Legislative Task Force on Veterans' Reintegration

Minutes

December 3, 2009

Participants

Sen. Martha Schrader – Co-Chair
Mike Burton – Co-Chair
Rep. Greg Matthews
Marge Reinhart
Barry Vertner
Margaret McDowell
Paula Brown
Jack Heims
Elanna Schlichting
Tootie Smith
Joby Reiley
Michelle Kochosky
SFC Phil Maas
JD Baucham
Michael Fisher
Bill Murry
Amy Guffy
Victoria Kohler
Rob Tell
Eileen Devine
David Greaves
GiGi Harris
Fritz Graham
Jim Sardo
Scott McCrae
Elan Lambert

A video conference between the Portland VA Medical Center and the Salem Community Based Outpatient Clinic began at 9 a.m. Introductions were made and Dr. Michael Fisher, Acting Director of the Portland VA Medical Center and Associate Director of the VISN, welcomed the participants to the VA facilities.

Jack Heims explained that the agenda for the Task Force meeting was to examine veteran Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), Homelessness and Suicide. Heims introduced Dr. Jim Sardo who began a presentation on Post Traumatic Stress Disorder.

Dr. Sardo noted that after eight years of war, the symptomology and conditions associated with PTSD are widely known, so he was going to focus on how to collaborate for treatment. According to Dr. Sardo, 37 percent of returning Operation Enduring

Freedom/Operation Iraqi Freedom veterans have a mental health diagnosis. Of that number, 25 percent are diagnosed with PTSD, 17 percent are diagnosed with depression and surprisingly, substance abuse among this group is low and below the national average for these conditions. Dr. Sardo believes this disparency may be due to issues related to the data collection process.

Dr. Sardo noted that the Portland VA Medical Center catchment area has about 63,000 enrolled veterans and between 10,000 and 12,000 receive mental health, while 1,000 receive substance abuse treatment and 1,000 are seen in the PTSD clinic.

The VA has implemented an evidence-based treatment system, according to Dr. Sardo. This treatment system is individually based instead of group based, which takes more time and resources.

Dr. Sardo explained that the VA believes in a “single front door” to reduce the number of people a veteran has to speak with to get help. The first question a veteran is asked is if they want a primary care provider. All veterans in the VA system are routinely screened for PTSD, Depression, Suicide and TBI. If a veteran screens positive for any of these, the veteran is moved to the appropriate clinic. In the case of PTSD, Depression and Suicide, the veteran moved to a mental health clinic where they are assed within 24 hours of the referral and are seen in by a clinician within 14 days.

There is a four-step process Dr. Sardo outlined:

1. Provide the veteran a diagnostic assessment
2. Move to evidence-based treatment plan
3. Re-assess veteran to determine if treatment plan is successful and determine if the veteran should be managed next by the PCP, Mental Health Generalist or someone else.
4. (Dr. Sardo did not elaborate on this step)

There are times when the veteran exhibits multiple issues, such as PTSD and substance abuse. Sometimes the veteran must be treated for the substance abuse before the PTSD treatment can be administered. Other times, the veteran needs in-patient PTSD counseling before substance abuse can be addressed. One of the new issues Dr. Sardo is facing is veterans who are opiate dependent and have chronic pain and PTSD. Dr. Sardo said a new clinic is opening up (Sabaxo Clinic) to wean these veterans off the opiates so their mental health issues can be addressed.

Joby Reiley asked Dr. Sardo to clarify who the 37 percent of veterans who have been diagnosed with mental health issues. Dr. Sardo said this group is the percentage of OIF/OEF veterans who have sought VA health care.

Mike Burton asked if there were statistics on the opiate-dependent veterans. Dr. Sardo indicated not at this time, but he did say more and more veterans are being asked to reduce their consumption of opiates.

Chair Burton asked Dr. Sardo if there were anything the Task Force could do for him, what would it be? Dr. Sardo responded that he would like to see continued efforts of cooperation, as well as increase and enhance post-deployment assessment and he supports keeping the returning National Guard on active-duty orders as per the 90-Day Soft Landing bill currently before Congress.

Dr. Sardo continued with a few more thoughts. First, he noted that when veterans are completely done with the military they are more likely to use VA medical services than when they still are in the Guard or Reserves, because Guardsmen and Reserves still fear career implication of seeking mental health.

Civilian doctors are being asked to provide the military with readiness assessments of their soldier patients, according to Dr. Sardo. To help with this, Dr. Sardo would like to see the Army and Air Guard provide clear guidance and training to civilian doctors as to how to make such a readiness/fitness assessment.

When asked if his staffing levels were sufficient, Dr. Sardo and Dr. David Greaves noted that in the past eight years since the beginning of the war, only one clinician was added to the PTSD team and that person's funding dictates that the person work with substance abuse, so in effect, there has been no growth in the program while the number of veterans seeking service has increased significantly. Dr. Greaves continued to explain that there is money coming into the VA; however, the money has strings attached that do not allow the flexibility to apply the money where it is needed within the program. Dr. Greaves further explained that on the national front homelessness and substance abuse, as well as TBI, are the hot topics and PTSD is not getting as much focus. Dr. Sardo expanded by saying that those VA facilities without a PTSD team were funded to create one, but existing teams, such as the one at the Portland VAMC, did not receive enhanced funding to meet the demand.

JD Baucham said one concern he has is that private-sector clinicians approved to take Fee Basis patients are not being reimbursed in a timely manner, which will result in even less access for veterans when these clinicians no longer take VA patients due to the delay. He would like the VA to work on this.

Heims next introduce Victoria Kohler who is the Portland VAMC's OEF/OIF Coordinator.

