

Statement of

VIETNAM VETERANS OF AMERICA

Submitted for the Record

By

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And

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Before the

House Committee on Veterans' Affairs

Regarding

The VA's Emergency Preparedness Posture and Related Issues

October 15, 2001

Chairman Smith, Ranking Member Evans, and other distinguished members of the Committee, Vietnam Veterans of America (VVA) is pleased to have this opportunity to provide our comments for the record on our concerns regarding the Department of Veterans Affairs (VA) preparedness to deal with a national emergency, including wartime contingencies. Because the VA is required to provide medical back up to the Defense Department in such emergencies, we believe it appropriate to briefly review the state of DoD's performance in this area over the last decade.

Operations Desert Shield and Desert Storm revealed many problems in the U.S. armed forces' ability to mobilize and deploy available medical personnel. This included inadequate data in the personnel information systems used to identify doctors and nurses for active duty assignments as well as a lack of peacetime training to prepare doctors and nurses for their wartime roles.¹ DoD attempted to address this after Congress authorized a demonstration project for training military doctors in civilian trauma centers in 1996, but the program's relatively small scope and DoD's dalliance in getting the program underway meant that as of early 1998 only four surgeons had completed the program.²

In a broader 1992 report on the ability of DoD, VA, and the National Disaster Medical System (NDMS) to handle wartime casualties, GAO made a number of observations that to VVA appear to still be valid nearly a decade later:

- DoD did not know enough about the qualifications or readiness of medical reservists
- The number of beds available in DoD, VA, and NDMS hospitals was overstated
- DoD lacked effective plans to develop additional specialty care, such as burn treatment
- Some communities do not have adequate plans to receive and transport casualties
- Casualty tracking systems were inadequate
- VAMC's had not planned for follow up care of beneficiaries displaced from those centers

All of these shortfalls have a common theme: they are capacity driven.

Throughout 2001, VVA has testified before this and other Congressional committee's regarding our deep concerns over the loss of capacity in the VA health care system to treat veterans with special needs: the seriously mentally ill, homeless veterans, blinded veterans, veterans suffering from spinal cord injuries, and veterans exposed to toxic substances. Should our country be forced into large-scale ground combat operations in Southwest Asia as part of a larger counterterrorism campaign, it is inevitable that we will see an influx of casualties requiring these kind of specialized services. Just as inevitably, DoD will turn to the VA for assistance in treating and subsequently caring for and compensating these veterans, particularly given the downsizing of the services' medical organizations in the wake of Desert Storm. Our

¹ *Operation Desert Storm: Full Army Medical Capability Not Achieved*, GAO/NSIAD-92-175. August 18, 1992.

² *Medical Readiness: Efforts are Underway for DoD Training in Civilian Trauma Centers*, GAO/NSIAD-98-75, April 1998.

view is that the VA is fundamentally unprepared to cope with this new crisis for at least two key reasons.

The first is the aforementioned reductions in the VA's capacity to treat veterans with specialized needs.

As we testified before the full committee earlier this year, since fiscal year 1996, VA's spending on Post-traumatic Stress Disorder (PTSD) treatment programs has declined by over 8% even as the number of patients in need of services has increased by over 20%. VA's ability to provide inpatient or residential PTSD care has been virtually eliminated. If one counts medical inflation, then PTSD program resources have declined by more than 30%. Likewise, programs for the seriously mentally ill have suffered a major reduction in capacity—a roughly 10% loss in resources against a nearly 10% increase in the number of patients. Veterans who should have been treated for PTSD on an inpatient basis are now dealt with infrequently and through outpatient programs that are inadequately staffed, under funded, and unevenly allocated nationally. Existing seriously mentally ill veterans are now wandering our streets, without proper treatment or hope for recovery. This is but one example of the overall diminishment of VHA capacity due to the continued starving VA of vitally needed funds.

Given these types of resource deficits, VVA believes that there is no way that the VA will be able to treat a new influx of veterans suffering from PTSD or other mental disorders brought on by combat in the wilds of Afghanistan or elsewhere in Southwest Asia. Bluntly stated, this is a mental health treatment disaster waiting to happen, particularly since VA cannot even properly deal with the patients they have now!

Substance abuse programs have also been ravaged. Despite a roughly 12% decline in the number of veterans seeking treatment, total resources declined by an astonishing 37%, amounting to a net reduction in services of 25%, not accounting for medical inflation. Even allowing medical inflation at only 8% per year (the private sector has been averaging over 10%), the sum total of reduction in substance abuse services is more than 60%! We note that the medical inflation rate we have quoted is our minimum estimate of its impact on the VA system; the real impact in reduction in services is likely much greater.

