

HEALING THE PHYSICAL INJURIES OF WAR

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

—————
JULY 22, 2010
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Serial No. 111-93
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Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

58-060

WASHINGTON : 2011

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HEALING THE PHYSICAL INJURIES OF WAR

THURSDAY, JULY 22, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:59 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Donnelly, McNerney, Halvorson, Perriello, Brown of South Carolina, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I will call the Subcommittee on Health to order, and I would like to thank everyone for coming this morning.

The purpose of today's hearing is to explore how we can best serve our veterans who have sustained severe physical wounds from the wars in Iraq and Afghanistan.

Today we will closely examine the U.S. Department of Veterans Affairs' (VA's) specialized service for the severely injured, which include blind rehabilitation, spinal cord injury (SCI) centers, poly-trauma centers, and prosthetic and sensory aids services.

With advances in protective body armor and combat medicine, our servicemembers are surviving war wounds which otherwise would have resulted in casualties. Many servicemembers who are severely injured in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) will require sophisticated, comprehensive, and often lifelong care.

We know that the blast injuries from improvised explosive devices (IEDs) are the most common cause of injuries and death among our OEF/OIF servicemembers. Blast injuries often include combinations of traumatic brain injury (TBI), blindness, spinal cord injuries, burns, and damage to the limbs, which results in amputations.

Today, we will examine whether VA is meeting the needs of our severely injured, and whether the veterans have access to the most current therapies for treating their physical war injuries. We will identify what VA is doing well and what areas they need improvement in. We will also explore how VA ensures that the quality of care is consistent and standardized across the VA health care system so that veterans receive the same high quality care regardless of which VA facility they visit. Finally, we will review VA's current efforts to coordinate specialized services for the severely injured

with the U.S. Department of Defense (DoD) and how we can achieve improved coordination between the two Departments.

I look forward to hearing the panels this morning, and I would turn it over to my good friend Ranking Member Mr. Brown for any opening statement he may have.

[The prepared statement of Chairman Michaud appears on p. 35.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN. Thank you, Mr. Chairman, and good morning all.

Yesterday we reached a milestone. It was 80 years ago on July the 21st, 1930, that President Herbert Hoover first established what we now know as the Department of Veterans Affairs. Since that day, VA has endeavored to fulfill their mission to care for those who have borne the battle and for those who return carrying the very worst wounds of war, including spinal cord injury, traumatic brain injury, amputations, and blindness.

The VA has developed specialized services to meet the unique rehabilitative needs of our veteran population. Providing these types of services to our very highest priority veterans is the backbone of the Department.

Since 1996, Congress has mandated that the VA maintain capacity for these specialized rehabilitative services, and in 2004, Congress enacted legislation to provide comprehensive services for severely injured servicemembers suffering with complex injuries resulting from blast injuries. This came to be called VA's Polytrauma System of Care.

More than 2.1 million servicemembers have been deployed since October 2001. As of April the 3rd, 1,552 had suffered amputations in Iraq or Afghanistan. Countless others have suffered TBI, SCI, eye trauma, hearing loss, or other severe combat wounds.

These young heroes are going to require a lifetime of rehabilitation and highly skilled medical services and support. They have risked life and limb in our name, and in return, it is our responsibility to provide them with the care they require and so dearly deserve.

As the battles in Iraq and Afghanistan persist, the specialized caregiver in VA medical, polytrauma, spinal cord injury, and blind rehabilitation centers continue to take on increasing importance.

We must diligently prioritize investments in specialized services, medical research, and recruitment to have all the tools necessary to provide all veterans, and especially our most severely wounded veterans, with an active and full life characterized by independence, functionality, and achievement.

I am grateful to our panelists and audience members for being here this morning, and I yield back.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Brown appears on p. 35.]

Mr. MICHAUD. Thank you very much, Mr. Brown.

I would like to call the first panel forward, and while they are coming forward I will introduce them. We first have Dr. Thomas Zampieri who represents the Blinded Veterans Association (BVA), Carl Blake, of the Paralyzed Veterans of America (PVA), Joy Ilem, from the Disabled American Veterans (DAV), Tom Tarantino who

is with Iraq and Afghanistan Veterans of America (IAVA), and Denise Williams who is from the American Legion.

I want to thank all of you for coming this morning and look forward to hearing your testimony today. We will start with Dr. Zampieri.

STATEMENTS OF THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; TOM TARANTINO, LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND DENISE A. WILLIAMS, ASSISTANT DIRECTOR OF HEALTH POLICY, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

STATEMENT OF THOMAS ZAMPIERI, PH.D.

Dr. ZAMPIERI. Mr. Chairman, Members of the Subcommittee, the Blinded Veterans Association appreciates this opportunity to present our testimony today, and I appreciate that the Committee is taking a look at the specialized programs in regards to the returning servicemembers with a variety of injuries.

I also appreciate the fact that that you highlighted that oftentimes in this town we don't hear a lot about the other injuries. Most of the research papers and scientific papers on these types of wounded coming back clearly demonstrate that they all have multiple injuries. It is rare you ever just have somebody that comes back with just quote "TBI." They have a variety of injuries. Burns, fractures, amputations, psychosocial problems associated with the multi-trauma that they have sustained, and so it is just good that this is being done today.

The VA, I want to start off on some good news, you know, the blind rehab service has expanded services throughout the system. Ironically back in 2004, they developed the plans for a continuum of care based on the idea that the aging population of veterans would need a lot of low-vision and blind rehabilitative services. Little, I think did they realize back then, that the plans that they were making to expand services would suddenly be immediately useful for the returning servicemembers with eye trauma and traumatic brain injuries with vision impairments associated with the TBIs.

And so what we have is now the VA has expanded, they have had ten in-patient blind centers, which offer comprehensive rehabilitative services for those with blindness, but they also have all the specialized staff in those centers such as consultants with the general surgeons, neurologists, psychiatrists, pharmacologists, occupational therapists, physical therapists, speech pathologists. The list goes on and on.

So those individuals referred into the ten blind centers get, I think, excellent care, but the VA has also expanded and they now have 55 sites where they have either low vision specialists or advanced blind rehabilitative centers, and those centers have specialized staff. They have actually hired about 250 staff, including about

60 low-vision optometrists, and they are screening these patients with vision problems and visual impairments. And so that is the good news.

I want to compliment the Chairman, because actually the number of blind rehabilitative outpatient specialists (BROS) that you helped sponsor and Congressman Brown helped support, doubled the number of blind rehab specialists that were in the system. Again, it is just good timing. So we went from about 25 blind rehabilitation specialists to 75 in the system. They are at all of the VA polytrauma centers. And so that is the good news this morning I guess.

The other thing that I want to touch on is there is a problem. The BROS that are assigned to the military treatment facilities have a problem in getting credentialed and privileged. It is something that has been worked on by the VA and they have had meetings with DoD representatives, but the problem is DoD has never had the credential or privilege. Anyone who is a BROS, an orientation mobility specialist, who has a master's degree, that category of occupation doesn't exist and it is been a problem, because the BROS are unable to actually do the training inside the military treatment centers, even though they can visit the patients, explain the training that they need, they are restricted, and that is an issue that I wanted to include in my testimony today.

Last, I want to talk about—there is problems, though, with the Vision Centers of Excellence. It is been slow to get it started to say the least. It is been slow in getting the staffing. It is been difficult to get any accurate budgets in the last couple years. Budget requests that come over from the Pentagon rarely have included any special request for funding, even though it has been identified as an area where there is a shortage of funding. It has taken a long time to get the staffing for the Vision Centers of Excellence, and also the electronic registry, which is important for tracking all of the eye injured has been not operational yet. The VA Information Technology (IT) Department and Department of Defense IT people have done a lot of work on the registry, but again, I hear stories about problems with finding the funding for the registry.

With that I will try to end this by thanking you again for having this hearing, and be glad to answer any questions you have on my testimony that I have submitted.

Thank you.

[The prepared statement of Dr. Zampieri appears on p. 36.]

