

Statement of
VIETNAM VETERANS OF AMERICA

Submitted By

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Before the
House Veterans' Affairs Committee
Subcommittee on Health

Regarding

Mental Health, Substance-Use Disorders, and Homeless Programs

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Mr. Chairman, Vietnam Veterans of America (VVA) is grateful the opportunity to express our views on this topic of vital interest to so many veterans in great need before this distinguished panel. My name is Dr. Linda Schwartz. In addition to currently being a Researcher at the Yale School of Nursing, I serve as Chairman of the VVA Task Force on Veterans Health. I am accompanied by Rick Weidman, who serves as Director of Government Relations for Vietnam Veterans of America.

VVA is grateful to the Subcommittee for your attention to the vital issue of the continued diminishment of mental health and behavioral sciences resources and treatment available at facilities operated by the Department of Veterans Affairs (VA). This diminishment denies some of our neediest veterans, who often cannot effectively advocate for themselves, access to vitally needed services. It is not only illegal of VA to allow this continued reduction in resources and funding, it is morally reprehensible.

Historical Perspective

It was not until the mass mobilization of volunteers and draftees during America's engagement in World War II that mental health and psychiatry became a significant concern of military medicine. Initially the startling numbers of men and women rejected for military service due to psychological and mental health problems heightened the Nation's awareness of a major condition not widely discussed or understood. This concern multiplied when the number of casualties sent home from the battle zones due to neuro-psychiatric wounds outnumbered casualties needing medical, surgical or trauma care. In many ways the numbers of veterans in need of psychiatric care began to define and shape the mission of the Veterans Administration in the post WW II era.

At the same time, Medical Schools eager to affiliate with VA Hospitals exerted new demands for acute care, surgical and research experiences for physicians in training. Thus, began the classic intramural struggle between Psychiatry versus the Medical-Surgical Services for patient beds, dollars, staffing and other support resources which has persisted for more than 50 years and now in a slightly different form surfaces as a major focus of today's hearing. It is important to note that amidst this tug of war, the more visible physiological needs of Korean and Vietnam War veterans positioned the care of VA patients with neuropsychiatric disorders in a "One Down Position."

Perhaps the most outrageous and unkindly cut came as a result of the Health Care Financing Administration (HCFA) use of Diagnostic Related Groupings (DRG's) as a method of quantifying patient care costs. DRG's were originally designed by Professor John D. Thompson at the Yale School of Medicine, Department of Epidemiologist and Public Health as a tool for estimating variations in the intensity of workload in the delivery of care to patients. As a student

of Professor Thompson, I learned that using DRG's to estimate the cost of health care was a misuse of the intent and utility of this methodology.

When VA adopted the HCFA criteria, the then VA Chief Medical Director Admiral Donald Custis also applied a -17% reduction or "discount" in cost estimates for the care of neuropsychiatric patients. Whether by design or by accident this decision in essence crippled and disenfranchised veterans with psychiatric problems and severely compromised VA's capacity to care for these very needy patients. Essentially this decision solidified a preference for funding Medical-Surgical Services and Programs became the VA standard. To many observers, by the early 1980s the VA system was driven much more by the needs of Medical Schools and the VA Medical establishment's own internal vested interests as opposed to the needs of veterans. With the remodeling of VA Health Care delivery systems in the 90s, the Congress acted wisely to protect specialized care programs including the treatment of seriously mentally ill veterans, substance abuse treatment programs, post traumatic stress disorder, and care and assistance to homeless veterans. Unfortunately the protections the Congress provided have not been enough to accomplish the task thus far.

The enactment of "capacity legislation" in 1996 clearly tasked VA with maintaining these programs and the equality of the care provided, which even at that time were deliberately under funded. As we look back from that time to this there is cause to celebrate many innovative and substantive improvements for care to American's veterans, some involving Medical Schools affiliated with the Veterans Health Administration. However, one cannot help but notice that veterans least able to speak for themselves, veterans who are mentally ill, veterans who have substance abuse problems--veterans who are homeless continue to be least well treated by the VA system of care, and one of the last priorities of some of the Network Directors.

