

**STATEMENT FOR THE RECORD
OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairman Miller, Ranking Member Michaud and Members of the Committee:

On behalf of Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime wounded, injured or ill veterans, along with 200,000 Auxiliary members, I am pleased to present our views on addressing the barriers veterans face when trying to gain access to mental health services from the Department of Veterans Affairs Veterans (VA). DAV is committed to fulfilling our promises to the men and women who served, and one of those promises is to ensure that veterans receive a full and lasting opportunity to recover from physical, emotional and psychological wounds that occur as a consequence of their military service experience.

We appreciate your determination, Mr. Chairman and Members of this Committee, for continued concentration on this important and pressing issue, as well as the opportunity to offer DAV's views on the challenges confronting the Veterans Health Administration (VHA) in meeting the critical mental health needs of our nation's veterans. DAV's statement focuses on the Committee's concerns about the status of VA's progress on growing mental health professional staffing levels; mandates outlined in the President's recent Executive Order to improve access to mental health services for veterans, service members and their families; addressing the recommendations in the 2012 Office of Inspector General (OIG) report on waiting times for mental health services; improving data collection related to access measures; scheduling processes and procedures; and partnering with non-VA mental health providers to address gaps in VA care.

Since the wars in Iraq and Afghanistan began over a decade ago, more than 2.4 million individuals were deployed to overseas combat theaters; many have deployed several times. Of this group of brave men and women, 1.5 million have been honorably discharged and are now eligible for VA health care. VA's most recent cumulative data shows that 834,467 of them have obtained VA health care and that 53 percent, or 444,551 veterans, have been diagnosed with a mental disorder.

Additionally, there were a record 349 military suicides in 2012, exceeding the 310 combat deaths reported during that period.

More than eleven years of war have clearly taken a toll on the mental and physical health of American military forces and the veterans among them who have returned to civilian life. Research shows that post deployment mental health readjustment challenges and post-traumatic stress disorder (PTSD) are prevalent in many returning service members and veterans. We believe that everyone returning from contingency operations overseas should be empowered to achieve maximal opportunity to recover and successfully readjust to civilian life. But to do so, as warranted by their circumstances, they must be able to gain "user-friendly" and easy access to Department of Defense (DoD) and VA mental health services—services that have been validated by research evidence to ensure their best opportunities for full recovery and reintegration with their families, jobs and private life.

Over the past five years, the post-deployment health status of our servicemen and women and veterans, suicide prevention, and timely access to appropriate mental health services, have been topics of numerous Congressional hearings, government reports and regular media scrutiny. Collectively, the hearing findings, reports and coverage cast a negative impression related to appropriate and timely access to services, often highlighting barriers to care and systemic flaws in an overly “medicalized,” bureaucratic health care system. Given the diligent oversight by the Veterans’ Committees in both Chambers, and the significant level of new resources that were authorized to address the existing deficits and to improve VA mental health services and other care for veterans, the current question posed by the Committee Chair is a valid one: “Is the VA’s complex system of mental health [care] and suicide prevention services improving the health and wellness of our heroes in need?”

Mr. Chairman, although flaws unquestionably can be found in the system, and must be addressed, DAV would be remiss in failing to recognize and applaud VA’s efforts to date to improve these programs. Tens of thousands of dedicated mental health practitioners and Readjustment Counseling Service Vet Center counselors work day-in and day-out, to help veterans who are struggling in their post-deployment readjustments.

Over the past five years, VA’s Office of Mental Health Services (OMHS) has developed and disseminated a comprehensive array of mental health services throughout the VA health care system, while accommodating a 35 percent increase in the number of veterans receiving mental health services and managing a 41 percent increase in mental health staff. At DAV, despite all the problems reported, we believe this is remarkable progress. In 2011 (most recent data), VA provided specialty, recovery focused mental health services to 1.3 million veterans, at very high levels of satisfaction. These services were both patient-centered and integrated into the basic care of the patients using VA services. Today, mental health is a prominent component of VA primary care – a long sought goal of DAV, other veterans’ advocates and the mental health research community.

VA offers veterans a wide range of mental health services, from treatment of the milder forms of depression and anxiety in primary care settings themselves, to intensive case management of veterans with serious, chronic mental challenges such as schizophrenia, schizo-affective disorder, and bi-polar disorder. VA also offers specialized programs and treatments for veterans struggling with substance-use disorders and post-deployment readjustment difficulties, including providing evidence-based treatments for PTSD for combat veterans and for those who endured and survived military sexual trauma.

