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STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS¡¦ AFFAIRS
UNITED STATES SENATE
MAY 23, 2007

Mr. Chairman, Ranking Member Craig 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 1.4 million service-disabled veterans, and along with its auxiliary, devotes its energies to rebuilding the lives of disabled veterans and their families.

You have requested testimony today on fifteen bills primarily focused on health care services for veterans under the jurisdiction of the Veterans Health Administration, Department of Veterans Affairs (VA). While my oral remarks will focus on only those bills about which we are particularly concerned, this statement reviews our position 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. 117¡XLane Evans Veterans Health and Benefits Improvement Act of 2007

S. 117 would establish eligibility for a mental health evaluation on demand by any veteran who served on or after September 11, 2001, and would require VA to provide that evaluation within 30 days of its request. It would also establish eligibility for these veterans for hospital, outpatient and nursing home care, and for marital and family counseling, for a two-year period from commencement of such services. Remaining sections of the bill would require a series of data gathering and reporting by the Secretaries of Veterans Affairs and Defense, of the populations of active duty personnel and veterans defined in the bill as "Global War on Terror" veterans¡Xessentially those who have served in a number of theaters of war, conflicts and other deployments since September 11, 2001.

DAV is generally supportive of any effort to improve access to care for sick and disabled veterans. Also, accurate data to aid understanding of these populations¡¦ needs by the agencies responsible for their care is beneficial in any population that benefits from federal programs. Nevertheless, some of the emphases of this bill seem problematic. The bill would require a comprehensive medical and mental health evaluation by a qualified professional within thirty days of request. We appreciate the intent of the provision to secure timely assessments, but based on our review of VA's general efforts to meet its workload requirements within those constraints, it is doubtful VA could routinely meet this requirement within available resources.

With respect to the data gathering and reporting requirements of the bill, we believe thousands of staff hours and millions of dollars for other support likely would be necessary to enable VA and DoD to comply with these requirements, assuming they would be able to comply. Also, some of the reporting cycles in the bill would be highly challenging for both agencies to meet, given the amount of work the bill would require to assemble the databases that would reveal those facts. Since these new requirements would need to be accomplished from within available funding, this bill troubles us. We ask the Committee to further study the proponent's goals to see if other approaches may be fashioned to produce the desired results sought.

S. 383¡XA bill to extend the period of eligibility for health care for combat service in the Persian Gulf War or future hostilities, from two years to five years after discharge or release

Servicemembers after having served in combat theaters often experience unique health care challenges related to military service. Therefore, the DAV believes these brave men and women deserve open access to the unique and specialized services provided by VA. This bill would help ensure that our newest generation of combat veterans returning from Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) gains access by extending the period of eligibility for VA health care services and programs.

The members of our most recent National Convention in Chicago, Illinois, passed Resolution No. 217 supporting legislation to extend the period of eligibility for free health care for combat veterans for conditions potentially related to their combat service from two years to five years after military service. Especially in regard to mental health sequalae related to combat exposure, veterans may not recognize within the current two-year window allowed that they need VA services. This bill gives such veterans and their families the benefit of the doubt and is in the best spirit of supporting veterans' needs without pre-judging or shortchanging them. Therefore, the DAV proudly supports this measure and looks forward to its enactment.

S. 472¡XA bill to authorize a new major medical facility project in Denver, Colorado, in the amount of $523 million

S. 472 would authorize a major medical facility project in Denver, Colorado. The DAV has no resolution from its membership concerning this issue; however, we would not oppose the enactment of this bill.

S. 479¡XThe Joshua Omvig Veterans Suicide Prevention Act

S. 479 would establish a broad based suicide prevention initiative in the VA. We support the goals of this bill and are pleased to endorse it. We do ask that the Committee consider modifying the bill to make clear that the suicide prevention programs the bill would establish are intended to be applied to programs within the Department and for veterans who are enrolled in VA health care under section 1705 of Title 38, United States Code, and to veterans otherwise in close contact with other programs of the Department (i.e., the Veterans Benefits Administration regional offices, the Readjustment Counseling Service Vet Centers, etc.). We do not believe the bill is intended to be applied to all veterans, irrespective of their circumstances.

S. 610¡XA bill to establish January 23, 2002, as the effective date of the modification of treatment for retirement annuity purposes of part-time service performed before April 7, 1986, by VA nurses, pursuant to the VA Health Care Programs Enhancement Act of 2001

S. 610 would retroactively authorize full-time work credits for federal retirement purposes for VA registered nurses who worked part-time and retired from active service prior to April 7, 1986. This bill would address the opinion of the Office of Personnel Management that a prior act of Congress failed to establish clear policy that these nurses be included in Congressionally mandated service recalculations for part-time VA nurses. Although these particular VA nurses retired long ago, in equity DAV believes these individuals, who provided vital services to sick and disabled veterans during their professional careers, deserve this benefit as accorded to other VA part-time nurses at that time. We applaud the sponsor's efforts to champion this cause for this small group of VA retirees.

