



Reserve Officers Association of the United States

House Committee on Veterans' Affairs

**A Call for System-Wide Change: Evaluating the Independent Assessment
of the Veterans Health Administration**

October 7, 2015

"Serving Citizen Warriors through Advocacy and Education since 1922."™

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The Reserve Officers Association of the United States (ROA) is a professional association of commissioned, non-commissioned and warrant officers of our nation's seven uniformed services. ROA was founded in 1922 by General of the Armies John “Black Jack” Pershing during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to national defense, with a goal to teach America about the dangers of unpreparedness. Under ROA’s 1950 congressional charter, our purpose is to promote the development and execution of policies that will provide adequate national defense. We do so by developing and offering expertise on the use and resourcing of America’s reserve components.

The association’s members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on active duty to meet critical needs of the uniformed services. ROA’s membership also includes commissioned officers from the United States Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security.

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The Reserve Officers Association is a member-supported organization. ROA has not received grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.

On behalf of our members, ROA thanks the committee for the opportunity to submit a statement on section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), to examine the access of Veterans to health care from the Department of Veterans Affairs (VA).

Organization of the Veterans Health Administration (VHA)

Of the nation's 22 million living veterans, VA provides health care for some 7 million patients, a 20 percent increase from 2009. The VA provides care for this one-third portion of the U.S. veteran population through its Veterans Health Administration (VHA), with a staff of more than 289,000 employees at more than 1,600 sites, including 167 medical centers, 1,018 community-based outpatient clinics, 300 vet centers, and 135 community living centers.

ROA agrees with Secretary of Veterans Affairs McDonald's plan to merge the three administration's regional centers into consolidated regional centers. This will allow assistance to be given on benefits and health issues at one location. This consolidation would present VA the opportunity to reduce headcount and also to redirect staff to improve the agency's performance where it lags. ROA could envision such "excess" staff being retrained and going to process benefits claims, where there is a shortage that has generated an increase in claims appeals. Staff selectively chosen for their integrity and interest in advocacy could perhaps provide internal oversight and investigations to ensure compliance with policies and procedures. VA could also redirect staff to manage strategic implementation. Some regional staff should focus on best practices and innovative change, to spread positive efforts system-wide.

Some or all of these initiatives might be met with well-intentioned opposition by the unions; in fact this is an opportunity for the unions to participate in substantively enhancing veterans' health care and benefits. These changes could contribute to better accountability for VA which is critical to quality care.

Location of health care resources

What is unclear is how much care is delivered for service-related disabilities and how much is delivered for non-service related disabilities. These are key factors in VHA's consideration in how it deploys resources. As a subset of service-related versus non-service-related care, VA must gather and assess data on the levels of care provided to better understand where they should focus resources. Health care is provided on several levels.

1. Primary care: health care provided by a medical professional (as a general practitioner or a pediatrician) with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment (Merriam Webster's medical definition). Primary care is the first level of contact between patients and physicians and medical care

providers. Primary care providers generally comprise primary care practitioners, nurse practitioners or physician assistants dealing with issues such as diagnosing mild healthcare issues or dealing with mild and sometimes acute medical problems. Most primary care problems are for back pain, skin care, osteoarthritis and joint disorders, lipid metabolism disorders, and upper respiratory tract disorders. Emergency medical care is also considered primary care. Excluding emergency care, primary care can be provided in a clinic, community center or hospital. Primary care physicians are also in charge of coordinating healthcare provision since they refer patients to various specialists for specialized treatment.

2. Secondary care: medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialized knowledge, skill, or equipment than the primary care physician has available to them (Merriam Webster's medical definition). Examples of such specialists are cardiologist, endocrinologist, neurologist, etc. Secondary care is primarily delivered in hospitals or special facilities where medical specialists are housed.
3. Tertiary care: highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities (Merriam Webster's medical definition). Tertiary care is almost exclusively delivered in hospitals given the need for advanced medical technology and the intensity and frequency of care.
4. Quaternary Care: Highly specialized care including experimental medicine. The distinction between tertiary and quaternary care can be blurry since quaternary care is in some ways an extension of tertiary care. Quaternary care is not offered at many medical facilities and is quite rare.