For at least the past five years, while under intense external pressure, VA has placed special emphasis on suicide prevention efforts, launched an aggressive anti-stigma, outreach and advertising campaign, and provided services for veterans involved in the criminal justice system, including direct VA participation in the veterans treatment courts initiative, to support both pre-release and jail-diversion programs in a rising number of states and cities. Peer-to-peer services, mental health consumer councils, and family and couples counseling and therapy services have also been evolving and spreading throughout the VA health care system. We at DAV are encouraged by these developments, we believe they are humane approaches, and are saving lives.

Yet despite noted progress, the Institute of Medicine (IOM) released a report, entitled *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations*, in July 2012, that addresses some of the Chairman’s concerns—specifically, whether the readjustment services available to veterans improving the health and wellness of our nation’s transitioning service members. In the report, after a comprehensive review of government programs for the treatment of PTSD, the IOM found a lack of coordination, assessment and monitoring by both DoD and VA. The IOM concluded treatment is not

reaching everyone who may need it, and that the Departments are not tracking which treatments are being used, or evaluating whether and how well they work over the long term.

DAV concurs with recommendations made by the IOM that VA and DoD should invest in targeted research to fully evaluate the effectiveness and health outcomes of existing PTSD treatment and rehabilitation programs and services. Likewise, VA and DoD should support research that investigates new and emerging technologies and web-based approaches to overcome barriers to accessing mental health care, and adhering as well to more comprehensive and long-term evidence-based treatments. The report noted that the IOM committee's analysis of innovative or complementary and alternative medicine treatments such as yoga, acupuncture and animal-assisted therapy was limited since these types of treatments lacked empirical evidence of their effectiveness. Given that these alternative treatments have become more popular and requested by many veterans, DAV urges that both DoD and VA carefully study and evaluate these treatments to judge their efficacy versus other approaches.

OFFICE OF INSPECTOR GENERAL 2012 RECOMMENDATIONS, AND PRIOR EXTERNAL REVIEWS

Based on a request from both Committees on Veterans Affairs, in April 2012, the VA OIG reported on the level of accuracy the Veterans Health Administration (VHA) documents in waiting times for mental health services for new and established patients, and whether the data VA collects is a true depiction of veterans' ability to gain and keep access to needed services. The OIG found that VHA's mental health performance data is inaccurate and unreliable and that VHA's data reporting of first-time access to full mental health evaluation was not a meaningful measure of waiting.

Since the OIG had found a similar practice in previous audits nearly seven years earlier, and given that VHA had not addressed the longstanding problem, OIG urged VHA to reassess its training, competency and oversight methods, and to develop appropriate controls to collect more reliable and accurate appointment data for mental health patients. The OIG concluded that the VHA "...patient scheduling system is broken, the appointment data is inaccurate and schedulers implement inconsistent practices capturing appointment information." These deficiencies in VHA's patient-appointment scheduling system have been documented in numerous reports.

STAFFING ISSUES

The OIG also recommended in the 2012 report that VHA conduct a comprehensive analysis of staffing to determine if mental health provider vacancies were systemic and impeding VA's ability to meet its published mental health timeliness standards.

The DAV shares the Committee's concerns about how VA plans to resolve its mental health staffing deficits to meet rising demand for critical mental health services. In April 2012, the Secretary announced VA would add approximately 1,600 mental health clinicians and 300 support staff to VA's existing mental health staff of 20,590, in an effort to help VA facilities meet burgeoning demand. In his testimony before this Committee on May 8, 2012, Secretary Shinseki testified that he estimated six months would be required for VA to hire most of these new mental health personnel. DAV awaits VA's report on the number of new providers who have been hired, and are now providing care to veterans. As we have noted in prior testimony, the bureaucratic and cumbersome human resources process in VA, especially in credentialing new VA professional providers, continues to hamper VA's ability to quickly put newly-hired individuals on the front lines caring for patients. For more insight on these challenges, please review our discussion of VA human resources concerns in the Fiscal Year 2014 Independent Budget, at www.independentbudget.org.

VHA's timely access goal is simply to treat a veteran patient in clinic within 14 days from the desired date of care. One method VA uses to monitor access to health care including mental health services is to calculate a patient's waiting time by measuring the number of days between the desired date of care to the date of the treatment appointment. Appointment schedulers at VA facilities must enter the correct desired date(s) of care in the automated scheduling system to ensure the accuracy of this measurement.