American servicemembers deployed to Afghanistan or any adjacent countries can count on fighting in a “drug rich” environment, as the following excerpt from the October 3, 2001 edition of the *Washington Post* makes clear:

“According to the State Department, the Taliban controls 96 percent of the territory where poppies are cultivated in Afghanistan. It promotes this activity to finance arms purchases and military operations. Although congressional sources said it is not clear that bin Laden benefits directly from drug money, McCaffrey said he is sure there is a "direct personal relationship" between the Taliban and al Qaeda, the international terrorist network led by bin Laden. He said much of the treasury initially accumulated by bin Laden came

from selling heroin in Europe.”³

Having financed their international mayhem through drug sales, we can rest assured that bin Laden and his Taliban allies will use their drug network to attempt to get as many deployed American military personnel as possible addicted to opiates or hashish. We must also be alive to the possibility that American forces worldwide may become the target of terrorist-financed drug addiction efforts. Given the virtual collapse in the VA's inpatient drug treatment program, VVA sees no way that the Veterans Health Administration could cope with a significant influx of new hard drug users attempting to get clean.

Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, explicitly requires the VA to “maintain its capacity to provide for the specialized treatment and rehabilitation of disabled veterans within distinct programs or facilities dedicated to the specialized needs of those veterans.” Instead, PTSD, substance abuse, mental illness, and homeless programs within the VA have virtually imploded due to inadequate funding. Under these conditions, how can anyone expect the VA's specialized services to be able to cope with a new generation of combat veterans?

Our organization has estimated that it will take a bare minimum of \$3 billion—over and above additional funds to offset past medical inflation—to begin to restore VA health care programs to their pre-1996 level. Much more would be required if large numbers of new Southwest Asia veterans enter the system.

Another major problem impacting the VA's ability to meet its wartime mission requirement is the VA's proposed Capital Asset Realignment for Enhanced Services (CARES) process.

Ostensibly, CARES is designed to allow the VA to rationalize its medical infrastructure by closing or consolidating facilities while shifting to an emphasis on outpatient treatment. In July 2001, VHA Undersecretary Garthwaite issued his preliminary recommendations for the first CARES-driven restructuring, in this case for VISN 12, which serves northern Illinois, Wisconsin, and parts of Michigan. Our analysis of this proposed restructuring highlights not only the impact it will have on the existing veteran population but on any future veterans created by the administration's counterterrorism campaign.

The CARES options selected by VA for the Northern and Central markets of VISN 12 stipulate that there would be no routine contracting for medical services in the more remote submarkets. Given the fact that there is no VAMC in the region between Iron Mountain and Tomah, VVA finds it incomprehensible that the VA would select options that do not *mandate* medical service contracting for the nearly 100,000 veterans who live in these two markets.

³ *Scrambling to Get on Board ...The New Battlefield*, The Washington Post online, Wednesday, October 3, 2001.

Not only are we concerned about the ability of veteran in rural areas to get access to quality, full-spectrum medical services, we are also deeply concerned about the lack of hospital access for veterans living in the Green Bay-Appleton-Manitowoc triangle. Veterans from these areas would have to drive 50+ miles to get full-spectrum medical services under the proposed plans—a totally unacceptable situation. One can only imagine the problems these veterans will face if they are displaced from the VA health care system by competition from more recently wounded veterans from Operation ENDURING FREEDOM.

Moreover, we are also deeply concerned that the Tomah VAMC's complete lack of surgical, SCI, and blind rehab beds will leave affected veterans in central and western Wisconsin without access to these services unless VA enters into appropriate contracting agreements with local providers. Given the VA's own acknowledgement that veterans from *outside* VISN 12 have been seeking access to VISN 12's already inadequate specialized services, we are quite certain that the 34 blind rehab beds at Hines VAMC are inadequate to serve the existing veteran population, to say nothing of potential ENDURING FREEDOM veterans.

Regarding the availability of private sector medical services within the VISN, BAH noted that

"This analysis suggests that the vacancy rate of private sector community hospitals could be as high as 43 percent, therefore suggesting there is excess capacity in the private sector with the potential for the VA to buy services."
(p. 2-19)

Of the 116 community hospitals in Wisconsin, VVA is quite certain that there are several hospitals the VA could contract with to ensure that veterans with specialized needs have access to the services they require, and that veterans in need of more routine care do not spend hours on the road in search of health care, particularly if they are displaced by ENDURING FREEDOM veterans seeking the same services. Based on previous GAO testimony and the observations of our members and service representatives in the field, we know that the problems described above are present throughout the entire VHA.

