**STATEMENT FOR THE RECORD OF NGAUS LEGISLATIVE DIRECTOR PETE DUFFY, COLONEL (RETIRED), FOR THE FEBRUARY 13, 2013 HEARING OF THE HOUSE VETERANS’ AFFAIRS COMMITTEE**

Thank you for all you have done for our veterans since 9/11 and for this opportunity to present this statement for the record.

**Background - Unique Citizen Service Member/Veteran**

The National Guard is unique among components of the Department of Defense (DoD) in that it has the dual state and federal missions. While serving operationally on Title 10 active duty status in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF), National Guard units are under the command and control of the President. However, upon release from active duty, members of the National Guard return as veterans to the far reaches of their states, where most continuing to serve in over 3,000 armories across the country under the command and control of their governors. As a special branch of the Selected Reserves they train not just for their federal missions, but for their potential state active duty missions such as fire fighting, flood control, and providing assistance to civil authorities in a variety of possible disaster scenarios.

Since 9/11, nearly a half a million National Guard members have deployed in contingency operations to gain veteran status. When they return from deployment, they are not located within the closed structure of a 24/7 supported active military installation, but rather reside in their home town communities where they rely heavily on the medical support of the Veterans Administration (VA) when they can overcome time and distance barriers to obtain it.

 Using the National Guard as an operational force will require a more accessible mental health program for members and their families post-deployment in order both to provide the care they deserve as veterans and to maintain the necessary medical readiness required by deployment cycles. It cannot be a simple post-deployment send off by the active military of “Good job. See you in five years.” To create a seamless medical transition from active duty to the VA, an improved medical screening of our members before they are released from active duty is essential to identify the medical issues that will be passed to the VA. The Department of Defense must also recognize its responsibility of sharing the burden with the VA in funding mental health care for our National Guard members between deployments, which remains an unmet readiness need.

The Department of Defense must also be called to task for the mishandling and disappearance of National Guard medical records in the OIF/OEF theaters and the shoddy administration of Guard and Reserve demobilization. Statistics published last year by the VA show that the VA denies National Guard and Reserve disability benefit compensation claims at four times the rate of those filed by active duty veterans. Lacking clear records to establish the service connection for their injuries, our Guard members face failure when they later file their VA disability claims for undocumented physical and behavioral injuries. This is a blot on the integrity of our federal government in its treatment of our veterans. This Committee must seriously and separately in another hearing consider legislation to establish a presumption of service connection for certain war common injuries of National Guard and Reserve veterans who later file disability benefit compensation claims based upon those injuries.

Military service in the National Guard is uniquely community based. The culture of the National Guard remains little understood outside of its own circles. When the Department of Defense testifies before Congress stating its programmatic needs, it will likely recognize the indispensable role of the more cost efficient National Guard as a vital operational force, but it will say little about, and seek less to, redress the benefit disparities, training challenges, and unmet medical readiness issues for National Guard members and their families at the state level before, during, and after deployment. We continue to ask Congress to give the Guard a fresh look with the best interests of the National Guard members, their families, and the defense of the homeland in mind.

**FULLY LEVERAGE THE VET CENTER MODEL**

For behavioral support, Guard veterans often look to the stellar Vet Centers located throughout the country where they and their families can obtain confidential peer to peer counseling as well as behavioral treatment from on site clinicians; telehealth programs; or from referrals to fee based clinicians paid for and pre approved by the Vet Centers.

Confidentiality is vital in bringing our veterans still serving in the Guard to treatment in order to assuage real concerns about the sharing of medical records with the Department of Defense which VA Medical Centers are authorized to do. The fee basing of referred care by the Vet Center to community providers establishes a model for this Committee to consider expanding to close the treatment gaps in our rural communities. A voucher program administered by the Vet Centers authorizing paid for treatment to qualified community providers would maximize scheduling flexibility and plug direct access gaps to care for our Guard veterans.

