

**GEORGE MILLER**

7TH DISTRICT, CALIFORNIA

2205 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-0507  
(202) 225-2095

[www.house.gov/georgemiller](http://www.house.gov/georgemiller)

DANIEL WEISS  
CHIEF OF STAFF

COMMITTEE ON EDUCATION  
AND THE WORKFORCE  
SENIOR DEMOCRAT

COMMITTEE ON RESOURCES

DEMOCRATIC POLICY COMMITTEE  
CHAIRMAN

**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515-0507**

BARBARA JOHNSON  
DISTRICT DIRECTOR

1333 WILLOW PASS ROAD  
SUITE 203  
CONCORD, CA 94520  
(925) 602-1880

3220 BLUME DRIVE  
SUITE 281  
RICHMOND, CA 94806  
(510) 262-6500

375 G STREET  
SUITE #1  
VALLEJO, CA 94592  
(707) 645-1888

TTY (202) 225-1904

April 19, 2007

The Honorable Ike Skelton  
Chairman  
House Armed Services Committee  
2120 Rayburn House Office Building  
Washington, DC 20515

The Honorable Bob Filner  
Chairman  
House Veterans Affairs Committee  
335 Cannon House Office Building  
Washington, DC 20515

Dear Chairmen Skelton and Filner:

Thank you both for your leadership on behalf of our nation's veterans and service members. As you know, repeated troop deployments to Iraq and Afghanistan have stretched our military readiness thin and are pushing our armed forces to the breaking point. The stress placed on our soldiers and their families, both during and after combat, has caused an alarmingly high rate of mental health issues, like post traumatic stress disorder, which we are ill-prepared to properly diagnose and treat. We owe it to the brave men and women in uniform, and their families, to give them the care and resources they need.

Your work in bringing the U.S. Troop Readiness, Veterans' Health, and Iraq Accountability Act, The Wounded Warrior Act, and the largest veteran's budget increase in American history to votes on the House Floor have been critical and long overdue steps to improve the state of veterans and active duty health care in this country.

Over the spring district work period, we convened a meeting with local area veterans, veterans' healthcare experts and providers from federal and county government, and health care experts from the private sector. Our conversation was both enlightening and extremely troubling.

While Veteran's healthcare services in both Contra Costa and Solano counties have been held up as model programs in many respects, officials there agree that the VA is understaffed and short of needed funding.

As the Armed Services and Veterans Affairs committees continue to hold hearings and develop legislation to improve the federal government's role in providing needed treatment and care for our nation's Veterans, we wanted to share with you the following findings from our meeting. In addition, attached for your reference are copies of reports and testimonies we received during our meeting.

### **Veterans Health Care Overall:**

- Review and revise Department of Defense's policies for physical and medical evaluation to ensure accountability, thoroughness and accuracy.
- Simplify the disability compensation program
- Authorize additional full time employees
- Deploy field-tested software to regional VA offices for enhancing workload productivity.
- Counsel all veterans on federal, state and local benefits available for veterans, their dependents and survivors.
- Improve coordination between the Veterans Benefits Administration and the Department of Defense.

### **Mental Health Care Access for Active Duty Personnel and Veterans**

- Create a centralized leadership for all military mental health issues
- Make mental health care services available to all active duty personnel and their families
- Improve overall research into how combat affects the warfighter, and the effectiveness of existing policies and programs to deal with those affects
- Focus more resources on the ability to diagnose adjustment disorder, substance abuse, PTSD, Traumatic Brain Injury, depression and family violence in all phases of a soldier's deployment cycle.
- Immediately increase efforts to recruit and retain a sufficient number of psychologists
- Implement specialized training for all psychologists dealing with military mental health issues and implement review process to ensure the training is being properly employed

Again, thank you both for your leadership on behalf of our nation's veterans and service members. We look forward to continuing our work with you both on these critical issues during the 110<sup>th</sup> Congress.

Sincerely,

Handwritten signature of George Miller in black ink.

GEORGE MILLER  
Member of Congress

Handwritten signature of Ellen Tauscher in black ink.