Data generated to measure a veteran patient's timely access to care continues to remain unreliable. There continues to be weaknesses in VA's policy and implementation of scheduling medical appointments based on several reports spanning more than a decade from VA's OIG and the U.S. Government Accountability Office.¹ The weaknesses reported include VA's definition of the "desired date" of the medical appointment contained in policy,² and VHA's training and oversight program to address the problems in measuring waiting times. We urge VA OIG to report on the status of those recommendations from its 2007 review, which indicated that five out of eight recommendations were either not implemented or were only partially implemented.

Without reliable data, VA will remain challenged in conducting meaningful analysis and decision-making that directly impact the quality, patient-centeredness and timely delivery of needed care, including mental health care.

After more than a decade of effort, VA's Office of Information and Technology has remarkably still not completed development of a replacement for VHA's antiquated, 25-plus year-old scheduling system, and one that can effectively manage the scheduling process, provide accurate workload data capture and reporting technology, and be responsive to the needs of VA's mental health patients and providers.

As noted in OIG's most recent report on veterans' access to mental health care, VA's "scheduling software is 25 years old and the software interface is not "user-friendly." This automated scheduling application has been an essential component of the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record, and performs multiple, interrelated functions. VistA captures and assembles utilization data, which is intended to enable VA to measure, manage and improve access, quality and efficiency of care, and evaluate the operating and capital resources used.

GAO reported in 2010 on VA management deficiencies, principally VA's second effort at developing a replacement scheduling system for the aging VistA.³ Since that time, VA has abandoned this project, and on December 21, 2012, VA issued a request for information in *Federal Business Opportunities* to update and rebuild the application, with responses due from industry by January 31, 2013. VA plans the new scheduling system to be standards-based, extensible and scalable and interoperable with the version of VistA held by the Open Source Electronic Health Record Agent (OSEHRA). According to VA, the new health scheduling system will rely on web- and mobile-device

¹ HEHS-00-90, VA Needs Better Data on Extent and Causes of Waiting Times, May 31, 2000; GAO-01-953, More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress, Aug 31, 2001; GAO-12-12, Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access, Oct 14, 2011; VA OIG Report No. 02-02129-95, Audit of Veterans Health Administration's Reported Medical Care Waiting Lists, May 14, 2003; VA OIG Report No. 04-02887-169, Audit of the Veterans Health Administration's Outpatient Scheduling Procedures, July 8, 2005; VA OIG Report No. 07-00616-199, Audit of the Veterans Health Administration's Outpatient Waiting Times, September 10, 2007, and; VA OIG Report No. 12-00900-168, Veterans Health Administration Review of Veterans' Access to Mental Health Care, April 23, 2012.

² VHA Directive 2010-027

³ GAO-10-579, Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System, May 27 2010.

capabilities for quick and secure communications with veterans, and support for resource allocation decisions based on truer data, with more opportunity to adjust capacity dynamically to meet changing needs.

Because of current weaknesses in measuring veteran patients' access to care, it is unclear to DAV at this time if VA's new direction will correct lengthy VA waiting times, yield accurate access measures, or result in less cumbersome scheduling processes and procedures. DAV recommends the Committee conduct further oversight on VA's plans and intentions with respect to the replacement of VistA. This challenge has become much more acute based on VA's and DoD's joint announcement last week of their decision to abandon their long sought joint electronic health record project that would have served both the veteran and military populations, to proceed in separate directions, but to rely on a Janis GUI interface technique to translate data from one system to the other. In this case, VA scheduling software and its ongoing problems are a major weakness that must be addressed. Most importantly, the OIG report noted that meaningful analysis and decision making required reliable data, not only related to veterans' access to care, but also on shifting trends in demand for services, the range of treatment availability and mix of staffing, provider productivity and treatment capacity of the facilities. From this study, the OIG made four major recommendations to VHA. Similar to previous external reviews, the VA Under Secretary for Health concurred with all recommendations and replied that a number of responsive actions were underway. Again, in this instance we are anxious to determine from VHA the progress made thus far on the above-referenced recommendations.

In August of 2012, the President issued an Executive Order (EO) to improve access to mental health services for veterans, service members, and military families. It was noted that based on the wars in Iraq and Afghanistan, the need for mental health services will only increase in the coming years as the nation deals with the effects of more than a decade of conflict. We concur and agree that coordination between the DoD and VA during service members' transitions to civilian life is essential to achieving the goal of timely access to the provision of high quality mental health treatment for those who need it.