S. 692¡XThe VA Hospital Quality Report Card Act of 2007

S. 692 would establish a "hospital report card" covering a variety of activities of hospital care occurring in the medical centers of the Department. Validation of the delivery of high quality care to service-disabled veterans is important. Therefore, we support this bill. We believe that veterans under VA care have the same rights as private sector patients to review the quality and safety of the care they receive while hospitalized. We do note, however, that the purposes of this bill do not cover the grand majority of overall patient care workload in VA health care, namely primary (outpatient) care and extended care services provided in VA's nursing home care units and its various contracted programs. Nevertheless, this is a good bill and one that is supported by DAV. We do note for the Committee's purposes, that the term "VA hospital" was supplanted by the term "VA medical center" in prior legislation. You may wish to consider conforming this bill accordingly, should the Committee decide to approve and report it.

S. 815¡XThe Veterans Health Care Empowerment Act of 2007

This measure, which seeks to provide health care benefits to veterans with service-connected disabilities at virtually any private medical facility, raises a number of concerns for the DAV. We and several other veterans service organizations sent a letter describing our concerns about this measure, which I will outline.

While well intentioned, this measure could result in a series of potential unintended consequences chief of which is the diminution of established quality, safety and continuity of VA care, as well as to rekindle debate on the so-called ¡§Medicare subvention¡¨ policy proposal that Congress and the Administration have been unable to resolve in ten years.

It is important to note that VA¡¦s specialized health care programs, authorized by Congress and designed expressly to meet the special needs of combat wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, poly-trauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans from those programs. The VA¡¦s medical and prosthetic research program, designed to study and hopefully cure the ills of disease and injury

consequent to military service, would lose focus and purpose were service-connected veterans no longer present in VA health care. Additionally, Title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104-262 was enacted.

In light of the escalating costs of health care in the private sector, VA has, to its credit, done an excellent job of holding down costs by effectively managing its in-house health programs and services for veterans. While as a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

An additional possible consequence if this measure were enacted would be to most likely shift care for service-connected veterans from discretionary to mandatory spending. While we are devoted to proposals that Congress move VA health accounts into the mandatory funding arena, we could not support a bill that would move VA from a primary provider of health care to an insurer, even if funding for that function were made mandatory.

We believe that mixing complex chronically-ill service-disabled veterans with other veterans in VA care creates a needed critical mass and properly balanced case mix. A diverse case mix with the variety of acute and chronic clinical patients that motivates excellence in the academic health center environments cements solid relations between those tertiary VA facilities and their health professions schools¡Xanother guarantor of quality of care.

We know this Committee wants to ensure service disabled veterans have access to the best care available. We believe VA can deliver that level of care. We recognize that VA is not always perfect, but we believe VA is working hard to address its shortcomings and in the long term offers the highest quality care available to veterans with special needs. If there are problems with VA care we would encourage VA to address these problems and for Congress to support critical oversight of programs and services, rather than recommending outsourcing of care as a solution.

S. 874¡XThe Services to Prevent Homelessness Act of 2007

S. 874 would direct the VA to provide financial assistance for supportive services for very low-income veterans¡¦ families in permanent housing. Under the bill VA would provide grants to certain eligible entities such as private nonprofit organizations or consumer cooperatives to provide various supportive services.

Funding for the supportive services would be taken from amounts appropriated to the VA for medical care. Amounts would be $15 million for fiscal year 2008; $20 million for fiscal year 2009; and, $25 million for fiscal year 2010.

The DAV statement of policy specifies that we will not oppose legislation unless it is evident that it will jeopardize benefits for service-connected disabled veterans. As such, while we support the intent of the bill to better address homeless veterans¡¦ needs, and to help them move toward independent living, we would strongly oppose offsetting the costs associated with S. 874 against other vital VA health care programs. Also, with regard to the health care and counseling services this bill would provide, we are concerned that as well-intentioned as it may be, that a grant under which health care services would be provided by private providers versus VA providers raises questions about cost, quality, continuity and safety similar to our views on other proposals with these goals.

