

Witness Testimony of Ms. Ariana Del Negro & Charles R. Gatlin, CPT, USA (Ret).

Mr. Chairman and Ranking Member Kirkpatrick, thank you for allowing us the opportunity to participate in this forum addressing the challenges and barriers Veterans and their families face when accessing mental health care and traumatic brain injury (TBI) services within the Veterans Administration (VA) system. My name is Ariana Del Negro. My husband, Charles Gatlin, CPT, USA (Ret) and I are here today to discuss the shortcomings of the compensation and pension (C&P) process as it relates to evaluating residuals of TBI and to propose initial suggestions to narrow outstanding gaps. Effectiveness of treatment services for TBI is highly contingent on establishing a foundation of trust between patient and provider.¹ Because C&P is often the first clinical encounter a Veteran has with the system, we believe interactions with professionals during the C&P process will influence the degree to which a Veteran will actively seek or engage treatment services within other parts of the VA system.² Thus, it is imperative that the C&P process operate fluidly and productively so as not to dissuade Veterans from seeking much needed care.

While this testimony is based on our experience with the Fort Harrison VA in Helena, Montana, there is evidence that the gross malpractice and undercutting of the Veteran and his/her family that we have witnessed is indicative of policies and procedures routinely endorsed within the local system and may even reflect current practice at many VAs throughout the nation, with potentially catastrophic consequences for hundreds, if not thousands, of Veterans and their families. Using our experience as a case study, we intend to identify critical gaps and barriers related to the handling of TBI claims that must be addressed at both institutional and policy levels to protect the long-term interests of the Veteran and his/her family.

Military experience

My husband, the Scout/Sniper and Reconnaissance Platoon Leader of his Infantry Battalion (25th Infantry Division, Schofield Barracks, Hawaii) deployed in August 2006 with his unit to the northern area of Iraq. He was awarded a Purple Heart for events that occurred on September 28, 2006: while dismounted outside his FOB in Kirkuk, a vehicle-borne improvised explosive device detonated less than 20 yards from where he was standing. His injury and loss of consciousness were witnessed and he was subsequently medevac'd to Balad Medical Center where he was diagnosed with a closed-head TBI. As detailed in my previous testimony delivered on October 17, 2007 to the Senate Committee on Veterans Affairs (available in the congressional record for reference), upon his return to Hawaii, we faced numerous obstacles in seeking appropriate medical care and rehabilitative services for his injury. Eventually, we were fortunate enough to obtain access to professional and coordinated rehabilitative care through the C5 program at Balboa Navy Medical Center working in conjunction with civilian services offered by the Sharp Institute's Community Reintegration Program in San Diego, California.

¹ Spelman FJ, Hung SC, Sealk KH, Burgo-Black AL. Post-deployment care for returning combat veterans. *J Gen Intern Med.* 2012;27:1200-1209.

² Elbogen EB, Wagner HR, Johnson SC, et al. Are Iraq and Afghanistan veterans using mental health services? New data from a national random-sample survey. *Psychiatr Serv.* 2013;64:131-141.

Sharp taught my husband invaluable compensatory strategies to overcome his limitations— compensatory strategies he still employs to this very day. The rehabilitative process incorporated patient education on the nuances of the injury, including the fact that some symptoms may never resolve. We also obtained helpful information regarding the scope of neuropsychological testing required to document impairments and monitor progress following TBI. Importantly, we learned that simple diagnostic tests were not sufficient to adequately capture objective evidence of deficit.

Over the course of three years, and in accordance with DoD/VA guidelines for the management of concussion and mild TBI,³ my husband underwent three comprehensive batteries of neuropsychological testing administered by highly qualified and appropriately licensed neuropsychologists—specialists described in a 2010 Veterans Health Initiative on TBI as “the key player in diagnosing cognitive impairments and emotional and behavioral sequelae of TBI.”⁴ At each appointment for testing, my husband and I were interviewed together and individually by the neuropsychologists; we were also asked to complete questionnaires that served to compare his premorbid vs post-injury functioning. In addition, neuropsychological evaluation required my husband to undergo hours of other testing using highly sensitive and specific tests to gauge the degree of his deficits. Neuropsychological testing is a labor-intensive process and the results of the testing require careful and detailed analysis which can take weeks to complete in order to ensure a fair assessment.

In each of the follow-up appointments with the neuropsychologists, we were told that his test results documented deficits in multiple areas, with each battery of testing showing objective clinical evidence of deficit that remained consistent across batteries. Following his final battery of testing in 2009, the neuropsychologist noted:

The results of this evaluation indicates that CPT Gatlin continues to experience impaired information processing speed, fine motor dexterity/speed, and impaired pure motor speed. He displays executive dysfunction and impaired visual attention. Relative to the neuropsychological assessments completed in 2006 and 2007, there appears to be an overall stability of dysfunction in the areas noted above.

