24 he heads up research and policy development on health,
25 benefits, and economic empowerment issues for the Wounded

1 Warriors Project. He formerly served as general counsel at
2 the Department of Veterans Affairs and is also a veteran of
3 the United States Army.

4 Thank you for your service, and welcome, Ralph.

5 Each of you will have 5 minutes for oral testimony.

6 Know that your entire written testimony will be made a part
7 of the record. So we will start with you, Matt, with your
8 oral testimony.

1 TESTIMONY OF MATT KUNTZ, EXECUTIVE DIRECTOR,
2 NATIONAL ALLIANCE ON MENTAL ILLNESS FOR MONTANA

3 Mr. Kuntz. Thank you, sir. Good morning, Chairman
4 Tester, Ranking Member Portman, and members of the
5 Committee. I am really honored to be here to testify. As
6 you mentioned, I came into the NAMI line of work the hard
7 way, like most of us do, but I am really honored to try to
8 help out as many people as possible, especially our rural
9 vets.

10 I would like to start out by just saying what the view
11 from Montana is. As you know, it is a very big State with
12 147,000 square miles, just over 1 million people, with
13 roughly six people per square mile. We have got one of the
14 Nation's highest per capita rates of military service, and
15 we are home to over 108,000 veterans, which is about 16.2
16 percent of the population. Our Indian Health Services
17 needs, we have 12 tribes and 7 reservations with over 66,000
18 Montanans of Native American heritage.

19 The scarcity of mental health professionals in Montana
20 is pretty hard to comprehend, and it really is a major
21 difficulty for our families. But the best way to describe
22 it is we have one psychiatrist between Billings and
23 Bismarck, North Dakota. That is a stretch of about 400
24 miles on the interstate, which is roughly the distance
25 between Boston and D.C. One psychiatrist to cover all that

1 area. There are fill-ins by psychiatric nurses and
2 telepsychiatry, but one warm body.

3 And I think the other thing that needs to be mentioned
4 because it underlies everything in Montana is the oil
5 development in the Bakken, and our eastern Montana and
6 western North Dakota is overtaxed with pretty much all
7 infrastructure issues, but especially mental health. And it
8 is taking what was a crisis and turning it into something
9 really terrifying.

10 So I just wanted to give some quick realities of what
11 happens in Montana, especially with our vets, to show
12 interlinked all of these different agencies are. For
13 instance, if there is a veteran in Darby, Montana, who goes
14 into crisis, he would probably be moved 16 miles to Hamilton
15 to stay at Western Montana's private inpatient crisis
16 center. After being there for a day or two, he will then be
17 transported to Helena where the VA's inpatient unit is--that
18 is 100 miles--and then will eventually return to his home
19 community where he will be treated either by the VA through
20 telepsychiatry or by the private health contractor. And
21 that is just how it looks from us.

22 Some of the things that I think that are really good
23 that are happening in Montana is that the contracting system
24 with the private providers is absolutely essential. The
25 psychiatric nursing program at Montana State is really

1 helping us fill the needs, and telepsychiatry has hit almost
2 a critical mass in Montana, especially with the CMS grant
3 for \$7.7 million for Montana and Wyoming.

4 Peer services is developing well, and I guess one of
5 the things that I would really like to see more is a
6 residency program. I think that we all talk about how bad
7 we need psychiatrists, but the fact is every State that
8 needs psychiatrists also needs a psychiatric residency
9 program. And if they are able to do some of these things,
10 if they are able to provide the services through
11 telemedicine, maybe there is a way to structure those
12 residency programs a little bit more flexibly as well.

13 Also, the loan repayment programs, our Nation really
14 relies on our inpatient psychiatrists, and how they should
15 be taken care of in loan repayment is a little bit different
16 than outpatient psychiatrists.

17 Thank you, Senator Tester, and I am willing to answer
18 any questions.

19 [The prepared statement of Mr. Kuntz follows:]

1 Senator Tester. Thank you, Matt. I appreciate your
2 testimony.

3 Next we have Ralph Ibson. Ralph?

1 TESTIMONY OF RALPH IBSON, NATIONAL POLICY
2 DIRECTOR, WOUNDED WARRIOR PROJECT

3 Mr. Ibson. Chairman Tester, thank you for inviting
4 Wounded Warrior Project to testify this morning. With our
5 mission of honoring and empowering those wounded in Iraq and
6 Afghanistan, the mental health of our returning veterans is
7 among our very highest priorities, and I am honored to be
8 here with Matt.

9 With our focus we see that, despite extensive Federal
10 efforts--and I do want to emphasize extensive Federal
11 efforts--there remain wide gaps in meeting the mental health
12 needs of this generation of warriors. Let me highlight one
13 critical concern.