Mr. MICHAUD. Thank you very much, Doctor.

Mr. Blake.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you Chairman Michaud and Members of the Subcommittee, on behalf of Paralyzed Veterans of America I would like to thank you for the opportunity to be here today to present our views on how the Department of Veterans Affairs is doing in caring for severely injured veterans, including Operation Enduring Freedom and Operation Iraqi Freedom veterans.

My comments will be limited primarily to veterans who have incurred spinal cord injury or dysfunction while on active duty.

It is important to emphasize that specialized services are part of the core mission and responsibility of the VA. For a long time, this has included spinal cord injury care, blinded rehabilitation, treatment for mental health conditions, including post-traumatic stress disorder, and similar conditions. Today, traumatic brain injury and polytrauma injuries are new areas that the VA has had to focus its attention on as part of their specialized care programs.

The VA's specialized services are incomparable resources that often cannot be duplicated in the private sector.

For PVA there is an ongoing issue that has not received a great deal of focus. Some active-duty soldiers with a new spinal cord injury or dysfunction are being transferred directly to civilian hospitals in the community and bypassing the VA health care system. This is particularly true of newly injured servicemembers who incur their spinal cord injury in places other than the combat theaters of Iraq and Afghanistan. This violates the Memorandum of Agreement between the VA and DoD that was effective January 1, 2007, requiring that care management services will be provided by the Military Medical Support Office, the appropriate Military Treatment Facility, and the admitting VA Medical Center as a joint collaboration, and that whenever possible the VA health care facility closest to the active-duty member's home of record should be contacted first.

In addition, it requires that to ensure optimal care, active-duty patients are to go directly to a VA medical facility without passing through a transit military hospital, clearly indicating the critical nature of rapidly integrating these veterans into an SCI health care system.

This is not happening. For example, PVA found that some servicemembers who incurred a spinal cord injury while serving in Afghanistan and Iraq were being transferred to Sheppard Spinal Center, a private facility located in Atlanta, when VA facilities are available in Augusta. When we raised our concerns with the VA regarding Augusta in a recent site visit report, the VA responded by conducting an information meeting at Sheppard to present information and increase referrals. However, reactionary measures such as this should not be the standard for addressing these types of concerns.

Of additional concern to PVA it was reported that some of these newly injured soldiers receiving treatment in private facilities are being discharged to community nursing homes after a period of time in these private rehabilitation facilities. In fact, some of these men and women have received sub-optimal rehabilitation and some are being discharged without proper equipment.

PVA is greatly concerned with this type of process and treatment. There is a serious need to reinforce compliance by DoD regarding the Memorandum of Agreement toward the treatment of soldiers with new spinal cord injury and disease (SCI/D) at VA SCI centers.

Ensuring that these men and women gain quick access to VA care in spinal cord injury centers is critically important because it begins what will become a lifelong treatment process.

SCI/D care in the VA is unique from private care for spinal cord injury rehabilitation because of the care coordination that the veteran receives for the remainder of his or her life.

We ask that the Subcommittee work with your colleagues of the House Committee on Armed Services to ensure that our SCI/D veterans are getting the complete, proper, and appropriate care they have earned and deserve.

PVA also remains concerned that the VA must maintain its capacity for the provision of SCI/D care as mandated by Public Law 104–262, the Veterans Health Care Eligibility Reform Act of 1996. This law required the VA to maintain its capacity to provide for the special treatment and rehabilitative needs of veterans with spinal cord injury, blindness, amputations, and mental illness.

The baseline of capacity for spinal cord injury was established based on the number of staffed beds and the number of full-time equivalent employees assigned to provide care on the date of enactment of the law.

Unfortunately, the single biggest accountability measure, an annual capacity reporting requirement, expired in April 2004. This allows the VA to make changes to its SCI/D capacity in a less than transparent manner.

In accordance with the recommendations of *The Independent Budget* for fiscal year 2011, PVA calls on this Subcommittee to approve legislation to reinstate this vitally important reporting requirement.

Lastly, Mr. Chairman, the SCI/D programs of the VA face a common challenge with the larger health care system, a shortage of qualified nurse staffing. In order to meet this challenge head on, some SCI centers in the VA have offered recruitment and retention bonuses to enhance their nurse staffs, unfortunately, this is not a uniform national policy and these actions are subject to the budget decisions of local VA medical center and Veterans Integrated Service Network directors.

In accordance with recommendations of *The Independent Budget*, we believe it is time for the Veterans Health Administration (VHA) to centralize policies and funding for systemwide recruitment and retention of SCI nurse staffing.

Additionally, we believe Congress should establish a specialty pay provision for nurses working in the SCI service, and should consider extending similar provisions to the other VA specialized services.

Once again, Mr. Chairman, Ranking Member Brown, I would like to thank you for the opportunity to testify. I would be happy to answer any questions that you or the Members of the Subcommittee might have.

Thank you.

[The prepared statement of Mr. Blake appears on p. 40.]

Mr. MICHAUD. Thank you very much.

Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you. Mr. Chairman and Members of the Subcommittee, thank you for inviting DAV to testify at this important hearing about VA specialty rehabilitation services for severely in-

jured Iraq and Afghanistan war veterans. My remarks are focused on VA's polytrauma and traumatic brain injury system of care.

According to VA, over the past 7 years, a total of 1,792 in-patients with severe injuries have been treated at VA's Polytrauma Rehabilitation Centers, also known as PRCs.

Early on in the wars, VA received little information about the treatment that wounded servicemembers had received before arriving at a VA facility; however, in late 2009, a team of VA polytrauma specialists visited the Landstuhl Army Medical Center in Germany to establish a regular information exchange on these transfer cases between the military and VA PRCs.

We are pleased with this relatively new development and believe it has begun to address the gaps in care that were clearly evident early on in the wars.

Recently, DAV's National Commander visited the Tampa VA PRC. He met with injured patients and families and received very positive feedback about the level and coordination of care provided, and the high regard these families held for the dedicated VA and DoD staff.

Also in preparing for this hearing, I had the opportunity to interview with a father of a severely brain injured servicemember now at the Tampa PRC. I was very pleased to learn that from the date of his son's injury to present, the communication and care coordination provided between DoD and VA in his opinion was seamless.

We acknowledge and commend the report of improved collaboration between the Departments, and we value the dedicated staffs that created and sustained this critical system to better coordinate and optimize care for the severely injured.

According to the Institute of Medicine (IOM), VA has established a comprehensive system for polytrauma and severe TBI care for acute and chronic needs that arise in the initial months and years post injury, but IOM also reported that protocols and programs to manage the lifetime effects of these conditions are not in place and have not been fully studied.

In this connection, DAV is aware of an extraordinary proposal called the Heroes Ranch. We understand that property is available for a proposed Tampa area facility to service a VA post-acute long-term residential brain injury model for the most severely injured.

According to the proposal, a three-tiered program would include post-acute long-term care for patients in a vegetative state or a state of emerging consciousness, subacute residential rehabilitation in a safe environment to treat patients with neurobehavioral deficits, and an outpatient day rehabilitation services program, a specialized form of adult day health care.

We understand this proposal is pending within VA, however, we are not clear if it has been approved or funded, therefore, we ask the Subcommittee to inquire about the status of this unique initiative.

For the severely impaired, in many cases, VA may need to provide permanent living arrangements in an age appropriate therapeutic environment, thus we are very pleased to see at least one PRC is planning for these unique facilities and we urge VA to move forward in establishing this type residential rehab model.

As highlighted in prior hearings, DAV also remains concerned about the problems that exist in the Federal Recovery Coordinator Program in social work case management system that are initial to coordinating complex components of care for polytrauma patients and their families. We believe these issues warrant continued oversight and evaluation by the Subcommittee.

Mr. Chairman, although not defined in the severely injured category, we would like to bring to the Subcommittee's attention our concerns about treatment and care for veterans with mild to moderate TBI residuals.