Because my husband’s progress had not improved since his previous evaluation, the neuropsychologist concluded: “there is reasonable degree of certainty that three years post-injury his deficits are likely to be stable and permanent.” And based on those findings, the Army medically retired (PDRL) my husband, inclusive of a 70% disability rating for his residuals of TBI.

Failures and contradictions at Fort Harrison

It was our intimate familiarity with the evaluation protocol for residuals of TBI that alerted us to the gross misconduct we would experience at the hands of the Fort Harrison VA. On August 24, 2011, my husband and I drove more than two hours from our home to the Fort Harrison VA for a C&P

³ Management of Concussion/mTBI Working Group. VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury. *J Rehabil Res Dev.* 2009;46:CP1-68.

⁴ Department of Veterans Affairs, Employee Education System. Veterans Health Initiative. Traumatic Brain Injury. Independent Study Course Released: April 2010. [pg. 141] Accessed 4/21/2014 at: <http://www.publichealth.va.gov/docs/vhi/traumatic-brain-injury-vhi.pdf>

appointment with Robert Bateen, PhD, a clinical psychologist tasked with evaluating my husband's residuals of TBI. Instead of beginning the appointment with a comprehensive interview as we had been accustomed to, our initial exchange with Dr. Bateen was brief and I left the room after only a few minutes so the remainder of the examination could be conducted. Instead of at least the 2-4 hours it typically takes to conduct neuropsychological testing, my husband emerged from his appointment no more than 60-90 minutes later.

The short duration of the appointment and the fact that neuropsychological tests were not performed led us to believe that evaluation for TBI residuals was not extensively or sufficiently conducted. We sought immediate clarification from the VBA as to whether the reason for not administering the tests was because the examiner would use the results of my husband's prior neuropsychological testing as the basis for his conclusions. We insisted that if the results were not going to be used appropriately, my husband should be referred for proper neuropsychological assessment. We brought our concerns to the attention of VBA as soon as possible with the precise intent of avoiding a long, drawn-out appeals process. Unfortunately, our petition fell on deaf ears and my husband was assigned only 10% for residuals of TBI (VASRD 8045). A 10% rating is assigned to patients with "subjective" complaints that cannot be detected by objective clinical testing. My husband was not being subjective in any of his complaints and the mere suggestion that there was no basis for these symptoms was perceived by my husband as questioning his integrity. Our repeated requests for additional neuropsychological testing were denied.

Several justifications were offered for assigning the low percentage and for denying referral.

Justifications for assigning the low percentage included the following:

- 1) **We were told that it was of greater benefit to my husband to rate his residuals individually rather than rate them collectively under VASRD 8045.** However, the two symptoms which have the most significant impact on my husband's instrumental activities of daily living—fine motor skill deficits and depth perception—were not accounted for.
- 2) **The examiner concluded that based on the screening test he used, there was no objective evidence documenting cognitive deficits and that if any deficits did exist, they were likely secondary to a diagnosis of post-traumatic stress disorder (PTSD) and not related to his TBI.** In a subsequent records review, Dr. Bateen did acknowledge "that a diagnosis of cognitive disorder, NOS, by history, would be acceptable," yet, he contradicted himself in the very same record entry, stating: "I would note that cognitive symptoms appear to be mild, *if present*, and do not appear to be at a level that significantly impacts functioning" (emphasis added). In his summation of the findings, Dr. Bateen again contradicted his suggestion that there was established evidence of deficit, concluding: "It should be noted that there was a complaint of mild memory loss, attention, concentration, and executive functions *without objective evidence on testing*. Again, concentration difficulties could be best explained in terms of the Veteran's post-traumatic stress disorder symptoms" (emphasis added).

- 3) **The examiners stated that there was “evidence that the Veteran’s symptoms are improving.”** However, they did not test him using the same tests as before, leaving no consistent yardstick with which to conclude whether these symptoms had in fact improved. Moreover, the test they did use was interpreted incorrectly (described below). The rationale used to justify the examiners’ conclusions were based on nonspecific mention of medical literature suggesting potential continuing improvement after one or two years. When my husband was seen at Fort Harrison, he was 5 years post-injury and his 3-year assessment noted no further improvements. There is a bounty of evidence-based literature, including literature produced by the VA, stating that some symptoms of persistent-post-concussive syndrome can be permanent. The VA’s predischarge document for *Traumatic Brain Injury (TBI) Evaluation: Comprehensive Version* notes: “Some sequelae of TBI may be permanent.”⁵
- 4) **My husband’s progress notes contained a statement that because he was attending graduate school, his complaints could not be that disabling.** Such an errant assumption is irresponsible, unsubstantiated, and discriminatory, not only to my husband, but to all Veterans who have worked hard to continue their educations in the face of adversity. It negated all of the hard work my husband dedicated to his schooling. He is registered with the disability office at the University of Montana and the limitations of his injury require significant discipline and profound effort to meet the demands of his schooling. He should be commended, not penalized for his accomplishments.