If data indicates service-connected disabilities require more secondary care, VA could determine if they have the right type and number of facilities and staff to provide such care. Beyond secondary care, veterans may need more extensive tertiary care if these service-related conditions become exacerbated and require intensive care and hospitalization. Since the veteran population includes a significant senior population (45.8% of the veteran population are 65 and older), hospitalization is more likely than the general population. Consequently, VA medical centers could also direct their resources to providing in-patient care for more intensive treatment.

VA is uniquely situated to collect data and fund research for veteran-related ailments. This research component of VA's mission justifies directing resources to quaternary care. Quaternary care tends to be more experimental and is more highly specialized than tertiary care. This experimental care can sync well with VA's mission to research ailments and disabilities that disproportionately affect the veteran population. These conditions may not always be properly

treated in civilian medical facilities. Thus, VA can provide this highly specialized quaternary care at its facilities to fulfill this need in the veteran community. VA’s groundbreaking work would inevitably enrich the health care sector’s ability to help the populace.

VA has seen outpatient visits increase significantly since 2002, according to the following table; but without differentiating service connected versus non-service connected visits, it’s hard to determine if resources are being appropriately used.

Selected Veterans Health Administration characteristics: FY2002 to FY2013

Fiscal Year	TOTAL ENROLLEES ¹	OUTPATIENT VISITS ²	INPATIENT ADMISSIONS
	(in millions)	(in millions)	(in thousands)
2002	6.8	46.5	564.7
2003	7.1	49.8	567.3
2004	7.3	54.0	589.8
2005	7.7	57.5	585.8
2006	7.9	59.1	568.9
2007	7.8	62.3	589.0
2008	7.8	67.7	641.4
2009	8.1	74.9	662.0
2010	8.3	80.2	682.3
2011	8.6	79.8	692.1
2012	8.8	83.6	703.5
2013	8.9	86.4	694.7

¹ Includes non-enrolled Veteran patients.

² Includes fee visits.

Source: Department of Veterans Affairs, VHA, Office of Policy and Planning

Prepared by the National Center for Veterans Analysis and Statistics.

Deliver health care to Veterans during the next 20 years

Who

Regardless of soothing pronouncements by political leaders wishing to anesthetize the public preceding a war (declared or – as is distressingly now uniformly the case – undeclared) conflict will generate military buildup; and its partial or complete conclusion will slough off spending, equipment, and the service of human beings.

Many of those human beings will have been physically and mentally impaired in the enterprise; the need to provide benefits and services to veterans will not go away.

In each decade the military services have continuously been involved in military engagements as shown below.

1939-1945	World War II (and subsequent Berlin crisis and airlift)
1950-1953	Korea, Taiwan, Lebanon
1965-1973	Vietnam, Bay of Pigs, Laos, Zaire
1980-1989	Iran, El Salvador, Libya, Sinai, Lebanon, Egypt, Honduras, Persian Gulf, Panama
1990-1999	First Gulf War, Bosnia, Kosovo. Liberia, Sierra Leone,
2001-Present	Second Gulf War: Afghanistan, Iraq, ISIL

One could argue that the services will never again grow to the size experienced during World War II and the Cold War, but despite reduced military end strengths, during our lifetimes, the need for veterans' care and benefits will not abate. The buildups of the past two or three generations will generate VA enrollments for decades. Two major drawdowns occurred with the end of the Cold War and the reduction of forces to Iraq and Afghanistan, yet increases in the disability rating groups continue.

While there may be fewer veterans, with the loss of our Second World War generation and the passage from us of those who served in the Korean and Vietnam wars, those entering the VA system since Vietnam have presented more disabilities than those of previous generations.