ELLEN TAUSCHER  
Member of Congress

enclosure

## Veterans Service Office

10 Douglas Drive, #100  
Martinez, CA 94553-4078  
(925) 313-1481  
(925) 313-1490 Fax

100 - 37th Street, # 1033  
Richmond, CA 94805-2179  
(510) 374-3241  
(510) 374-7955 FAX

## Contra Costa County



**Gary D. Villalba**  
County Veterans Service Officer

**Jill M. Martinez**  
Branch Office Manager  
Richmond

April 12, 2007

The Honorable George Miller  
Congressional District 7  
The Honorable Ellen Tauscher  
Congressional District 10

**Subject: Meeting to Discuss Service and Benefit Delivery Issues for Severely Wounded/Injured Military Personnel and Veterans Returning from Afghanistan, Operation Enduring Freedom (OEF), and Iraq, Operation Iraqi Freedom (OIF)!**

I wish to thank you both and Dr. Brian O'Neill, Director, VA Northern California Health Care System (VANCHCS), for hosting this meeting today to discuss the above concerns and to present recommendations to enhance the service and benefit delivery process for returning OEF/OIF participants who have been severely injured. While our focus today is on OEF/OIF participants, we must not forget all of the men and women, past and present, who have served in the Armed Forces of America with honor, valor and sacrifice in defense of our precious freedoms during war and peacetime.

The comments and recommendations contained herein are based upon systemic problems and not from a political perspective.

**I present the following three (3) essential issues:**

- I. Department of Defense (DOD) Military Physical Evaluation Board (PEB) and Medical Evaluation Board (MEB) Findings are often Incomplete and Inaccurate!**

### **Background Regarding Incomplete and Inaccurate PEB and MEB Findings!**

There is no doubt that our military personnel are receiving the best of medical care from our military hospitals and clinics. However, the critical and important PEB/MEB process tends to be flawed historically for the following reasons:

- DOD personnel have a tendency to rush the PEB/MEB process thus producing inaccurate and incomplete medical findings for critically wounded/injured military personnel.
- My staff and I have seen recent examples of PEB/MEB findings hastily put together which lack recognition and proper diagnosis of secondary,

- adjunct, residual physical and mental conditions stemming from major combat or non-combat injuries such as amputations and brain trauma.
- Some examples of frequent undocumented, undiagnosed and untreated secondary, adjunct and residual conditions are: internal injuries; significant bilateral tinnitus and hearing loss due to combat acoustic trauma; vision impairment; post traumatic stress disorder (PTSD) to include but not limited to symptoms such as anxiety, depression, rage, sleep disturbance (nightmares, thrashing, cold sweats) intrusive thoughts and survival guilt. Thus, the veteran may be deprived from VA compensation he or she may be entitled to for these issues.
  - DOD staff often convey to the soon to be veteran, "Don't worry, the VA will take care of you...."
  - The soon to be veteran will now have a difficult time acquiring subsequent diagnosis and documentation with proper medical nexus opinions to support the fact that secondary, adjunct, residual conditions now exist and are related to the primary injuries.
  - Incomplete and inaccurate PEB/MEB findings show a lack of respect while the person is still on active duty.
  - Once separated from service, the now veteran will have to navigate the complex and cumbersome VA disability compensation program which will be addressed later.

### Recommendation 1

**DOD staff responsible for PEB/MEB findings must be made accountable to produce thorough and accurate medical findings to include all secondary, adjunct and residual physical and mental conditions. Therefore, DOD must review and revise the current PEB/MEB protocol process to insure thorough and accurate findings.**

## **II. U.S. Department of Veterans Affairs (VA), Veterans Benefits Administration (VBA) Claims and Appeals Backlog.**

### Background Regarding VBA Backlog in Processing Disability Claims!

VBA has a dedicated and hard working corps of employees who deal with a complex and cumbersome adjudication process. My focus here is to discuss the longstanding backlog of VA disability compensation claims/appeals and some of the pertinent causes.

Recently, VBA Central Office directed the VA Regional Offices to set up "Red Teams" to give top priority to OEF/OIF claims. Although I endorse this initiative, it is important to note that the shifting of finite staffing and resources to satisfy one need for one group of veterans only exasperates the backlog wait for other veterans and survivors with pending claims. We have seen similar initiatives before such as the "Tiger Teams" at a centralized VA

Regional Office in Cleveland, OH to accommodate claims for veterans 70 years old or older.