S. 882¡XA bill to require a pilot program on the facilitation of the transition of members of the Armed Forces to receipt of veterans health care benefits upon completion of military service

This measure seeks to ensure that military servicemembers receive a continuity of care and assistance in and after the transition from military service to veteran status. Specifically, this bill would require the VA to conduct a five-year pilot program to assess the feasibility and advisability of awarding grants to ¡§eligible entities¡¨ to assist transitioning military servicemembers, particularly those with serious wounds, injuries, or mental disorders, women members, and members of the National Guard and reserves, in applying for and receiving VA health care benefits and services.

Further, this bill requires at least one location of the pilot program to be in the vicinity of: (1) a military medical treatment facility that treats OIF/OEF servicemembers who are seriously wounded; (2) a VA medical center located in a rural area; and (3) a VA medical center located in an urban area.

The DAV believes that both VA and DoD have complementary and critical roles in ensuring servicemembers and returning combat veterans scheduled for discharge, receive prompt, comprehensive quality care and services from each agency; however, there remains a clear need for additional services and better coordination for transitioning servicemembers from military to veterans status and reintegration into the community as a productive member of society. However, DAV has no resolution on this issue, and does not accept grants from the U.S. Government.

S. 994¡XThe Disabled Veterans Fairness Act

S. 994 would make significant changes to the VA beneficiary travel program, authorized under section 111 of Title 38, United States Code. The VA beneficiary travel program is intended by Congress to assist veterans in need of VA health care to gain access to that care. As you are aware, the mileage reimbursement rate is currently fixed at eleven cents per mile, but actual reimbursement is limited by law with a $3.00 per trip deductible capped at $18.00 per month. The mileage reimbursement rate has not been changed in 30 years, even though the VA Secretary is delegated authority by Congress to make rate changes when warranted. The law also requires the Secretary to make periodic assessments of the need to authorize changes to that rate. Unfortunately, no Secretary has acted to make those changes, despite the obvious need to update the rate of reimbursement to reflect rises in travel and transportation costs.

In 1987, the DAV, in coordination with VA¡¦s Voluntary Service Program, began buying and donating vans to VA for the purpose of transporting veterans for outpatient care. Since that time, the DAV National Transportation Network has formed a very significant and successful partnership with VA and DAV. We have donated almost 1,800 vans to VA facilities at a cost exceeding $20 million. These vans and their DAV volunteer drivers and medical center volunteer transportation coordinators have transported nearly 520,000 veterans over 388 million miles. We plan to continue and enhance this program, not only because the VA beneficiary travel rate is so low, but also we have found our transportation network serves as a truly vital link between veterans and crucial VA health care. Its absence would equate to the actual denial of care for many eligible veterans.

DAV has a long-standing resolution (Resolution No. 212) supporting repeal of the beneficiary travel pay deductible for service-connected veterans and to increase travel reimbursement rates for all veterans who are eligible for reimbursement. We believe S. 994 offers a fair and equitable resolution to this dilemma about which we have been concerned for many years. We urge this Committee to approve and enact legislation this year to reform the VA beneficiary travel program. Bringing reimbursement rates into line with those paid to Federal officials and federal employees, is a fair resolution.

Mr. Chairman, given the situations and dislocations of the families of severely injured veterans of OIF/OEF who now are in VA facilities for long-term rehabilitation, DAV hopes Congress also will address and appropriate funding consistent with enabling the immediate family members of these several hundred veterans to be reimbursed their travel and lodging expenses while their loved ones remain incapacitated. These families are suffering greatly and are making extreme sacrifices in relocating to be close to their loved ones, often far from home, without good accommodations, and without any authorized reimbursement for their expenses. We believe consideration of some relief, even if temporary, is warranted.

S. 1026¡XA bill to designate the VA Medical Center in Augusta, Georgia, as the ¡§Charlie Norwood Department of Veterans Affairs Medical Center¡¨

S. 1026 would name the VA medical center in Augusta, Georgia, as the Charlie Norwood Department of Veterans Affairs Medical Center. The DAV has no resolution from its membership concerning this issue; however, we would not oppose the enactment of this bill.

S. 1043¡XA bill to require the Secretary of VA to submit a report to Congress on proposed changes to the use of the West Los Angeles, California, VA Medical Center

S. 1043 would require the VA to submit a report to Congress on proposed changes to the use of the West Los Angeles Department of Veterans Affairs Medical Center in California. Since this deals with a local matter, we do not have a resolution on this issue.

S. 1147¡XHonor Our Commitment to Veterans Act

This bill would legislatively moot Title 38, section 1705, thereby rescinding the Secretary¡¦s authority to establish and operate a system of annual enrollments for VA health care, and it would make every American veteran entitled to enrollment for VA health care on request. Over

1,000,000 veterans have unsuccessfully attempted to enroll in VA health care since the cut-off of new enrollments for Priority 8 veterans occurred in 2003. While we certainly support the proponent¡¦s premise that every veteran who wants it should be able to enroll in VA health care, without a major infusion of new funding, enactment of this bill would worsen VA¡¦s financial situation, not improve it, and would likely have a negative impact on the system as a whole. We recommend the Committee defer action on this bill until after Congress enacts mandatory, guaranteed or assured funding for VA health care.