Multiple sources indicate that in the near future VA will likely be confronted with a significant OEF/OIF injured population with these problems. We believe VA level two PRC sites may struggle to provide the specialized or individualized interdisciplinary care and support this particular population will need.

We ask the Subcommittee to provide oversight to ensure sufficient resources and staff are available for VA to also accomplish this mission.

Additionally, VA TBI specialists with whom we have consulted believe a new specialized dual track program is necessary to meet the individualized needs of veterans with mild to moderate TBI residuals accompanied by post-traumatic stress disorder.

Mr. Chairman, for these reasons we hope VA will now turn its attention to the needs of thousands of veterans with less life threatening, but still troubling brain injuries, caused by war that are little understood but in need of significant attention.

Mr. Chairman, this concludes my statement and I will be able to take any questions you may have.

Thank you.

[The prepared statement of Ms. Ilem appears on p. 42.]

Mr. MICHAUD. Thank you very much.

Mr. Tarantino.

STATEMENT OF TOM TARANTINO

Mr. TARANTINO. Thank you, Mr. Chairman, Ranking Member, and Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America's 190,000 members and supporters, I would like to thank you for allowing us to testify before the Subcommittee.

My name is Tom Tarantino and I am a Legislative Associate with IAVA. I proudly served in the Army for 10 years, and during these 10 years, my most significant and important duty was to take care of other soldiers. In the military, they teach us to have each other's backs. And although my uniform is now a suit and tie, I am proud to work with Congress to continue to have the backs now and in the future.

Over the past few years, the Committee has secured impressive improvements to the VA health care system. IAVA applauds the work this Committee has done and will continue to do in the months and years to come.

Now we have asked our members what they thought of treatment they are receiving at the VA and we received a wide range of opinions, both complimentary and critical. However, several common themes appeared. Long waits for appointments, frequent

interaction with rude administrative staff, a growing distrust of VA health care, and long drives to VA facilities. Fortunately, we received very few complaints about the actual quality of care at VA medical centers. But in addition to the concerns listed above, our members have expressed concern with how the VA deals with traumatic brain injury.

To properly treat returning combat veterans with mild to severe TBI, the VA must completely rethink and adapt their medical rehabilitation practices. IAVA is concerned that the VA has limited or denied access to some veterans seeking recovery services for TBI, because current statute requires that the VA provide services to restore function to wounded veterans. And while full recovery should always be the desired outcome for rehabilitation, sustaining current function or just preventing future harm should also warrant access to VA services.

And I have no doubt that Members of this Committee agree that the VA's role isn't just to help those who might get better, but also to help and support those who might get worse.

IAVA recommends adjusting these statutes to embrace the realities of injuries like TBI. Veterans should be able to focus on maintenance and recovery not fighting with the VA.

Among our members seeking services at the VA, the single most common complaint is how long it takes just to schedule an appointment. Despite improvements of wait times for primary care and specialty care, many veterans have experienced unacceptably long waits just to speak to someone who can get them an appointment that is 4 to 6 weeks away. Unfortunately, I have experienced this myself. After spending 45 minutes attempting to get my primary care team on the phone I gave up and vented by frustration on *Twitter*. Fortunately somebody at the VA follows my *Twitter* feed and I actually received a call from the Medical Director's Office at DC a day later. I was able to get an appointment because of the magic in new media, but the point is that no veteran should wait 45 minutes listening to a phone ring.

In addition to the long wait times, some veterans have to drive almost an entire day to get to their local VA facility, and IAVA is concerned that the VA has yet to develop a consistent and humane policy for answering that age old question of how far is too far to make a veteran drive to the VA?

Now we acknowledge that the VA can't always be a short drive for every veteran, these veterans however should be given a choice to continue using VA care or access more convenient local medical care.

We also believe the VA should assist veterans who need to drive to their appointments. They should provide a lodging stipend and mileage reimbursement for veterans forced to travel long distances for VA medical care, and it should be comparable to the stipend paid to VA employees when they travel.

Now those of us in this room know that the VA provides good care and services; however, the reality is that some of our members openly fear going to the VA. Recent media reports about HIV (human immunodeficiency virus) and hepatitis exposure only served to fuel that fire. A veteran who reads about his or her battle buddies being exposed to infectious diseases while being treated at

a VA medical center will likely think twice before they try to seek the care and services they need.

Now whether or not those fears are actually warranted is a topic for another hearing, but the end result is the same, that if the VA and VA health has a massive public relations problem, and until the VA adequately addresses this issue, many combat veterans will be weary to seek treatment.

IAVA believes that in order for the VA to conduct effective outreach, it must centralize its efforts and aggressively re-brand itself to the American people as one Department of Veterans Affairs.

Now the VA provides great health care, it has sent generations of Americans to college, it is enabled millions of veterans to own their own home, and regularly contributes to the advancement of medical science. It is absolutely astounding to me that only a handful of Americans actually know that.

In addition to re-branding itself to America, the VA has to develop a relationship with servicemembers while they are still in service. Like many successful college alumni associations that greet students at orientation and put on student programs throughout their entire time in college, the VA must shed its passive persona and start recruiting veterans and their families more aggressively into VA programs.

Now overall, the VA continues to provide good care to our Nation's veterans; however, we must continue to strive for better. In the military they taught us to never stop improving our fights positions and always be forever vigilant. It is this proactive ethos that continues to lead to victory on the battle field. And if we are to honor the service and sacrifice of American's warriors, we must instill this spirit in all the services that we develop to care for them.

I want to thank you for your time and attention and I would happy to answer any questions.

[The prepared statement of Mr. Tarantino appears on p. 49.]

Mr. MICHAUD. Thank you very much.

Ms. Williams.

STATEMENT OF DENISE A. WILLIAMS

Ms. WILLIAMS. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on the Department of Veterans Affairs efforts to care for severely injured servicemembers from OIF and OEF.

The United States military operations in Iraq and Afghanistan has produced a significant number of servicemen and women with amputations. According to the DoD, as of April 3rd, 2010, there has been a total of 1,552 members that suffered amputations. This unique population of younger servicemembers requires extraordinary medical care and rehabilitation. Walter Reed Army Medical Center, among many DoD facilities dedicated to assisting wounded warriors, has highly advanced programs to care for warriors with amputations.

In response to the large number of veterans with prosthetics and rehabilitative needs, VA established the Polytrauma Rehabilitation Centers, however, the American Legion is concerned about VA's ability to consistently meet the long-term needs of these young veterans.

As stated by the Military Medicine Journal, rehabilitation is a crucial step in optimizing long-term function and quality of life after amputation.

Although returning veterans with combat-related amputations may be getting the best in rehabilitative care and technology available, their expected long-term health care outcomes are considerably less clear.

It is imperative that both DoD and VA clinicians seriously consider the issues associated with combat-related amputees and try to alleviate any foreseeable problems that OIF/OEF amputees may face in the future.

The VA has made great strides in addressing the increased influx of young veterans with amputations; however, it has been reported that VA does not have the state-of-art prostheses available in comparison to the DoD. That is why it is of utmost importance that VA receives the adequate funding to ensure that all VA medical facilities are fully equipped to address these veterans' prosthetic needs.

This is especially vital for the veterans that reside in rural and highly rural areas. It would be a grave disservice to these veterans if they have to bear the burden of traveling hundreds of miles in order to receive care in addition to enduring their debilitating condition.

The American Legion applauds VA on the establishment of the Prosthetics Women's Workgroup to enhance the care of female veterans in regard to their prosthetics requirement. Despite this implementation, there are still cases where the fitting of the prostheses for women veterans has presented problems due to their smaller physique.

The American Legion urges VA to increase their focus on amputation and prosthetics research programs in order to enhance and create innovative means to address this population of veterans' health care needs.

During our "System Worth Saving" site visits to the polytrauma centers, some facilities reported that there were staffing shortages in certain specialty areas such as physical medicine and rehabilitation, speech and language pathology, physical therapy, and certified rehabilitation nursing. This was attributed to the competitive salaries being offered for these positions in the private sector.

