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STATEMENT OF
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ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
OCTOBER 24, 2007

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

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

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

S. 38-the Veterans' Mental Health Outreach and Access Act of 2007

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

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

We appreciate the intent of the bill in serving veterans in rural areas, which has historically been a challenge for VA. On a positive note, this bill would be consistent with VA's principles to use coordinated contract care only when services are unavailable in the VA-a firm position that DAV holds. At the same time, the legislation would address the needs of the veteran's immediate family as it relates to his or her recovery and would build on the tested concept of having peers

with similar personal military experiences from which they have recovered, to provide outreach and support-an approach that probably would increase the likelihood of engaging veterans in readjustment and treatment and may provide new vocational rehabilitation options for some veterans who provide this counseling.

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

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

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

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

S. 2004-A bill to amend title 38, United States Code, to establish not less than six epilepsy centers of excellence in the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes.

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

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

S. 2142-the Veterans Emergency Care Fairness Act of 2007

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

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

S. 2160-the Veterans Pain Care Act of 2007

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

and training of healthcare professionals in assessment, diagnosis, treatment and management of acute and chronic pain.

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

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

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

S. 2162-the Mental Health Improvements Act of 2007

This measure would establish new program requirements and new emphases on programs for treatment of post-traumatic stress disorder (PTSD) and substance use disorder-with special regard for the treatment of veterans who suffer from co-morbid associations of these disorders.

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

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

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

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

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

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

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

It is our understanding that the National Center for PTSD is focused primarily on research in PTSD, while your intentions for these six new centers would focus them on direct clinical care, as regional referral specialty centers in the care of these co-morbid conditions. Should this bill be enacted, we hope that the seven facilities would work in tandem to advance both the clinical and research fields associated with PTSD and substance use disorders. An additional concern relates to Title II Section 201 of the bill-while we support the peer counseling concept we continue to have concerns about contracting with non-VA providers for specialized PTSD treatment. While we appreciate the Chairman's efforts to address unmet needs in underserved areas we refer you to the comments we provided on S. 38, the Veterans' Mental Health Outreach and Access Act of 2007. We would value the opportunity to work with the Committee staff to make further adjustments to the provisions in this section of the bill so that we can fully support this well-intended measure.

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