The provisions of PL 104-265 not only offered eligibility reform (broadening of that eligibility) sought by the VA, but charged the Secretary of VA with maintaining capacity to provide for specialized treatment and rehabilitation needs of veterans with spinal cord dysfunction, blindness, amputations and mental illness in a manner that affords those veterans reasonable access to care. This statute also mandates maintenance of services for those specialized needs, and "ensure the overall capacity of VA to provide such services is not reduced." The defining baseline year for determining capacity authorized was set at Fiscal Year 1996.

Congress also required the Under Secretary for Health to create the Advisory Committee on Severely Chronically Mentally Ill Veterans. This Committee is charged with assisting the Undersecretary and the Secretary with monitoring the capacity of VA under those priorities. This committee determined that the number of veterans treated and the dollars expended for their care in specialized programs were appropriate for quantifying the question of capacity. I have been privileged to witness the deliberation of this committee as a member of the Consumer Group. I have been impressed by their determination to fairly assess the progress and refine the

delivery system. I have not been impressed favorably by the response of the top leadership of VA, which continues to debate “the meaning of the word is” as opposed to admitting what is apparent to all concerned: VA is not meeting the requirements of the law, and is therefore acting illegally.

Capacity Report 2000

Mr. Chairman, there has been a significant reduction in specialized capacity to treat substance abuse that has occurred between FY 1996 and FY 2000. Our organizational representatives around the country share information with us at the National level that would suggest that the decimation of alcohol and substance abuse services continues unabated. To maintain, as some have at VA, that the dramatic reductions in available services is not the cause of the reduced number of veterans in treatment for substance abuse is sophistry Newspeak thinking worthy of the now defunct Soviet system.

There is, of course, wide variation that exists among Veterans Integrated System Networks (VISNs), and even from VA Medical Center (VAMC) to VAMC within VISNs in the maintenance of specialized capacity. What the VA has done is to give the VISN directors unprecedented power and authority, with virtually no accountability except in the area of fiscal restraint (read: denial of vitally needed services to those with the least public voice!). The inability and/or unwillingness of the VA to hold these employees accountable appears to VVA to be an effort for top VA officials to preserve deniability of what they know is happening as a result of affording VISN Directors with license.

Although there were increased numbers of veterans who met the definition for seriously mentally ill, there was a reduction in funding for the specialized treatment for these veterans. That much is apparent to all who will see what they are looking at in regard to resources allocated to SCMI.

VA had a increase (8%) in the number of individual veterans that met the definition of SMI which was accompanied by a decrease (9%) in funding. (These figures do not at all account for medical inflation that is at least 8 % to 9% per year.) Some attribute the decline in funding to a shift from patient treatment settings to outpatient and community based care. Originally, the “company line” put forth was that elimination of inpatient programs would allow these dollars to be put right into outpatient services for substance abuse treatment, seriously mentally ill patients, post traumatic stress disorder, and other neuropsychiatry problems. It simply never happened in most places. Much of the cuts in funding made at the national level were absorbed at the local level by eliminating care and services for the veterans least able to speak up.

VHA has now issued policy directives establishing centralized review of proposed “major” changes in mental health programs in the field which has dramatically improved the oversight of program of Mental Health and Behavioral Sciences, and enhanced compliance for VHA policies.

However, most of the really big cuts have already been taken, and VAMCs and VISNs now continue to reduce resources just under the threshold where they would have to get permission from the Central Office of VA. If the threshold is a 10% reduction (which it is in most cases) they simply reduce by 9% per year (which is really at least a 17% cut, when inflation is taken into account), thus avoiding having to let anyone at the National level know what they are doing.

