

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

WITH RESPECT TO
PENDING HEALTH CARE LEGISLATION

WASHINGTON, DC

JANUARY 17, 2008

Mr. Chairman and Members of the Subcommittee:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I am pleased to be before you providing the organization's views on an array of health care legislation.

The majority of the bills before us today revolve around a central theme: access to care. Whether a rural veteran, a female veteran, or one of our heroic wounded warriors, there are gaps in the Department of Veterans' Affairs' (VA) ability to provide first-rate care. The bills under consideration today aim to close those gaps, ensuring that all of our veterans are adequately cared for, which is a goal that all of us certainly share.

H.R. 2790

This legislation would create a full-time Director of Physician Assistant Services to report to the Under Secretary of Health with respect to the training, role of, and optimal participation of Physician Assistants (PA). We are pleased to support it.

Congress created a PA advisor role when it passed the *Veterans Benefits and Healthcare Improvement Act of 2000* (P.L. 106-419). The law required the appointment of a PA Advisor to work with and advise the Under Secretary of Health "on all matters relating to the utilization and employment of physician assistants in the Administration." Since that time, however, the Veterans Health Administration (VHA) has not appointed a full-time advisor, instead appointing a part-time advisor who serves in the role in addition to his or her regularly scheduled duties while working in the field, far from where VA makes its decisions.

The current PA advisor role is likely not what Congress envisioned when it created the role, and the PA advisor has had little voice in the VA planning process; VA has not appointed the PA advisor to any of the major health care strategic planning committees.

With the role that PAs play in the VA health care process, it only makes sense to invite their participation and perspective. VA is the largest employer of PAs in the country, with

approximately 1,600. They provide health care to around a quarter of all primary care patients, treating a wide variety of illnesses and disabilities under the supervision of a VA physician. Since they play such a critical role in the effective delivery of health care to this nation's veterans, they should have a voice in the larger process. We urge passage of this legislation and the creation of a full-time PA Director position within the VA Central Office.

H.R. 3458

The VFW is certainly supportive of the intent of this legislation, which would create a pilot program to care for veterans suffering from traumatic brain injuries (TBI) in rural areas.

It is clear that VA needs to do a better job caring for our wounded warriors, especially for those who transition from the Polytrauma Rehabilitation Centers, but also for those who suffered, but did not stay at those specialized clinics. As we learn more about TBI, we are also finding that veterans can suffer from it without having any apparent physical injuries, meaning there are likely larger number of veterans suffering from mild or moderate TBI – diagnosis can come later, but only if VA properly screens the veteran.

We have all seen the television reports and read the heart-wrenching stories about wounded warriors falling through the cracks. It is truly shameful that these brave men and women have had to suffer. We can and must do better.

This legislation acknowledges these problems, and works to correct some of them. It would create, in five rural states, a pilot program that would provide trained case managers to veterans suffering from TBI, and allow VA to contract for care in places where VA is unable to meet the demand for care. All are worthy goals.

We would ask, however, that the Committee be mindful of any potential overlap with the Wounded Warrior legislation that has been making its way through Congress as part of the National Defense Authorization. It is our understanding that the provisions, which earlier cleared both chambers of Congress, are non-controversial and that they will likely be a part of any upcoming Defense Authorization bill.

As always, we would hope that VA would be able to develop the in-house experience to deal with all these problems, and we believe that this should remain VA's ultimate goal. In the meantime, there are hundreds of veterans with a demonstrated need who would benefit from the contracting care this legislation would provide. We cannot afford to wait; they must receive adequate care as soon as possible.

H.R. 3620

The VFW is pleased to support H.R. 3620, the Homecoming Enhancement Research and Oversight Act. This legislation calls for a comprehensive study on the physical and mental health care needs of OEF/OIF veterans, produced by DOD, VA and the National Academy of Sciences.