Some of the pertinent causes for the historical backlog, in my humble professional opinion, are the following:

- As mentioned earlier, the VA disability compensation program is a very complex and cumbersome administrative adjudication process second to none.
- Federal laws and regulations (38 USC and 38 CFR respectively) and VA policies with precedent legal opinions have mandated that the claimant (the veteran or survivor) provide layers of evidential documentation and comply with multiple procedural requirements.
- In 1988, Congress passed the VA Judicial Review Act and with it came the advent of the federal U.S. Court of Veterans Appeals (COVA) in 1989. The Court is now called the Court of Appeals for Veterans Claims (CAVC). Although there have been positive landmark Court decisions which have benefited veterans, the passage of this act advanced the VA adjudication/administrative and rating process into a legal morass further complicating the administrative process for both VA employees and the claimant.
- Frequent new congressional mandates, which become law and must be implemented into regulations by VA, often create additional claim workload and appeals with no additional staff commensurate with the added responsibilities. A recent example is the Veterans Claims Assistance Act (VCAA).
- Dedicated VA employees at VBA have become enslaved to a multitude of computer software/data programs, often untested thoroughly in the field, and frequently being replaced by other systems. More time is being spent inputting data into multiple independent programs and less time adjudicating the claims.
- The VBA continues to receive an enormous amount of incomplete claims from veterans and other claimants which lack proper completion of VA forms, frequent non-clarification of issues and no supporting documentation with the claim. The VBA staff must now spend extra time sending duty to assist notices and multiple correspondence letters to claimants who have submitted these types of claims thus increasing the delay in processing other pending claims. In addition, the VA also receives occasional frivolous claims which have to be acted upon. These types of claims are often from veterans and other claimants who are not receiving advocacy and representation from VA accredited County Veteran Service Officers/Offices (CVSO's) or accredited Veteran Service Organization (VSO) representatives.

## Recommendation 2

- The VA disability compensation program must be revised and simplified.
- Request Congress to authorize additional full time employees (FTE) for claims examiner and rating specialist positions to deal with the perpetual high volume of new compensations claims, claims for increase, re-open claims and appeals.
- The VA Central Office software programs should be designed to enhance workload productivity and be thoroughly tested in the field prior to implementation.
- The VA Central Office staff should solicit, on a frequent basis, suggestions and ideas from field staff within VA Regional offices and from CVSO's and VSO's.
- OEF/OIF veterans and all veterans should be referred to their local CVSO for comprehensive benefits counseling on federal, state and local entitlements for veterans, their dependents and survivors. CVSO services also include claims/appeals development, preparation and submission. Also, case management is provided to track claims and to provide ongoing and future assistance as circumstances change.
- Encourage better coordination between DOD PEB/MEB staff and VBA staff to facilitate computer systems sharing and documentation sharing.

### III. VA Veterans Health Administration (VHA) Patient Overload!

The VA health care system and its employees, especially within VANCHCS, have a proven record of excellence in providing quality health care and research programs to veterans. In the past few years, national print and electronic media has documented and rated VA health care as one of the very best in our country. I would put the approval rate at 98% from testimony received from our veteran clients we serve in Contra Costa County.

However, with success comes increase demand for VA health care from new and ongoing veterans from World War II to present. This coupled with the new influx of OEF and OIF veterans has pushed the system to the brink, in my opinion. Moreover, there was an internal systemic cause for the inability of the VHA to expand its infrastructure sufficiently, add additional physicians, nurses, clinicians, technicians and support from 1996 to an infamous date January 16, 2003.

For the first time in VA health care history, the then Secretary of VA announced on "January 16, 2003" that effective after this date, "Veterans assigned to Priority Groups 8e or 8g are not eligible for enrollment as a result of the enrollment restriction which suspended enrolling new high-income veterans who apply for care after January 16, 2003."

