

**STATEMENT OF
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AMERICANISM COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE STATUS OF MILITARY AND DEPARTMENT OF VETERANS AFFAIRS
HEALTH CARE COORDINATION
INCLUDING
POST-DEPLOYMENT HEALTH CARE OF RECENTLY DISCHARGED VETERANS**

San Antonio, Texas - April 13, 2004

Mr. Chairman and Members of the Subcommittee:

On behalf of the 2.8 million members of The American Legion, I thank you for this opportunity to present our organizational views on the status of military and VA health care coordination including post-deployment health care of recently discharged veterans. We commend the Subcommittee for holding this hearing on this timely and important subject.

With the continuing global war on terrorism and the events in Iraq and Afghanistan, it is critically important that the Department of Defense and the VA coordinate healthcare delivery to our returning troops and new veterans of these conflicts. No veteran should be allowed to slip through the cracks between these massive agencies for lack of information or outreach.

Perhaps it was easier in President Lincoln's day "*to care for him who shall have borne the battle and for his widow and his orphan.*" The Government then was limited in what it knew or could do about caring for survivors of the Civil War. The physical wounds of war were no less horrific than today, however, nearly nothing was then known of the delayed effects of participation in the brutal business of war. Veterans went home, or not, to the farms and cities with pensions for disfigurement, missing limbs or organs of sense and little else. The residuals of diseases such as cholera and scurvy endemic in garrisons and prisoner of war camps generally were not recognized as war-related and veterans were usually left to fend for themselves. Veterans whom we would now diagnose with Post-Traumatic Stress Disorder died from exposure and alcoholism in the streets or were warehoused in proliferating insane asylums and prisons. Those veterans who were totally disabled were, if they were lucky, allowed to live out their lives in veterans' homes run by the States. The first of these was Rocky Hill State Veterans Home and Hospital in Connecticut that is still serving veterans today.

The point here is that with each succeeding war, we have learned more and more about what war does to the human body and psyche, both immediately and later in life. Our knowledge of these

effects is now so extensive that the government that called them to sacrifice must objectively follow our veterans who return from war; from the very moment they shed the uniforms in which they fought. For example, it is now known that almost every individual who is exposed to prolonged periods of combat exposure will exhibit symptoms of Acute Stress Disorder. Once removed from the stressors, most troops readjust within a month or two and those that do not are considered for a diagnosis of PTSD. For this reason, returning troops may be kept in garrison for a short period of observation so that those troops who do not readjust well may be counseled and referred to VA on release from active duty. Lessons learned from the experience of veterans of the Vietnam War and extensive research into combat-related stress reactions by the VA's exemplary National Center for Post-Traumatic Stress Disorder have led to these protocols.

According to the most recent Analysis of VA Health Care Utilization (Report 5, dated March 29, 2004), 127,970 veterans have returned from Operation Iraqi Freedom. Fourteen percent (17,800) have sought healthcare from VA. Of those veterans, 15.1% (2,691) were diagnosed with mental disorders. The most frequently diagnosed (970 veterans) mental disorder was ICD-9 Code 309 Adjustment Reaction including 626 diagnoses of Post-Traumatic Stress Disorder (PTSD). The only discrete non-dental diagnoses with higher rates were infectious and parasitic diseases (1103), essential hypertension (996) and deafness (1212). So far, coordination between the DoD and VA systems with regard to OIF and Operation Enduring Freedom (OEF) appears to be working well at the operational level. Pre- and post-deployment health screenings of troops has improved since the initial problems noted in various reports by the General Accounting Office (GAO).

On the DoD end, The American Legion is heartened by the implementation of the Army's new Disabled Soldier Support System (DS3). In previous conflicts no program to transition disabled soldiers into the VA system existed. Veterans presented themselves to VA and were required to prove their own eligibility. As noted above, the new knowledge of the front-end sequelae of combat indicates a requirement for follow-up. The deployment cycle support feature of DS3 facilitates referrals to VA. DS3 provides its severely disabled soldiers and their families with a system of advocacy, including representation by Veteran Service Organizations (VSOs) such as The American Legion. VSOs are involved at the Physical/Medical Evaluation Board (PEB/MEB) level at major Military Treatment Facilities (MTFs) and follow the veteran to his or her initial contact with VA healthcare. If the soldier is medically retired, the VSO conducts a Needs Assessment and tailors specific assistance to the soldier and family. On release from DoD, the veteran is handed off to a "hometown" VSO for enrollment in VA medical care and application for VA disability compensation. Periodic telephonic follow-up by DoD then ensues for a minimum of five years. This is a commendable initiative, designed to deliver services to the veteran with a minimum of delay and red tape and The American Legion appreciates DoD's precedential involvement of VSOs at the level of the MTF. Hopefully, this will evolve into the same symbiotic relationship that VSOs now enjoy with VA. Time will tell.