Moreover, the notional DoD-VA sharing agreement in the VISN 12 CARES proposal underscores another serious problem: the fundamentally different nature of the patients the two agencies treat.

Clinically, veterans are generally older and in poorer health than their active duty counterparts. Accordingly, their medical needs are in many ways fundamentally different. Secondly, we are concerned that any DoD-VA sharing agreement would be dominated by DoD, which has a far larger budget and a greatly increased role and status in the wake of the World Trade Center and Pentagon terror attacks this month. Our fear is that DoD's needs will take priority over those of the VA and the veteran population it serves, to the detriment of the health of the veteran population.

We would withdraw our objection to these proposed sharing arrangements *only* if the Congress and the VA guarantee veterans access to health care through adequate, readily accessible private health care providers. Even with such contracting arrangements, however, one fundamental problem would remain: most private sector clinicians have even *less* understanding of the special needs and circumstances involved in treating veterans than do VA or DoD clinicians. What DoD, VA, and the Congress must come to recognize is that if our country wants to ensure that it has an adequate pool of health care providers trained in *veterans health problems*, it must create the medical education infrastructure to recruit and train such providers *now*.

Additionally, we are extremely concerned about the impact of the current Guard and Reserve mobilization will have on the VA. How many VA doctors, nurses, and support personnel are also in the Guard and Reserve? Who will backfill those who've been called up? In the Washington metro area alone, VVA has already heard of cases where mobilized VA personnel have been pulling double shifts—one at the VA, the other at their mobilization center/station. Tired medical professionals can make deadly mistakes in high-stress situations. How many potential additional casualties will we create by overworking and under-strength VA medical staff? The committee must have answers to these questions immediately, and corrective action must swiftly follow.

Another major area of concern for VVA is the VA's ability to deal with some of the more serious diseases that are endemic to Afghanistan, particularly Crimean Congo hemorrhagic fever (CCHF), which is fatal in roughly 35% of cases. As the disease is tick-borne, troops bivouacked in the field will be most vulnerable to infection; hospital workers are also at considerable risk. Obviously, next to a direct biological warfare attack, CCHF represents the most serious health threat for U.S. troops deploying to the region.

Moreover, less life-threatening but still serious endemic disease threats will also confront American forces in this theater of operations. Specifically, we are concerned about "sandfly fever," which can cause severe flu like symptoms that can last for up to a week. Last week, the *Washington Post* reported on the results of a 1996 study in which U.S. and Pakistani physicians measured the antibody response to various diseases in three different groups of Pakistani military personnel. The researchers found that 27%-70% of the study subjects had antibodies to sandfly fever virus, strongly suggesting that American military personnel face a serious medical hazard from this endemic disease.

How many VA physicians have experience in dealing with CCHF or sandfly fever? It bears mentioning that initially, DoD and VA health screeners missed the presence of *leishmania tropica* among a small group of Desert Storm veterans. Serious questions remain about the adequacy of VA's screening and treatment efforts for these kind of diseases. This committee should demand that both DoD and VA show what measures they have in place to deal with these extremely serious health threats, and especially to track infected personnel in a longitudinal study to determine the long-term health risks of such exposures.

Significantly more money is needed in veterans health care beginning now, and not next year after further layoffs and hiring freezes have even further diminished the capacity of VHA, and hence the capacity of the VA to fulfill the vital mission of contributing to the national security of the United States.

It is critical that the VA and the Congress recognize that this new war we face will affect not only veterans but their family members as well. How well equipped is the VA to provide counseling and other services to family members affected by this crisis? Given the state of the VA as we have outlined it above, we are fairly certain that aid to spouses or survivors is relatively low on VA's list of priorities.

Another factor this committee must consider is how well the VA is prepared to help deal with a civilian mass casualty scenario like the one that occurred in New York City. How quickly would VA medical establishments be able to provide trauma or other emergency support to local hospitals in major cities should those hospitals be overrun with civilian casualties? We suspect the answer would not be reassuring, particularly since the total number of inpatient VA beds has declined from 53,000 in FY 95 to only 22,000 in FY 2000 (the last year for which figures are available).

