ADRIAN ATIZADO ASSISTANT NATIONAL LEGISLATIVE DIRECTOR OF THE DISABLED AMERICAN VETERANS

STATEMENT OF ADRIAN ATIZADO

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BEFORE THE COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE
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Mr. Chairman, Ranking Member Burr and other Members of the Committee:
Thank you for inviting the Disabled American Veterans (DAV) to testify at this important hearing of the Committee on Veterans' Affairs. DAV is an organization of 1.3 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

As you may be aware, our DAV advocacy campaign, Stand Up For Veterans, is well underway. Its purpose is to generate greater public understanding and build support for changes in veterans' health care programs, benefits, and services for all the men and women injured or disabled in service to the Nation, including those from the wars in Iraq and Afghanistan, as well as those from prior eras and conflicts. In this effort, our campaign focuses our organization's priorities which we hope this Committee will consider as it prepares its legislative agenda for the 111th Congress:

- VA Health Care Funding Reform
- Disability Compensation Improvements
- Family Caregiver Support and Services
- Women Veterans Health Care
- Traumatic Brain Injury
- Mental Health Care and Substance-use Disorder

VA Health Care Funding Reform

While great strides have been made in Congress to increase the level of Department of Veterans Affairs (VA) health care funding during the past several years, there is a long history of significant delays in receiving those funds. Notwithstanding notable improvements in the past two years, VA has received its annual funding for veterans' health care late in 19 of the past 22 years. Unlike Medicare or Medicaid, the VA must rely on Congress and the President to pass a new appropriations law each year to provide VA hospitals and clinics with the funding they need to treat sick and disabled veterans.

Due to the late and unpredictable budget process, VA is increasingly challenged to properly treat the physical and mental scars of war for all veterans needing care. Further, not knowing when or at what level VA will receive funding from year to year - or whether Congress will approve or

oppose the Administration's proposals - hinders the ability of VA officials to efficiently plan and responsibly manage VA health care.

Broken financing causes unnecessary delays and backlogs in the system: hiring key staff is put off, or just not done, while injuries like PTSD or TBI are too often not diagnosed or treated in a timely manner. Since 2001, the number of VA patients has grown by two million - a 50 percent increase - and our newest generation of veterans has increasingly complex mental and physical health care needs that will require a lifetime of care. Moreover, a 2007 report by the VA's Office of Inspector General concluded that 27% of the injured veterans seeking treatment at VA facilities had to wait more than 30 days for their appointments.

For the past decade, the DAV and its allies in the Partnership for Veterans Health Care Budget Reform - a coalition of nine veterans service organizations with a combined membership of eight million veterans - have sought to fundamentally change the way veterans health care is funded. While mandatory funding has been the focus over the past several years, the Partnership helped develop and fully endorsed S. 3527, the Veterans Health Care Budget Reform Act, introduced in the 110th Congress. This legislation has also been endorsed by The Military Coalition, comprised of 35 organizations representing more than 5.5 million members of the uniformed services - active, reserve, retired, survivors, veterans - and their families. The DAV thanks the Chairman of this Committee and his eight co-sponsors for introducing this measure which received bipartisan support and has been endorsed by then President-elect Obama and [the recently confirmed] VA Secretary Eric Shinseki.

We believe this legislation proposes a reasonable alternative to achieve the same goals as mandatory funding, by authorizing Congress to appropriate funding for veterans' health care one year in advance and adding transparency to VA's internal budget process. With the goal of ensuring sufficient, timely, and predictable veterans health care funding through advance appropriations, Congress retains full discretion to set funding levels for each fiscal year, and the legislation does not eliminate, reduce or diminish Congress' ability to provide strong oversight over VA programs, services and policies.

Introduction and passage of the Veterans Health Care Budget Reform Act in the 111th Congress would address DAV's highest priority in VA health care.

Improving VA Disability Claims Process

The Department of Veterans Affairs (VA) disability claims process is a complex and burdensome system whose timeliness has declined in recent years to unacceptable levels, resulting in more than 800,000 backlogged claims. The complexity of this challenge ensures that there is no "magic bullet" solution capable of quickly resolving the claims backlog. Our broad view is that it is imperative that VA empower personnel with exceptional knowledge of current processes to manage and reduce the claims backlog without eroding decades of progress. The DAV believes the cumbersome and lengthy administrative claims and appeals process can be streamlined (1) by merging and eliminating redundancies within the benefits delivery system, and (2) integrating its electronic framework into a single, state of the art information system to create, as much as practical, a new electronic claims process.