Kohler began by outlining the program, which has been in existence for about 2 ½ years. She explained that OEF/OIF veterans medical issues are:

1. Muscle-Skeletal
2. Mental Health
3. Ill-Defined Medical Conditions
4. Hearing Loss
5. Dental

Of these veterans, 60 percent have both physical and mental health issues. Every OEF/OIF veteran who enrolls in VA health care sees a physician, a psychologist and a counselor. Kohler said that the Portland VA sees 6,200 OEF/OIF veterans, but her program engages only about 20 percent.

Kohler explained that her program also is very engaged with the 300 Oregon veterans who had chemical exposure while in Iraq and that she will be going to Ft. Lewis to meet returning soldiers from the Oregon Guard 41st Infantry Combat Team. Soldiers will be mandated to meet with her as part of their demobilization.

Sen. Martha Schrader asked how Kohler's program deals with family members of OEF/OIF veterans. Kohler explained that there is a family support group and she attends family outreach events, such as an upcoming Yellow Ribbon event. Michelle Kochosky joined the conversation and explained her role as the National Guard's Family Support Coordinator, noting she has 20 employees and hundreds of volunteers that engage family not only while the soldier is deployed, but for as long as two years after deployment.

As the discussion dissipated, Heims introduced Eileen Devine who would present on veterans homelessness.

Devine reminded the Task Force that VA Secretary Shinseki has made a pledge to end veteran homelessness in five years. To that end, the VA has increased funding of its homelessness program by 23 percent and has provided 10,000 more housing vouchers throughout the country. The VA has implemented a "No Wrong Door" approach to serving homeless veterans so that no matter how such a veteran engages the VA system, they can be served. Devine said that veterans who contact the VA receive a return call within 24 hours – she also noted that a lot of homeless veterans actually have cell phones, which seems strange but is true. Devine talked about the need to be persistent, especially with chronic, long-term homeless veterans and to keep visiting the homeless camps. To date, no money has been assigned to Oregon.

During the last one-night count in Multnomah County, 12 percent of the homeless self-identified as veterans.

Devine then explained the HUD/VASH (Housing and Urban Development/VA Supported Housing) voucher program. In partnership with Section 8 housing, VA provide vouchers worth about $600 to housing authorities to provide housing for homeless veterans. This amount covers the monthly rent. Currently, there are 105 vouchers for Portland and another 70 in Vancouver. The voucher stays with the veterans so if they move to another Section 8 location, they still are paid for. The one glitch in the system is the voucher does not pay for first and last months rent and deposits. To bridge that gap, VA has sought to partner with another group who has provided grants for that purpose. Another issue is it takes a homeless veteran up to 90 days to secure a Section 8 apartment, during which time the veteran still is homeless even with the approved voucher. However, the voucher can be used for families, and currently Portland has 98 vouchers issued affecting 40 children of veterans.

Chair Schrader asked about rural areas, such as Estacada and John Day. Devine explained that the voucher could be used there, but there is an issue of capacity in these area. In other words, is there enough Section 8 housing to accommodate the need in the rural areas?

Devine then explained the VA's Grant Per Diem program, which provides funding for transitional housing. Currently, Oregon has 168 transitional housing beds, which are then funded via contract with the VA. The Grant Per Diem is approximately $30 a day per bed. This program is not based on need, but instead based on a competitive grant writing process.

Once all questions were answered, Heims introduced Rob Tell who is the Portland VA Medical Center's Suicide Prevention Coordinator.

Tell explained that every VA medical center has a suicide prevention coordinator. He said that the number one risk factor for veteran suicide is depression, which is five times the risk as other factors. The next risk is TBI, which is 50 percent more of a risk than other factors. Tell said that some are surprised that PTSD is not in and of itself the highest risk factor.

Of veteran suicides, only 20 percent were engaged with the VA, according to Tell. He explained that most veterans will not come to the VA.

Heims interrupted Tell and had David Greaves give a presentation on TBI due to some participants who had to leave shortly.

Greaves explained that 1 in 5 returning veterans have at least mild TBI. At Walter Reed Hospital, 40 percent have TBI. The Portland VA has opened a poly-trauma clinic to deal with TBI, Greaves said, but he noted that the severe cases are sent to Palo Alto, the less severe to Seattle and then the next less severe to Portland. This is the system that the VA has established.

Greaves also noted that veterans are given a four-part assessment for TBI and if they screen positive they are sent to a post-deployment clinic for follow up.

Scott McCrae noted he is concerned that we are missing many cases of TBI, because soldiers will not self-identify during demobilization, because it often means being taken out of line and being put on medical hold instead of going home.

There was some further discussion on TBI and then Tell continued with his suicide prevention overview.

Tell outlined the suicide hotline number (800-273-TALK) and said that 1 of 5 VA medical centers are engaged in a program called Safe Vet, which links VA medical centers to local community emergency rooms. Tell explained that often people

threatening suicide are brought to the local hospital emergency room. Many suicidal veterans have a number of trips to the emergency room. Safe Vet partners with these emergency rooms by call the VA when they have a veteran and a VA practitioner will go the emergency room to engage the veteran. After hours and on weekends, the emergency room can contact the suicide hotline. Safe Vet is a two-year program that was funded via grant. On a side note, Tell said that the state law currently is being interpreted to prohibit a law enforcement officer to take a veteran anywhere but their local ER. Heims said that problem is being addressed by the legislature.

A second grant VA received is for rural health and provide daily follow up phone interviews with veteran patients who need more management of their situation. This grant also pays for a two-year program.

Heims then made the Task Force aware of an educational video that is intended for health care providers outside of the VA system to educate them on resources at the VA. The video is almost complete and just needs a short segment by the Governor.

The Task Force completed its overview for the meeting and decided that it would meet again during the first week of January 2010. The Chairs and staff will arrange a day and then will communicate that with the Task Force.

The meeting adjourned at 11:05 a.m.