Considering the complex nature of these severely wounded veterans, the American Legion finds this unacceptable. The Department of Veterans Affairs needs to step up their recruiting efforts in these areas so that in the future these veterans are not faced with the dilemma of going outside of the VA for care.

There are currently 49,460 blind veterans enrolled in the VA health care system and that number is expected to increase because of the number of eye injuries in Iraq and Afghanistan. DoD reports that in the current conflict, eye injuries account for 13 percent of all injuries. The American Academy of Ophthalmology reports that eye injuries are a very common form of morbidity in a combat environment.

DoD does not provide rehabilitation for blindness. Unlike other injuries where after rehabilitation warriors may be retained and

continue service, blinded warriors are medically discharged and relegated to utilize the VA for their rehabilitative needs.

Section 1623 of the National Defense Authorization Act of 2008 requires DoD to establish a Center of Excellence in the prevention, diagnosis, treatment, and rehabilitation of eye injuries, and for DoD to collaborate with VA on matters pertaining to the Center.

In addition, Section 1623 directs DoD and VA to implement a joint program on traumatic brain injury post-traumatic visual syndrome, including vision screening, diagnosis, rehabilitative management, and vision research. Unfortunately, the Center has yet to be fully established because of constant funding delays and bureaucratic hurdles.

The American Legion calls for immediate action from the Secretary of Defense and the Secretary of VA to rectify this important issue.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on these important issues.

This concludes my written statement and I would welcome any questions you may have.

[The prepared statement of Ms. Williams appears on p. 53.]

Mr. MICHAUD. Thank you very much, Ms. Williams. And once again, I would like to thank all the panelists for your testimony and also for the recommendations included within your testimony, which will be very helpful.

This question is for all the panelists. I have heard anecdotes from veterans who applaud the prosthetic services that they receive at the Department of Defense, but are very leery of the care that they might receive through the VA system. Do you believe that DoD provides better overall prosthetic services compared to the VA, or do you believe that these anecdotes that I am hearing represent just a few, isolated cases?

Ms. LEM. I will go ahead and take a stab at that.

I think early on, you know, we heard reports, I mean, I remember from hearing even with Tammy Duckworth, you know, one of the situations is—that is very unique is DoD and Walter Reed obviously have had, you know, the focus has been on them for really doing much of the prosthetics and rehab there on site.

I know that VA, from attending their prosthetic meetings, you know, have integrated their people to go out there and see, you know, what is going on as these people start to transfer back to VA, but the complaints were, you know, when they return to the VA to have either their item serviced or to continue their rehabilitation, they ran into sort of a disconnect from, you know, anyone at the facility where they had been working with the prosthetist and had very much attention to and access to all the newest items and options, you know, at the DoD site. You know, it seemed very different within the VA.

I think that, you know, VA's prosthetic services tried to really improve that and make, you know, good strides in trying to make sure that they are ready to accept these veterans as they transition back into VA to prepare—to repair their equipment, to have—I

know that they have access to all of the vendors that are working out there, and they have done this liaison work.

I am hoping that, you know, that that perception as Tom as mentioned, you know, it lingers when you hear so much about DoD and then people want to return there because it is a very sensitive issue in terms of the people that they are working with and the items that they are working with, and then to have to go to a new system where people that haven't seen the high-tech equipment, you know, you don't have a lot of confidence. I am sure, if they are saying that is the first time I have seen that. But the truth is they are getting access to some of the most high quality equipment that nobody has seen.

So I am hoping it is changing, but it still may be the case in some situations.

Mr. BLAKE. Mr. Chairman, I just sort of want to piggyback a little bit on what Joy had to say and also make another comment first.

Representing a membership that is probably one of the highest in users of prosthetic devices and equipment from the VA, I would say that our members generally never—I won't say never—generally do not have problems getting the most state-of-the-art wheelchairs and other types of equipment that they need. In the occasion where maybe there is some difficulty getting a piece of prosthetic equipment or whatever it may be, it is usually just a matter of working with the prosthetics department through our service officers or what have you to make sure that the right steps are taken. But our members are not experiencing a lot of problems getting what they need. And believe me when it comes to state-of-the-art wheelchairs, you would be surprised at what is out there.

I want to sort of tag along with what Joy had to say. I think you would find that DoD is not unlike VA in sort of the prosthetic structure, and some of the VA's prosthetic services, not unlike the rest of its health care, has become adaptable to changing needs of this generation. Prosthetics is no exception.

I think a lot of focus is put on the—we talk about these advanced prosthetics that the servicemembers are getting from DoD, but it really boils down to them getting them through Walter Reed, Bethesda, Brooke or some of the major military check points. But if they went back to a lot of home stations, I think you would find that a lot of these military treatment facilities, they don't exactly have the capacity to meet their needs when it comes to prosthetics or the maintenance required for that equipment either.

So DoD is not unlike VA in this respect. And I think VA is probably trying to address it more than DoD would in that respect. And we have heard time and again from Mr. Downs, who oversees the VA's prosthetics, that I think he recognizes the need for them to become more adaptable and get it to the field so that as these men and women ultimately are going to come to their local facilities the VA can meet their needs, particularly on the maintenance of this high-end equipment.

I mean, they are intimately involved in what is going on out at Walter Reed in particular, because that is sort of where everything begins when it comes to these advanced prosthetics.

So you can beat up on the VA for it, but in fairness to the VA, I mean they are seeing demands on their system that they never could have imagined before now also.

Mr. MICHAUD. Thank you very much.

My last question, for all the panelists is, in talking to your membership, do you believe that specialty care within the VA system is provided equally among all VA facilities?

Mr. BLAKE. I will speak to the SCI side of it. I think because of the model that has been established we feel pretty confident that it is sort of a uniform policy in the way all SCI care is provided across the system. That again is a function of the way the entire SCI service has been set up through the hub and spoke model.

We are encouraged to see that the VA is sort of moving that way in the polytrauma aspect, and yet there are a lot of challenges as it relates to TBI that Joy raised and going forward that the VA is going to have to figure out how to deal with along the way.

But I feel pretty confident that they do the right think across the board when it comes to SCI service in particular.

Ms. ILEM. I would add onto that.

Some of the complaints that we have heard from veterans contacting us about mild to moderate TBI is that, you know, their families sort of recognized they had an issue, they had been using the VA system for other things, went to the VA, weren't satisfied in areas of the country.

I mean, I had received calls sort of from different locations saying, you know, I ended up in the private sector with VA fee basing me into an outpatient program that really offered a range of things that I have learned so much in the last 6 months in terms of, you know, mild TBI, how to deal with it from my family center care addressing, you know, a range of issues and opportunities for them to have this wide range of outpatient care. And in those cases, you know, I have contacted the VA directly and tried to find out is it, you know, just this location that they are having this problem or is this a systemic problem? It is hard to say unless, you know, somewhere like PVA, you know, really has people on the ground that are doing site visits in the region. Within that specific area, you know, that is a concern of ours.

We are hoping that in certain areas they have the interdisciplinary teams that are needed to provide that care and that they have developed a wide range of services and a good type of program for that, but I am not convinced of that that it is everywhere yet.

I think at certain locations, you know, with the—obviously with the major polytrauma centers, but as you go further out and then obviously in the rural areas where those services are not available, you know, and they have to connect them with the nearest private-sector facilities, you know, we would like to see some continuity of care and make sure that care is available everywhere.

Mr. MICHAUD. All right.

Ms. WILLIAMS. I would like to add that during our site visit that was a main issue, staffing shortages as Joy just mentioned. In the areas where they have the polytrauma centers you will see where they have a lot of specialty care available, but as you go out to the other facilities there is definitely a shortage for specialty care, and

we hear that from the veterans and we have also heard that from VA staff themselves at the facilities that there is a shortage.