Post Traumatic Stress Disorder (PTSD)

Last Fiscal Year, VA reported a 22% increase in the number of veterans with PTSD since 1996. At the same time funding for these programs decreased by 8%. (Once again, this does not account for inflation, so the reductions were actually much greater.) A number of VISNs eliminated inpatient treatment for PTSD altogether, and are severely straining the best programs by not filling vacancies and forcing “social graduations” from relatively intensive outpatient programs.

However, even within VISNs there is inconsistency, and even greater inconsistencies between VISNs. For example, seven VISNs increased their expenditures while 15 reduced funding for these specialized services.

Veterans Who Are Homeless

Last fiscal year, VA reported an increase of 26% in the number of veterans who are homeless. This number included veterans who received care in a VA program specifically designed for specialized programs including substance abuse treatment and the Domiciliary Care Program.

The reductions in funding for treatment of SMI veterans who are homeless can be directly linked to the reduction in funding for substance abuse treatment programs. In other words, the VA has been creating homeless veterans faster than the Congress can devise, pass, and fund new programs to help reduce homelessness among veterans. It is time that all concerned recognize this fact.

Substance Abuse Treatment

The most significant reduction in specialized medical services capacity to treat substance abuse appears to have occurred between FY 1996 and FY 1999. Wide variations exist nationally among VISNs and within VISNs in the maintenance of substance abuse treatment capacity. The actual level of need is unknown, because construction of the budget of VA is never preceded by even an attempt at an honest assessment of needs at the local and regional levels. The reduction in the number of veterans in substance abuse treatment means that the law of supply and demand has come into play. Less treatment programs available mean less veterans in the program

Since the capacity legislation came into law, funding for Substance Abuse Treatment Programs overall were reduced by 37%. While some VISNs treated greater numbers of veterans, others drastically reduced the number of veterans treated, all but eliminating substance abuse treatment at some stations. While the better VISNs increase in such treatment availability of treatment reflects greater attention to the “whole veteran” concept and model of treatment, in some cases it has meant a few outpatient visits for veterans and then a referral to Alcoholics Anonymous. This has enabled some VISN Directors to pad their numbers, without really getting at the core issues of the veteran’s health problems. In other VISNs there really has been a significant improvement in resources and in the treatment modalities that has resulted in many veterans becoming more healthy. So we know that at least some in the VA recognize their responsibilities in this regard and have the expertise and the competence to get the job done right the first time.

Wellness Model” of Veterans Health Care

Vietnam Veterans of America (VVA) has been committed to a holistic “wellness” model of care for veterans for almost twenty years. VVA also believes strongly that there is a significant difference between veterans’ health care and general health care that happens to be for veterans. Similarly, there is a significant difference between veterans’ mental health care and general mental health care that happens to be for veterans.

The “wellness” model means that all VA programs should be measured against the test of whether and how much that program helps return the individual veteran to the highest degree of physical and psycho-social health, which would enable the veteran to achieve the highest degree of autonomy and independence possible. This cannot mean just treating the most pressing of the acute care needs that drove the veteran to seek care, and then releasing that veteran to continue to “churn” through the system. This is terribly harmful to the veteran, and wastes valuable resources. Our Nation can and must do better.

For veterans of working age, VVA believes that the litmus test of how well the VA has done its job should be measured by whether the veterans is assisted to obtain and sustain meaningful work, at a living wage. (That is why VVA continues to press for meaningful reforms in the employment programs at the Department of Labor and in VA Vocational Rehabilitation programs.)

Fifteen years ago VVA proposed to this Committee in testimony changing Dr. Paul Errera’s job title to “Deputy Chief Medical Director for Veterans Mental Health” with the commensurate additional authority and clout to affect resources and methodologies for treatment at the service delivery level. VVA also proposed at the same time that VA be required to take a complete military history for every veteran who sought treatment from a VA facility, and that VA be compelled to follow through on the conditions, illnesses, and maladies to which a veteran may have potentially been exposed to during military service,

including traumatic events. Both of these recommendations were brushed aside at that time. We hope that this current group of distinguished Members of Congress will take bold steps to correct what has been a chronic problem that has now reached true crisis proportions.