Another reality intertwined with the foregoing is that the quality assurance and training programs in use by the Veterans Benefits Administration are inadequate as tools to sample the validity of decisions on claims. The VA must fundamentally change its quality assurance/accountability systems and training programs in order to successfully reform the compensation system. However, the underlying challenge here is that it must do so without significant infrastructure changes.

Similar to the claims process itself, the Veterans Benefits Administration's (VBA) training programs are plagued by a lack of accountability that perpetuates VA's inability to produce accurate and equitable decisions on claims. Training, quality assurance, and accountability changes must be approached in that order, while VBA resists hasty broad-brush approaches. Subject matter experts from all corners of the veterans' benefits arena should collaborate toward one goal-improve training in order to improve rating quality, and hold employees accountable in order to assure a quality product.

Military personnel injured on active duty have been hamstrung with a Department of Defense (DOD) disability evaluation system that discharges them from active duty with unacceptable variances in disability ratings. These outcomes are the result of the current system which is unmanageable and inconsistent. The problem has been a focus of veterans service organizations for a substantial period of time and our observations were validated by the Veterans' Disability Benefits Commission which was chartered by the National Defense Authorization Act of 2004. In its review, the commission found for example that the Army is less likely than other military groups to assign a disability rating of 30% or more, the cutoff for a person to receive lifetime retirement payments and health care. The Pentagon has a strong incentive to assign ratings of less than 30% so the Services can avoid paying higher disability benefits.

The military announced on November 7, 2008 an expansion of the Disability Evaluation System Pilot with all military services now taking part in a follow-on of the National Capitol Region test program. Now wounded service members leaving the military may have easier, quicker access to their veterans' benefits under this expanded pilot program that will offer streamlined disability evaluations. That is, provided they are of the fortunate few assigned to one of the 19 military installations. The initial phase of the expansion started on October 1, at Fort Meade, Maryland and Fort Belvoir, Virginia. The remaining 17 installations will begin upon completion of site preparations and personnel orientation and training, during an eight-month period from November 2008 to May 2009.

Although the Disability Evaluation System Pilot is a notable improvement, its productivity pace was slow with only 700 service members who participated in the pilot having their cases finalized over a ten-month period. The issues that hinder the timely resolution of disability claims by the VA for veterans are the same as those for active duty service members transitioning to veteran status.

Family Caregivers Support and Services

The nature, prevalence, and degree of injuries that veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) are sometimes so severe that family members, whose lives and livelihoods have been interrupted to care for their loved ones, need increased federal support and assistance.

They face daunting and life-long challenges. Often, they must drop everything to be at the bedside and take care of the physical and mental injuries of their sons, daughters, spouses, or parents. They must deal with a complex system of overlapping and changing support programs which poses a great challenge for family caregivers to understand and navigate, too often resulting in a state of confusion for the caregiver.

Once severely disabled veterans return home, their family caregivers provide the needed support to maintain the veteran's quality of life and independence while living in their community. Even though it is widely recognized that informal caregiving can delay or avoid institutionalization of the veteran, caring for a severely disabled veteran exacts a high cost on family caregivers. They often shoulder physical burdens, mental strain, and psychosocial challenges as a result of their caregiving responsibilities. They face the disruption and change of their family's life, withdrawal from school or loss of employment and employer-based benefits, often sacrificing their own health, well-being, and economic future in order to care for a loved one.

Although close family members are often willing to bear the burden of being primary caregivers for severely disabled veterans - thus relieving VA of that obligation or the cost of institutionalization - they seldom receive sufficient support services or financial assistance from the government.

The DAV believes these informal caregivers should receive a comprehensive array of support services, to include respite care, financial compensation, vocational counseling, basic health care, relationship, marriage and family counseling, and mental health care to address the multiple burdens they face. Among other things, a "Caregiver Toolkit" should be provided to family caregivers, to include a concise "recovery roadmap" to assist families in understanding and maneuvering through the complex systems of care and federal, state, and local resources available to them. Moreover, policymaking and planning to better serve family caregivers of severely injured veterans should include statistically representative data from a periodic national survey and individual assessments of family caregivers of severely injured and disabled veterans. By supporting the caregiver, we support the disabled veteran.