Dr. ZAMPIERI. The same thing. The major centers, both the military polytrauma centers, Walter Reed, Bethesda, Brooke Army Medical Center, Balboa in San Diego, or you go to any of the four VA polytrauma centers, it is amazing. I think everybody gets seen by everybody. I mean it is not unusual to have a team of 30 different specialists seeing a patient.

And the hand off has improved dramatically from back in 2005 when I was sitting in this room I think with a couple things. One is we always are concerned that, you know, everybody focuses I think on, you know, the famous beat up in this town is Walter Reed when something goes wrong, and the universe focuses there, but the patients who are evacuated back through Landstuhl come back into the United States, I think there is a misperception that well everybody goes through Bethesda or Walter Reed, and in actuality, some people will admit that about 30 percent of all the wounded and walking wounded actually go back to the original home platform base of deployment.

So if you go to Fort Drum or Fort Carson, Colorado, or Fort Gordon, Georgia, or just name a base, Fort Hood, Texas, you will find individuals who were evacuated back through the system that didn't get seen in one of these highly specialized centers, and some of those are the ones that we find that have a vision problem that, you know, they didn't have a lot of other severe injuries so they were evacked back and then they sort of get lost. Somebody on one side doesn't notify the VA blind rehab services or the local Visual Impairment Services Team (VIST) coordinator that they have somebody that is experiencing vision problems, and that there is treatment available, that there is specialized devices from prosthetics that are available to help them in their recovery and treatment.

And so that is why the Vision Centers of Excellence is important, because it isn't just the major trauma severe cases that need to be tracked, it is all of the types of injuries, mild, moderate, severe, as far as vision goes, that need to be carefully tracked and followed, and the providers need to be able to exchange the information between them—between the VA providers, the ophthalmologist and the military, their colleagues in the military treatment facilities. Because again, a person at Fort Drum, New York, may suddenly have somebody come in that was evacuated back from Landstuhl with injuries and that is where one of the problems is.

Thank you.

Mr. MICHAUD. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it.

Mr. Zampieri, on that point again, I understand your frustration with the delays in the planned construction and operation of the Vision Center of Excellence. How confident are you that your timeline will be met?

Dr. ZAMPIERI. Thank you very much.

Wow. I have been chasing the ghost of timelines for quite a while, and I am not sure. You know, in fact someone said that what was originally—you know, the Vision Centers of Excellence by the way is not a clinical surgical center, it is an administrative

headquarters to coordinate and facilitate information flow of connectivity between all of these patients and the providers, and so you are not building a surgical rehab center or whatever, it is like 4,000 square feet of office space, and here we are, the money was provided in the war supplemental last August and originally it was hoped that the construction would start this summer, then I was told it wouldn't start until this fall, and now I am being told that instead of January, February, or March, that it won't get done until next May or June.

I mean this is really phenomenally incompetent. I mean, I don't know how else to put it. You know, they open up a 72,000 square foot National Intrepid Center of Excellence for traumatic brain injuries and mental health, which cost \$68 million, has all the state-of-the-art equipment in it, over 100 employees, those are clinicians and providers and counselors and therapists, and they do that and a grand opening, at the same time they can't renovate 3,800 square feet of just office cubicles so that we can get this thing up and running and people all collocated instead of temporary office spaces where they have been moved like three times in the last year and a half?

And so yeah, I am a little frustrated, and I don't believe any of the timelines.

And also I might as well, since you asked, there is never a budget anywhere in anybody's testimony, and I am frankly very frustrated about that.

Thank you.

Mr. BILIRAKIS. Thank you.

Mr. Blake, I appreciate your interest in reinstating what we call the capacity report; however, I am concerned that the requirements for that report need to be reevaluated and updated to ensure that the information contained in the report is relevant and functional. Would you be willing to work with us on that?

Mr. BLAKE. Absolutely, and we have already discussed this with the staff. There was some discussion about why the capacity report even expired in the first place, and I have already talked to our staff at PVA as well about the willingness to try to figure out what would be a more useful report, what kind of information should it include, and how could it be used once these reports were to be processed again?

So the short answer is, yes, sir, very much.

Mr. BILIRAKIS. Thanks so much, I appreciate it.

Ms. Ilem, I hope I didn't mispronounce your name. In your testimony you mentioned the proposed facility in Tampa called the Heroes Ranch, which is in my Congressional district. I think this is a wonderful concept. I have some background here and I have talked to the James A. Haley VA Medical Center about this and I believe it could be a viable solution to the problem of how to treat our catastrophically wounded warriors.

Can you tell me more? Give me your thoughts on this, and if you can elaborate a little bit I would really appreciate it because it is something that I would like to pursue.

Ms. ILEM. Sure. As I noted in my statement our National Commander was able to visit the facility and came back and told me about this proposal that he had seen.

One of the things we have been hearing from different people actually starting a couple a years ago is the concern about a number of patients, you know, probably not a significant number, but still those that may not be able to go home, they may not have someone to care for them at home, and it really wouldn't be a—you know, a really appropriate place to put them that was within a Federal system to make sure that they have continued rehabilitation throughout, and obviously these would be the most severely impaired.

So my understanding of the overview of the project was to really have this residential facility that would be for these very specific group of people.

And I asked some folks there, you know, why a place away from a clinical setting? And they mentioned to me that, you know, when they have taken people out, some of the severely wounded, when they get them out of the clinical setting they really start to see some progress and a responsiveness in some of these people, and so it is so important to be in an environment that is not perhaps just a clinical, you know, the clinical setting.

Also, you know, this would be a very highly specialized type of care setting and model, and so I am really hoping to hear from VA if they are able to comment on it.

DAV would certainly support, as we have talked about it in *The Independent Budget*, we have talked about it in the testimony, that there is probably going to be a need for maybe a couple of these centers in the country to make sure that these people aren't forgotten after, you know, time goes by and that we really provide them with the state-of-the-art care that they need, even those that perhaps aren't going to be able to be reintegrated with their families or into society in any real way, but they need a setting too that continues the care for them.

So we would love to collaborate with your staff and you on this project, and hopefully VA can shed some light on this and let us know what the status of the initiative may be.

Mr. BILIRAKIS. Thank you very much. Thank you for your willingness to work with me on that.

Mr. Chairman, I have one last question, is that okay? All right. Again for Ms. Ilem.

You mention in your testimony that the Institute of Medicine March 2010 report said, and I quote, "Although VA has established a comprehensive system of rehabilitation services for polytrauma and severe TBI patients that addresses acute and chronic needs that arise in the initial months and years after injury, protocols, and programs to manage the devastating lifetime effects that many of these veterans must live with are not in place." That is a real shame.

Can you tell me where the VA is failing and what can we do about it?

Ms. ILEM. I don't know if I would use the word failing, because I mean, I was impressed that VA has developed these post-acute facilities, the residential facilities that are attached with the poly-trauma centers that are almost apartment like that is staffed with clinical staff so when veterans are getting ready to discharge from the facility but not quite ready to go home to make sure they are

going to be safe and really be able to care for themselves or be in an assisted living situation. And I think there is that component.

And they are looking at some of these things right after the post acute. I mean obviously the focus has been on this, you know, the long period that it takes to rehabilitation. Oftentimes many surgeries, transferring back between DoD and VA. And I think VA has developed these programs right outside of that.

The concern is about this lifetime of care for some of these folks who just may not have the support or the ability to really function on their own and may need, you know, continued support, as well as their family members who are dealing with this traumatic injury along with them.

So I think this proposal was so exciting about the Heroes Ranch because it also mentioned this integration of family centered, an opportunity—you could see people being able to go there that were with the veteran and perhaps have their own track of information and being able to deal with this sort of a respite for them as well, but also learning environment of all the pressures that they deal with as long term caregivers.

And so I think it is good news that we are starting to see this come up within the VA, because obviously we think they are going to be the folks that are going to have the lifetime care, you know, responsibility for these folks.

And so, you know, I think that was the concern and IOM sort of fleshed that out to say they are doing a good job for this, you know, immediate time in maybe the first couple years, but after that what are we going to do and how are we going to follow them?