Finally, the committee must review the VA's physical security measures and the integrity of its employee identification process. How easy is it for unauthorized persons to obtain official VA credentials? How easy is it for unauthorized persons to gain access to the uniforms and equipment used by VA contractors, and thus gain access to VA facilities? These questions need immediate answers.

VVA and this committee share a common goal: ensuring that all veterans have access to quality health care services. Unfortunately, years of neglect and inadequate resources have left the VA incapable of meeting its current obligations to existing veterans, much less the capacity to deal with significant numbers of ENDURING FREEDOM veterans. We applaud Secretary Principi and this committee for their efforts to secure additional resources for the VA. We would respectfully suggest, however, that the VA must move immediately to comply with PL 104-262 by seeking sufficient resources from the Congress to restore and maintain capacity within the VA health care system. The VA's top organizational priority must be a recentralization of the specialized services, followed by the implementation of stringent accountability measures for senior managers within the VHA. Just as Secretary Principi acted decisively in dealing with the recent fraud scandal within the VBA, so too must he act decisively to restore the VHA's capacity to treat both current and future veterans.

Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these extremely important issues, and we look forward to working with you, Mr. Chairman, and your distinguished colleagues on this Committee to address and resolve these and other important matters of concern to our nation's veterans.

VIETNAM VETERANS OF AMERICA
Funding Statement
September 20, 2001

Vietnam Veterans of America (VVA) is a national 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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Philip A. Litter, Esq. has served as Chair of VVA's National Government Affairs Committee since April 1998. He has also variously served as an officer, director, delegate, and committee member in VVA at the national, state, and local levels since 1988. Mr. Litter is a life member of VVA, and a member of the American Legion.

A lifelong resident of western New York state, Mr. Litter has served in his community as an elected official, and maintains an active role in community affairs, in addition to his work on veterans issues.

Mr. Litter is employed as the Principal Law Clerk to a Supreme Court Justice in Rochester, N.Y. He holds Bachelors and Masters degrees from the State University of New York and graduated from the Syracuse University College of Law in 1988. He and his wife Theresa, a former Army nurse who he met in 1968, have two grown sons—one, a computer software engineer who is an Army Reserve Captain; the other, a research chemist in Madison, Wisconsin. Phil and Theresa—who have recently become grandparents—reside in Rochester, New York.

**Linda Spoonster Schwartz
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Linda Schwartz received her diploma in Nursing from Saint Thomas Hospital School of Nursing in Akron, Ohio. She is a Cum Laude graduate of the University of Maryland and received a Masters in Psychiatric Nursing from Yale University School of Nursing. She completed her Doctoral Degree in Public Health in April 1998. Her dissertation "Physical Health Problems of Military Women Who Served During the Vietnam War" is the first major research investigation of the health of women veterans of the Vietnam Era.

Dr. Schwartz is medically retired as a Major from the United States Air Force due to injuries she sustained in an aircraft accident while on duty in the Air Force.

Dr. Schwartz has a long history of involvement in nursing and veteran organizations. She has served as President of both the Connecticut Nurses Association and the Connecticut Nurses Foundation. In 1987, she was elected to the Board of Directors of the American Nurses Association (ANA). She also served as Member of the board and Treasurer of the ANA PAC (1987-89). She is currently an Associate Research Scientist at the Yale School of Nursing.

Linda has served as Trustee of the Connecticut Department of Veterans Affairs since 1988. She served 10 years on the VA Advisory Committee on Readjustment of Vietnam Era Veterans. She has also served as Chair of the VA Women Advisory Committee from 1997-2000. Dr. Schwartz was a member of the Board of Directors of Vietnam Veterans of America from 1989-95. She was one of the founders and served (1990-96) as the President of the Vietnam Veterans Assistance Fund (VAAF), a charitable organization certified from the Combined Federal Campaign, which focuses on the needs of the nation's 9.2 million Vietnam Era Veterans.

From 1992-99, Dr. Schwartz served in a volunteer capacity as the Co-Director of "Project Partnership," a VAAF program that involved the acquisition and development of four homes for homeless and disabled veterans in collaboration with the West Haven VA Medical Center. Project Partnership became incorporated as a 501(c)(3) nonprofit organization on November 22, 1997 in West Haven, Connecticut.

Dr. Schwartz resided in Pawcatuck, Connecticut with her husband Stanley (a restaurateur) and her daughter Lorraine, a 1998 graduate of Syracuse University.