The VA’s justifications as to why our requests for referral to appropriate neuropsychological testing were denied included the following:

- 1) **My husband’s prior neuropsychological test results suggested stability of dysfunction and therefore further testing was not deemed required.** It remains unclear why the examiners elected to agree with the opinion of the previous neuropsychologist regarding stability of dysfunction, yet failed to honor the overall results from that testing when conducting their own assessments.
- 2) **The VA does not require a full battery of neuropsychological testing to evaluate residuals of previously diagnosed TBI “because the rating of residuals is not based on the quantum of damage, but rather how the veteran applicant is functioning at the time of his or her evaluation in the areas of home, education, or occupation.”** While my husband has been able to attend school, I will be candid: his home life and relationships with other family members are far from functional. In his brief meeting with my husband, Dr. Bateen failed to sufficiently inquire as to those facets of my husband’s life, nor did he ask me, his primary caregiver; as

⁵ Traumatic Brain Injury (TBI) Evaluation: Comprehensive Version. [under ‘definition of traumatic brain injury’] Accessed 4/21/2014 at <http://benefits.va.gov/PREDISCHARGE/DOCS/disexm58.pdf>

established in the medical community, the primary caregiver is the individual with the greatest insight into their loved one's degree of disability.⁶

- 3) **The VA does not employ or contract with neuropsychologists in the state.** At the time my husband was evaluated at Fort Harrison, we were informed that the system did not have a neuropsychologist on staff who was certified to conduct C&P examinations. We were also told by the VBA office that they could not refer us to any local neuropsychologists because they did not contract out with any and could only do so if those providers received training that would authorize them to conduct the C&P examination. Of the 71 DBQs the VA has drafted, 8 are not available for use by private providers, including the DBQ for TBI.⁷ (I refer the reader to the written testimony of Tana Ostrowski, COTA/L, CBIS, Community Bridges, Rehabilitation Institute of Montana, for further insight as to the extent Fort Harrison has elected to partner with community resources).
- 4) **The VA does not want to pay for it.** Addressing my husband's case specifically, Alison N. Cernich, PhD, Deputy Director, Defense Central Office, Mental Health Services, stated:
Veterans Health Administration performs over a million Department of Veterans Affairs disability evaluations yearly. To mandate a repeat full psychological battery for 'residual' functional evaluations for every veteran who claims any cognitive impact from TBI would have a large negative impact on the Veterans Health Administration and Veterans Benefits Administration. The sheer cost and delay in obtaining such a large number would divert money needed for benefits, delay administration of claims even further, and divert providers from actual treatment.

Two points are worthy of mention here. First, if the VA did not want to pay for neuropsychological testing for my husband, why not honor his previous test results—test results that the VA acknowledged represented his current level of functioning? Second, and most telling, is the recent revelation that Fort Harrison has suddenly changed their practice and are now referring Veterans to qualified neuropsychologists for C&P examinations, despite these alleged financial burdens.

Naked Truths & Consequences: VA Evaluations and Ratings for Residuals of TBI at Fort Harrison

- ***VA places greater importance on saving time than thoroughness; makes unreasonable demands for scheduling***

⁶ American Academy of Clinical Neuropsychology. American Academy of Clinical Neuropsychology (AACN) practice guidelines for neuropsychological assessment and consultation. *Clin Neuropsychol.* 2007;21:209-231

⁷ Veterans Benefits Administration. Disability Benefits Questionnaires, Frequently Asked Questions. Accessed 4/20/2014 at http://www.benefits.va.gov/compensation/dbq_FAQs.asp.

VHA Directive 1603 regarding disability evaluations acknowledges "...the importance of a thorough evaluation to the Veteran or Servicemember in terms of eligibility for future benefits..."⁸ Specifically, in the case of TBI, the aforementioned predischarge document serves as a means to collect clinical data to be used by both the military and the VA for their disability assessments. Drafted by the VA, the very first line of the form's narrative reads: "The potential residuals of traumatic brain injury necessitate a comprehensive examination to document all disabling effects."⁹ However, according to Dr. Cernich, again addressing my husband's case: "A C&P exam is conducted in a very structured manner according to the Veterans' Benefits Administration legal needs. The exam is to be part of a quick and accurate response considering that over one million applications for disability benefits are received by VA each year."