14 Many who served in Iraq and Afghanistan remain
15 reluctant to receive mental health care. Research indicates
16 that half of those who need care are not getting it, and a
17 high percentage of those who elect to pursue care drop out
18 prematurely. Much more progress is needed to reverse these
19 trends, in our view.

20 Many factors play a role in that process, but in some
21 cases, it also appears to be a function of family issues.
22 And while current law, law that you helped enact, directs VA
23 to provide needed mental health services to immediate family
24 members of OEF/OIF veterans, VA has not implemented that
25 provision.

1 To your focus this morning, Mr. Chairman, nowhere are
2 the gaps in meeting warriors' mental health needs wider than
3 in rural America. VA policy says in essence, and as
4 discussed earlier, that VA facilities must be able to
5 provide veterans' needed mental health care, and if they
6 cannot because of lack of on-site staff of geographical
7 inaccessibility, other options must be used, including
8 telehealth or contract arrangements.

9 But even veterans who live in remote areas often
10 encounter local VA reluctance or even resistance to
11 authorizing community-based care. With limited exceptions,
12 we see only modest VA use of contract arrangements to
13 overcome access gaps. And as indicated, with 55 percent of
14 U.S. counties, all rural, having no practicing mental health
15 clinicians and situations as Matt described in Montana, VA's
16 policy of providing contract care is hardly a comprehensive
17 answer. And with the drawdown of forces in Afghanistan, the
18 access challenge will only grow.

19 We do see promise in programs mentioned this morning.
20 VA's telemental health capability has seen exponential
21 growth, and we certainly see room for VA to greatly expand
22 use of telemental health to engage more warriors and are
23 pleased that Dr. Petzel agrees, as reflected in his
24 testimony.

25 A second important programmatic effort was sparked by

1 the directive in the President's Executive order of last
2 August, that VA hire and train 800 veterans to serve as
3 peer-to-peer counselors. We see that as a model for winning
4 warriors' trust in entering into mental health treatment and
5 staying in treatment. And we also see it as having
6 potential in rural areas. Our one concern is that the
7 initiative is not really targeted at supporting OEF/OIF
8 veterans where the need is greatest, in our view. That,
9 Senators, as you know, also incorporate a peer-to-peer
10 model, and we see that as a key aspect of the success of
11 that program and are pleased, again, at Dr. Petzel's
12 acknowledgment that that is a program that needs to expand.

13 Finally, let me suggest that many OEF/OIF warriors with
14 PTSD and other mental health conditions are also struggling
15 to readjust to a new normal, to uncertainties about
16 finances, career, education, employment. And no single VA
17 program necessarily addresses that full range of issues that
18 many young warriors face. Few, if any, VA programs are
19 embedded in a veteran's community, and yet VA and community
20 each has a distinct role to play. For some veterans, as we
21 see it, community reintegration make take a community-wide
22 effort, and we see a role here for VA. But as yet no real
23 centralized effort to harness such partnerships.

24 With limited exceptions, VA mental health programs are
25 generally not focused or integrated with the adjacent

1 community, and while VA has broad authority to enter into
2 partnership with community providers and Congress just last
3 year in the NDAA strongly encouraged that, we do not see
4 much happening on that front.

5 Finally, we believe VA should work with communities in
6 providing needed mental health services to wounded warriors.
7 This should include providing training to clinicians on
8 military culture and the combat experience. Simply having
9 more providers or access to providers who do not really
10 understand the experience veterans have been through or PTSD
11 is not itself a real answer.

12 We look forward to working with the Subcommittee on the
13 important issues discussed this morning, and thank you for
14 consideration of our views. I am happy to answer questions.

15 [The prepared statement of Mr. Ibson follows:]

1 Senator Tester. Well, thank you, Ralph. Thank you
2 both for your testimony. I appreciate it very, very much.

3 I am going to start with you, Ralph, on what you just
4 last said, because I think it is an issue that I have heard
5 actually from the veterans themselves, and that is the
6 training of the clinicians, making sure that when a veteran
7 who has some issues goes and sees a clinician, that they
8 actually have an understanding of what got that person to
9 the point where they are at.

10 How do we best do this? It seems to me that there are
11 several steps involved, and, by the way, you correct me if I
12 am wrong. I mean, first you have to build the partnership,
13 and then you have got to make sure the folks who are dealing
14 with the veterans understand what the veteran has been
15 through. How is the best way to move forward with that from
16 a VA perspective? Because I think you are spot on, quite
17 frankly.