Women Veterans Health Care

Although women have historically been a very small percentage of patients in the VA health care system, VA estimates that the number of women using VA health care services will double in less than five years if the current enrollment rate continues. In addition, of the more than 102,000 women who have served and separated from military deployment in Iraq and Afghanistan, over 48,000 have already received health care from VA. With an unprecedented and increasing number of women in the military and serving in Iraq and Afghanistan, VA is challenged to provide consistent, comprehensive, quality health care services to women veterans today and in the future.

Women returning from combat theaters have unique physical and mental health care needs. More women service members are being exposed to combat situations, have experienced sexual trauma during military service, and need specialized post-deployment and mental health care services. The increasing demand for services and changing demographics of this population, coupled with the need to have more clinicians with women's health expertise, will challenge VA resources and service delivery systems.

According to VA's own data, women veterans receive lower quality health care than men and do not consistently receive the recommended health care services to meet current VA standards. Unfortunately, VA has moved away from comprehensive women's health clinics in recent years, favoring a health services model that is fragmented and fails to adequately address the comprehensive needs of women veterans. It is critical that women veterans gain access to high quality primary and gender-specific care, as well as mental health services from qualified clinicians.

Legislation is needed to ensure women veterans' health programs are properly assessed and enhanced so that access, quality, safety, and satisfaction with care are equal for women and men. To improve quality and reduce disparities in health care services for women receiving VA care, the Department should conduct a comprehensive long-term, longitudinal study on the unique health challenges facing women veterans who have served in combat theatres.

VA must also redesign its women veterans care delivery model and establish an integrated system of health care delivery that covers a comprehensive continuum of care and serves as a best practice in the field. To accomplish this, VA should:

- Identify and implement the best clinical models of care to meet the comprehensive health care needs of women veterans using the VA health care system;
- Improve its ability to assess and treat women who have experienced combat and/or military sexual trauma; and increase the use of gender specific, evidence-based treatments; and

• Receive sufficient resources to have at least one provider with women's health care expertise on duty at every VA medical facility.

Traumatic Brain Injury

Traumatic brain injury (TBI), a common injury to OEF/OIF veterans, can cause devastating and often permanent damage. Even mild-to-moderate TBI, which can be much harder to diagnose, will often lead to lasting physical and psychological problems. In addition, many OEF/OIF veterans have suffered "mild" - but pathologically significant - brain injuries that have gone undiagnosed and largely untreated. Behavioral problems, memory loss, disruptive acts, depression and substance-use disorder are common symptoms associated with TBI.

According to a RAND study released in April 2008, 19 percent of returning OEF/OIF service members report possible TBI. The RAND study estimated that over 300,000 service members

had experienced TBI, but only 44 percent of these had been evaluated by a physician. Veterans with TBI often have difficulty communicating their health status or seeking proper assistance. Complicating this situation, many rural veterans are unable or unwilling to overcome the barrier of distance to reach the nearest VA medical facility.

In order to detect and treat TBI, proper screening and personalized recovery plans are essential, particularly for those cases that are mild-to-moderate in severity. There is also a need to increase DOD and VA specialists with TBI expertise to assist in identifying and managing the complex conditions prevalent in this population. To date, DOD lacks a system-wide approach for identification, management, and surveillance of individuals who sustain mild-to-moderate TBI in combat, and VA programs addressing the needs of service members with mild-to¬moderate TBI have not been fully developed or implemented.

More research is necessary to understand the long-term consequences of TBI, as well as the development of best practices in treating these injuries. These studies should also focus on older veterans who may have suffered these injuries in earlier wars, detect mild-to-moderate cases of TBI, and study their consequences. With Congressional oversight, we are hopeful that these needs will be met by the Defense and Veterans Brain Injury Center, one of the Defense Centers of Excellence, whose mission is to serve active duty military, their dependents and veterans with TBI through state-of-the-art medical care, innovative clinical research initiatives, and educational programs. In addition, we believe that a VA Central Office-based TBI program should be established which would be an effective means of organizing and improving VA's responsiveness to veterans with TBI.

Mental Health Care

According to VA, as of August 2008, over 945,000 OEF/OIF service members have separated from military service. Of those, over 400,000 OEF/OIF veterans have sought VA health care since 2002, and over 178,483 have received a diagnosis of a possible mental health disorder. Within that group, 105,465 have been given a probable diagnosis of post-traumatic stress disorder (PTSD).