S. 1205¡XA bill to require a pilot program on assisting veterans service organizations and other veterans groups in developing and promoting peer support programs that facilitate community reintegration of veterans returning from active duty, and for other purposes

This bill would establish a pilot grant program with veterans service organizations, and other organizations, to provide ¡§navigators¡¨ to aid veterans in obtaining the VA health care services they need. While we appreciate the sponsor¡¦s intention to provide veterans service organizations more means to outreach to and provide veterans greater opportunity to reintegrate after serving their deployments, DAV does not accept grants from the U.S. Government.

Our programs are operated by the generosity of private donors and through paid memberships by our members and their families. DAV already employs a cadre of 260 National Service Officers, whose job it is to outreach to veterans in every community. Also, DAV has an army of volunteers on the ground in VA health and benefits offices and working in our National Transportation Network nationwide. Our DAV members and volunteers are in touch with literally millions of veterans to help raise awareness about VA benefits and services.

S. 1233¡XVeterans Traumatic Brain Injury Rehabilitation Act of 2007

Mr. Chairman, we commend your efforts in crafting S. 1233. The provisions of S. 1233 would greatly enhance and strengthen VA's rehabilitation program for veterans with severe and moderate Traumatic Brain Injury (TBI). TBI is a life-altering and devastating injury. Even with the best of care and the most seamless transition back to home, TBI can disrupt and test the resources of even the most resilient and financially secure families.

The consequences of TBI usually involve a range of disabilities and symptoms, which are often not clearly delineated. Indeed, the International Classification of Diseases and Health Problems, commonly known as ICD, does not list a single code for TBI but does contain codes for many of the common consequences of TBI, such as epilepsy. The neurological, cognitive, and behavioral changes due to TBI are complex, varied, and diverse and may change in severity or develop over time. Longer-term neurological problems often include movement disorders, seizures, headaches, and sleep disorders. Common residual cognitive problems include memory, attention and concentration impairments. Depending on the area of the brain injured, judgment, planning, problem-solving and other executive functioning skills may also be impaired. Visual perception problems and language impairments are usual but often go undiagnosed. Prevalent behavioral issues include personality changes, aggression, agitation, learning difficulties, shallow self-awareness, altered sexual functioning, impulsivity, and social dis-inhibition. Many individuals self-medicate with alcohol to deal with the dis-inhibitory symptoms and disruption to their sleep cycle.

S. 1233 would take many significant steps to ensure that veterans with TBI receive high quality rehabilitation in their communities and to encourage VA to develop the needed expertise and capacity to meet the lifelong needs of veterans with this injury. Therefore, DAV supports this bill.

Rehabilitation and Community Reintegration Plan

Section 3 of the bill would require VA providers to develop and implement a detailed comprehensive multidisciplinary and individualized rehabilitation and community reintegration plans. This plan would be based upon an assessment, and periodic reassessment, of the physical, cognitive, vocational, and psychosocial impairments of veterans and the family support needs of veterans after discharge from inpatient care.

It is appropriate that the individualized plan be developed and discussed with the injured veteran and his or her family, to the maximum extent feasible, before the veteran is discharged from inpatient acute rehabilitation. This provision would be empowering for veterans and their families and could help improve rehabilitation outcomes.

Section 3 also would give veterans and their families the option to trigger a review of the rehabilitation and reintegration plan and its implementation. Affording an injured veteran, and in cases of incapacity, family members or guardians, with an opportunity to request a review of the rehabilitation plan would ensure that veterans and families, have a systemic way to maximize an injured veteran¡¦s functioning.

In developing a rehabilitation plan for an active duty servicemember, S. 1233 would require VA providers to collaborate with Department of Defense (DoD) providers. We support the clear objective of this provision to address a significant vulnerability in injured active duty servicemembers must navigate a labyrinth to receive continued post-acute rehabilitative care from VA, with DoD approval. Implicit in the provision is the promise that collaboration would prompt each agency to address any challenges in coordinating the delivery of services before the servicemember is transferred.

Access to High Quality and Community Based Rehabilitative Services.