The study, which would consist of two major phases, would look at the key issues and unknowns confronting those who were deployed overseas as part of OEF/OIF. It would include a study of the effects of multiple deployments, the scope of traumatic brain injuries and their effects on the service member and his or her family, and the long-term impact of other war-related illnesses and disabilities such as post-traumatic stress disorder. Notably, the study would also assess the physical and mental health care needs of women veterans. We also appreciate the emphasis this legislation would place on families and the effects these illnesses and disabilities appear to have on them. With the large number of citizen soldiers fighting these conflicts, it is only proper to see how all are affected, because it is clear that it is not just the man or woman in uniform who suffers.

A study such as this is essential to allow VA and DOD to properly manage what appears to be a crisis in our returning veterans. This assessment would give the departments and policy managers a clear idea of what the problems are, allowing us to develop plans to treat the disabilities and impairments we are seeing. The studies that we have seen have hinted at the problem, and have shown us enough to make initial efforts at improving the care of these brave men and women. However, we can and must do more.

We must be proactive with our approach, and move forward. Proper study of the issues will allow VA and DOD to see if their programs are accurately meeting the needs of this deserving population of veterans, and will better allow us to prepare for their care into the future. There is plenty that we do not yet know about the needs of these veterans, and the more we find out, the better prepared we will be to fulfill this nation's sacred obligations to her sick and disabled veterans.

H.R. 3819 and H.R. 4146

The VFW is pleased to offer our support for these two pieces of legislation that deal with an issue important to a number of our members. These two bills would close a loophole in current law that causes a number of veterans each year to be saddled with expensive hospital bills for care related to emergency treatment.

Section 1725 of Title 38 authorizes VA to reimburse veterans for medical expenses related to emergency care at non-VA facilities if the veteran is enrolled and using the VA health care system, and if he has no other form of medical insurance. This is an important safety net for many veterans who have no other means to pay for potentially life-saving care.

Under that same section, the definitions in (f)(1)(C) create that loophole that harms veterans. Current law requires that the non-VA facility transfer the veteran to a VA facility when the veteran is stable. However, in areas, where there is no suitable VA facility or when the facility is unable to accept the patient, the veteran is forced to stay at the non-VA facility and VA makes no payment for that emergency care. In this case, VA's inability to adequately provide the care the veteran needs ends up costing the veteran thousands of dollars out of his or her own pocket, something that is unconscionable. Clearly, this unfair policy punishes veterans unfortunate enough to live in areas where no VA facilities are available or able to accept a veteran. The policy punishes them for something that is no fault of their own.

Both bills amend that section and close the loophole. H.R. 3819 goes a step further. It mandates that the Secretary provide reimbursement by striking the “may reimburse” from Section 1725 (a) and replacing it with “shall reimburse.” This would eliminate any potential for a weakening of the policy. H.R. 3819 also would amend Section 1728 of Title 38 to specify emergency care as a medical expense eligible for reimbursement to certain categories of service-connected veterans. While we support the concept, we would note that the Committee should carefully consider any externalities that could pop up from replacing “such care or services” with “emergency treatment,” especially when section 1728(a)(1) already specifies that reimbursement is for “such care or services [that] were rendered in a medical emergency.”

With that in mind, we would urge the Committee to swiftly approve legislation that would close this loophole so that VA can properly reimburse those veterans who would be unfairly penalized by the current law.

H.R. 4053

The VFW is happy to support the Mental Health Improvements Act, comprehensive legislation that aims to improve the level of mental health services that VA provides, especially with respect to PTSD and substance abuse disorders. This legislation acknowledges and aims to improve the treatment of what is sadly a growing problem among veterans, especially OEF/OIF veterans. As the findings of the bill note, a 2005 DOD study found a 23% rate of Active Duty personnel who acknowledge a significant problem with alcohol use.

Title I of the bill focuses on substance use disorders, especially in conjunction with PTSD and other mental health issues. It would require VA to provide treatment – including counseling, therapy, and detoxification services – for substance use disorders at each VA medical center and community-based outpatient clinic, although it gives the Secretary the authority to decide if services are not needed at a particular location.

Additionally, it would provide funding for services to veterans suffering from PTSD with substance use disorders. Notably, it would allow VA to conduct these services in concert with peer groups, but also families. This flexibility would allow VA to develop a program that best works for individual veterans, adapting it to the veteran’s particular needs for the most effective results.

