

# SYSTEMIC ISSUES AT THE VETERANS ADMINISTRATION AS PERCEIVED BY THE FAMILY OF DANIEL SOMERS



## MISSION STATEMENT

No servicemember or veteran should suffer the wide range of fundamental deficiencies in essential services that Daniel endured. The VA health system should be readily accessible and accountable to patients in need, as well as their families and support network.

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\*This report is submitted as originally prepared with appropriate updates noted.

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<sup>1</sup> Prepared in consultation with Daniel's widow (Bachelor of Science in Nursing) and mother-in-law (a psychiatrist).

## DANIEL'S CAREER TIMELINE & DUTIES

- 1/23/03 Date of enlistment in CA National Guard  
Basic Training  
Ft. Huachuca for MOS training (18 weeks)  
Assignment to National Guard Unit C Co 250<sup>th</sup> MI BN, Long Beach CA
- 1/3/04 - 2/7/05 Iraq deployment  
Daniel's description of the character of his service in Iraq:  
*I was assigned as a member of a Tactical Human intelligence Team (THT), for which I was also the HMMWV turret gunner. I performed more than four hundred combat missions in this role, and as a result was exposed to numerous IED, VBIED, and rocket attacks. My THT was assigned to work in tandem with a special Iraqi unit (I am barred from saying which unit or why), to include accompanying said unit on raids and other operations.*
- 2/28/05 Report date to Defense Language Institute (DLI) Monterey CA
- 3/3/05-6/22/06 Arabic studies at DLI (graduated with honors)
- June 2006 Moved to Washington DC for a position with L3 (with permission from National Guard Unit)
- Early 2007 – 10/2007 Redeployment to Iraq as a contractor with L3: Daniel worked with JSOC through his former unit in Mosul where he ran The Northern Iraq Intelligence Center. His official role was as a senior analyst for the Levant (Lebanon, Syria, Jordan, Israel and part of Turkey). Some of his activities included being part of on-the-ground missions with JSOC troops.
- 10/2007 – 1/14/08 At high risk of redeployment by Army due to IRR status; First attempt to gain entry to Phoenix VA system.
- 2/1/2008 First appointment at Phoenix VAMC (Caseworker) – per VAMC document
- 5/11/2009 Last appointment at Phoenix VAMC (Social Worker) – per VAMC document
- 10/2010 Applied to vocational rehabilitation; denied
- 1/22/11 Terminal date of reserve/military obligation
- 10/8/2011 Filed claims benefit appeal after receiving VA notice that “gulf war syndrome” was being acknowledged.
- 6/10/13 Date of death

## EXECUTIVE SUMMARY

This report and call to action reflects Daniel Somers' experience with Veteran Administration (VA) services. When we began to advocate for reforms in light of Daniel's experience, our concern was that the program failures that Daniel encountered were symptomatic of deeper and broader issues in the program services — potentially affecting a much broader population of service members and veterans. Recent revelations of gross neglect and mismanagement at the VA have proven our initial concerns to be well-founded.

The purpose of this report was, and continues to be:

- To identify specific, fundamental problems, shortcomings and needs in VA policies and operational management, processes, procedures, and practices that Daniel experienced in his touch-points with the program.
- To suggest that persisting experiences such as these can have progressive and devastating effects on those with serious needs seeking VA care.
- To bring into question whether such a wide range and long series of experiences, in such fundamental areas as those recounted here, are indicative of systemic problems or weaknesses in VA programs.
- To propose specific, prioritized, and practical reforms that could address the identified problems and shortcomings.
- To advocate for a fundamental change in the culture of the VA system based on the recognition that those seeking treatment are patients first.

## **SUMMARY OUTLINE OF ISSUES**

### **Part 1. Phoenix VA Healthcare/Veterans Health Administration:**

#### **A. Procedural Reforms**

1. Undefined VA status of National Guard service members during interim period
2. 'Double bind' therapy policy has the effect of denying services
3. Insufficient personnel training and basic customer/patient relationship management (Sensitivity training; advocates; ombudsman)
4. Using HIPAA as an excuse.