Efforts to streamline the claims process into a one-size-fits-all approach have ended up working against the individual Veteran. Particularly with respect to TBI, the nuances of the injury vary significantly from patient to patient, and such nuances affect degree of disability and quality of life differently. Evaluating the residuals of TBI mandates an individualized and focused approach. A better balance is needed that offers increased efficiency without adversely affecting efficacy.

In addition, the system's goal of setting short deadlines to meet national standards for which appointments must be made and completed is not realistic. I recognize the reasoning behind trying to move Veterans through the system quickly. However, patient demographics of Veterans have changed in recent years. The profound influx of young men and women requires a different approach to meet the needs of today's generation of Veterans.

I refer to the Fort Harrison VA as a system that expects me and my husband to dance for them, rather than *with* them. The expectations placed upon any Veteran and his/her family to navigate through the C&P process are unreasonable. And, in cases when a Veteran has residual and disabling symptoms from TBI, such burdens can be even more profound. In Montana, and in other areas of the country, the main VA can be hundreds of miles away from where a Veteran and his/her family live. Attending appointments at distant locations (and sometimes at ridiculous early hours) requires significant planning; some families have to take off from work, find child care, and incur significant out-of-pocket costs that are not routinely reimbursed by the VA.

In our case, my husband was in school. The nature of his injury required additional effort for his schooling; missing classes would set him back academically. Instead of recognizing his limitations, the schedulers made requests that were entirely inappropriate. I had to educate them that part and parcel of his injury is the effect that fatigue has on his symptoms; thus, it was not possible for us to drive to Helena in the morning, attend a laborious appointment, and drive back to Missoula in time for him to

⁸ Department of Veterans Affairs. Veterans Health Administration. VHA Directive 1603. "Certification of clinicians performing VA disability evaluations" [sic] April 7, 2013. Accessed 4/21/2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1643

⁹ Traumatic Brain Injury (TBI) Evaluation: Comprehensive Version. Accessed 4/21/2014 at <http://benefits.va.gov/PREDISCHARGE/DOCS/disexm58.pdf>

attend class. I also had to frequently remind them that I had commitments to my job and could not always meet their scheduling demands. I had to emphasize that it was not an option for him to go by himself; as his caregiver, I was the one uniquely positioned to be able to communicate his limitations and current functioning to the examiners.

It was tremendously frustrating to have to relay facts about the injury that should have already been available throughout the system. Seven years have passed since the release of multiple reports and calls for educational initiatives addressing TBI. There is little excuse for why those within the system who have regular interactions with wounded Veterans remain oblivious to the nuances of one of the signature wounds of current conflicts.

- ***C&P examiners unqualified and frequently practice outside the scope of their expertise; certification programs are insufficient***

In our own experience with the C&P process at Fort Harrison, several C&P examiners were neither properly licensed nor qualified to competently assess degree of disability across a host of specialized medical conditions. In my husband's case, they tasked a clinical psychologist without proper neuropsychological training to evaluate residuals of TBI related to cognition. It is as if the VA sends a patient with cancer to an eye doctor for assessment.

Our concerns are not conjecture; they are founded on evidence-based principles and they have since been independently validated by the State of Montana Board of Psychology. My husband and I filed a grievance against Dr. Bateen with the Board, asking them to determine whether Dr. Bateen had practiced outside the scope of his expertise when evaluating and determining the degree of cognitive deficits attributed to my husband's TBI. In its amended notice dated November 8, 2013, the Board stated that "The act of examining the cognitive aspects of brain behavior changes due to traumatic brain injury is by definition engaging in clinical neuropsychology." Therefore, they asserted that Dr. Bateen "created an unreasonable risk of physical or mental harm or serious financial loss to Gatlin, when Licensee [Bateen]:...offered opinions in a specialized area of psychology for which he was not qualified." Our case was not unique. At Dr. Bateen's own admission, he had previously conducted these type of examinations on "hundreds" of patients.

In all of his C&P appointments for his residuals of TBI, my husband never saw a single M.D. In addition to his evaluation by Dr. Bateen (PhD), he was seen by a physician assistant and a nurse practitioner. The latter was asked to evaluate my husband's fine motor skill deficits. In her notes, she acknowledges the profound deficits in function, but states that she "is unable to explain" the reasoning behind such deficits. Based on her report, and despite comprehensive assessment and diagnosis of motor skill deficits secondary to my husband's TBI while in service (results of testing for my husband's fine motor skills in his left hand were impaired below the 1st percentile), the Fort Harrison VA denied service connection for this complaint on the basis that "the medical evidence of record fails to show that this disability has been clinically diagnosed." We argue that this disability could not be clinically diagnosed by the VA examiner because the examiner was not qualified or trained to diagnose it.