**IMPLEMENT A VOUCHER PROGRAM FOR VETERAN COMMUNITY BASED MENTAL HEALTH CARE**

The issues of veterans’ unemployment and mental health maintenance cannot be separated. Before veterans can maintain gainful employment in a challenging job environment, they must be able to maintain a healthy mental status and establish supportive social networks.

In 2007, the Rand Corporation published a study titled, “The Invisible wounds of War.” It found that at the time 300,000 veterans of Operation Iraqi Freedom and Operation enduring Freedom suffered from either PTSD or major depression. This number can only have grown after five more years of war. The harmful effects of these untreated invisible wounds on our veterans hinder their ability to reintegrate with their families and communities, work productively, and to live independently and peacefully.

Rand recommended that a network of local, state, and federal resources centered at the community level be available to deliver evidence-based care to veterans whenever and wherever they are located. Veterans must have the ability to utilize trained and certified services in their communities. In addition to training providers, the VA must educate veterans and their families on how to recognize the signs of behavioral illness and how and where to obtain treatment.

VA and Vet Center facilities are often located hundreds of miles from our National Guard veterans living in rural areas. Requiring a veteran, once employed, to drive hundreds of miles to obtain care at a VA facility necessitates the veteran taking time off from work for reasons likely difficult to explain to an employer. Most employees can ill afford to miss work, particularly after an extended absence from deployment in the case of our Guard veterans. The VA needs to leverage community resources to proactively engage veterans in caring for their mental health needs in a confidential and convenient manner that does not require long distance travel or delayed appointments.

To facilitate the leveraging of mental health care providers in our communities, the VA through its Office of Mental Health Services or through its highly effective Vet Centers can actively exercise its authority to contract with private entities in local communities, or creatively implement a voucher program that would allow our veterans to seek fee-based treatment locally with certified providers outside the brick and mortar of the Veterans Administration facilities and even the Vet Centers.

The Vet Center in Spokane for example serves an area as big as the state of Pennsylvania. It is not practical for veterans in this catchment area to drive hundreds of miles to seek counseling or behavioral clinical care. That Vet Center pre screens fee based providers to whom it will refer veterans for confidential treatment in its management area. It also monitors the process to make sure the veteran is actually receiving care paid for by the Vet Center. This system already works. However, a voucher process would improve efficiencies by relieving the Vet Center of its scheduling burden by allowing the veteran to directly make his or her own appointment with providers as needed.

The VA and Vet Centers also need to fully leverage existing state administrative mental health and veteran networks. Working with the state mental health care provider licensing authorities, community providers certified by the VA or Vet Center to treat veterans could be identified at the state agency level with vouchers to pay for treatment by those providers administered by the state department of veterans affairs who likely may have an even greater list of veterans in the state than the VA or Vet Center.

 Several of our veterans have fallen through the cracks of the VA health care system, and will continue to do so. According to the Vietnam Veterans of America, last year only 30% of our veteran population had enrolled in VA medical programs. Many veterans end up in the care of state social service programs in cooperation with state and national veteran organizations. The VA has the authority to assist in maintaining this safety net of care for veterans in a stressful economic climate for our states with a voucher program or expanded contracting with private entities. It needs to act.

**HIPPA CONFIDENTIALITY MUST BE OBSERVED WITH MENTAL HEALTH CARE**

Most of our National Guard veterans of OIF/OEF eligible for VA care post-deployment are still serving with their units and subject to redeployment. Given the evolving electronic medical records interoperability between the VA and the Department of Defense (DoD), a confidentiality issue exists relative to mental health treatment records for these veterans who remain in the military who do not want their records shared by the VA with their military commanders for fear of career reprisals.

It is essential that HIPPA confidentiality be maintained by the VA for the mental health treatment records of these veterans to encourage their treatment with VA providers. Our Vet Centers already operate with full confidentiality which makes them the service center of choice for Guard members who want to maintain confidentiality of their mental health counseling records relative to protect against perceived negative repercussions in their units. HIPPA rules observe confidentiality but draw the line with patients who are dangers to themselves or their communities whose cases must be reported. Prevent.

