

Written Statement of Paul Errera, M.D. for oversight hearing, June 20, 2001,
Subcommittee on Health, Committee on Veteran's Affairs, U.S. House of
Representatives

Mr. Chairman, Members of the Committee, I first appeared before this body sixteen years ago in my capacity as the physician who headed all VA mental health programs – a physician who was considered, at times, by some, too outspoken in advocating for veterans with mental illness. At that time, newly arrived in Washington with big ideas, and with even bigger dreams of realizing them, I was bold enough to ask for something very special from you. I did not ask for money. I did not ask for staff. I asked for your attention and for your compassion. I explained that I came to speak to you on behalf of veterans who were not very good at speaking for themselves because of difficulties they had with their concentration, difficulties they had with overwhelming emotions, and in many cases difficulties they had with nightmarish memories of war. During the years following my first appearance you paid attention indeed. Faced with the disaster of homeless veterans on the streets of America, you spurred the development of the Homeless Chronically Mentally Ill Veterans program in 1987 and the Domiciliary Care for Homeless veterans in 1988. You stimulated our involvement with community providers with Project Challenge and the Homeless Veterans Providers Grant and Per Diem program. You were concerned about enhancing clinical care for Vietnam veterans with PTSD and you funded the PTSD clinical teams program and many others. You provided expansion funds to treat addictive disorders in association with the war on drugs.

I would especially like to acknowledge and applaud the Committee's tremendous achievement this year in successfully advocating for increased funding for VA generally, and mental health services in particular. And yet, we in mental health suffered significant losses. In the early 1970's, shortly after Congress funded its first wave of VA substance abuse treatment programs, GAO conducted an evaluation of those programs and found that in many cases the funds had been diverted to other purposes. The needs of the mentally ill, it was explained by local experts, really were not so great and there were other opportunities in medicine. These developments were not surprising. The mentally ill have long been subject to stigma and bias and remain among the lowest priorities of the medical establishment. It is easy to say their needs are not great, or even if they were great, that psychiatric treatment is ineffective. I know these arguments well. They were wrong then and they are wrong now. In the early years, the funds you supplied were fenced – they could only be spent on their intended purpose. That fully and effectively prevented the kinds of problems uncovered by the GAO in earlier years.

But your actions in promoting these programs were not popular with some in VA. Local leaders did not like being told what programs to fund, and in the early 1990's the protection of these funds by fencing ended. In some places, but not all, they continued to be valued, but without protections some programs began to erode.

In 1995 VA began a period of major change, much, but not all of it, for the better. You may remember that after the defeat of the Clinton health plan, managed care began to transform American medicine with its focus on maximizing efficiency by limiting the use of inpatient care and emphasizing primary, general medical care rather than specialty

care. The VA in those days of tumult seemed eager to “keep up with the Joneses” and began importing many managed care slogans and techniques – utilization review, emphasis on primary care, reduction of inpatient services. VA also developed a decentralized system of local control. The advantage of this approach was that local managers were attentive to unique local needs. But it also meant that national priorities, like those you had supported, lost their major base of support.

Somewhat unfortunately, the system VA began to imitate was, in some ways, a system well designed for healthy employees of large corporations, not for people with chronic illnesses, and it appeared in those dark days of 1995 that VA might abandon its unique mission of caring for the poor and disabled among veterans – the very people whom managed care systematically, and I must acknowledge, skillfully, avoided. You may remember those ads offering free health club memberships if you signed up with health plan X. It turned out those ads were not designed to keep members of health plan x healthy, but rather to attract healthy members whose costs would be low. The message of capitated funding was “see more veterans with lower service needs.” In VA our credo was 30% lower costs, 20% more patients, 10% of funds from external sources. This credo said in its unmistakable shorthand – turn your backs on those who need you most.

You came to our rescue. You wrote a law in 1996, which required VA to maintain its capacity to care for disabled veterans with severe mental illness, with spinal cord injuries, with amputations, and veterans who were blind. Your law required VA to provide specialized services to these veterans to meet their unique needs for rehabilitation.