At the VA end, on March 19, 2003 Secretary of Veterans Affairs Anthony Principi announced that, under authority granted by Pub. L. 105-368, any veteran returning from a combat zone will be entitled to two years of free VA healthcare starting from date of discharge from Federal service. This benefit applies to active duty, Reserve and National Guard personnel, irrespective of any service-connected disability status, and will not affect the veterans continuing eligibility

for care of service-connected conditions after the two-year period expires. VA is currently conducting aggressive outreach to Reserve and National Guard troops who may not be aware of the benefit. VA is also working to overcome well-publicized unacceptable veteran interactions with individual VA healthcare facilities related to wait-times for initial appointments. A number of long-term strategies, policies and procedures have been implemented to assure that timely, appropriate care is provided to returning service members.

In the announcement, the Secretary noted the progress made in VA's ongoing partnership with DoD, specifically standardized post-deployment physical examination guidelines and establishment of the War-Related Illness Centers in Washington, DC and East Orange, New Jersey. Two joint post-deployment VA/DoD clinical practice guidelines (CPGs) have been released to educate physicians and other providers in deployment and exposure related health concerns. The current CPGs address general post-deployment issues and unexplained fatigue and pain. A new CPG is soon to be released on the management of traumatic stress with the aim of preventing acute and chronic PTSD. In another unprecedented move, the Surgeons General of the Services have enthusiastically approved the detailing of Veterans Benefits Administration (VBA) benefits counselors and Veterans Health Administration (VHA) clinical social workers to MTFs receiving casualties from OIF/OEF.

Mr. Chairman, the outstanding efforts of the VA and DoD to avert the problems encountered after Operations Desert Shield and Desert Storm have been innovative and laudable. Never before have the VA, DoD and the VSO community come together so effectively to ensure that those *who shall have borne the battle* receive the care and benefits they have earned and deserve because of their service.

More daunting challenges lie ahead in institutionalizing this progress for availability in this and future conflicts. Now described under the rubric of "seamless transition", attempts to bring together the DoD and VA healthcare are nothing new. Pub.L. 97-174, the Department of Veterans Affairs/Department of Defense Health Resource Sharing Operations Act of 1982, paved the way for VA/DoD cooperation in the sharing of resources during national emergencies. Since then a plethora of legislation has mandated and encouraged further VA/DoD cooperation. The most recent and significant of these new laws is Pub.L. 107-314, the National Defense Authorization Act of 2003--Subtitle C: DoD-VA Health Resources Sharing which requires VA and DoD to develop and publish a joint strategic vision statement and a joint strategic plan to shape, focus, and prioritize the coordination and sharing efforts among appropriate elements of the two Departments and incorporate the goals and requirements of the joint sharing plan into the strategic and performance plan of each Department.

Major resources are being applied by both Departments to comply with this law. A few current projects include:

The *Joint VA/DoD Electronic Health Records Plan-HealthPeople*. This overarching initiative guides activities and deliverables of VA and DoD sharing and will result in a "virtual" health record accessible by authorized users within DoD and VA. It will be comprised of a family of systems or converged applications between DoD and VA. The VA/DoD Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health and the DoD Assistant Secretary of Defense for Health Affairs, is providing senior level executive oversight and

management of the Departments' activities related to health systems interoperability. The HEC meets routinely to review and/or approve, when timely and appropriate, new and on-going initiatives or health IT sharing projects for coordination between VA and DoD.

The *Clinical Data Repository/Health Data Repository (CHDR)*. This project seeks to ensure the interoperability of the DoD Clinical Data Repository (CDR) with the VA Health Data Repository (HDR) by FY 2005. CHDR is the effort to develop the software component services that will be used by the Composite Health Care System (CHCS II) CDR and the Health_e_Vet HDR to exchange clinical data in order to provide services in a seamless fashion to both TRICARE and Health_e_Vet beneficiaries. The Departments formed an active working group to lead this effort and are making significant progress toward building a prototype.

Lab Data Sharing & Interoperability (LDSI). This project will facilitate electronic order entry and results retrieval between DoD, VA, and commercial reference labs to maximize label resources and reduce costs. Phase One was successfully completed with the release of software that supports the ability of VA to initiate lab requests for filling at DoD labs. Development of software permitting DoD to initiate the request for filling at VA labs began December 1, 2003.

U.S. field commanders are aware that their responsibilities include Force Health Protection and this has become a major theme in military operations. The Congress has wisely seen to it that this theme extends to the highest reaches of the Pentagon and Department of Veterans Affairs. The American Legion is confident that the goal of seamless transition will be achieved as the requisite technologies are developed and adapted. We also believe that this will serve to enhance the professionalism, prestige and pride-of-service of those men and women currently serving in the 21st Century All-Volunteer Military of this Nation and will encourage others to serve.

Mr. Chairman I conclude my remarks with a quotation from our first Commander-in Chief :

“The willingness with which our young people are able to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated by the nation.”

I again thank the Subcommittee for this opportunity to present the views of The American Legion on the subject of today's hearing. I will be happy to answer any questions you may have.