In short, this means that any combat veteran from World War II, Korea, Vietnam, Gulf War and other conflicts who are assigned to Priority Group 8e or 8g and do

not qualify for any of the other priority groups will not be allowed access to VA health care until further notice. Frankly, this is outrageous.

One of the significant contributing factors for this policy change began in 1996 when the then Undersecretary of VHA went around the country encouraging "all" veterans to enroll in the VA health care system. The Undersecretary solicited support from stakeholders such as CVSO's and VSO's. We CVSO's for decades have encouraged and assisted veterans with VA health care enrollment.

I attended the 1996 California meeting in Sacramento with the Undersecretary and his entourage. After the impressive presentation, it was opened up for questions. When I was called upon I assured the Undersecretary that CVSO's have historically been promoting and encouraging veterans to enroll in VA health care. However, I mentioned to him that this national campaign, with all of the advertising being done, will in time overwhelm the VA health care system with new patients thus creating even more problems for patients with the delay in obtaining appointments with physicians, specialty clinics etc. The delay in obtaining medical appointments has been a major problem from the late 1990's to present although VHA has worked hard to address this issue. So I asked the simple question: Has VA requested from Congress the additional funds necessary for new community based outpatient clinics (CBOC's), hospitals, physicians, nurses, clinicians, technicians and support staff that will be required? No clear answer was provided at that time.

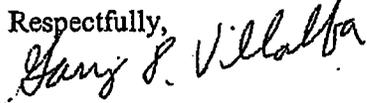
It is also important to note that from an advocacy perspective, the VHA is and will continue to deal with the aging veteran population who represent a significant number of current enrollees and future enrollees. This special group of veterans are experiencing or soon to experience geriatric issues such as dementia, alzheimer's, post-stroke recovery/rehabilitation, cardiac issues, neurological diseases (Parkinson's disease, ALS, MS, etc), dental just to name a few. VA emergency hospitalization, dental, long term care and nursing care eligibility criteria are very restrictive to most enrollees in the VA health care system. This is a problem we advocates in the field deal with on a daily basis.

### Recommendation 3

**VA Central Office VHA leadership should never again wage advertising campaigns to promote increased veteran enrollment without having conducted thorough research, analysis and demographic studies to ascertain required funding needed to meet the anticipated increased demand for health care. Then, VHA should proceed to work with Congress for securing proper funding.**

Again, thank you for the opportunity to discuss these three areas of concerns that not only impact OEF and OIF veterans but they impact all veterans who are receiving service and benefits from DOD, VA VBA and VHA.

Respectfully,



Gary D. Villalba  
Contra Costa County Veterans Service Officer

Cc:

Dr. Brian O'Neill, Director, VANCHCS  
Pritz K. Navara, Veterans Service Center Manager, VA Regional Office, Oakland (VBA)  
John Cullen, County Administrator

**Executive Summary Of Presentation Made By Dr. Brian O'Neill to  
Congresspersons Miller and Tauscher at the Martinez campus of the VA Northern  
CA Health Care System (NCHCS)**

The topic of the presentation was how VA is responding to the influx of returning active duty service men and women and veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).

**I Demographics:** Of the 631,174 OIF and OEF veterans who have left active duty and become eligible for VA health care since fiscal year (FY) 2002, 46% are former active duty troops and 54% are reserve and national guard (as of November 2006). This compares to the approximately 1.4 million troops who have served in the two theaters of operation since the beginning of the conflicts in Iraq and Afghanistan (the difference represents those who remain active duty). Of those 631,174 discharged, 205,097 (32%) separated veterans have sought VA health care since 2002. Of these, 97% have been seen as outpatients and 3% have been hospitalized at least once in a VA hospital.

The figures for the VA NCHCS parallel these demographics. We have seen approximately 2000 total OEF/OIF veterans, of which seven are considered seriously injured (includes one triple amputee, one double amputee, and one single amputee). At the Regional Referral VA at Palo Alto, the number of seriously injured veterans is much higher. For NCHCS, the OEF/OIF veterans comprise 3.3% of our current total workload (the figure is about 4% nationally).