18 Mr. Ibson. Well, Mr. Chairman, I think you have really
19 put your finger on an important point or emphasized an
20 important point, and that is that the treatment process has
21 to begin with developing a relationship of trust, and I
22 think essential to that is that the veteran perceive that
23 the provider understands his or her problems, understands
24 where he or she has been. And, you know, the VA has done a
25 heroic job of training its clinicians on evidence-based

1 therapies. I do not purport to be an educator or, you know,
2 have insight on the best way of training, but I do not see
3 the equivalent focus on helping ensure that those providers
4 really understand veterans. And I do see, you know, even as
5 VA has expanded, has filled many of those vacancies, has
6 hired 1,300-plus, from the veterans' perspective, when they
7 encounter a clinician who they perceive does not understand
8 them, they leave.

9 Senator Tester. Yes, I agree with that, and that is
10 the worst possible outcome, quite frankly, as far as cure
11 goes.

12 Matt, despite significant investments that have been
13 made to address the complex wounds of war, we continue to
14 see--and you deal with this firsthand--high rates of
15 depression, divorce, domestic abuse, an unacceptably high
16 number of servicemembers, as has already been pointed out
17 today, commit suicide every day. It is overwhelming and at
18 times it is difficult to tell whether we are actually making
19 progress, making a significant impact on what is going on
20 out there.

21 You know, we need to ensure that the VA is able to
22 identify and treat these folks with their issues in a
23 meaningful way, and we need to ensure that they are
24 appropriately staffed in a rural area like Montana. You
25 talked about Billings and Bismarck, 400 miles away. We have

1 got a training staff, but sometimes there is no staff to
2 train in certain areas because there are not the mental
3 health professionals there.

4 So to ensure that we have, you know, accessible folks
5 there now, as an advocate you have been personally involved
6 with this epidemic. You have seen the investments that have
7 been made. You talked about telemedicine. Are there other
8 things out there that are working besides telemedicine? And
9 is telemedicine working well?

10 Mr. Kuntz. Sir, I think telemedicine is working well.
11 It is a great, wonderful thing, and the tribal veterans rep
12 program was one of the first ones that brought it to
13 Montana, and it is valuable. There is no question. I think
14 that one of the other things that I thought was really good
15 was, as you know well, the VA really struggled to staff its
16 inpatient facility in Helena, and it just sat open, and they
17 could not run it due to lack of psychiatrists. And I think
18 that the way that they were able to change their staffing
19 structure to use it with one inpatient psychiatrist, one
20 outpatient, and a couple of nurse practitioners, like that
21 willingness to adapt to what actually happens on the ground
22 in Montana, we do not have three inpatient psychiatrists to
23 run a facility like that. And the VA learned. It took them
24 awhile.

25 But one of the other things I think is--like the peer

1 support is critical and important, and it also provides much
2 needed jobs for veterans that struggle with these kind of
3 issues. But the retention of the counselors I think in some
4 ways is a bigger issue than actually whether or not they
5 have served. I know many veterans that I talk to just say
6 it is a matter of kind of changing bodies in front of them.
7 And if they open up their soul and describe their combat
8 needs, describe all of their issues going on with them, and
9 then the person is gone, I mean, like I talked to one vet
10 that works across the street, and he had three counselors in
11 a year. I mean, I think that while we need to focus on
12 getting the perfect, right training and everything--

13 Senator Tester. Sure, yes. multifaceted. So what is
14 the issue on retention? Why are they leaving? Is it
15 salary? Is it--what is it? Quality of life? Are they
16 burning out, getting out of the business? Why are they
17 leaving? Why are we seeing the turnover?

18 Mr. Kuntz. It is really hard to tell, sir. I think it
19 is different for every one of them. But what shocks me is I
20 guess how in the box and how constrained they are, I mean,
21 and the limits of what they are given to work with. I do
22 think that they are pretty heavily worked. Hopefully they
23 will be working with peer specialists, but also like they do
24 not even give them business cards sometimes, no voicemail
25 for some of these counselors. And how do you--

1 Senator Tester. Right. I got you.

2 Ralph, do you want to add anything to that as far as
3 what is working and what is not working and where the--well,
4 just that, what is working and what is not.

5 Mr. Ibson. Well, I have seen that same telemental
6 health demonstration that Dr. Petzel alluded to, and I would
7 agree with his assessment, and I would agree as well with
8 Matt's perspective on the retention issue, which I think is
9 not limited to counselors. I do think--we attempted about a
10 year and a half ago to survey mental health clinicians, and
11 I would not want to suggest it was a scientific survey, but
12 it was disturbing to see results that suggested, you know,
13 serious morale problems at many facilities.