Section 4 of S. 1233 would require the VA to implement the individualized rehabilitation plan through non-VA providers in situations where VA lacks the capacity to provide the intensity of required care or the distance from the veteran's home to a VA facility renders treatment infeasible. The provision also requires that non-VA providers be accredited by an independent peer-review program for specialized TBI programs. This provision clarifies that veterans have a right to community based rehabilitation, but only when VA cannot provide the care and when the non-VA provider is accredited.

We support the two key implied presumptions in this provision; 1) that the VA must have the capacity to be the provider of choice and 2) that proximity to care is a key component to ongoing rehabilitation and community reintegration.

We support the implicit goal of this bill to give VA an incentive to develop its capacity to provide high quality care. VA's four lead Polytrauma Rehabilitation Centers have achieved and maintained, without qualification, accreditation from the Commission on the Accreditation of Rehabilitation Facilities for acute inpatient TBI rehabilitation program but not a single VA facility has achieved accreditation for outpatient, home-based, residential or community based TBI rehabilitation. We urge this Committee to encourage VA to seek such accreditation at Level II and Level III polytrauma sites.

Research, education, and clinical care program on TBI

Sections 5 and 8 of S. 1233 would expand VA's TBI research, education and clinical programs. Section 5 would give VA providers, in collaboration with the Defense and Veterans Brain Injury Center, the incentive to conduct innovative research and intensive treatment to increase the functioning of such veterans with severe TBI, who are minimally conscious. While the number of veterans in this population is small, it is imperative that we care for these very vulnerable veterans. This proposed program for intensive neuro-rehabilitation is highly commendable.

Because the screening, diagnosis and treatment of mild or moderate TBI is so significant we would urge the Committee to address the issue of education on this issue in a separate and more expansive provision. We would welcome the opportunity to work with the committee to discuss ways to enhance VA's current screening program, to establish a VA TBI registry which would include OEF/OIF veterans at risk for TBI, to develop outreach programs to target veterans with mild TBI, and identify effective treatments for veterans with mild TBI.

Section 8 also improves VA's research program on two prevalent conditions which result from TBI, seizures and visually-related neurological conditions, by encouraging the VA to use its research programs to study the diagnosis, treatment and prevention of these conditions. The proposed provision also leverages the expertise of federally-funded model TBI treatment systems by requiring the VA to collaborate with these academic and non-VA based programs. We support this provision and also support expanding VA's capacity to diagnose and treat veterans who develop epilepsy. Given our understanding of the relationship between TBI and epilepsy, we believe VA needs a national program for epilepsy care, and we encourage the Committee to support the revitalization of VA Epilepsy Centers of Excellence.

Expanding Residential and Long-term Care Options for Veterans with TBI

Section 6 of S. 1233 would establish a five year pilot TBI assisted living program to assess the effectiveness of assisted living programs in enhancing the rehabilitation, quality of life and community integration of veterans with TBI. The provision also ensures that VA continues to provide case management for the care of these veterans. We support this provision, since it will help veterans with TBI to have more independent lives in their communities. In that connection, we call your attention to the July 2004 VA report to Congress in response to Public Law 106-117, The Veterans Millennium Health Care and Benefits Act, which authorized VA to establish a pilot program to determine the ¡§feasibility and practicability of enabling veterans to secure needed assisted living services as an alternative to nursing home care.¡¨ We believe veterans suffering

from mild-to-moderate TBI, as well as their families, would benefit from assisted living arrangements. We also believe the report to Congress in 2004 validated an important role for assisted living facilities in VA long term care.

Section 7 would require VA to provide age-appropriate nursing home care for younger veterans who need such care. While it is our hope that the number of young veterans who are so disabled by TBI as to require nursing home care is small, we applaud the Committee for ensuring that these disabled veterans have care that is consistent with their needs.

Other issues in need of legislative action

S. 1233 is an important bill which takes significant and bold steps towards improving access and quality of care for veterans with TBI. As the committee moves forward during this Congress to continue its oversight and legislative efforts in the area of TBI we would welcome the opportunity to work with the Committee on the following areas:

ƒÜ Ensuring all enrolled (new and established) OIF/OEF veterans are screened, assessed and treated for their mild or moderate TBI.
ƒÜ Expanding vocational rehabilitation programs for veterans with TBI.
ƒÜ Development of specialized substance use disorder programs to help veterans with TBI who self-medicate.
ƒÜ Develop specialized outreach and education programs related to TBI for members of the National Guard and Reserves.
ƒÜ Developing an independent patient advocacy system for veterans with TBI.
ƒÜ Development of support programs to help families of veterans with TBI.

Mr. Chairman, again, the members and auxiliary of DAV appreciate being represented at this hearing today, and I appreciate being asked to testify on these bills. I will be pleased to respond to any of your or other Members¡¦ questions.