According to VA, "From 2009 to 2013, the average number of issues included in a disability claim increased from 2.8 to 4.9. In particular, VBA has noticed an increase in complexity of the claims from the newer generation of Veterans who participated in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. These young heroes have a greater chance of surviving serious injuries and often return home with multiple amputations, blindness, burns, multi-organ system damage, and most notably, with the signature wounds of the war -- traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). In addition, VBA continues to receive complex claims from Veterans of the Vietnam Era, who submit more claims than Veterans from any other period of service." VA testimony on December 4, 2013 by Mr. Tom Murphy, Director, Compensation Service.

The following table shows the increase in veterans with service connected disabilities and the increase in number of disabilities resulting in higher ratings.

Service-connected Disabled Veterans by Disability Rating Group: FY2002 to FY2013

Fiscal Year	Total Veterans with a Service-Connected Disability	0 to 20 percent	30 to 40 percent	50 to 60 percent	70 to 100 percent
2002	2,398,287	1,209,274	527,820	266,886	394,307
2003	2,485,229	1,204,038	546,157	287,978	447,056
2004	2,555,696	1,200,715	558,306	304,341	492,334
2005	2,636,979	1,199,271	573,994	324,637	539,077
2006	2,725,824	1,207,358	594,765	345,832	577,869
2007	2,844,178	1,229,001	621,440	371,622	622,115
2008	2,952,285	1,237,868	643,882	398,679	671,856
2009	3,069,652	1,244,230	665,211	427,902	732,309
2010	3,210,261	1,258,882	689,599	459,657	802,123
2011	3,354,741	1,258,987	711,305	492,692	891,757
2012	3,536,802	1,266,501	729,813	532,192	1,008,296
2013	3,743,259	1,281,492	749,531	572,421	1,139,815

Source: Department of Veterans Affairs, VBA; 1999-2013: Annual Benefits Reports

Prepared by the National Center for Veterans Analysis and Statistics.

Congress and VA must use the number of veterans, the number of visits, and the types of conditions to determine the services required for the next 20 years. In the past it appears future needs were forecast using the current number of veterans, resulting in an overtaxed system unable to meet health care in a timely manner. Likely compelled by a toxic mix of political and budgetary pressure from the incumbent administration and VA’s own cultural blinders, VA senior executives consistently low-ball future needs. VA thus resists expansions of care, such as it did with Agent Orange, ALS (until then-Secretary Anthony Principi boldly decreed a service connection), Gulf War illness, and the entire issue of battlefield toxicity.

VA must recognize that it can resist the reality of Veteran needs only so long: history shows that it ultimately loses, forced by public will – at great loss to its prestige and goodwill – to provide Veterans the care promised in its own motto. The agency, for example, must factor into its planning the complications that will occur from the loss of limbs as a result of the Iraq and Afghanistan veteran cohort’s aging. Advances in health care must also be considered as part of future increases in resources. Recently, VA was unable to estimate the cost of new Hepatitis C drug therapies and had to go back to Congress for additional funding. Gene therapy and stem cell research will more likely identify “cure” approaches, which could result in higher cost than the treatment-centered medicine of today.

What

The health care industry's development is being driven by technology as much as dollars. It is easy to say that VA care in the next 20 years will use many of these advances. The harder part will be deciding how much VA should invest in new technologies versus what should be contracted for, shared in partnerships with other providers, or leased; this calculus includes the often staggering costs of use: training, infrastructure support, and maintenance.

The rise of outpatient care indicates a growing appetite for mobile health care. Such care can be in part provided by evidenced-based apps that can prescribe, aid in making diagnoses, applications for case management, and apps that track medical conditions. In addition to the use of apps, the ability to use video is becoming part of our everyday environment. Such new, but already mainstreaming technologies as "telemedicine" overcome distance and provider scarcity, have been shown to be accepted by patients, especially younger patients, and would potentially facilitate the reduction of unnecessary brick and mortar.