From the data above we know that nationally 32% of veterans who have left active duty have accessed VA health care. We can expect the numbers to increase over time due to recognition of new medical problems, outreach, and the DoD Post-Deployment Health Reassessment Program, which is discussed below. Moreover, there are about 800,000 active duty service men and women who have not yet been discharged and currently access care through DoD. These service men and women will be discharged one day and will be expected to access VA care. Thus we expect higher future utilization and are planning in accordance with this.

**II. Seamless Transition:** Veterans Health Administration (VHA) has established a national program, the "Transition Assistance and Case Management Program" for OEF/OIF veterans. The program is designed to ensure a seamless transition process, coordinating services and VHA case management of OEF/OIF veterans and service members.

VHA has assigned social workers to serve as Liaisons at the ten major Military Treatment Facilities (MTF). The VA Liaisons provide information to service members and families about VA health care services and facilities. They assist MTF staff to transfer the care of injured/ill OEF/OIF service members to VA health care facilities. In addition, they make a "warm hand-off" to the OEF/OIF Program Manager at the receiving VA medical center.

Each VA medical center appoints a nurse or social worker as OEF/OIF Program Manager. The OEF/OIF Program Manager is the link to the VA Liaison at the military hospital for transfers and: 1. arranges for inpatient beds; 2. schedules outpatient appointments; and 3. arranges for home equipment. Moreover, the OEF/OIF Program Manager will: 1. serve as the OEF/OIF primary point of contact for the service members and veterans; 2. coordinate all services provided to OEF/OIF service members and veterans; 3. oversee facility seamless transition activities, including post-deployment health reassessment activities; and 4., oversee outreach to OEF/OIF veterans, including Guard and Reserve members.

The OEF/OIF Program manager will: 1. screen all OEF/OIF veterans treated at the facility for case management needs; 2. assign case managers for all severely injured/ill and others who need/want one; and 3. oversee case management services including nurse and social worker OEF/OIF case managers; blind veteran coordinators and spinal cord injury coordinators; polytrauma case managers; and women veterans program managers. They also coordinate closely with Veterans Benefits Administration (VBA) Regional Office to track benefits claims of OEF/OIF service members and veterans.

The VA NCHCS OEF/OIF Program Manager is a social worker, Joanne Pinotti. In addition, a second social worker is currently being recruited to do case management and outreach. This will provide one dedicated social worker in each division whose sole responsibility relates to OEF/OIF veterans and service members. They are augmented by the approximately 15 additional social workers who are employed at the NCHCS. In the six months covering October 2006 through the end of march 2007, the NCHCS OEF/OIF Program Manager has attended 19 different outreach forums/activities.

In a new effort to further ensure seamless transition, VHA is hiring 100 Transition Patient Advocates nationally to serve as ombudsmen for severely-injured or ill OEF/OIF service members and veterans across episodes and sites of care. They will help to resolve problems and address concerns of patients and families.

**III. Post-Deployment Health Reassessment:** VA NCHCS participates fully in the DoD Post-Deployment Health Reassessment (PDHRA) Program for returning deployed service members. The PDHRA offers education, screening, and a global health assessment for all service members in the period of 90-180 days post-deployment. Our Combat Veteran Case Manager provides education on enrollment and VA benefits. At larger events, we often have Business Office staff in attendance to assist with enrollment forms and to expedite registration and appointments. VA NCHCS is currently involved in 2-3 PDHRA events per month which cover from one to three days and serve anywhere from 30-200 attendees. All OEF/OIF veterans who seek care are screened to ensure that they have participated in the PDHRA Program. We monitor our screening success rate, and we exceeded the national target of 90% with a first quarter score of 95.2%, the second highest in the country.

New OEF/OIF veterans at NCHCS are often welcomed personally on their first visit and escorted to their appointments. Support staff are trained to welcome these veterans warmly and to thank them for their service.

The VA NCHCS Intranet has a link to our internal OEF/OIF site which provides the contact names and phone numbers of key staff in the program. The site also provides links to policies, directives, and other resources along with a Message From The Director which sets forth the VA NCHCS' mission to care for combat veterans and to provide them with priority treatment.

We are monitored twice monthly on any OEF/OIF veterans who have inadvertently been placed on the electronic wait list, or given appointments beyond thirty days (unless at their request). We take immediate action to correct any errors.