In accordance with VHA Directive 1603, clinicians who conduct C&P examinations for residuals of TBI are required to complete the CPEP Traumatic Brain Injury training module and complete the post-test.¹⁰ While access to the content of the training module is not available to the public, the post-test for the specific module is available online at:

https://www.vesservices.com/secure/va/CPEP_Traumatic_Brain_Injury.pdf. Having worked in the world of continuing medical education for more than 12 years, I can testify that the post-test questions are resoundingly weak, do not address evidence-based practice, and fail to meet the rigorous standards of demonstrating that new acquired knowledge will translate into improved practice performance. Outcomes studies to definitively measure the true efficacy of CPEP training modules should be mandatory.

- ***VA examiners use inappropriate tests, misinterpret test results, make unfounded clinical conclusions, and fail to uphold the standard of care***

According to the VA/DoD Clinical Practice Guideline For Management of Concussion/mTBI issued in 2009, “Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under control conditions, and findings interpreted by trained clinicians.”¹¹ The highly sensitive and specific tests used by the neuropsychologists in their 2006, 2007, and 2009 evaluations of my husband included select subsets of the Wechsler Adult Intelligence Scale-III (WAIS-III), Million Behavior Medicine Diagnostic (MBMD), Conners Continuous Performance Test-II (CPT-II), and the Wisconsin Card Sorting Test-4 (WCST-4), as well as a number of tests to measure fine motor skill function. At the Fort Harrison VA, only one test—the Repeatable Battery for the Association of Neuropsychological Status (RBANS)—was used. Moreover, it was used inappropriately and the test results were interpreted incorrectly.

RBANS is a brief screening test originally developed to screen for dementia in the elderly. It has inherent limitations in its use for evaluating executive functions, category fluency, and motor responses, and it is not adequately sensitive to milder forms of brain dysfunction.¹² All of these limitations are precisely the areas where deficits were noted in my husband’s prior neuropsychological testing. Therefore, and as ruled by the Montana State Licensing Board of Psychology:

Because Gatlin’s medical history established he had a TBI and had significant deficits three years post injury, it was improper for Licensee to use RBANS as the testing instrument to determine Gatlin’s cognitive functioning and to use it [as] the basis to formulate his evaluation conclusions. Therefore, the Licensee’s assessment was insufficient to provide appropriate substantiation for his findings.

¹⁰ Department of Veterans Affairs. Veterans Health Administration. VHA Directive 1603. “Certification of clinicians performing VA disability evaluations” [sic] April 7, 2013. Accessed 4/21/2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1643

¹¹ Management of Concussion/mTBI Working Group. VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury. *J Rehabil Res Dev*. 2009;46:CP1-68.

¹² Lezak MD, Howieson DB, & Loring DW. (2004). *Neuropsychological assessment* (4th ed.). New York: Oxford University Press. [pg 697]

Despite the Board's conclusions, Dr. Cernich, in her statement issued on behalf of Dr. Bateen, states: "I conclude that Dr. Bateen appropriately conducted a C&P residual examination with recommended screening measure that has been validated for use with individuals with TBI." However, the paper she references the reader to substantiate her conclusion is a study that discusses the utility of the RBANS in *moderate and severe TBIs, not injuries classified as mild*. In describing the limitations of their study, McKay, et al write: "The current sample was comprised of individuals from a Midwest treatment centre who had sustained moderate to severe brain injuries with a large range in time since injury. *Therefore, the generalizability of these results may be limited and thus research would benefit from replication in other populations with differing injury and demographic characteristics*" (emphasis added).¹³

Dr. Bateen noted my husband had an Attention score of 85 on RBANS and initially concluded that that score was in the average range. However, the Montana State Licensing Board of Psychologists concluded that it was not average, noting "It is in the low average range at the 16th percentile. This score is one standard deviation below the mean, which is a level of performance commonly viewed as impaired by clinical neuropsychologists." Of note, the study by McKay, et al reported that the subsets comprising the RBANS Attention Index correlated strongly with the comparable WAIS-III counterparts. If the McKay paper is intended to serve as a seminal study justifying the actions of VA clinicians to use RBANS, then it would have behooved Dr. Bateen to compare the deficits he noted in the attention index with my husband's score of the comparable WAIS-III measure also documenting deficits.