The legislation would also create six new Centers of Excellence within VA to address PTSD and Substance Use disorders. These centers would provide comprehensive inpatient treatment for those veterans most in need of help with these sometimes-debilitating diseases. We are especially appreciative of the proposal to require the creation of a referral process for when veterans are ready to leave the centers. This could help to eliminate the possibility of a veteran falling through the cracks, ensuring that the veteran really does receive the additional care that they would need to recover and return to normal life.

The VFW also supports Section 201 of the legislation, which would create a new pilot program of peer outreach and support to help provide readjustment counseling and other mental health services. With respect to the peer outreach and support, we believe that these types of therapies and support are often preferable to certain veterans. They may appear to be less formal and more casual, a style that may be conducive to more effective results among some veterans. We would

hope that the results from the pilot program would lead to improvements in VA's overall mental health and readjustment programs.

Section 201 would also authorize VA to provide mental health care to veterans in rural areas through contracts awarded by the newly created Office of Rural Health. While ultimately, the VFW would like to see VA have the ability and capacity to provide the full continuum of care to all veterans within its systems, we support this measure as it fills a critical gap in service to those veterans who truly need it. We would urge, however, that VA and Congress provide strong oversight of these programs to ensure that they really are meeting the needs of our veterans, and that they are complying with all VA privacy and clinical protocols.

We also support Titles III and IV of the legislation. They would require an in-depth study of PTSD and substance use disorders and extend VA's Special Committee on PTSD through the end of 2012. I would also make a note of the meaningful change in Section 401 of the bill, which would add marriage and family counseling to the list of services VA should offer. As we have seen with the current conflict, the range of mental health services veterans suffer from do not just affect the individual, but also their families. We must do better, if not just to help those family members who suffer silently outside of VA's normal range of treatment, but also to improve the home life of those veterans suffering, giving them stability and comfort in their home life. That stability is critical to the effective treatment of the veteran, and anything we can do to improve upon it, is something we must do.

We thank Ms. Berkley and the members of this Subcommittee who have signed on to this bill for supporting it, and we would urge its approval. It could really have a meaningful impact upon thousands of veterans suffering from the invisible wounds of war.

H.R. 4107

The VFW is pleased to offer our strong support for this legislation, which would expand and improve upon the health care services provided to women veterans. Female veterans from OEF/OIF are experiencing many types of conflict that previous generations did not. They are involved in a conflict with no true frontline and in a high-stress situation with almost no relent.

The difficulties they face, and the level of reported mental health issues that all OEF/OIF veterans have is itself a challenge for VA. It is essential that VA's strategies not be a one-size-fits-all approach, but one that adapts and provides our men and women with tailored programs to give them every chance to return to civilian life fully healthy. This is especially so for our women veterans, many of whom are facing unprecedented levels of stress and conflict, and who, when they return, enter a VA that is predominantly used to caring for male veterans.

VA has made great strides in the care provided to women veterans, but they can definitely do more. *The Veterans Emergency Care Fairness Act* would push VA even further along, and would address some of the most critical issues our female veterans face.

Title I of the bill would authorize a number of studies and assessments as to VA's capacity for care, but also for what the future needs of women veterans will be. Section 101 would create an essential long-term epidemiological study on the full range of health issues female OEF/OIF veterans face. This is critical because it is uncharted territory. With increasing numbers of women veterans in a hostile combat zone, there are higher rates of exposures and incidents that

must be studied so that we know what health care issues will come up in the short- and long-term. There is much we do not know, and lots of essential information that is necessary to study to ensure that VA is meeting their full needs.

Section 102 would require VA to study any potential barriers to care faced by women veterans to determine any improvements that VA must make so that women veterans can access the care to which they are entitled. This is especially true of those women veterans who choose not to use VA care. Is it because of a stigma associated with VA, a previous bad experience or other reasons? To better prepare for the future, VA must know the answers to these questions and we strongly support this study. Along those same lines, section 103 would require VA to develop an internal assessment of the services it provides to women veterans, as well as plans to improve where it finds gaps. We, too, welcome this assessment.