#### **B. Reforms Requiring Additional Funding**

1. Inadequate appointment system impedes/reduces access and lacks basic documentation
2. Critical need for compatibility between computer systems
3. Insufficient treatment resource planning and training (Succession planning; provider shortage; outsourcing; peer support groups)
4. Inadequate pain management services
5. Uncoordinated inter-Agency goals, policy and procedures (Formulary limitations)
6. Inadequate facilities, inefficient charting process, and inappropriate caseload management (Bed shortage; facility limitations)

### **Part 2. Phoenix VA Benefits/Veterans Benefits Administration:**

#### **A. No way to ascertain status of claim**

#### **B. Lack of appointment system interfaces and prioritized, proactive procedures**

#### **C. Lack of communication between Disability Determination and Voc Rehab**

## PROBLEM(S) ENCOUNTERED / RECOMMENDATIONS

### **Phoenix VA Healthcare/Veterans Health Administration:**

#### **A. Procedural Reforms**

##### **1. Undefined VA status of National Guard members during interim period**

There was a three month period when Daniel returned from his second tour (October 2007) when he was not active duty National Guard, but was “inactive ready reserve”. He attempted to get services through the VA at this time, but was told by them that he had to be seen at a military hospital. When he attempted to be seen at a military hospital, he was told he had to go to the VA. This blurred status affects both National Guard and Reserve members.

UPDATE: We have been told by the VA Administration in Washington DC that they have instituted new procedures that require the VA to be the default provider. We have not been able to verify this.

#### RECOMMENDATIONS:

- Train staff at the VAMC's to better understand unique IRR status of Guard and Reserve.
  
- Make this an area that is examined and evaluated at each VAMC during inspections.

##### **2. 'Double bind' therapy policy has the effect of denying services**

Daniel was told by the Phoenix VAMC that he was not eligible for individual therapy unless he first went to group therapy. Discussing his traumas would have revealed classified information, so he could not be in group therapy. At one point he was told he could have group therapy or no therapy at all. Since Daniel's death, we have heard from other veterans in other VAMC's that they have been told the same thing.

UPDATE: Rep. Kyrsten Sinema has introduced H.R.3387 to address this issue.

#### RECOMMENDATIONS:

Individual therapy should be offered to traumatized veterans who did classified work either at the VAMC or by contracting to an outside psychiatric provider.

- EVERY veteran should be able to be evaluated to determine the best means of treatment.

### **3. Insufficient personnel training and basic customer/patient relationship management (Sensitivity training; advocates; ombudsman)**

Daniel related the following incident to both his wife and mother-in-law (independently and on different occasions): He presented to the Phoenix VAMC asking for help. He was told that there were no beds available in the psych unit or the ER. He ended up in a ball, on the floor, crying in the waiting area. He was told by staff that he could stay there until he felt safe enough to drive home.

As this bed shortage scenario illustrates, there was a severe lack of sensitivity on the part of the Phoenix VAMC staff with whom Daniel came in contact. This insensitivity extended to those with whom he attempted to (1) make healthcare appointments and (2) gather information about his claims status.

When Daniel would allow his wife, who is a practicing BSN, to come to the hospital with him, she had to be very assertive. She used her experience as a nurse to advocate for him at the VA ER to get them to take his symptoms, including pain, seriously.

Two weeks after Daniel's death, his widow was contacted by the Phoenix VA Suicide Prevention Coordinator. He offered his condolences and asked if he could help with anything, but when she asked for help with the disability claim delays and related the multiple barriers to care for veterans, he said he couldn't do anything. He did offer to send her a pamphlet on grieving. When the pamphlet came, it was wrapped in a white sheet of paper that only had her name and address on it. There was no personalized letter of any kind; the only thing in the envelope was an 8 ½ x 11

photocopied piece of paper which was literature for a local non-VA counseling organization (La Frontera).

In addition, when the Suicide Prevention Coordinator verified the address to send the pamphlet, the system he was using had the incorrect address, one that they had not lived at for four years.

UPDATE: We have learned that Daniel could have requested, and certainly should have been offered, either a voucher for care at a nearby hospital or transfer to another VAMC within the VISN.

#### RECOMMENDATIONS:

- Staff should routinely receive training to sensitize them to the unique needs of this patient population.