Mr. BILIRAKIS. Great. Thank you very much, I appreciate it. Let us get it done together.

Mr. MICHAUD. Mr. Perriello.

Mr. PERRIELLO. Thank you, Mr. Chairman, just two questions.

First, you know, the Chairman was kind enough to come down to my district and do a field hearing this week in Bedford, Virginia, and one of the things that I think was most powerful was hearing the story of Lynn Tucker who has three sons who are all marines who face different health issues, and her son Ben has had severe brain injury and requires 24/7 care actually from a dirt bike accident, it was not service related.

But one of the things that she talked about most in her story was given that it is highly specialized care how often she is bounced between different facilities, different VA hospitals, different clinics without a lot of coordination and effort.

And so I guess—and we have heard some of that today. While the quality of care is often very strong, once its gotten to it is the barrier of getting there and particularly when it may involve multiple locations over time and some use of civilian as well as VA facilities.

So I guess the question is with some sense of urgency, what are the immediate steps that can be taken within the VA to help coordinate the—when it comes to specialized care, and particularly in rural communities?

Dr. ZAMPIERI. I guess just one thought is, you know, it is important that the military case managers, social workers are aware—

exactly aware of the resources there are in the VA system for specialized care.

You know, it seems like an easy quote “thing to do,” but you know, really you are dealing with hundreds of people at hundreds of different sites making sure that they are aware that their counterparts in the VA system like in case of vision impaired service-members, that there are VIST coordinators at every VA hospital. You know, and so it doesn’t matter if you are in Montana or southern Virginia or up in Maine, you know, there is a VIST there, and that person can help facilitate getting that person all the specialized things that they need whether it is prosthetics or eye appointments or whatever.

But if that side of the fence doesn’t have their staff aware—and I am sure it is the same with the other specialties with regards to those kind of problems.

Mr. PERRIELLO. But your general sense is the program is working we simply don’t have enough people or that it is just given the complexity this is the best we are going to be able to do?

Dr. ZAMPIERI. Communications between those people. I don’t know if you can—maybe in smaller facilities make the argument there isn’t enough staff, it is more the sense of the staff that are there are they informed, and also do they have the links that they have to communicate with the VA people that they need?

You know, it is actually sort of scary if you go out to Walter Reed there are so many case managers that you actually have to figure out who is not a family member, you know, because they are there everywhere. It is whether or not, you know, somebody is picking up the phone and contacting the right person back at the local clinic, VA hospital, whatever.

Mr. BLAKE. Well, Mr. Perriello, first let me say I had the opportunity to sit in on the field hearing in the back of the room on Monday and Ms. Tucker’s testimony was very powerful, I will say that.

I think Tom hit on—from my perspective there were two things that stood out to me. One was an obvious break down in communication in her son’s particular case. She talked about going to Durham and Danville and Salem and all these different places, nobody ever seemed to talk to each other and nobody knew what was going on with her son’s case. And so I think the structures are in place to meet her son’s needs, but they were obviously not being met.

The other thing that sort of stood out to me was I would say her son would probably be—would fall under the classification of polytrauma even though seemingly his biggest concern was just immediately TBI, but I think that is the area where we would sort of be caught in. And yet, very little did she talk about his treatment at Richmond where the polytrauma center actually is and the care coordination that should go on for her son.

I thought that it sounded like to me she said she had a couple people that were her go to people, but that wasn’t care coordination, these are sort of her contacts in the VA to help her get things done, but that screams to me that who is the person who ultimately has responsibility for ensuring that his care is being met across the spectrum?

So I think there is an obvious—maybe some evaluation needs to be done to go back and look at how is the VA doing care management of these individuals? And I think the rule setting is the challenge. You know, when you have individuals who are—who live within even 100 miles—you know, SCI veterans are a unique example, because there aren't a lot of SCI centers around the country. I mean they are fairly well geographically placed, but there are some areas where it is hundreds of miles to an SCI center, and yet our members have sort of grown accustomed to what they can get and where they can get it. Through the model that the SCI uses they go to the nearest SCI center to their acute care, but they can also go to local facilities where there is sort of a step down, and we sort of developed this hub and spoke model to ensure that they can get some form of care, even some degree of the specialized care at the local level as best as possible. And I think the TBI aspect is something that the VA is still trying to get its arms around.

So I hate to say that is sort of the unfortunate situation she was in, but the things from her case in particular I think that stood out were care management and communication, and it is obviously important in the rural setting because of the break down that goes on between the VA sort of putting the word out there and what is available and how they can get you around to certain places.

But the fact that that young man was taken to four or five different facilities, plus she went to a couple of private facilities, I mean that was just—made me cringe just thinking about it, so.

Mr. PERRIELLO. Yeah.

Ms. ILEM. I would just have one thing to add to that. I think that the Office of Rural Health, we have been somewhat disappointed in that program—that office getting really stood up and that could help with a lot of these types of situations, so.

Mr. PERRIELLO. If I can do one more quick question just for Mr. Tarantino. And thank you for coming down to the hearing, Mr. Blake, we really appreciate that, and thank you for your service.

One of the things you talked about was re-branding the VA. So going out of the weeds for a second and into kind of the big picture, you know, there is nothing worse in that experience than being on the phone, I have to deal with it with my cable company all the time, because you know—and I give up because it is not worth it to get my DVR fixed, but that really doesn't matter at the end of the day. We are talking about life and death issues of people just getting turned off in the system.

So one of the questions I have in terms of the branding work that needs to be done is how much is that a matter of this younger generation coming back, the OEF/OIF men and women, what is their perception of both the quality of care at the VA which you have spoken to and the ease of accessing it? Where do we stand right now in terms of what you hear on that?

Mr. TARANTINO. Well, Congressman, I think for those who are actually able to get into the VA and receive care the quality is very good, and we hear that from our membership, they provide very good care.

The problem is that there is this negative perception, and this is partly structural within the VA and it is also partly a public perception.

You know, VA, as I don't have to tell you, we know that the VA is three separate agencies that largely work independent of each other, but when they communicate to the American people that is the way that they communicate. The VHA communicates, the Veterans Benefits Administration (VBA) communicates, the National Cemetery Administration, you know, talks to the American people. But as a veteran, someone who doesn't live in DC and is not in the veterans affairs world, I don't understand that.

When my GI Bill check is late I am not upset with the VBA. When I, you know, can't get an appointment I am not upset with the VHA, I am upset with the VA, and that is the mind set, but the VA doesn't communicate to people the way people perceive them.

So I think that is something they really need to start changing.

And I think when you are talking about just the younger generation you need to start looking at how Iraq and Afghanistan veterans communicate with the world. The VA is starting this. They are building up their new media strategy, but they really need to start breaking down those barriers.

Every time I talk to someone at the VA to talk about outreach the big question they ask is, how do I reach out to veterans? Well first of all you have not to stop reaching out to veterans, because we are ten percent of the—less than ten percent of the population, we don't all live in one place, we don't all watch the same movies or read the same newspapers, we are everywhere. You need to start reaching out to America. Because quite often you are not going to catch the veteran. You are not going to go catch the veteran and say hey, I need to go get in services. You are going to catch their mother, their brother, their girlfriend, their buddies who are going to say hey man, you need help, go, and I know, because I see this, I can see the VA, and maybe you should go talk to the VA because they are there for you.

Right now if you are not a veteran, the VA basically just ignores you, and that is the wrong answer.

Mr. PERRIELLO. Thank you.

Mr. MICHAUD. Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman. And thank you all so much for being here. And I know we are preaching to the choir and vice versa, you guys are great, and I know I have more questions than I have time for, so I will probably be submitting them for the record and we will get some answers back. Again, I don't know where to start.

First of all, can I just start with Tom here. You do a phenomenal job with what you have, and I know that I don't want to put you on the spot, but later on I want you to tell me who told you that you are not going to get your 4,000 square feet of space until next summer. I want to know, because that is ridiculous.