You let there be no doubt that VA was not to imitate the ways of managed care, but to renew or at least maintain its capacity to care for those veterans with the least opportunities in other health care systems.

You left it to VA to define “capacity”, and although this was a major challenge, VA came up with a definition of this population and 2 simple measures of capacity: the number of patients treated, and the dollars spent on those patients.

What do the numbers say? VA’s FY 1999 report on capacity showed an 8% decline in expenditures for the severely mentally ill (without adjusting for inflation) and a 36% decrease in the funding of substance abuse patients -- while the VA budget increased overall by 10%. Other groups covered by this law, in contrast, saw funding increases: spinal cord dysfunction (10% increase), blindness (20% increase), traumatic brain injury (74% increase). In six VISNs, expenditures for the seriously mentally ill declined by 20% or more.

VHA says it has reduced its emphasis on inpatient care for the purpose of strengthening its delivery of outpatient care. Well, the first part is true. Between 1995 and 2000 VA closed 64% of its inpatient mental health beds, which included closing 90% of its substance abuse inpatient beds. But what happened on the outpatient side? From 1994 to 1997, there was an increase every year in the number of veterans who received specialized outpatient substance abuse services from VA. That was good. But then in 1998, just when the inpatient substance abuse beds were closing most rapidly, the number of outpatients receiving specialized substance abuse services began to drop and the drop is accelerating, from 2% from FY 98 to 99, to 7% from 99 to 2000. In some VISNs the changes are even more shocking than this. We have heard this before when it comes to

the mentally ill. We will reduce A but don't worry we will substitute B. And then B doesn't happen. There is one word for this behavior. Wrong. Plain wrong.

The Under Secretary of Health's oversight Special Committee repeatedly alerted VA that it was not complying with the law, but no meaningful action has been taken to correct this profoundly inequitable treatment of veterans with severe mental illness. In fact, the usual excuses have been called upon – we are being more efficient, there is less need for these services, and anyway the services are not very effective, and these veterans just want a place to stay and compensation. Left to its own devices VHA has rolled back your commitment to veterans with mental illness.

Why didn't the capacity law provide an adequate check on this tendency? The sad fact is that VA officials have historically paid far more attention to Appropriations Committee report language (which does not have the force of law) than to statutory requirements initiated by the Veterans' Affairs Committee. To be entirely candid, I believe the prevailing view at VA has been that "the Authorizing Committees can only scold us so we can afford to pay them lip service". The Appropriations Committee on the other hand has demonstrated that it can discipline the Department by reducing its funding, so VA officials do what that Committee directs, even though the direction is simply expressed in a report. VA officials have clearly looked for ways to circumvent both the language and the spirit of the statutory requirement to maintain VA's specialized capacity and programs to serve veterans with mental illness and substance abuse disorders. In hindsight, those who were disinclined to honor this statutory requirement have found "wiggle room" in the statute and wiggled their way around its clear intent.

So what should we do next? I urge this Committee to consider this hearing as a first step only. The needs of veterans with mental illness are too important to permit VA officials to leave the hearing table this morning, go back to their desks, and put this issue on the back burner for a few more years. Because I can assure you that will happen if you simply assume that this hearing alone will prompt real change. I urge you to put VA officials on notice that there will be a follow-up hearing not later than September by which time you will expect VA officials to produce real and demonstrable changes – in policy and practice – in every network to effectuate the intent of the capacity law.

Recognizing that there has been no effective check on the manner in which network directors or the Under Secretary for Health implemented (or failed to implement) the capacity law, I urge you to direct the VA's Inspector General to take on that role. To my knowledge, that office has failed to provide effective oversight – as it should have – in ensuring that the Department is meeting its obligations under the capacity law. There is a clear need for an internal "policeman" to hold those responsible for management of the VA health care system accountable for the fundamental obligations this law has imposed. Given the record of noncompliance, in my view, and I hope yours, I urge you to direct the IG to audit compliance with this law on a regular, ongoing basis.