The EO focused on six areas including: suicide prevention; enhanced partnerships between VA and community mental health providers; expanded VA mental health services staffing; improved mental health research, and appointment of a military and veterans mental health interagency task force. Specific mandates in the EO included: expanding the 1-800-273-TALK "Veterans Crisis Line" capacity by 50 percent; developing and implementing a joint VA-DoD national suicide prevention campaign; establishing no fewer than 15 pilot programs and formal agreements with community-based mental health providers; hiring and training at least 800 new VA peer counselors by December 31, 2013; hiring 1,600 VA new mental health professionals by June 30, 2013; establishing a "National Research Action Plan" within eight months of the EO; developing in the DoD and Department of Health and Human Services (HHS) a comprehensive longitudinal mental health study with an emphasis on PTSD and TBI, including enrollment of at least 100,000 service members by December 31, 2012; and, development of an Interagency Task Force of VA, DoD and HHS to identify reforms and take actions that facilitate implementation of the strategies outlined in the EO.

This is clearly an ambitious plan, and we look forward to VA's report of progress on the outlined initiatives to improve access to mental health services for veterans, service members, and military families.

PARTNERING WITH NON-VA RESOURCES TO EXTEND ACCESS FOR VETERANS WITH MENTAL HEALTH CHALLENGES

Mr. Chairman, you recently endorsed a VA-TRICARE outsourcing alliance to serve the mental health needs of newer veterans that VA is, admittedly, struggling to meet today. Having offered little to

bolster the confidence of DAV's members and millions of other veterans and their families that mental health services are, in fact, being effectively provided by VA where and when a newer veteran might need such care, we urge VA to work with the Committee to ensure that, if mental health care is expanded using the existing TRICARE network or some other outside network, veterans must receive direct assistance by VA in coordinating such services, and the care veterans receive must reflect the integrated and holistic nature of VA mental health care.

In working with Congress on this issue, the primary question is whether VA *should* partner with community mental health resources to provide this care when local waiting times exceed VA's own policies. When a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important for VA to determine the kind of mental health services needed and whether the most appropriate care would come from a VA provider or a community-based source. This type of triage is critical, because effective mental health treatment is dependent upon a consistent, continuous-care relationship with a provider. Once a trusting therapeutic relationship is established between a veteran and a provider, that connection should not be disrupted because of a lack of VA resources, a local parochial decision, or for the convenience of the government.

Moreover, it is imperative that if a veteran is referred by VA to a community resource we would insist the care be coordinated with VA. According to the IOM study cited earlier, care coordination is at the center of integration, and has been identified as a key component of high-quality health care. We agree. A critical component of care coordination is health information sharing between VA and non-VA providers. Information flow increases the availability of patient utilization and quality of care data, and improves communication among providers inside and outside of VA. The absence of obtaining this kind of health information poses a barrier to implement patient care strategies such as care coordination, disease management, prevention, and use of care protocols. These are some of the principal flaws of VA's current approach in fee-basis and contract care.

Today, as an evidence-based, data-driven and integrated health care system, VA has little meaningful information about how the care the Department currently purchases from outside communities affects clinical outcomes and health status of the veteran patient population receiving those services.

DAV's desire is to avoid this situation for veterans who may be referred by VA to receive mental health care from community sources, whether in TRICARE networks or community mental health centers. VA commissioned the RAND Corporation and the Altarum Institute to conduct an independent evaluation of the quality of the VA's mental health care system; they released a technical report in October 2011 titled, *Veterans Health Administration Mental Health Program Evaluation*. This report found a high degree to which veterans diagnosed with at least one of five mental health conditions also have difficulties with physical functioning and general health. That is, these veterans, while representing only 15 percent of the VHA patient population in 2007, accounted for one-third of all VHA health care costs because of their high levels of medical care consumption.

Because of the likelihood these veterans will need more than only mental health services, VA must be able to coordinate outside care with the services it is able to directly provide, and do so in an integrated manner. Integrated health care means the delivery of comprehensive services that are well-coordinated, with effective communication and health information sharing among providers, whether they are inside or outside of VA. Patients become informed and involved in their treatment, and when properly integrated, the care is high-quality and cost effective.

DAV believes VA's current authority to purchase by contract health care in the community ensures a continuum of medical care; however, this authority to date has been specifically intended by

Congress to be a supportive (and restrictive) tool, to strengthen the VA health care system and improve the quality of health care provided to veterans, while ensuring no diminution of services that VA provides directly to veterans.