And I also want to point out that maybe the public doesn't know that you take people's mileage that they have extra and don't you help people to fly places so that you can help them? Because you don't have very many centers and people don't have very much money and you don't get much help from the VA. So I want everybody to know that, you know, they can donate their mileage, right,

to help you and the people that you help get to places, because that is a very important thing.

Also somebody was talking about, you know, being understaffed, and I want to just piggyback on what Mr. Perriello said. This is about communication. I have a master's degree in communication, and I don't say that just to pat myself on the back, but I got that later in life, and maybe it is something a little more, but when I became a Congressperson I had just been through the fact that my husband and I had a son that was seriously injured in Afghanistan, and I knew that if I were lucky enough to become a Congressperson that I was going to make it my mission to help families who had gone through the same thing. My husband spent the night with Jay and I went back and forth on the shuttle bus listening to families and what they were going through.

So when I became the Congressperson, I hired a full-time caseworker that just did veterans' issues, because the problem is communication. We have so many people that are so busy doing all their different things, but everybody is trying to reinvent the wheel. So I have a caseworker who just does veteran case work, and she goes out every night doing her outreach. I hate to say it, but she is now the one that spends all day long doing all the things that maybe the VA or the different people should be doing, but that one person doing all the outreach can help. And if we do more communication and outreach, maybe we wouldn't have these kind of problems that we have.

So I am just trying to find out from all of you how we can do a better job or how the VA can do a better job on that communication between each other.

Now the other thing that we are trying to do in our district is have that central location. We have a hospital that is soon to be empty that I am insisting on, I am not going to take no for an answer, that we change into a VA medical facility that we have all those different specialties at so that it is a one-stop shop, that people don't have to drive to far.

What I am trying to figure out is what we have been talking about since I became a Member of Congress that we have a seamless transition. I don't see it. And I think it was Mr. Blake that said that DoD isn't keeping track and they aren't doing the reporting that they need to. How do we do that reporting, and is the VA ready to get the report that if we do are we ready for that? Mr. Blake.

Mr. BLAKE. I didn't say that comment, but I am going to try to address the question.

Mrs. HALVORSON. Okay, I apologize if it wasn't you.

Mr. BLAKE. I think the problem is ensuring that there is the transition to VA from DoD and that DoD doesn't necessarily have that as their top priority.

Mrs. HALVORSON. Uh-huh.

Mr. BLAKE. I mean they are still going to do their best to take care of them whether it be at Landstuhl or Walter Reed or what have you, but I don't think that the first consideration in their mind is to immediately coordinate with the VA for their care. It depends on what type of injury I think the servicemember has incurred about.

Also I talked about the SCI side, and the DoD generally does a pretty good job with that, but you know, I can't speak for blinded veterans. I think you would have a much more—

Mrs. HALVORSON. And I think I said it wrong. What is happening, I believe, is that DoD doesn't publicly track the data on the seriously injured, but if they did and then once they are out of theater is the VA ready to get at that data? Because the Department of Defense, when they are done with being in that budget, they are happily ready to get rid of them to put them in the VA budget. I am trying to—

Mr. BLAKE. I am going to try to answer for Tom here again.

Mrs. HALVORSON. Okay.

Mr. BLAKE. I don't know that it is a matter of not publicly tracking the data, it is just that they're not even necessarily tracking the right data.

Mrs. HALVORSON. Okay.

Mr. BLAKE. I think—and Tom can probably speak better to this for the blinded side—I think that there are a lot of folks who are not being captured in their evaluation for what are their problems that they are experiencing when they go.

Mrs. HALVORSON. Right.

Mr. BLAKE. So you know, in the case of blinded veterans they are finding all these individuals who escaped the system and were never identified as having a problem.

We have seen this with TBI in particular where Joy mentioned the mild to moderate side. A lot of these folks are escaping—I hate to say escaping—they are leaving the service and then later things start to crop up and those things were never identified while they were in service.

So a lot of things go missed when they are trying to ensure that these individuals are going to get the care down the road.

Dr. ZAMPIERI. Yeah, the electronic registries are an issue. I think what you are getting at is that.

You know, it is interesting bureaucracy is Ph.D. is political science but I spent 25 years as a clinical person. I did surgery and so I throw that out there because I was also an aero medical flight surgeon in the Army and retired as a major, so I think I know a little bit about the system as a medical provider.

Mrs. HALVORSON. Sure.

Dr. ZAMPIERI. And what happens is bureaucracies look at these electronic registries as repetitive duplication efforts, unnecessary expenses, et cetera, et cetera. What they don't understand from a clinical point of view is that the registries, whether it is amputees, spinal cord, vision impaired, whatever the registry is, there is key clinical information that needs to be seen by the other providers. Whether it is a DoD provider that had a person that has come back from a VA polytrauma center or whether it is a VA provider who is an ophthalmologist that is at Kansas City who has a veteran who shows up that has had surgery in Landstuhl, surgery at Walter Reed, surgery down at Richmond, Virginia, at the polytrauma center and he ends up back out there. Those surgical records that are unique to what is important to that ophthalmologist is what is important in the registry.

Also it is important for all these registries for outcomes.

You know, a little stunning fact that I told Secretary Shinseki a year ago when I met with him was that we have outcome studies from Vietnam eye trauma cases, 50 percent of them went blind 10 years after. Somebody ought to be worried about, you know, if there are several thousand serious penetrating eye injured are we going to have that same rate in 2020 that they had in 1978 when they did 10 year follow up of injured servicemembers in Vietnam in 1968?

So any way, the bureaucracies love to say well, you know, we are going to eventually have a fully interoperable exchange of health care electronic records and so you don't need all these registries. And I have been told that, and again from the research standpoint, it is important that you have those registries because of the coordination of research. If somebody starts on a research program on the DoD side and ends up in the VA, whether it is clinical outcomes, whether it is development of certain policies, whether it is, you know, just being able to answer how many are certain types of retinal injuries, whatever, optic nerve injuries there are.

Any way, sorry. I am really frustrated when people say well, you know it is going to cost \$8 million for that eye trauma registry, and that is just going to be repetitive of all these other registries. Well guess what, there is a reason for that. And again, you know, you look at the Vietnam experiences or the Korean War experiences or World War II experiences, you know, you want to improve things.

Mr. MICHAUD. Mr. McNerney.

Dr. ZAMPIERI. Thank you.

Mr. MICHAUD. We will be called for votes shortly, so if we can try to finish up this panel.

Mr. MCNERNEY. Okay, thank you, Mr. Chairman.

Yesterday I was in here in the same room and we had a hearing on some of the new treatments that are available for post-traumatic stress and for traumatic brain injury, and I couldn't help but think that some of the treatments and methodologies are transferable to the physical injuries that are not in the same category. And so I just ask that you consider coordinating your efforts.

There is a lot going on out there. And today I have seen a tremendous transformation of American society from the 1970s to now when so many groups, so many individuals are reaching out and trying to do what they can to help veterans and to make veterans welcome. So it is a great feeling to see that happening out there, and I welcome everyone here and thank you for your hard work. I can see you are all dedicated to what you are trying to achieve.

I have some specific questions. Mr. Blake, you noted that many servicemembers with mild traumatic brain injury leave the service without having the proper diagnosis and consequently that they are unaware that they need or should be looking for treatment.

How do you recommend that we move forward in either preventing that from happening, making sure that we get the proper diagnosis before they leave or reach them when they are having the problems that make them aware that they need service or help?

Mr. BLAKE. Well, I would say it is not as simple as just saying they are just being diagnosed because oftentimes it is not that easy, but one of the things we have put a lot of emphasis on over

the—for many years, not just in recent past—is the need for really comprehensive medical examinations of these servicemembers both post-deployment and when they are preparing to leave the service.

There has been a lot of grousing over the years about medical screening and things like that that are done to exit servicemembers either from theaters or from the service altogether and I am not sure that goes far enough. It doesn't benefit the servicemember in the long run, because a lot of times this is self-reporting and that is not going to help them out, and you know, it has an outcome for them both of the benefit side and the health care side in the future.