 It is critical that confidentiality this be established as soon as possible legislatively with the VA much the same as it is currently observed in Vet Centers. We believe that the VA is operating under advice from its legal staff that all VA medical records can be transferred to DoD. Lack of confidentiality will chill the treatment process and is likely contributed to the under utilization of VA medical care by our veterans.

**REQUIRE THE VA TO FULLY IMPLEMENT SECTION 304 OF THE CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT 0F 2009, PUBLIC LAW 111-163, TO PROVIDE MENTAL HEALTH SERVICES TO VETERAN AND THEIIMMEDIATE FAMILY MEMBERS OF OIF/OEF VETERANS USING PRIVATE ENTITIES**

Post-deployment, our National Guard members and their families heavily rely on the VA for mental health care. Congress recognized as much in passing The Caregivers and Veterans Omnibus Health Services Act of 2009, Public Law **111-163, enacted May 6, 2010,** now requires the VA to reach out not just to veterans but to their immediate families as well to assist in the reintegration process.

The law also authorized the VA Secretary the Secretary to contract with community mental health centers and other qualified entities to provide the subject services only in areas the Secretary determines are not adequately served by other health care facilities or vet centers of the Department of Veterans Affairs. It is not clear how thoroughly the VA has fully taken advantage of this authority to contract with private entities to deliver community based mental health services.

Section 304 of the Family Caregiver Act (reproduced in the Appendix) required the VA to make full mental health services available also to the immediate family members of OIF/OEF veteran for three years post-deployment. However, the VA delayed for at least two years in making the full range of its Office of Mental Health Services (OMHS) programs available to immediate to families as required by Section 304. It is not clear today that the program has been fully implemented.

Section 304 was enacted on May 6, 2010. For many, the three year post-deployment period will begin to lapse in 2013. The VA OMHS needed to fully comply with Section 304 in a timely manner. Because the VA’s unreasonably delayed implementation of this important program, this Committee needs to consider extending the subject three year post deployment limitation period another three years to allow family members to access their care.

It also needs to lean harder on the VA to fully utilize its contracting to better leverage private entities and to use a voucher system described above to make community based treatment more accessible and convenient. Our veterans and their immediate families may be a small subset, but they are worth it.

**THE DEPARTMENT OF DEFENSE MUST COOPERATIVELY WORK WITH THE VA IN SCREENING BEHAVIORAL HEALTH CARE NEEDS OF OUR MEMBERS BEFORE THEY ARE RELEASED FROM ACTIVE DUTY**

At all stages of PTSD and depression, treatment is time sensitive. However, this is particularly important after onset, as the illness could persist for a lifetime if not promptly and adequately treated, and could render the member permanently disabled. The effects of this permanent disability on the member’s entire family can be devastating. It is absolutely imperative that members returning from deployment be screened with full confidentiality at the home station while still on active duty by trained and qualified mental health care providers from VA staff and/or qualified health care providers from the civilian community. These providers could include primary care physicians, physician assistants, and nurse practitioners who have training in assessing psychological health presentations. Prompt diagnosis and treatment will help to mitigate the lasting effects of mental illness. This examination process must be managed by the VA in coordination with the National Guard Director of Psychological Health for the respective state, and the state’s Department of Mental Health to allow transition for follow up treatment by the full VA and civilian network of providers within the state.

As an American Legion staffer at Walter Reed once stated, the main problem for Reserve Component injured service members is that they are “rushed out of the system” before their service connected injuries and disability claims have been resolved. Our injured members should not be given the “bum’s rush” and released from active duty until a copy of their complete military medical file, including any field treatment notes, has been transferred to the VA, their discoverable service connected military medical issues have been identified, any service connected VA disability physicals have been performed similar to what is provided to the active forces before they are released from active duty, and the initial determination of any service connected VA disability claim has been rendered. Unless medically not feasible, our members should be retained on active duty in their home state for treatment to discourage them from reporting injures out of fear of being retained at a distant demobilization site.