Mr. Chairman, in accordance with DAV Resolution No. 212, adopted by our members at our most recent National Convention in 2012, we urge VA to establish a purchased-care coordination program that complements the capabilities and capacities of each VA medical facility. Furthermore, we urge Congress and the Administration to conduct strong oversight of VA's purchased-care program to ensure service-connected disabled veterans are not encumbered in receiving non-VA care at VA's expense.

DAV RECOMMENDATIONS

DAV has recommended that VA develop a proper triage, and a better mental health staffing model, to help VA clinicians manage their patient workloads to address the unique treatment needs of each veteran, and to tailor treatment approaches to those needs. At your May 2012 hearing, VA also noted work was underway on a prototype staffing model that was being tested in three Veterans Integrated Service Networks (VISN). We are anxious to learn of the progress of the determination on whether VA can deploy this prototype throughout its nationwide system, and whether it works well for mental health in particular.

We have urged VA to be flexible and creative in its approach to solving this pressing issue of mental health and readjustment needs of younger veterans, including the use of treatment options ranging from non-traditional alternative and complementary care, peer- and non-medical counseling, to traditional evidence-based therapies, depending on the needs of individuals. We look forward to hearing about VA's progress in making these adjustments.

CLOSING

Despite obvious improvements, it is clear to us that much progress still needs to be accomplished by VHA to fulfill the nation's obligations to veterans who are challenged by serious and, in some cases, chronic mental illness, and particularly for younger veterans who are impacted by post-deployment mental health, repatriation, and transition challenges. Currently, we see the pressing need for more timely mental health services for many of our returning wartime wounded, injured and ill veterans, particularly in early intervention services for veterans with substance-use disorders, and for evidence-based treatments for those with PTSD, suicidal ideation, depression and other consequences of combat exposure. If these symptoms are not readily addressed at onset, they can easily compound and become chronic and lifelong. The costs mount in personal, family, emotional, medical, financial and social damage to those who have honorably served their nation, and to society in general. Delays or failures in addressing these problems can result in self-destructive acts, job and family disintegration, incarceration, homelessness, and even suicide.

Mr. Chairman, DAV has previously testified, that in our considered opinion, sending these veterans out of the system *en masse* is not the answer—this group particularly can benefit from VA's expertise in treating post-traumatic stress, PTSD, substance-use disorders, TBI and other post-deployment transition challenges. To that end, it is essential that VHA address and resolve the barriers that obstruct mental health and substance abuse care and prevent consistent, timely access to care at VA facilities nationwide.

Unfortunately, the problems in VA's mental health programs are complex, and cannot be resolved by any single reform. The root causes for existing barriers to care are multiple, systems-based,

longstanding, and complex. DAV urges VA to address these deficits by addressing the root causes, not solely managing symptoms of the problem.

We believe the policy changes made by VA's Office of Mental Health Services over the past decade are positive and will ultimately equate to better patient care and improved mental health outcomes—but significant challenges are evident and need continued attention, intensity, resources and oversight—and the development of sound and workable solutions to ease the pressure while meeting veterans' needs. In our opinion, VHA must develop a number of short- and long-range goals to resolve existing problems identified by the OIG, GAO, Congress and the veterans' service organization (VSO) community. VHA must develop reliable data systems; fix the flaws in its appointment and scheduling system with effective policies and IT systems that fill the current gaps and are responsive to mental health needs; develop an accurate mental health staffing model that accounts for both primary and a multitude of complex specialty mental health capacity demands; revolutionize its hiring practices and eliminate the barriers that obstruct timely hiring of mental health providers and support staff; adjust its practices to address the complexities of co-occurring general health, mental health and psychosocial problems of veterans, in a truly patient-centered manner, and re-establish trust with the veterans that VA is charged to serve.

The DAV appreciates the efforts made by VA to improve the safety, consistency, and effectiveness of mental health care programs for all veterans. We also appreciate that Congress is continuing to provide increased funding in pursuit of a comprehensive set of services to meet the mental health needs of veterans, in particular veterans with wartime service who present post-deployment readjustment needs. We urge the Committee's continued oversight of VA's progress in fully implementing its Mental Health Strategic Plan and resolving the existing barriers that prevent some veterans from receiving the services they need to fully readjust and reintegrate following military service.

Chairman Miller and Members of the Committee, this concludes my prepared statement. DAV appreciates the opportunity to provide this testimony for the record of this important hearing.