UPDATE: A common complaint that we have heard is that too much of the training is on-line or computer-based.

- Staff should be made to feel comfortable with alerting superiors to atypical situations that might require immediate attention.
- Dramatically increase “secret shopper” and Mental Health site visits to include every VAMC on a 12-18 month cycle as opposed to the current 3 year cycle to ensure policies, procedures and best practices are being followed.
- All professional staff should be encouraged to act as advocates on behalf of their patients, such as for denied services and formulary exceptions.
- Provide incentives for accepted innovative ideas to improve systems and procedures.
- Provide a means for front line personnel to give comments and feedback on current policies and procedures, perhaps to a party outside of their facility.

- Provide a better procedure for employees to report problems to the OIG and other parties so that they truly do remain anonymous.
- Each facility should have a fulltime ombudsman whose position is prominently advertised, is easily accessible and is responsive to the needs of every veteran.
- Suicide Prevention staff should offer to have appropriate personnel return the call – or refer them to the direct line of the appropriate personnel - if they cannot answer a question or concern of the surviving spouse/parent.
- Suicide Prevention staff should offer a range of pamphlets listing all local and VA support groups.
- Suicide Prevention staff should send a personalized letter expressing condolences.
- Suicide Prevention staff should be prepared to offer some counseling at the time of the condolence phone call.

#### **4. UPDATE: Use of HIPAA as an excuse for not involving family members and for not using modern technology.**

We met with Phoenix VA Administrators (Sharon Helman, Darren Deering, D.O., Lance Robinson and Sylvia Vela, M.D.) on July 23, 2013 at their request to address the problems Daniel had with their system. Throughout our discussions with them over the next few months, they repeatedly cited HIPAA as the reason that they (a) could not contact a family member about Daniel's suicidal ideation; (b) would not have been able to speak to us even if we had known that we could have contacted them directly; (c) could not use email or text messages [1] to remind Daniel of his appointments or [2] to follow up on a no-show appointment. They indicated that they could not even text each other within the VAMC.

### **B. Reforms Requiring Additional Funding**

#### **1. Inadequate Appointment System impedes/reduces access and lacks basic documentation**

Even after National Guard discharge, Daniel could not get an appointment for months. He had to get a private sector mental health evaluation and that doctor called contacts she had at the VA pleading that he be seen ASAP. (This was done by his mother-in-law who is a psychiatrist.)

Phoenix VAMC still uses a postcard system for appointments. Daniel told us, his wife and mother-in-law, that when he would call for an appointment, he would be told to await a postcard in the mail for his appointment date/time. If he could not make the appointment, he could not find a way to reschedule it. There was not even a way to find out if a postcard had been sent, nor if it was sent to the correct address.

#### RECOMMENDATIONS:

- Terminate the postcard system.
  
- Use a phone system that allows the veteran easy access to a call center staffed with enough people to make, confirm, reschedule and/or cancel an appointment.
  
- Initial contact should result in:
  - Veteran's personal data info being updated and current in appointment system (& across all data systems – DOD, Benefits, Healthcare)
  - A first appointment as triaged by appropriate specialty personnel
  - Veteran's assignment to a Navigator (case manager)
  - Confirmation that the veteran has received the information packet (provided at discharge from service) of how to navigate the VA system for healthcare, benefits and support groups
  - Determination if veteran has a primary caregiver and ensure proper HIPAA waivers are in place to include that person in treatment.

- Encourage every veteran to supply a list of Points of Contact to act as their Support Network with appropriate HIPAA waivers.
- Make follow up appointments before the veteran leaves the VAMC offices.
- Institute a tickler system procedure for following up with the seriously ill (physical or mental) veteran if the veteran is unable to make an appointment before leaving the office.
- Reconfirm all appointments by phone, text or email the day before the appointment.
- Provide assistance to ensure that all veterans sign up for “My Chart” access at their first appointment. Provide appropriate training to veterans unfamiliar with system access. Veterans who do not have computer access or are unable/unwilling to register for “My Chart” should be flagged in system.
- Follow up with the veteran for all missed appointments.