It is absolutely necessary to allow home station screening for all returning members by trained health care professionals who can screen, observe, and ask relevant questions with the skill necessary to elicit medical issues either unknown to the self-reporting member, or unreported for fear of being retained at a far removed demobilization site. In performing their due diligence before the issuance of an insurance policy, insurance companies do not allow individuals to self assess their health. Neither should the military. If geographical separation from families is causing some to underreport, or not report, physical or psychological combat injuries on the PDHA, then continuing this process at the home station for those in need would likely produce a better yield at a critical time when this information needs to be captured in order for prompt and effective treatment to be administered.

Please see the copy of a November 5, 2008 electronic message to NGAUS from Dr. Dana Headapohl set forth in the Appendix that still pertains. Dr. Headapohl strongly recommended a surveillance program for our members before they are released from active duty. Dr. Headapohl opines the obvious in stating that **inadequate medical screening of our members before they are released from active duty is “unacceptable to a group that has been asked to sacrifice for our country.” (emphasis added)**

**Conclusion**

Thank you for that you have done for our veterans since 9/11. Please view our efforts as part of a customer feedback process to refine and improve the ongoing vital and enormous undertaking of the VA. Our National Guard veterans, both still serving and separated, will remain one of your largest base of customers who will continue to require your attention. Thank you for this opportunity to testify.

**E-mail from Dana Headapohl, MD, to NGAUS**

Colonel Duffy - I am sending links to articles about the importance of providing medical surveillance examinations for workers in jobs with specific hazardous exposures. I believe this approach could be modified to evaluate National Guard members returning from Iraq and Afghanistan for PTSD, TBIs and depression.

The OSHA medical surveillance model includes the following basic elements:

1. Identification of potential hazardous exposures (chemical, physical, biologic).

2. Screening workers for appropriateness of placement into a specific work environment with such exposures. For example, individuals with compromised liver functions should not be placed in environments with unprotected exposures to hepatotoxins.

3. Monitoring workers after unprotected exposure incidents. Examples- monitoring pulmonary function in a worker exposed to a chlorine gas spill, or following hepatitis and HIV markers in a nurse after a needle stick injury.

4. Conducting exit examinations at the end of an assignment with hazardous exposures, to ensure that workers have not suffered adverse health effects from those exposures.

(including concussive explosions or other traumatic events).

Surveillance exams of all types (OSHA mandated surveillance programs, population health screening for chronic disease risk factors) have been a part of my practice of Occupational and Preventive Medicine in Montana for the past 22 years. Early diagnosis and treatment is especially essential for potential medical problems facing military members serving in Iraq and Afghanistan - post traumatic stress disorder (PTSD), traumatic brain injury (TBI) and depression. Timely diagnosis and aggressive treatment is essential especially for these problems, to maximize treatment success and functioning and to mitigate suffering.

There are a number of organizations that design and implement medical surveillance programs. There is no reason the same approach could not be applied to the specific exposures and potential medical problems facing National Guard troops in Iraq and Afghanistan. With proper program design and local provider training, this program would not need to be costly. In my clinical experience, male patients especially are more likely to report symptoms of PTSD, TBI, or depression in the context of an examination rather than questionnaire.  Findings can present subtly, but if untreated can have devastating effects on the individual, family and work place.

In my practice, I have seen a number of Vietnam veterans, and more recently National Guard members who have returned from deployment in Iraq or Afghanistan, who have been inadequately screened and/or are suffering unnecessarily because of geographical barriers to adequate treatment. This is unacceptable treatment of group that has been asked to sacrifice for our country. They deserve better.

I applaud your organization's efforts to lobby for better post deployment screening and treatment of the National Guard members returning from Iraq and Afghanistan.

Dana Headapohl MD

 <http://www.aafp.org/afp/20000501/2785.html>

<https://www.desc.dla.mil/DCM/Files/QSRHealth%20Medical%20Exam_1.pdf>     This is about military surveillance exams.

<http://www.lohp.org/graphics/pdf/hw24en06.pdf>

<http://www.cdc.gov/niosh/sbw/management/wald.html>

<http://www.ushealthworks.com/Page.aspx?Name=Services_MedSur>