

Somers Congressional Testimony

House Committee on Veterans Affairs Testimony July 10, 2014

Thank you Chairman Miller, Ranking Member Michaud, and Committee members.

We are grateful for the opportunity to testify today, and it is especially good to see Representative Kirkpatrick, who has been a great ally to us in our effort to advance reforms of the VA based on the experience of our son, Daniel Somers.

As many of you know, our journey started on June 10, 2013, when Daniel took his own life following his return from a second deployment in Iraq. At that time, he suffered from Post-Traumatic Stress Disorder, Traumatic Brain Injury and Gulf War Syndrome. Daniel spent nearly six futile and tragic years trying to access the VA health and benefit systems before finally collapsing under the weight of his own despair. We have attached “The Story of Daniel Somers” to our testimony, which provides the details of his efforts, and we hope you will read it if you have not already done so.

Today, it is our hope that we can begin the process which will ultimately provide hope and care to the 22 veterans a day who are presently ending their lives.

Four days after Daniel’s death, we sat with Daniel’s wife, who has a Bachelor of Science in Nursing, and his mother-in-law, who is a psychiatrist, and prepared a 19 page report that we titled Systemic Issues at the VA. We have shared that document with several of you over the last year, and it is also attached to our testimony.

The purpose of this report remains the same as when we wrote it: to improve access to first-rate health care at the VA, to make the VA accountable to veterans it was created to serve and to make every VA employee an advocate for each veteran.

(VHA)

A1. At the start, Daniel was turned away from the VA due to his National Guard Inactive Ready Reserve status.

A2. Upon initially accessing the VA system, he was, essentially, denied therapy.

A3. He had innumerable problems with VA staff being uncaring, insensitive and adversarial. Literally no one at the facility advocated for him.

A4. Administrators frequently cited HIPAA as the reason for not involving family members and for not being able to use modern technology.

B1. The VA's appointment system known as VISTA is at best inadequate. It impedes access and lacks basic documentation.

B2. The VA information technology infrastructure is antiquated and prevents related agencies from sharing critical information. There is a desperate need for compatibility between computer systems within the Veterans Health Administration, the Veterans Benefits Administration, and the DOD.

B3. Continuity of care was not a priority. There was no succession planning, no procedures in place for "warm handoffs"; no contracts in place for locum tenens; and a fierce refusal to outsource anyone or anything.

B4. At the time Daniel was at the Phoenix VA, there was no pain management clinic to help him with his chronic and acute fibromyalgia pain.

B5. There were few coordinated inter-Agency goals, policies and procedures. The fact that the formularies of the DOD and VA are separate and different makes no sense since many DOD patients who are stabilized on a particular medication regimen must re-justify their needs when they transfer to the VA.

B6. There were inadequate facilities and an inefficient charting process.

(VBA)

There was no way for Daniel to ascertain the status of his benefits claim.

There was no VHA/VBA appointment system interfacing, nor prioritized, proactive procedures.

There was no communication between Disability Determination and Vocational Rehabilitation.

This report is offered in the spirit of a call to action and reflects the experiences of Daniel with VA program services beginning in the fall of 2007 until his death last June as seen through our eyes.

Our concern then was that the impediments and deficiencies which Daniel encountered were symptomatic of deeper and broader issues in the VA – potentially affecting the experiences of a much broader population of service members and veterans. Unfortunately, this has been proven true as dramatically evidenced by recent revelations.

Many of the reforms outlined in our report will require additional funding for the VA. But with that new funding should come greater scrutiny and a demand for better, measurable results.

There is, however, an alternative to attempting to repair the existing, broken system. We believe Congress should seriously consider fundamentally revamping the mission of the VA health system. In the new model we envision, the VA would transition into a Center of Excellence specifically for war-related injuries, while the more routine care provided by the rest of the VA healthcare system would be opened to private-sector service providers—much like Tricare. That approach would compel the current model to self-improve and compete for veterans’ business. This would ultimately allow all veterans to seek the best care available, while allowing the VA to focus its resources and expertise on the treatment of complex injuries suffered in modern warfare.

We thank you for your time, and would be happy to further discuss our recommendations and suggestions. 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 and reform of the entire VA system. And if the VA, Committee or Congress as a whole make the decision to involve other stakeholders in a more formal reform process, we would be honored to be among those chosen to represent the views of affected families.