14 Now, this reflected a period of understaffing, and so
15 I, you know, I acknowledge that as well.

16 Senator Tester. Right.

17 Mr. Ibson. But many spoke of the system as top-down,
18 as failing to appreciate, you know, the importance of
19 allowing clinicians to build that trust relationship of
20 imposing performance requirements that were highly focused
21 on evidence-based practices, exposure therapies, which,
22 while having solid evidence base, were not appealing to the
23 veterans. Many of the veterans could not handle, you know,
24 dealing on a weekly basis with re-exposure to the trauma
25 they had experienced, and yet that was the directive from on

1 high.

2 So, again, VA has done, I understand, a survey of its
3 own last September on clinician attitudes. I think it would
4 be helpful to see the results of that study, that survey.
5 It would be helpful to understand the factors that drive the
6 10-percent vacancy data that Dr. Petzel cited. I think a
7 system that honored its clinicians from those peer-to-peer
8 counselors on up would be a system that would be a more
9 successful one.

10 Senator Tester. I am going to ask you guys a question
11 that I was going to ask Dr. Petzel, but I did not want to
12 keep him here all day long. But I think you guys can answer
13 it in maybe a better way than he could because you are
14 driving the bus at the other end of the experience here.

15 Licensed professional mental health counselors,
16 marriage and family therapists, they make up about 40
17 percent of the overall mental health independent practice
18 workforce. In the VA, they make up less than 1 percent. Is
19 there a reason for that? Other than the fact that--I mean,
20 is there a reason on the ground that these folks--are they
21 less desirable to be counselors or not? Or is there
22 something out there that I am missing other than--can you
23 help me with this?

24 Mr. Kuntz. Sir, there may be a reason for that, but I
25 will just say flat out it is not a valid one.

1 Senator Tester. Okay.

2 Mr. Kuntz. We need them.

3 Senator Tester. Okay. Ralph, do you want to add
4 anything to that?

5 Mr. Ibson. I would not disagree with that perspective.

6 Senator Tester. Okay. Good. I want to talk about the
7 gaps that you talked about a little bit, Ralph, in your
8 testimony. There are some real inhibiting things that are
9 in our society about people who go in for mental health
10 treatment. There is a stigma attached to it. There can be
11 employment problems afterwards, not because they have issues
12 with mental health, but it is because the employer might not
13 want them to begin with.

14 What can we do to minimize the stigma, to be able--so
15 these folks are more likely to go in and get help when they
16 need it? Because it is curable. We know it is curable. It
17 can be fixed. Or is there anything we can do about it? I
18 mean, it is--

19 Mr. Ibson. Well, I do think there are--you know, there
20 has been a probably 20-year or longer effort to address
21 stigma. I think, you know, organizations like NAMI have
22 played an important part in that. I think there is evidence
23 that suggests that veterans themselves, warriors of this
24 generation, still are distrustful of mental health care. It
25 is not solely a stigma issue. And I think the peer-to-peer

1 counselors, you know, can play an enormously important part
2 in belying those views and drawing warriors into treatment
3 and helping sustain them in treatment.

4 I think, you know, again, Matt's point that we have to
5 honor those warrior employees, make them feel they are an
6 important part of the team and make their working conditions
7 appropriate. But I do think, you know, the infrastructure,
8 the policies are in place to close those gaps.

9 Senator Tester. Okay. Matt, do you have anything to
10 add to that?

11 Mr. Kuntz. Sir, I have, I guess, two things. One is I
12 think we need to take the magic out of what this is through
13 research. I mean, a really big problem with the lack of--
14 the stigma is based on lack of understanding. And we do not
15 understand the brain well enough, and especially these
16 diagnostic patterns. With the DSMs changing and everything,
17 the best clinicians really struggle to identify what a
18 person has and, I mean, I think because we do not have valid
19 scientific instruments to measure whether or not people have
20 thee conditions, they are measured by behavioral health
21 surveys, it just leads to a level of distrust, and people do
22 not have a way of saying, okay, my neuro circuitry is
23 disrupted, so I get help for this. You know, like it is--

24 Senator Tester. I understand.

25 Mr. Kuntz. Anything that we could do to improve that.

1 The other thing, I think, is we have a lot of different
2 anti-stigma efforts, but they do not really highlight people
3 that had PTSD and depression in the past. We do not read
4 about--or we do not see the anti-stigma things that talk
5 about Winston Churchill's depression, that talk about
6 Abraham Lincoln's depression. Some of the greatest
7 Americans struggled with these conditions, and why don't we
8 bring them up? So I would love to see a little bit more of
9 that.

