LARRY D. MOORE LEGISLATIVE CHAIRMAN VETERANS OF FOREIGN WARS OF THE UNITED STATES DEPARTMENT OF OHIO

STATEMENT OF
LARRY D. MOORE LEGISLATIVE CHAIRMAN
VETERANS OF FOREIGN WARS OF THE UNITED STATES
DEPARTMENT OF OHIO
BEFORE THE
HOUSE AND SENATE COMMITTEES ON VETERANS' AFFAIRS
JOINT FIELDING HEARING
WITH RESPECT TO
ISSUES FACING VETERANS IN RURAL AREAS OF APPALACHIA

MAY 29, 2007

SENATOR BROWN AND REPRESENTATIVE SPACE:

I am pleased to be here before you today representing the one hundred and thirty-nine thousand men and women of the Veterans of Foreign Wars Department of Ohio and our Ladies Auxiliary.

The first issue to be addressed today is access to the VA healthcare system by veterans living in rural areas. Continuing to expand VA community based outreach clinics by either leasing existing space or new construction should be one of the priorities of the VA and Congress. The goal of these clinics is to bring health care to a local level for our veterans, and expanding these types of facilities into rural areas only makes good sense. The Community Based Outpatient Clinics provide basic healthcare needs, with an emphasis on preventive measures to screen and test for such things as diabetes, heart conditions, prostate cancer, and mental health conditions. The clinics staff registered nurses and licensed social case workers, who provide medical and mental healthcare covering an average of six counties both in the clinic office and at the veterans personal home. Studies have shown that VA healthcare is less costly than in the private sector. Expansion of these clinics would potentially save the taxpayers millions of dollars, and continue to bring medical treatments on a local level rather than the past practice of a regional VA medical center. If the primary doctor feels the veteran needs to see a specialist, then he will make an appointment at one of the VA medical centers; however, this causes a problem for veterans living in rural areas, because these centers can be hundreds of miles from his home with no public transportation available. This forces him to either provide his own transportation or rely on a family member or a friend to transport him for his appointment.

The VA does provide gas mileage reimbursement to VA medical facilities for appointments, but not at the present IRS rate of 48 ½ cents per mile currently allowed to any businessman or county, state or federal employee - the VA allows veterans only 11 cents per mile. Most veterans I work with find this to be a complete joke, and will not even bother filling out the paperwork for the reimbursement. Not only do I agree that this is a complete joke, but also I feel this is a total insult to those who honorably served this country. I would ask Congress to investigate, and find a solution to allow a gas reimbursement that reflects today's high gasoline cost, not that of 1960. The majority of veterans must make multiple trips to these regional VA medical centers - for example on average it takes three trips for hearing aids, dental crowns, and eyeglasses, and

cancer treatments of radiation and chemotherapy can take ten trips. To someone living in an already economically depressed region, can you imagine the difficulty and personal expense to the veteran and his family?! Is this what Congress meant in 1996 when legislation was passed, stating that all honorably discharged veterans were eligible for VA health care as long you can get there?!

The VA Health Administration has developed a program to provide more home care to patients. The program, which would allow practitioners to manage more patients, is called care coordination. This program would help eliminate the need for frequent visits by patients to VA medical facilities. Through the Internet, telephone lines and telemedicine units such as glucometer devices, VHA medical professionals will remotely observe patients with multiple chronic conditions such mental illness, diabetes, congestive heart failure, and spinal cord injury. One such device, called a Telebuddy, attaches to a patient's phone jack. The patient responds to questions about how he is feeling and whether he took his medication. If there is no problem, the device flashes green. If the patient does not answer, the patient's case manager is notified. This is an extremely useful tool to those VA staffers who make these house calls, especially on the mental health side, these units are programmed to ask targeted questions that could provide early warning that the veterans possible depression or PTSD condition maybe at a level dangerous to himself or his family.

Construction of new CBOCs cannot happen over night, and in the meantime, short term solutions need to be addressed. Some of those short-term solutions presently being considered by Congress are the following:

H.R. 92, the Veterans Timely Access to Health Care Act
H.R. 315, the HEALTHY Vets Act
H.R. 339

The VFW strongly supports the intent of these types of legislation. We do have concerns, however, with the potential for overuse of contracting care but there are certainly areas where its use is proper. Fee-basis care is more expensive than that of the VA, and we believe that it would do great harm to those veterans who elect to stay in the high-quality VA health care system by taking away funding for the system as a whole.

H.R. 1426
The VFW strongly opposes this legislation, which would allow any veteran to elect to receive contracted care whenever they choose. Although this legislation aims to expand the coverage available to veterans, it would only dilute the quality and quantity of the services provided to new and existing veterans today and into the future. That is unacceptable.

Draft Bill, the Rural Veterans Health Care Act

The VFW supports this bill, which would make changes and improvements to the availability of health care for rural veterans. With over 44% of returning service members living in rural areas,

the access problems they and all veterans face are of increasing importance. This legislation acknowledges that, and we are happy to support it.

Lastly, I would ask Congress to bear in mind the long-term cost of care for those wounded service members returning from the War on Terror. Head and limb injuries are signature wounds of this war, because Iraqi insurgents have made the IED their weapon of choice. Modern armor and rapid care mean that most of the injured survive, but many live with traumatic brain injuries and amputations. I would point out the hidden danger with respect to head injuries - between January 2003 and April 2006, of the 692 traumatic brain injuries treated at Walter Reed Army Hospital, nearly 90% had non-penetrating head injuries from the sheer concussion of the blast from IEDs. Returning combat veterans may not know they have suffered such a wound, and since this type of injury isn't immediately apparent or visible to the naked eye, medical personnel may miss the diagnosis if the proper screening methods are not used. Coupled with TBI type injuries is Post Traumatic Stress Disorder (PTSD). Many service-members have had multiple deployments to combat zones, and studies now show there is a 50% greater chance these combat veterans may develop issues involving PTSD; and in most cases these are young men and women with serious service-connected disabilities, who will need expensive care for many years. My hope is more emphasis will be put on screening for TBI, depression, and PTSD. I do not wish to have another sobbing mother sit in my office personally blaming herself for her twenty-year old marine reservist son's suicide, who just returned from a tour in Iraq.

The VA System may not be perfect, but when adequately funded in a timely manner by Congress, the ability to deliver quality healthcare and reduce lengthy claims waiting periods for service-connected disabilities could be achieved.

Senator Brown and Representative Space, this concludes the VFW's testimony, I would be happy to answer any questions you may have.
Thank you