In a later record entry into my husband's record, Dr. Bateen acknowledges the significance of my husband's attention score on RBANS, adding that a diagnosis of a cognitive disorder, NOS "would be appropriate" However, he concludes that any cognitive difficulties were secondary to my husband's PTSD and not to his TBI. Although beyond the scope of this testimony, the economic attractiveness of attributing cognitive deficits to PTSD, rather than to TBI is well established. Moreover, it can have significant repercussions in the treatment setting, as studies have shown that a large proportion of Veterans diagnosed with PTSD do not seek mental health care,¹⁴ and of those that do, there are high attrition rates within programs, including those for PTSD-related cognitive impairment.¹⁵ As summarized by the Montana Board, "Incorrectly categorizing Gatlin's attention score and erroneously ascribing it to PTSD and generally failing to address or reconcile Licensee's findings with those of the previous evaluations are examples of Licensee's failure to conduct the assessment in accordance with the applicable standard of care."

There is evidence to suggest that the use of RBANS is not limited to the Fort Harrison VA. According to Dr. Bateen, "This test had been used at the VA in Texas for a screening tool to conduct the C&P exams." What is uncertain is the degree to which RBANS is being used within the VHA system for diagnostic and treatment purposes. Therefore, and especially since the practices of Dr. Bateen were endorsed by the

¹³ McKay C, Casey JE, Wertheimer J, Fichtenberg NL. Reliability and validity of the RBANS in a traumatic brain injured sample. *Arch Clin Neuropsychol*. 2007;22:91-98.

¹⁴ Tanielian TL, Jaycox LH, eds. *Invisible wounds of war: psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation; 2008.

¹⁵ Seal KH1, Maguen S, Cohen B, et al. VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *J Trauma Stress*. 2010;23:5-16.

administration at Fort Harrison, including Christine Gregory, Director, VA Montana Health Care System, and Gregory Normandin, MD, responsible for oversight of C&P examiners on staff, and because Dr. Cernich asserted that the use of RBANS was appropriate, a thorough audit of at least the Fort Harrison VA, if not all VA systems, is warranted to determine the frequency of using RBANS and whether those tests were properly administered and interpreted.

- ***Examiners make contradictory concluding statements, lack of parity between examiners allow raters to cherry pick information***

Noted above as it relates to my husband's claim, there were instances in which Dr. Bateen contradicted his own conclusions, including instances where disagreement occurred in the exact same record entry relating to the presence or absence of a cognitive disorder, NOS. This practice is not reserved to Dr. Bateen alone. In another instance, Beverly McGowan, APRN-BC, concluded in one record entry that her "Clinical examination notes associated symptoms of chronic headaches, mild speech impairment, vertigo, fine motor skills that are more likely than not related to the veteran's TBI." Three months later and without reexamining my husband, she asserts in his record that "review of the claim file medical records provides evidence that the veteran's symptoms are improving..."

The VBA is adamant that raters are not medical professionals and that they rely exclusively on the medical opinions of its VHA examiners. Addressing the facts of my husband's case specifically, Janice S. Jacobs, Deputy Undersecretary for Disability Assistance states that "Generally, the VA most often relies upon the VAE [VA examination] in determining not only entitlement to service connection, but also the severity level associated with the conditions claimed." Therefore, consistency of opinion is a necessity and opinions by C&P examiners must be written in a manner which can be properly interpreted by a layman. The system offers specific language that examiners must use when writing opinions that is intended to aid the raters in their decision making.¹⁶ Such statements include, but are not limited to: "More likely than not;" "At least as likely as not;" "Less likely than not;" and the inability to render an opinion "without resorting to mere speculation." Failure to use appropriate legal language can compromise the Veteran's right to the VA's benefit of the doubt rule, which favors the Veteran (38 U.S.C.A. § 5107(b)).

In my husband's case, the VBA raters used the inconsistencies and nebulous wording of opinions to cherry-pick information from his record rather than querying the examiners for clarification. Such cherry-picking is of profound concern and calls into question the objectivity of the overall rating consideration, as well as the overarching qualifications and integrity of some of those involved in the C&P process at the Fort Harrison VA. Because VBA raters style themselves as mere processors of the information offered by VHA examiners, they assume no responsibility for misusing the information and place the entire onus on VHA examiners. Similarly, there is no assumption of responsibility on the part of VHA examiners. In her statement related to my husband's case, Dr. Cernich states: "The clinician who performs this residual evaluation does not make the benefit rating decision and the recognition that

¹⁶ Worthen MD, Moering RG. A practical guide to conducting VA compensation and pension exams for PTSD and other mental disorders. *Psychological Injury and Law*. 2011;4:187-216.

based on review of records, cognitive disorder, NOS could be considered allows the rating official latitude to include this diagnosis as justification for benefit designation.”

Why the system’s raters are not medical professionals is puzzling. How is a rater without healthcare training to make sense of notes entered by VHA examiners? Simplified DBQs are not sufficient, especially since there is absolutely no standardization of reporting. Rural VA systems, where availability of qualified examiners is extremely limited, may be most vulnerable to inconsistencies between departments.