I also urge the Committee to develop and move legislation to close what in hindsight appear to be major loopholes in the "capacity" law. For example, the capacity law directs the Department as a whole to maintain programs and capacity. However, individual network directors, who often make critical decisions on resource and program allocation within their geographic service area, have felt free to ignore that requirement. In doing so, they maintain that the statute does not bar individual networks from reducing program capacity. Mr. Chairman, with your indulgence, I have taken the liberty of

offering several suggestions for amending the capacity law and provided those recommendations as an attachment to my testimony. I ask that the document be made a part of the record and, I hope the Committee will give serious consideration to acting on these recommendations.

What about the Under Secretary for Health's Special Committee for the Severely Mentally Ill? My feeling is that the office of the Under Secretary for Health is not an effective level to address this issue because it more strongly embodies the values and priorities of the medical providers, rather than the values and needs of the veteran consumers. An effective action would be to move the committee to a higher level – the level of the Secretary – an Advisory Committee on the Care of Veterans with Severe Mental Illness that would clearly establish the importance of specialized care for these patients.

“Why?” you will say, “has all this not been mentioned loudly before?” The answer is that there are some things one can say a month before one retires; that one cannot say when one is a loyal member of a team. I love the VA and I respect its leaders. But, the bias against people with mental illness is insidious, subtle, and pervasive. Sadly it comes naturally to many people facing budget cuts to reduce mental health programs. It is an implicit standard operating procedure that I have seen active in VA quite consistently during the last 35 years – and it needs to be checked.

As those of you whom I have known over the years may have noticed, my hands shake more now, my gait is less steady, and my voice is not as firm as it was in past years. I have Parkinson's disease, a disease of brain metabolism that is probably not that different from those of the patients to whom I have devoted my professional life. Yet, while I confess I do not have hard data on this, my hunch is that funding for treatment of Parkinson's disease does not face the problems that I have described for the treatment of mental illness.

I will be retiring from VA service next month. My parting perspective is that try as we may, fundamental changes in attitudes towards severe mental illness have changed less than they need to. You have made a huge difference for these veterans. Please continue. VA is a national treasure. Preserve it well.

Attachment:

ATTACHMENT:

Recommended Changes to the VA “Capacity” Law: 38 U.S. Code Section
1706(b)

(suggested changes reflected in bold, underscored language)

(b)(1) In managing the provision of hospital care and medical services under such section, the Secretary shall ensure that the Department **(and each geographic service area of the Veterans Health Administration)** maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that overall capacity of the Department **(and each geographic service area of the Veterans Health Administration)** to provide those services, as of October 9, 1996. **The capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities shall be measured by the dollars – adjusted for inflation - expended for care of such veterans in dedicated programs which provide such specialized treatment and rehabilitative services through specialized staff.** The Secretary shall carry out this paragraph in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

(2)***

(3) (A) To ensure compliance with paragraph (1) –

(i) **The Inspector General of the Department shall carry out an annual Audit to ensure that the requirements of this subsection are being carried out.**

(ii) The Under Secretary for Health shall prescribe objective standards of job performance....

(B)***

(C)***

Summary of Proposed Changes in the “Capacity” Law

The proposed changes to the “capacity” law are intended to close loopholes and help ensure compliance with the intent of that law. The suggested changes, accordingly, would:

- ◆ clarify that the obligation to maintain capacity, and thereby to provide access not simply to a clinician (whose training and experience may not have equipped him or her to diagnose and treat appropriately the unique disabilities

covered by this law) but to appropriate, specialized services, is an obligation which must be met in each of the VA's 22 networks;

- ◆ ensure that the intent of the law is not frustrated by an administrative substitution of "outcome" or other measures for objective measures to determine that VA's capacity to provide needed, specialized services is not eroded or abandoned; and
- ◆ ensure, in the face of very weak record of compliance with this law on the part of the Veterans Health Administration, that there is in place a strong, independent mechanism to audit and enforce compliance with the requirements of the law.