UPDATE: Per a meeting that we had with Jan Kemp, RN, PhD (who at the time was the National Mental Health Director for Suicide Prevention for the VA) this has been procedure since 2008, but when we asked the Phoenix Administration about it in August of 2013, they claimed ignorance of the procedure.

- **CRITICAL - Every contact with the veteran should be documented (in system and chart).**
- Identify all veterans with multi-system conditions (ie, Gulf War Syndrome, Burn Pit Exposure)
  - Establish multi-specialty clinics wherein these veterans can be seen        -or –
  - Establish a system whereby multiple providers meet weekly to conference on this class of patients
- Drastically improve wait time goals to meet or exceed the best of the private sector.

*UPDATE from August 2013:* Robert Petzel, MD, in March 2013 before a sub hearing of the US Senate Committee on Veterans' Affairs, stated that access to care goals are:

- 7 days for Primary care based on "Desire Date" and
- "just-in-time mental health care" with a goal of same day access

As of August 2013 the Phoenix VAMC Director informed us that wait times there were:

- Primary care: 40% within 14 days of "create date"
  - Mental Health: 75% within 14 days of "create date"
- 
- A third category should be added that addresses seriously ill veterans who require triaged appointments. The wait time for this category should be 100% within 24 hours of call.
  - The veteran's personal contact information should be updated at each contact. The following information should be updated across ALL data systems:
    - SSN/military identification
    - Spelling of name
    - Phone
    - Address
    - Email
  - Performance evaluations should be done on the above issues on a regular and timely basis, perhaps by an independent 3<sup>rd</sup> party.

## **2. Lack of compatibility between computer systems (URGENT NEED)**

- **The VISTA system (DOS based) should be replaced in all VAMC's with a system that will interface with the VA Healthcare chart system (CPRS), the VA Benefit system and the DOD system.**

### RECOMMENDATION:

Daniel's story, as well as the process of its presentation in circles of responsibility, speaks to a root issue: the need for an

information technology system that provides ongoing (persistent), open (transparent) inclusion of all voices in the process. In short, move the system from “a need to know” basis to one of “responsibility to share”. This could be an opportunity for the VA to move much of its business into 21st century Web 2.0 and Government 2.0.

**UPDATE:** You have at your fingertips the OMB’s Federal Enterprise Architecture. Per the FEA website: *EA is uniquely positioned as the management best practice which can provide a consistent view across all program and service areas to support planning and decision-making. EA standards also promote mission success by serving as an authoritative reference, and by promoting functional integration and resource optimization with both internal and external service partners.*

### **3. Insufficient treatment resource planning and training (Succession planning; provider shortages; outsourcing; peer support groups)**

Daniel had been seeing a psychiatrist at the VAMC with whom he had established a trusting relationship. At the end of an appointment, the provider told him that he was retiring and would not be available for future appointments. Upon leaving the VAMC, he was told that the VAMC was short-staffed in the mental health department and that he would be notified by postcard when he was reassigned to a new provider. He was never contacted.

We were told at the Phoenix VAMC that there is no contractual obligation for providers to give adequate advance notice to the VAMC of their resignation or retirement so that adequate continuity of care can be provided. We are also told that a significant number of psychiatrists were transferred over from clinical care to do disability evaluations when that became a VA priority, making the shortage of doctors for patient care even more severe.

RECOMMENDATIONS:

- Add a provision within all professional contracts to require a 90 day (or other appropriate time period) notice of termination of services to allow for continuity of care.

**UPDATE:** We have investigated this option and have learned that this falls within the power of the Secretary of Veterans Affairs and not the OPM. We recently addressed this issue with Acting Undersecretary for Health, VHA Robert Jesse, MD, PhD.

- Recruit additional mental health professionals.

**UPDATE:** This has been done, but there are not enough trained mental health professionals available within the entire medical community.

- If a VAMC is understaffed in a specialty, it should provide active assistance to the veteran to obtain required/necessary services from a private sector professional.
- Educate veterans in the procedure to request, procure and get reimbursement for private sector services.

- Loosen VISN requirements. Currently VAMC's must look to other facilities/providers within their region for placement. This can result in patients being a great distance from their support group. (i.e.- the Phoenix VAMC is within the same VISN as El Paso, Texas)

- Increase access to local facilities and providers in the private sector with a minimum amount of paperwork/red tape when providers and/or services are not available when needed.