In regard to the taking of military history, VVA is grateful to this Committee for taking steps toward requiring such a military history at the end of the 106th Congress. VVA is also grateful to Dr. Thomas Garthwaite for conceptualizing and initiating the “Veterans Health Initiative” in September of 1999, that includes plans for such a universal use of military histories to ensure that each veteran has a complete diagnosis of everything that may be causing him or her neuro-psychiatric, physiological, or other health problems today. Taken together with bold and decisive action to restore SCMI and other specialized services to at least the resource level of FY 1996 (adjusted for inflation), the above efforts can result in major improvements in what can only be fairly described as a dire situation today.

Statement of the Problem

Mr. Chairman, we could go on for a very great length in just briefly outlining the parameters of the problem. Perhaps it will suffice to state that there has clearly been a blatant disregard for the law in regard to maintaining the specialized services, particularly all elements of Seriously and Chronically Mentally Ill treatment and services. This has happened because there are no “teeth” or repercussions built into the law requiring maintenance of capacity. VISN and VAMC officials can ignore “best practices” and the chief consultant for mental health with total impunity. Those same officials can (and apparently do) pay little or no heed to requests and directives in regard to specialized services that are put forward by the highest levels of VA.

Possible Useful Steps for the Committee

Vietnam Veterans of America (VVA) suggest that the Committee consider the following steps to begin to meet what we regard as a chronic situation that has now become a crisis that is growing in proportion by the month.

First, VVA urges the Congress to move quickly to pass legislation that would re-centralize all of the specialized services, plus homeless programs and hepatitis C programs. The model here is the bold action the Congress took to address the problem with prosthetics needs of veterans being ignored, and we suggest that the same model be employed for all of the other services that the Congress has deemed to be at the core of the Veterans Health Administration’s mission, and toward which VISN Directors have amply shown they cannot, as a group be trusted to act correctly or responsibly or lawfully.

Two, VVA urges the Congress to establish much greater line authority for results in the care in these veterans affected in the clinical domain, and away from the “bean counters” having full sway. Part of this action should include some real authority and clout for the so-called consultants who are nominally head of each of the specialized services as well as the homeless and the hepatitis C efforts.

Three, the VA must be provided the funds and full support of the Congress to mobilize needed expertise to produce proper information technology systems that can even make it possible to discover what is happening clinically or otherwise in a short amount of time, and not years later, after the damage has been done by runaway VISN Directors. Secretary Principi has announced an initiative to create a useful IT system, and he deserves full support from all Members of Congress in this effort.

It is outrageous that VA Central Office cannot even tell the Congress how much money is going where, to be used for what purpose, at any given time. Nor can the VA collect aggregate information on the patient treatment files to judge whether outcomes overall or in a specific area are positive.

It is absurd that UPS can find any of the millions of packages it handles every day, at any location in the world, the physical condition of that package, and its status in regard to delivery, BUT the VA cannot do the same in regard to sick veterans in its system. Nor does the VA know how many staff it has, with what specialization, serving how many veterans at any given VA facility on any given day. Certainly the Congress would not put up with such lack of knowledge from any of our military commanders. Can you seriously imagine the Commandant of the Marine Corps not knowing the number of troops or status of equipment and materiel possessed by elements in his command at any given time?

Four, the system of “Best Practices” must be changed so that the VA central office officials know at any given time who has accessed the central repository to download and read the materials, who has trained all of their staff in said best practices, and whether such best practices are being adhered to in service delivery at a given facility, with what results. VA spent millions to create this electronic library and to compile the best practices as a wonderful tool, but have done virtually nothing to even check whether this tool is used, much less used to more effectively serve veterans.

Five, VVA strongly urges the Congress to mandate that the VA prepare a plan for rebuilding organizational capacity in the specialized services that has been lost since Fiscal Year 1996. VVA has estimated that it will take a bare minimum of \$3 Billion over a three year period to begin to restore lost organizational capacity in the specialized services. We testified to that effect several times earlier this year, and recommended that such funding be \$600 million the first year, \$1 Billion the second year, and \$1.4 billion the third year. These funds would

be over and above additional funds to offset inflation and/or to meet other specific needs. VVA reiterates said call for restoration of capacity today.