We fully support the sections contained in Title II of the legislation, which deal with the improvement and expansion of health-care programs for women veterans. We especially appreciate the addition of two recently separated female veterans to the VA Advisory Committees on women veterans and minority veterans.

The VFW supports section 204, which would create a pilot program to provide child care for women veterans receiving health care through VA. This is a terrific idea, which has the potential to eliminate a barrier for care, especially for single mothers. We note, however, that there are also a number of single fathers who would also benefit from the pilot program, but would be prevented from using these child care services under the definition of “qualified veteran” in Section 204(a)(3).

The VFW thanks Ms Herseth-Sandlin and Ms. Brown-Waite for the introduction of this important bill, and we would urge the Committee to approve it because of the difference it could make for our women veterans today, but also for long into the future.

H.R. 4204

The VFW supports the “Veterans Suicide Study Act,” legislation that would require VA to determine the number of veterans who have committed suicide over the last decade.

VA has made improvements to its suicide prevention programs, improving training for VA staff and employees, and raising awareness of the seriousness and importance of this issue. VA has established a national suicide prevention hotline, and hired suicide prevention coordinators at its medical centers.

Nobody knows the true number of veteran suicides, for a variety of reasons, but even just one loss is a tragedy. VA’s Epidemiology Service is using rates from previous conflicts to estimate the rate of suicide among OEF/OIF veterans. Although this may provide VA with an acceptable starting point, hard data is going to be much more valuable with VA’s efforts to provide truly effective mental health coverage and to improve its suicide prevention efforts.

Recent studies have shown a demonstrable link between exposure to a combat zone and the risk of suicide, most notably in the November 2007 Institute of Medicine report on “Physiologic, Psychologic and Psychosocial Effects of Deployment-Related Stress.”

While this legislation would not lead to the direct treatment and care of more veterans, the numbers and information collected by this report could help VA and DOD get an accurate picture as to the scope of the problem, and uncover cases and examples that might otherwise go hidden. With the seriousness of this problem and the attention we must pay to it, more information is certainly better. The more information available to VA, DOD and Congress, the more prepared we all are to live up to this nation's responsibilities to care for her veterans. Suicide among our veterans, especially those newly returning from combat, is a tragedy, and we owe it to our heroes to do everything in our power to prevent it from ever occurring.

H.R 4231

The VFW supports this legislation, which would create a pilot program to provide mental health counseling at non-VA facilities for veterans who live in rural areas. One of the challenges VA has faced since OEF/OIF began has been on how to best care for those veterans who live in more remote areas, especially with the intensive levels of care some of their illnesses and disabilities require.

This is an issue with no true satisfactory answer, especially as we would prefer that VA be able to provide a high level of care to all eligible veterans. As we have seen with many veterans who live in rural areas, this is not always feasible. Veterans living far away from VA clinics or medical centers simply have a more difficult time receiving the same level of care that a veteran who lives in a town with a clinic receives. *The Rural Veterans Health Care Access Act* recognizes this and takes steps to improve their access to care.

To achieve this, it creates a 5-year pilot program that allows VA to provide six-month vouchers for enrolled OEF/OIF veterans who live at least 30 miles from a VA facility that provides full-time mental health services to receive care with private mental health counselors. We are pleased to see that the counseling services include family counseling, since they often suffer from the effects of the veteran's mental health illness, and counseling can increase family stability, which is often a critical component in the rehabilitation of these complex mental health illnesses.

While ideal circumstances would have VA providing this level of care to all eligible veterans, we understand the difficult situation today's veterans are in. We would hope that VA not rely on contract care to provide these specialized services and that the Department continue to make attempts to provide these services, but in the meantime, we cannot afford to leave these brave men and women waiting. This is the least we can do to make them whole, and to ease their transition back into civilian life.

As with our support for H.R. 4053, however, we would urge vigorous oversight of this contract authority to determine whether veterans are truly being helped and that the services VA pays for live up to VA's clinical, safety and privacy standards.

Mr. Chairman, this concludes my testimony. I again thank you for the opportunity to present the VFW's views and I would be happy to answer any questions that you or the members of the Subcommittee may have.