**UPDATE:** Last fall Congress allocated \$9.3 billion to replace the current voucher system with the PC3 (Patient Centered Community Care) program, whereby veterans could utilize either the TriWest Healthcare Alliance or Health Net Federal Services provider network to obtain specialty services. To our knowledge, this system has yet to roll out. Is there some reason why we think that giving them even more money to do the same thing will work now?

- Educate providers and staff to be patient advocates for the procurement of outside services when these services are lacking and/or not within the VA's timely guidelines.
- Actively recruit and train veterans who have suffered from PTSD, TBI, Gulf War Syndrome, MST and Burn Pit Exposure who are capable of participating as mentors in a peer support system. ACTIVELY PUBLICIZE IT and ensure that all newly diagnosed veterans are assigned a mentor.
- Provide Congressional members with information to take back to their States regarding the Star Behavioral Health program which trains non-VA mental health providers how to treat veterans. This program is in need of funding at the State and/or federal level to continue their work and to expand their training to non-VA, non-mental health providers in an effort to help those providers identify veterans in need of referral.
- Provide a forum for medical specialty boards to discuss establishing a mandatory rotation during Psychiatric and Primary Care residencies (Family Practice, Internal Medicine, ER, Ob/Gyn, Pediatrics) on how to identify military/veteran-specific issues such as PTS, TBI, GWS, MST and Burn Pit Exposure so that proper referrals can be made.

#### **4. Inadequate pain management services**

Daniel was diagnosed with PTSD, TBI and Gulf War Syndrome (which by definition includes chronic fatigue, fibromyalgia, irritable bowel syndrome, depression and cluster headaches). Due to his irritable bowel syndrome, his body was not always capable of absorbing oral medications. This condition was aggravated by the fact that changing generic drug manufacturers would frequently cause an exacerbation of his symptoms each time the generic changed.

Even with his private sector doctor's notes stating that he had tried the VA's formulary of drugs for pain, he could not get a Fentanyl patch as it

was not on the VA formulary. In addition, he was told that because a VA doctor had not prescribed him the formulary medications, he would have to re-try them so that it could be documented in his VA chart before any request for exception could be made.

When a veteran presents to either the VA or private sector hospital for an acute pain episode, providers look at the list of drugs and dosages he is on and label him as a “drug seeker” and refuse treatment.

#### RECOMMENDATIONS:

- **URGENT** - Every VAMC must have a comprehensive Pain Management Program.
- Clearly notate the veteran’s VA chart as being a participant in the VAMC’s pain management program.
- Establish a nationwide database for veterans requiring treatment for breakthrough pain at civilian facilities.
  - Provide an ID card to the veteran which lists a 24 hour “800” number to a pain management hotline.
  - Staff the “800” number with live personnel who have access to these veterans’ medical records and can authorize treatment at any facility in the acute situation.
  - The veteran should be given an appointment to be seen within 24 hours at the nearest VAMC or authorized outside provider at the time of the call.
- Review and evaluate the DOD and VA formularies to create a uniform formulary with realistic procedures and appeals for requesting exceptions to the formulary.

#### **5. Uncoordinated inter-Agency goals, policies and procedures (Formulary limitations)**

See above for Fentanyl patch issues.

Daniel had been wait-listed for a civilian MDMA (ecstasy) clinical trial for his PTSD. He was researching options for LSD trials for fibromyalgia.

Daniel felt that the DEA instills in providers a fear of punishment for prescribing higher doses of narcotics, regardless of the need. Daniel had wanted to move from the Phoenix area to the State of Washington as the heat in Phoenix aggravated his PTSD issues. He feared the move would further delay the completion of his Benefit claim.

#### RECOMMENDATIONS:

- The VA should be at the forefront of cutting edge clinical trials for PTSD, TBI and Gulf War Syndrome symptoms (especially fibromyalgia).
- If unable to conduct these trials within the VA system, the VA should be the most fierce and vigorous advocate of community clinical trials in these areas.
- The DEA should be encouraged to relax their restrictions on the use of Schedule I medications in clinical trials.