The VHA and VBA constantly point fingers at each other and the system as a whole fails to take accountability or action to rectify clear improprieties. Each department begins with a 'V' and ends with an 'A', and, frankly, as the wife of Veteran, I don't care what letter falls in between. I don't think the Veteran and his/her family should have to suffer because the two entities cannot figure out a more productive and cohesive way to work together.

VHA Directive 1603 acknowledges that “Given the importance of a thorough evaluation to the Veteran or Servicemember in terms of eligibility for future benefits, it is critical that standards are consistently enforced and applied fairly across VISNs.”¹⁷ The profound discrepancy between the language used in the VHA directives vs the actual processes in place are of particular concern. It is as if the language issued in VHA directives is used to simply pacify individuals, not define internal policy (at least in my husband's case). Moreover, the subjective language used in such directives gives the VA a way out of having to take accountability. Thus, one issue at play is the degree of authority of the directives. Are they intended as "guidelines" or are they intended as "policies"? And how are they enforced?

- ***VA plays lip service to the needs of Veterans and their families; places legal loopholes ahead of Veterans’ best interests***

The VA promulgates messages to Veterans and their families to falsely bolster trust in the system. As some examples: “Integrity, Commitment, Advocacy, Respect, and Excellence” are the core values the VA self-identifies as underscoring its obligations to Veterans and their families.¹⁸ Forming the acronym “I CARE,” the VA states that “these core values come together as five promises we make as individuals and as an organization to those we serve.” In addition, VHA Directive 2013-002 cites that “VHA’s goal is for Veterans to describe the disability examination process as ‘informative, supportive, caring, and even delightful.’”¹⁹ Specific to the Fort Harrison VA, Christine Gregory took over as Director VA Montana Health Care System in March 2013 under the guise of being “committed to leading an organization that

¹⁷ Department of Veterans Affairs. Veterans Health Administration. VHA Directive 1603. “Certification of clinicians performing VA disability evaluations” [sic] April 7, 2013. Accessed 4/21/2014 at:

http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1643

¹⁸ U.S. Department of Veterans Affairs. About VA. Core Values. http://www.va.gov/about_va/mission.asp

¹⁹ Department of Veterans Affairs. Veterans Health Administration. VHA Directive 2013-002. “Documentation of medical evidence for disability evaluation purposes.” January 14, 2013. Accessed 4/22/2014 at:

http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2856

embodies open communication and transparency.”²⁰ We are here today to testify that while well-intentioned, the system, with few exceptions, is failing horribly at honoring its core values, system goals, and responsibilities.

First, those exceptions warrant recognition. Our frustrations are limited to those VA employees who do not uphold the responsibilities of their positions. There are many employees within the VA system on both VHA and VBA sides of the house who are professional and friendly and who go out of their way for Veterans. We would like to formally recognize Marcy Steffy, RN, OEF/OIF Case Manager at Fort Harrison and VISN 19 FOIA Officers Shay Perrera-Boettcher and Melissa Petersen, for their professionalism and integrity. These individuals represent the models for which the rest of the system should emulate.

For close to three years, my husband and I have been advocating for ourselves and other families in seeking proactive and effective strategies to resolve system inconsistencies at Fort Harrison. We followed the system’s chain of command, voicing our concerns to multiple parties within Fort Harrison, including patient representatives; Trena Bonde, MD, Chief of Staff; Dr. Normandin, MD; Ms. Gregory; Koryn Arnold, Veterans Service Center Manager; and a gaggle of others. We also contacted the Western Regional Office (Phoenix, Arizona) to discuss the matter with Regional Director Willie Clark. Unfortunately, instead of building bridges for communication and correction, they have erected thick brick walls in efforts to silence and stonewall those with good intentions. All of our efforts to open the doors of communication to discuss our concerns and prevent them from occurring again have been and continue to be completely disregarded. It has reached ridiculous proportions; if we call the Director’s office with a question, her office staff state that she will not speak with us and that any questions should be directed to the Office of Regional Counsel in Denver, Colorado (Region 16). When contacting Regional Counsel, Jeffrey Stacey, we are insulted, disrespected, called “disingenuous,” and accused of being combative. Voicemails for employees, particularly Koryn Arnold, go unreturned. The administration at Fort Harrison, and by extension, the Office of Regional Counsel in Denver, and the Western Regional Office, all operate with impunity. They have tried to impose their will to silence us in order to avoid the larger implications involving accountability and their obligations to the Veteran’s community.