The above-mentioned 2008 RAND study estimated that approximately 300,000 OEF/OIF veterans had symptoms of PTSD or major depression with the best predictor for these conditions being exposure to combat trauma during deployment. Further, the report stated 53 percent of service members with PTSD or depression sought help from a provider, but that 50 percent of those who sought care received minimally adequate treatment.

Current research strongly suggests that PTSD can be treated successfully with appropriate therapies and evidence-based treatments. Although VA has improved its mental health programs in recent years, the scope of care provided, and its distribution across the 1,400 existing VA sites of health care does not meet the needs of veterans with post-deployment PTSD, depression, and co-morbid substance use disorders. VA's National Mental Health Strategic Plan also reveals systematic shortfalls in veterans' access, and documents gaps in scope and quality of VA behavioral health programs nationwide.

Congress should continue to oversee implementation of the VA's National Mental Health Strategic Plan and its Uniform Mental Health Services initiative. Frequent reports to document progress should be made to Congressional committees, consumer councils, veterans' service organizations including DAV, and to VA's Committee on Care of Veterans with Serious Mental Illness.

VA should reformulate its approach to mental health to focus on recovery consistent with the principles of the New Freedom Commission on Mental Health, and VA should fully implement the recommendation of the Institute of Medicine to embrace these recovery therapies, while furthering research in PTSD, including research in improved screening methodologies and stigma reduction techniques.

Substance-Use Disorder

Substance-use disorders are occurring at high rates among OEF/OIF veterans, based on converging evidence from studies of active duty personnel and recently discharged veterans. Studies of returning reservists and active duty members indicate that approximately one quarter acknowledge an alcohol problem. Rates are higher for those with multiple deployments, a growing cohort as the war continues. This is consistent with national studies that find rates of substance use twice as high among those exposed to serious stress.

Substance use occurs on a continuum ranging from non-problematic use to hazardous/harmful misuse to abuse to full dependence. For many of these OEF/OIF veterans their alcohol misuse or abuse is new. Binge drinking and citations for driving under the influence (DUI) are characteristic of misuse and abuse in this age population. Many of these veterans could benefit from short-term and early interventions, such as motivational counseling, which have proven their efficacy.

Recent surveys of OEF/OIF veterans returning from deployment have found increasing incidence of alcohol and other substance misuse in this population. In an anonymous study of active duty personnel by the DOD, 23 percent of respondents acknowledged having a significant alcohol problem. Also, an Army study of soldiers serving in Iraq concluded that while about 12 percent of soldiers reported alcohol misuse, only 0.2 percent were referred for treatment. Of those referred, only a small number received care within 90 days of screening.

Over the past decade, VA's substance use disorder treatment and rehabilitation services have been in decline. Only recently has VA begun to re-evaluate, rebuild and expand these specialized programs and to coordinate these services to address post-deployment mental health co-morbidities. Currently VA substance abuse treatment programs are targeted to veterans with severe substance abuse or dependence. Short-term interventions specifically targeted to veterans with hazardous or harmful levels of use or early abuse are generally not available.

VA should focus intensive efforts to improve and increase early intervention and prevention of substance-use disorder in the veteran population. Ready access to robust mental health and substance-use treatment programs are critical to avoiding long-term health consequences post-deployment. VA must also continue moving forward with a Uniform Mental Health Services policy initiative that includes proper screening and access to a full continuum of care for

substance-use disorders at all VA facilities. While some progress has been made, the pace needs to increase.

The DAV thanks this Committee for its efforts last Congress in passing S. 2162, the Veterans' Mental Health and Other Care Improvements Act of 2008 (Public Law 110-387). This act, supported by DAV, requires VA to provide a full continuum of care for substance-use disorders, including consistent and universal periodic screening in all its health-care facilities and programs involving OEF/OIF combat veterans-especially those in primary care. Congress must provide strong oversight and VA should aggressively enforce and implement these specialized programs, and ensure that sufficient funding is made available to achieve these goals.

DAV has been pleased by Congressional responsiveness to many of the proposals emanating from our Stand Up For Veterans campaign that we have shared and discussed with members of this Committee, your staff, and others in Congress. We thank the Chairman for introducing S. 252, the Veterans Health Care Authorization Act of 2009. This bill, drawn in large part from a staff conference package based on S. 2969 of the 110th Congress, contains many provisions that would address our priorities and concerns. We urge its passage early in this Congress.

Mr. Chairman, this concludes my statement and I would be happy to answer questions on these issues from you or other Members of the Committee.