**UPDATE - JULY 2013:** A staffer on the Senate Veterans Affairs Committee related a story to us about having broken his arm while on vacation in an area outside of his normal VA. He presented to the nearest VA and it took over four hours for that VA to even verify his eligibility. In addition, they weren't even able to "see" his medical records.

#### **6. Inadequate facilities, inefficient charting process, and inappropriate caseload management (Bed shortage; facility limitations)**

Daniel's Phoenix VAMC ER visit is testimony to these deficiencies. (See A3 of this report: He presented to the Phoenix VAMC asking for help. He was told that there were no beds available in the psych unit or the ER. He ended up in a ball, on the floor, crying in the waiting area. He was told by staff that he could stay there until he felt safe enough to drive home.)

#### RECOMMENDATIONS:

- Allocate funds to increase the number of psychiatric unit and ER beds available at all VAMC's as needed and/or allow individual VAMC's to contract with local hospitals and psychiatric facilities on an "as needed" basis.

*While we were putting this report together in June 2013, a currently employed licensed social worker at the Phoenix VA offered these three observations under the condition that she remain anonymous:*

- *Some Phoenix VAMC clinical staff have been stationed in a warehouse/plant services facility, but veterans cannot be seen there due to safety issues. Therefore, clinicians see veterans at the VAMC, but then must go back to the warehouse to write their clinical notes.*
- *Until an expansion of the Phoenix VAMC facility can be done, evaluate if there are non-clinical personnel (including management) that might be more appropriately housed at the warehouse, allowing for full use of the hospital grounds for clinical staff. (Administrative staff at the Phoenix VA complained about a requirement for VAMC's to have 20 years rent banked in the first year of renting.)*
- *Allow telecommuting for charting, so that clinical staff don't waste time moving between buildings after seeing each patient.*
- *Due to funding of different programs, social worker caseloads vary greatly at the Phoenix VAMC. Social workers seeing veterans assigned to the mental health case management section are assigned only 9 patients. Those who see homeless veterans have about 30 in their caseloads. However, for veterans who are ill enough to seek psychiatric care (and not assigned in either of the first two categories) literally thousands are assigned to one social worker.*
- *Re-evaluate and reassess caseloads to determine if additional categories might be needed and/or caseload balancing is required.*
- *Veterans have said that it is "degrading" to be seen at the Central Arizona Shelter Service (CASS). It is an area that is unsafe and rampant with crime. They feel it is demoralizing to be housed there. Flyers are posted at the Phoenix VAMC*

*describing HUDVASH housing for homeless vets. The flyer states that there are walk-in hours for assessment, but intakes have been moved to LODESTAR, which is physically located at CASS where VA staff work.*

- *Veterans, particularly those with PTSD, require a calm, safe environment to prevent additional exacerbation of their symptoms. Moving these services to a safer location would show much needed respect and honor for veterans and provide them a sense of dignity when they are hurting and often suicidal. They need a safe place to heal.*

## **Phoenix VA Benefits/Veterans Benefits Administration**

### **1. No way to ascertain status of claim**

For years, there was no way for Daniel to determine what the status of his benefits claim was. When it was finally announced that it was going to be online, he was able to access the information. However, the status was never updated or accurate. He told us of submitting additional paperwork in November of 2012 that still was not showing as having been received as of February 2013. He finally received a notice that the “drop dead” completion date for his claim was May 2013. It was not finalized until July 2013, six weeks after his death.

#### RECOMMENDATIONS:

- Determine if claims need to be triaged in any way. Provide clear guidelines for such to VBA personnel as well as veterans/VSO's.
- Assign a number to each claim as it is filed indicating how many claims are ahead of it.
- Assign an ultimate “point person” who is responsible to contact the veteran regarding his claim: i.e., missing documentation, needed appointments, delay notifications. This person should be easily accessible to the veteran regarding all aspects of his claim.

## **2. Lack of Appointment System interfaces and prioritized, proactive procedures**

The one time that Daniel did get through to someone in the Benefit Claims department, he was told that his claim “went to the bottom of the pile” because he did not show up for a scheduled “final evaluation physical”. He was told a postcard had been sent informing him of this appointment, though he never received it. When pressed, he was told that it was documented in the Benefits system that a postcard was to be sent, but not in the Scheduling system database, “so maybe it never got sent out”.