**IV. Mental Health Funding:** VA Central Office has provided approximately \$100 million in the last year to address mental health needs of all veterans, with an emphasis on OEF/OIF veterans. OEF/OIF veterans are at high risk for Post-Traumatic Stress Disorder (PTSD), mental health disorders including depression and suicide, and substance and alcohol use disorders. All returning OEF/OIF veterans who present are screened for the above disorders, and we are monitored on how successful our screening program is. Patients who screen positive are referred for continuing care. In the last two years NCHCS has received approximately 37 new dedicated positions to hire psychiatrists, psychologists, social workers, nurses, and other specialized mental health workers. Some of these positions have been filled, and some are currently being recruited. The specific programs that they support within the NCHCS include PTSD, alcohol and substance treatment, general mental health treatment, suicide prevention, and "mental health intensive care management" (in this program our mental health team treats chronic mentally ill patients within their homes).

**V. Polytrauma System of Care:** VHA has established an integrated Polytrauma System of Care (PSC) to ensure the provision of care for complex and severe combat injuries, in accordance with Public Laws 108-447 and 108-422. The system consists of four components: 1. four regional Polytrauma Rehabilitation Centers (PRC) (including one locally at Palo Alto); 2. twenty-one Polytrauma Network Sites (PNS), of which our network program is also located at Palo Alto; 3. local Polytrauma Support Clinic Teams (PSCT) (the VA NCHCS has been so designated); and 4. Polytrauma Points of Contact (POC). This new generation of veterans may require lifelong management and follow-up for their injury related sequelae as well as general health care maintenance and prevention. A tiered system of care will provide access to specialty care as close to home as possible as well as establish a cost-effective infrastructure.

VA NCHCS is currently establishing our Polytrauma Support Clinic Team (PSCT). The PSCT will provide primary care, basic specialty and consultative services. The team will be responsible for managing patients with a stable treatment plan, providing regular follow-up visits, and responding to new problems that may emerge. The PSCT will consult with Palo Alto concerning issues outside our area of expertise.

Our PSCT will provide specialized care for veterans with traumatic brain injury, traumatic amputation and other polytraumatic conditions. The types of specialists that we will be recruiting to provide this care includes neuropsychologists, psychiatrists, neurologists, physical medicine and rehabilitation physicians, social workers, orthopedists, occupational therapists, physical therapists, social workers/case managers and speech language pathologists. These additional positions are not currently funded so we are proceeding with recruitment out of our current operating budget.

**VI. Traumatic Brain Injury (TBI) in OEF/OIF Veterans: Screening and Evaluation in the VA:** There has been a belated recognition that TBI has often gone unrecognized, resulting in untreated medical conditions, disruption to families, relationships and jobs, and failure to award compensation benefits where due. To catch up for this deficiency, VA has published a TBI Information letter from the Under-Secretary in January 2006; developed a TBI course as part of its Veterans Health Initiative education program; mandated training for all VA clinicians who may care for TBI patients (by March of 2007) which was completed by 47,000 VA staff.

In 2006 a decision was made to implement screening for all OEF/OIF veterans for possible TBI. A multidisciplinary team of national experts developed the screening tool as well as a "clinical reminder", an informatics tool which is part of the integrated VA Electronic Medical Record. This tool automatically identifies patients who need screening and presents questions to the provider. A positive result automatically leads to consults for further evaluation. The system collects data in electronic medical records allowing national roll up and analysis. Reports can be generated identifying patients who still need to be screened.

When a patient screens positive he or she is referred to a special TBI clinic where an extensive evaluation occurs using a battery of detailed neurocognitive tests. If upon further evaluation a diagnosis of TBI is established, the patient is referred for continuous care, including education of patient and family, occupational therapy, etc. The patient is also then assisted in the application process for benefits through Veterans Benefits Administration (VBA).

At the VA NCHCS, evaluation for TBI occurs via our Polytrauma Support Clinic Team (PSCT), as described above. Screening and referral has already begun, and we expect soon to have data on the frequency with which patients are diagnosed with TBI.