VVA notes the simple fact that there is just not enough funding in the Veterans Health Administration system today. VVA applauds the strong efforts of Chairman Smith to secure more vitally needed funding for veterans programs, as well as those of Ranking Democrat Lane Evans. However, we note that many of the distortions in the system have been either created or certainly greatly exacerbated by the extraordinary scarcity of resources since the three year “flat-lined” era in FY 97, FY 98, and FY99.

The VA has yet to recover from the serious damage of those years. In order to recover, one needs to honestly assess the needs (and NOT start with “what did we do this year, and what is OMB’s overall mark?”) and then set forth a plan to restore needed capacity in an orderly manner.

Six, VVA asks that the Congress move to pass legislation that would accomplish “forward funding” of most of the VA’s activities and certainly the Veterans Health Administration. Many programs at the Department of Defense and at the Department of Labor use this funding methodology, so we know that it is legally possible to accomplish this change.

What this means is that in the first year, VA would be appropriated 21 months of funding to take them from October 1, 2002 to June 30, 2004. The FY 2004 fiscal year would then begin on July 1, 2004. In this way, VHA and other VA managers will have known for 9 months how much money they will have for the next Fiscal Year, and can therefore make more effective use of said funds toward accomplishing the mission as directed by the Congress. Obviously, this would require close cooperation and collaboration with the budget and appropriations elements of the Congress, but it would do much to begin to make our veterans health care system both more effective as well as more efficient.

Seven, VVA urges that you modify the legislation creating the Advisory Committee on Serious and Chronic Mental Illness to mandate strong consumer participation. Similarly, we urge the same legislation require that each VA Medical Center have a functioning mental health alumni group and Consumer Mental Health Advisory Committee by June of 2002.

Similarly, VVA notes that although the Management Advisory Committees (MACs) in each VISN have been somewhat effective in a few VISNs, but generally ineffective in many VISNs because of travel distances, dramatic differences in the problems and situations of VAMCs in the same VISN, and deliberate actions of some VISN Directors, there is still an abiding need for the VA to actually listen to the veterans community.

Therefore, we urge the Committee to ensure that each VAMC Director be required to meet with the veterans organizations and other leaders and advocates for veterans health care (such as homeless veteran service providers) at least once per every three months, if not at least once every other month. The purpose of these meetings would be substantive dialogue on problems affecting health care at that medical center. It should be made clear that the purpose is NOT for local VA officials to present an over-prepared briefing that takes up all of the allotted time leaving no significant time for dialogue and questions.

Last, but certainly not least, VVA calls on the Committee to move quickly to pass the Heather French Homeless Act of 2001. VVA believes that this bill will help us make significant progress toward providing real help for veterans whose problems have become so acute that they find themselves homeless. The provisions of this

Proposed legislation will, when enacted, help solidify some of the significant improvements in homeless services provided by or through grants from the VA.

However, the Heather French Act can only have a real chance of fulfilling the real promise and potential of its provisions if the organizational capacity to provide serious and chronic mental illness treatment and services is restored to the FY 1996 level.

In addition to passage of Mr. Evans' Heather French Homeless Veterans Act with most of the provisions as drafted, VVA believes that it is essential to provide additional funding sources to community based veteran service providers and local chapters or posts of national veterans groups that are providing essential and desperately needed services in a holistic manner to veterans who are homeless or at significant risk of being homeless. Many times these groups can be much more flexible and much more effective than the VA with some elements of the veterans population.

Vietnam Veterans of America is grateful to the Chairman, the Ranking Democrat, and all of the Members of this distinguished Subcommittee for the opportunity to present our views.

VIETNAM VETERANS OF AMERICA

**Funding Statement
June 20, 2001**

The national organization Vietnam Veteran of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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