Where

According to VA (www.ruralhealth.va.gov/about), "*Currently, 3.2 million rural veterans are enrolled in the VA system. This represents 36 percent of the total enrolled veteran population based on the 2010 U.S. Census. Men and women veterans from geographically rural areas make up a disproportionate share of servicemembers and comprise approximately 31 percent of the enrolled Operation Enduring Freedom and Operation Iraqi Freedom [OEF/OIF] veterans, many of whom return to their rural communities.*" Placing this into context, the 2010 census shows 16 percent of the U.S. population lives in rural areas.

The use of technology to overcome distance for rural veterans has already been discussed above; however, it could also be addressed through mobile health clinics and vet centers that have regular prescribed destinations. Veterans have clearly shown a preference for mobile Vet Centers.

Recently, Congress noted in Senate Report 114-057, "*The Readjustment Counseling Service is composed of over 2,200 employees in 300 Vet Centers, 80 Mobile Vet Centers, and the Vet Center Combat Call Center. The Committee remains strongly supportive of these programs and notes the number of Vet Centers or Mobile Vet Centers is not expected to increase despite an increasing workload. In fact, VA estimates it will continue to operate the exact number of Vet Centers in fiscal year 2017 as it did in fiscal year 2014.*"



<http://www.blogs.va.gov/VAntage/wp-content/uploads/2012/01/VetCenter2.jpg>

ROA is concerned with VA's all-too-characteristic sluggishness in embracing innovation, in this case mobile health care: VA's own accounting shows that telehealth is growing. In fiscal year 2014 VA served more than 690,000 veterans through their telehealth programs, a significant increase from fiscal year 2014 when they treated 608,000 veterans through telehealth. Of this group, approximately 55 percent were for veterans living in rural areas. In 2013, Vet Centers served more than 195,900 veterans, servicemembers and military members, and provided 1,587,181 no-cost visits for readjustment counseling, military sexual trauma counseling, and bereavement counseling services.

Thematically, this points to the growth in "distributed" health care – care delivered where it's needed, often far away from a distant hospital mother ship or even a community-based outpatient clinic. VA's thousand-strong CBOC system is good, yet expensive; even as it augments VA medical centers, it can be augmented cheaply and effectively in many cases by mobile units.

According to the VA Inspector General the VA has not done as good a job using their Mobile Medical Units as they have the Mobile Vet Centers. The IG identified that some were used as little as 5 days a month.

The IG found, "VHA lacks information about the operations of its MMUs and has not collected sufficient data to determine whether MMUs improved rural veterans' health care access. VHA lacks information on the number, locations, purpose, patient workloads, and MMU operating costs."



<http://www.va.gov/oig/pubs/VAOIG-13-03213-152.pdf>

An alternative to deploying vans would be to deploy employees. VA could consider sharing agreements by placing VA employees with existing non-VA or DoD health facilities or even with clinics in department stores or drug stores. This could be done to meet care needs for more routine requirements such as, initial assessments or flu and cold season treatments. VA employees could be available in these types of facilities on a part-time basis to provide care close to where veterans live. Individuals who live in urban areas can have just as much difficulty reaching VA facilities as those that live in rural areas.

Conclusion

Delivering health care to veterans in the next 20 years must be done far better than has been done in the last 20 years. Forecasting requirements must involve considering where veterans live and are moving to as years go by, what services they will need based on service-connected versus non-service connected conditions, how technology will change care delivery, the likelihood that sheer demand for care among individuals will increase as the technology-driven availability of cure and treatment increases, and – finally and terribly – the certainty that war will provide a new generation of Veterans needing care: if the past century is at all instructive, notions of peace are illusory.

ROA appreciates the opportunity to discuss health care delivery to Veterans. We look forward to working with the commission, the Department of Veterans Affairs, and Congress to offer our support and perspective.