10 Senator Tester. Okay, good. I want to talk about
11 partnerships, particularly between the VA and the Wounded
12 Warrior Project, and there may be partnerships between NAMI
13 and the VA that I am unaware of, or maybe there are some
14 opportunities for partnerships that we could make them aware
15 of.

16 I have been aware of and, quite frankly, been out on
17 some programs like Healing Waters in Montana, and you
18 mentioned a project, Project Odyssey, in your testimony,
19 which is maybe classified in the peer-to-peer program, or
20 maybe it is separate--

21 Mr. Ibson. Yes, sir, it has a strong element of peer-
22 to-peer.

23 Senator Tester. Yes. I guess if you guys could shed
24 light on programs like that, their effectiveness, and how we
25 might be able to expand on other programs that could--I

1 mean, there are programs out there working with animals,
2 horses in particular, dogs, and just kind of talk about
3 opportunities out there to collaborate on peer activities
4 related to the outdoors to relieve stress.

5 Mr. Ibson. Well, if I could follow up, Mr. Chairman,
6 Project Odyssey is one of 18 different programs our
7 organization operates. It is a program that takes warriors
8 out in retreat-like settings. It might be to Montana for,
9 you know, an outdoor activity or mountains in Vermont,
10 wherever. But it takes them out in groups, has a trained--
11 you know, has a therapist with them, and focuses on building
12 peer-to-peer relationships to confront in some cases for the
13 first time their post-traumatic stress disorder or other
14 combat-related mental health conditions, and it has been
15 very successful in, you know, helping veterans confront
16 those issues and get into treatment, to overcome the stigma
17 and barriers. And it is a program that we have run for a
18 number of years and ran in collaboration with VA, and it is
19 a Vet Center program, and to our disappointment, VA pulled
20 out of it in about 2010. The suggestion was they lacked the
21 authority or felt they lacked the authority to continue.

22 Since then, Congress last year enacted legislation
23 making it crystal clear that that authority exists, and we
24 had hoped that that would lead to reinstatement of that
25 partnership. That has not happened yet.

1 Senator Tester. Matt, do you have anything to add?

2 Mr. Kuntz. Yes, sir. My favorite program for this--I
3 am totally biased because I was involved in helping start
4 it. My sister, Dr. Janna Sherrill, and a veteran from
5 Missoula, Jesse Scollin, started it up. It is called X
6 Sports 4 Vets in Missoula. What it is, they take--it was
7 based on taking veterans river boarding--I believe it was a
8 6-week program--and it engages them in an extremely high
9 adrenalin activity, and then it was tied in with counseling
10 afterwards, and the level of success in what I saw from that
11 program was just astonishing. And the veteran
12 participation, they not only joined it and they got involved
13 in it, but they took it over themselves and run it. It
14 really is amazing, and it is done in partnership with the
15 Missoula Vet Center, and I know it is a model that could be
16 expanded to other sports and stuff. But the neat thing
17 about this in comparison to some of the other ones is it is
18 not a retreat. It is kind of--it takes them in their
19 community in a sport or something that they can do
20 afterwards and gets them involved with a group of men and
21 women that they eventually form bonds and friendships with,
22 and it also introduces them to civilians like the rafting
23 guide that helped start it.

24 That was the first civilian that some of these vets
25 have bonded with, and they respected him because he takes a

1 little tiny raft on the Lochsa River, and it really is
2 remarkable. But I have not seen any efforts from the top to
3 try to expand that beyond Montana.

4 Senator Tester. Last question, and this is going to be
5 a quick one for you, Ralph. Who funds your Project Odyssey
6 now?

7 Mr. Ibson. We get donations, typically small donations
8 around the country.

9 Senator Tester. All private--

10 Mr. Ibson. Yes, it is all private sector, no Federal.

11 Senator Tester. All right.

12 Mr. Ibson. We do not take Federal money.

13 Senator Tester. All right. Thank you, guys, very
14 much. I want to thank you again for your testimony this
15 morning. I very, very much appreciate it. I think overall
16 this hearing has underscored some of the important progress
17 that I think we have made, but it also highlighted some
18 additional efforts that we need to make. And I look forward
19 to working with Ranking Member Portman and our witnesses
20 here today on these issues to make sure that we can address
21 the health care needs of our citizens and they are met
22 regardless of where they live. And in that regard, I just
23 want to thank you two fellows for being here this morning.
24 Again, I appreciate your work.

25 This hearing record will remain open for 15 days for

1 any additional comments or questions that may be submitted
2 to the record. And with that, the hearing is adjourned.

3 [Whereupon, at 11:45 a.m., the Subcommittee was
4 adjourned.]