The leadership at Fort Harrison touts that they “are committed in VA Montana Health Care System to providing the highest quality of care to our Veterans.”²¹ And yet when an independent state government entity identified several instances of failure to provide such care, Fort Harrison’s administration tucked their heads in their shells and failed to take appropriate corrective actions. If such violations of the standard of care occurred in any other setting, that employee would immediately be put on administrative leave and/or terminated. However, to this day, Dr. Bateen continues to work at Fort Harrison as a fee-based employee conducting C&P examinations for PTSD and residuals of TBI. The fact that Dr. Bateen continues to practice is demonstrative of the fact that the Fort Harrison VA completely disregards the best interests of the Veterans.

²⁰ “New director outlines goals, vision for VA Montana Health Care System” April 18, 2013. Billings Gazette. http://billingsgazette.com/news/local/new-director-outlines-goals-vision-for-va-montana-health-care/article_a7883360-bd56-505c-a4c3-86683b540dc0.html#ixzz2zXQTrit1

²¹ Letter from Christine Gregory to Congressman Steve Daines (R-MT). August 22, 2013.

In order to conduct C&P examinations, all examiners must be state licensed, but can be licensed by a state other than the state in which they practice at the VA. The VA argues that because Dr. Bateen was evaluating my husband for his disability, he was not acting as a care provider and therefore is not obligated to honor the tenets of his licensing. The VA classifies Dr. Bateen as a federal employee and argues that he is immune from liability with the state, even though, he can only be an employee if he has that appropriate licensing. What is the point of requiring C&P examiners to hold licenses if they do not have to actually follow the fundamental oath they took? Where is their obligation to their professional fields and their patients and why does the VA think such obligations are not binding?

The U.S. Attorney's Office is now representing Dr. Bateen in the matter against the state (Case No. 994-2014), which speaks volumes as to the depths to which the VA will sink to avoid a change in policy that would benefit Veterans. This case is no longer about holding a licensee accountable for violating the tenets of his licensing with the state; in my opinion, the VA has now made it a case regarding state vs federal rights. It is curious that the VA uses budget concerns to justify not sending a Veteran for neuropsychological testing, yet they are more than willing to use tax-payer dollars to represent an examiner who fundamentally failed to do his job. Such actions are deplorable.

The consequences to the Veteran and his/her family of allowing VA employees to perform insufficient examinations so that C&P raters can undermine what the Veteran is rightfully due cannot be overstated. The consequences are not only monetarily based. Stresses associated with dealing with the VA adversely impact familial relationships and the situation is compounded when a Veteran has TBI with emotional components. In situations where an appropriate rating means the difference between 90% and 100%, the implications are not just financial; it is also the difference between access to vision and dental services, the difference between being potentially eligible or not for educational benefits for family members, among other benefits extended to Veterans at 100% disability.

I think the best way to convey the seriousness of this situation is to consider the perspective from other families. Can you imagine being one of those families that discovers you were short-changed, that the VA knew it and yet did nothing? Can you imagine the frustration of having to go through the appeals process and the length of time required to fix the problem, assuming it will be fixed? Can you imagine how much \$100/month could improve quality of life for your family? And what about those families who may not know that they are being wronged, who may not know what questions to ask, or who may not have the time, energy, or resources to fight a bureaucratic system? Who is going to watch out for their best interests?

Recommendations and Concluding Remarks

Given what we have addressed today, my husband and I propose the following as actionable points to address shortcomings in the C&P system specific to residuals of TBI:

1. Audit the medical records and claims files of Veterans diagnosed with TBI who were seen at Fort Harrison to ensure that only the highest standards of testing are employed.

2. Initiate a VA Inspector General's investigation into whether the practices at Fort Harrison represent criminal and collusive actions to undermine Veterans' benefits.
3. Routinely retrain C&P examiners and raters on system protocols; ensure examiners use consistent language in drafting their opinions in order to obviate cherry-picking of information.
4. Amend CPEP TBI training module to meet rigorous standards of continuing education; conduct an outcomes study evaluating effectiveness of training on practice performance.
5. Expand access to CPEP TBI training module and Veterans Health Initiative on TBI to VBA raters to increase familiarity with medical terminology, etc.
6. Increase collaboration with community services to ensure appropriate access to specialized care and to obviate the need to travel long distances for basic appointments.
7. Adopt and enforce a protocol for accountability when deviations from standard practice are made.
8. Institute compassionate training to all VA employees, including administrators.

My husband and I are sickened by hypocrisies within the VA. The "I CARE" acronym and its promises are offensive to those of us who rightfully know that the system as it now stands is not capable of upholding its supposed core values. I challenge the VA to honor their promises to us of **integrity** ("Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage") and **excellence** ("Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them"). Until the VA actually lives up to their promises, Veterans will continue to mistrust the system.

We are exhausted fighting a system that is supposed to fight for us. My husband fought for this Country honorably. It's time for someone to fight for him and other deserving Veterans and their families.