### RECOMMENDATIONS:

- As previously stated, the VISTA appointment system is an antiquated DOS-based system that does not interface with other databases. It is URGENT that this system be replaced with a new system that interfaces with both the VAMC chart system (CPRS) and the DOD database.
  
- For appointments that are so critical, the Benefits Department must make personal contact with the veteran when scheduling these appointments.
  
- If the veteran no shows for this final evaluation appointment, every effort must be made to immediately reschedule the appointment at the earliest possible time or in special cases where the veteran feels unable to leave his residence, allow for a Home Visit by clinical staff.

## **3. Lack of communication between Disability Determination and Vocational Rehab**

When Daniel applied for Voc Rehab benefits, the psychologist who evaluated him made the determination that he was “unemployable” and 100% PTSD disabled and recommended that Daniel appeal the 30% disability that he had been given. Service-connected disabilities are not consistently awarded at the correct percentage the first time

they are awarded. The Benefits Department will award less than the total. When challenged on this by an articulate veteran, they will make the correction. However, if the veteran is less articulate or less persistent, he is told that the lower percentage is correct. Veterans have to make noise to get what they deserve and be treated fairly. Many are too ill to do this.

#### RECOMMENDATIONS:

- Rather than have the veteran file an appeal, the Voc Rehab Department should have the ability to communicate directly with the Disability Determination Department and ask for a review and revision of the initial disability findings on behalf of the veteran.
  
- Apply uniform rules to Disability Determination and institute a procedure for all appeals through the previously mentioned Ombudsman or other Advocate system.
  
- The Voc Rehab database should interface with all other databases (DOD, Disability Determination and VAMC).

## SUMMARY AND CALL TO ACTION

This report documents a tragic story of touch-points and interactions with the organizational business system of a U.S. government program that fell short of acceptable and, perhaps in some instances, humane treatment of a patient and citizen who selflessly served our country at great personal cost.

The report is offered in the spirit of a **call to action**, summoning public efforts to rectify and improve services as they apply to the broader population of veterans.

- It identifies a broad spectrum of issues that warrant a **comprehensive public review**
- It puts forward specific recommendations which, viewed together, present a profile for developing **a concerted program of continuous improvement going forward.**

The report raises some tough and uncomfortable questions regarding **the VA's end-to-end health services delivery system** - specific policies and operational processes, procedures and practices. One agonizing question: In some cases, can persistent or coincident and cumulative deficiencies in the system contribute to, rather than alleviate a veteran's sense of helplessness?

In particular, a program of continuous improvement must increase awareness of, prioritize, and enhance treatment responses to conditions

that involve PTSD, TBI and suicidal tendencies. These conditions require and deserve a process path of extreme resort. Especially in cases of combat servicemen exposed to the most extreme horrors of war, who continue to battle them at home - a rippling battle with costly social and government program consequences.

To debate what the increased cost of current proposed legislation is to what has been provided in the past is not the point. We know that the VA was not providing proper care nor providing care to all eligible veterans. The point is, we need to know what the true cost of treating all eligible veterans actually is and we will never know that until we are treating and paying for all of the veterans needing healthcare.

An alternative to all of these potential funding solutions would be to consider transitioning the VA into a Center of Excellence for war-related injuries, opening the VA healthcare process to privatization, as Tricare does, to compel the current model to self-improve and compete for veterans' business. This would ultimately allow the veteran to seek the best possible care and provide a clear focus for the VA.

We also respectfully request that as this Committee consider our testimony, this report and those of others, that you actively involve all of the VSO's into your decision-making process and that you encourage your colleagues in the full House to do the same. There is no better voice for our veterans than veterans themselves.

We thank you for your time. We sincerely hope that the systemic issues raised here will provide a platform to bring the new VA Administration together with lawmakers, veterans and private sector medical professionals and administrators for a comprehensive review of the entire VA system. Should they, this Committee or Congress as a whole make the decision to involve other stakeholders in ongoing discussion, we would be honored to be among those representing the views of affected families.