Ms. ILEM. I would just like to add, you know, sometimes we hear one step forward but then two steps back.

We recently had heard that theater they were going, you know, very quick examinations following if someone was near a blast, perhaps doesn't physically know that they have had an injury, but definitely want to measure, you know, how close they were to the blast, and you know, we have heard a couple of different things and it certainly starts right there in being able to track.

Then we started to hear that because servicemembers wanted to return with their unit and didn't want to be pulled out that they would try to, you know, answer the questions in a way or were familiar with, you know, how to answer them so that they wouldn't be pulled out.

But if we really don't have an accurate tracking that, you know, over a period of time they have been exposed to this number of blasts, and then you know, be able to follow that along, you know, it is very difficult later on and oftentimes it is the family who are the first ones who recognize it that there is a change in this person, all be it subtle, you know, they have problems holding a job, you know temper issues, a variety of things.

So again, it is a DoD, VA collaboration where you really want to see this great hand off, but right from the start being able to have accurate information so down line you can say hey, you know, this person was exposed to this number of blasts, let us really do a good, you know, cognitive assessment on this person and see if we have some, you know, minor or you know, mild deficit, but still, you know.

Mr. MCNERNEY. I mean ultimately I think we will develop—well not we, but somebody is going to develop a way to diagnose this relatively early, but right now we have to depend on recordkeeping and so on to do that.

I have two more questions, I hope I have enough time.

Mr. Tarantino, you raised some concerns about the VA limiting or denying access to some veterans who need services with traumatic brain injury. Can you expand on that point a little bit and give some examples of the type of care that is being limited or denied?

Mr. TARANTINO. Yes, Congressman. Basically, we have been hearing a lot from our members who have tried to receive care at local medical centers, and this is kind of a theme that has come up over and over where members who have sought traumatic TBI care are being denied because they are not—their rehabilitation land essentially they are not going to get consistently better, they are going to need to just maintain their services.

I am actually looking for, there is actually in our written testimony we do have a story of—I am trying to find it, excuse me—of a vet who was denied care. She was denied services. Basically, they said well, you don't qualify for the services we provide because you are looking for long-term maintenance and that is not what we are providing.

Mr. MCNERNEY. Well, probably also because they don't recognize that she has that sort of injury I am guessing, but that seems to be what you are getting at.

Mr. TARANTINO. Right. I mean this is a larger issue of we need to start restructuring the way we look at these wounds. You know, we are not just looking at wounds that, you know, you are going to get care and you are going to recover and ultimately you will get better—fully better. A lot of these wounds are going to be either just maintaining that basic level of functioning, which is going to require a lot of time and money and patience, and frankly a structure that isn't built at the VA to where we need it, but it is also going to be some of this can be degenerative, and we are going to need to double our efforts in making sure that these veterans' quality of life can at least be maintained and that the VA is going to be able to provide services to them whether it be 24-hour care, whether it, you know, just be continual adaptive services.

I mean this speaks to that larger issue, our entire range of adaptive services is horribly, horribly out of date.

Mr. MCNERNEY. Okay, thank you.

Ms. Williams, in your testimony you applauded the VA for efforts in the area of prosthetics for women veterans, and that is a great achievement.

My question is, are there gender differences where the needs of women are not being met whether it is for blind rehabilitation, spinal cord injuries, or so on and polytrauma that are not as well met for women as they are for the men veterans?

Ms. WILLIAMS. In terms of the spinal cord injury there was a part that I found during my research that was not included in the testimony, and I wanted to—I can bring that to your attention regarding women with spinal cord injuries and the difficulties that they face in receiving their medical care, specifically their Pap smear and what they have to go through in order to receive the care because of if they are in a wheelchair and if they have lost use of their legs.

There are certain—I am having a brain cramp—but it is the debilitating condition that the females face with the spinal cord injury compared to their males having to receive their breast exam, what they have to go through to receive a mammogram and their Pap smear as a spinal cord injury.

Mr. MCNERNEY. Okay, those are good specific topics. And if you could keep us informed about the progress of that sort of treatment, it would be beneficial I think for the VA.

Ms. WILLIAMS. Sure.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. Once again, I would like to thank the panel for coming this morning. Your testimony has been very helpful and I look forward to working with you as we provide services for our veterans. Once again, thank you very much.

We will try to get through the second panel before they actually call the votes, and I would ask the second panel to come forward.

We have Dr. Jack Smith, Acting Deputy Assistant Secretary for Clinical and Program Policy from the Department of Defense, and Dr. Lucille Beck from the Veterans Administration, who is accompanied by Dr. Margaret Hammond from the VA, Deborah Amdur from the VA and Billie Randolph from the VA.

I want to thank our second panel for coming forward. We do have your full written testimony, which will be submitted for the record, so if you could summarize your written testimony so we are able to ask questions before they call for votes, I would appreciate it.

We will start with Dr. Smith.

STATEMENTS OF JACK SMITH, M.D., MMM, ACTING DEPUTY ASSISTANT SECRETARY FOR CLINICAL AND PROGRAM POLICY, U.S. DEPARTMENT OF DEFENSE; LUCILLE B. BECK, PH.D., CHIEF CONSULTANT, REHABILITATION SERVICES, OFFICE OF PATIENT CARE SERVICES, AND DIRECTOR, AUDIOLOGY AND SPEECH PATHOLOGY SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MARGARET C. HAMMOND, M.D., CHIEF CONSULTANT, SPINAL CORD INJURIES AND DISORDERS SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND BILLIE RANDOLPH, DEPUTY CHIEF, PROSTHETICS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF JACK SMITH, M.D., MMM

Dr. SMITH. Well thank you, Chairman Michaud, distinguished Members of the Subcommittee, thank you for the opportunity to appear here to talk to you about the Department of Defense's medical care for those who have suffered physical injuries in combat.

On October 16th, 2009, Secretary of Defense Gates stated quote, "Beyond waging the wars we are in, treatment of our wounded, their continuing care, and eventual reintegration into everyday life is my highest priority. I consider this a solemn pact between those who have risked and suffered and the Nation that owes them its eternal gratitude."

We who work in Military Health System completely agree with Secretary Gates and share his commitment to provide the best possible treatment for our wounded warriors.

One of the Military Health System's foremost sustained priorities is to improve the experience of care for those who are receiving treatment in our military treatment facilities every day, the wounded, ill, and injured from our current conflicts who are moving through the joint patient evacuation system from point of injury and theater of operations to the point of definitive care in the United States where many are recovering from at our flag ship military medical centers in the National Capital area and other clinical centers around the country.

DoD has also long been a leader in research on improved treatments for traumatic injuries.

The U.S. Army Institute of Surgical Research located at the Brooke Army Medical Center in Texas, is dedicated to laboratory, clinical trauma, and combat care research. Its mission is to identify opportunities for improvement and discover new treatments for combat injuries for servicemembers across the full spectrum of military operations.

Severely injured servicemembers often require prolonged treatment, time to heal, and rehabilitative care before a decision can be made on the medical ability to remain on active duty.

The Military Health System (MHS) is meeting this challenge by improving our coordination of health care for servicemembers with our partners in the VA.

The MHS is committed to ensuring that servicemembers are provided outstanding clinical care and streamlined administrative processes to return them to duty status if possible or to assist them with a transition to civilian life in coordination with the VA in an effective and timely manner.

To ensure a seamless transition of health services from one agency to another, the MHS and the VA are working together to ensure that medical providers have a full understanding of the care capabilities within both agencies and that clear communication of the transition plan between providers and each agency and with the patient and family occur.

We are also working to ensure both timely transfer of all pertinent medical records before or at the time of transfer of the patient, and appropriate communication after the transfer between the medical providers and with the patient and family.

The Department of Defense continues to improve the transition of health care between the agencies by working in partnership with the VA to establish and support Federal Recovery Coordination Program, the VA Liaisons for Health Care Program, and the Recovery Coordination Program.

DoD has also established a number of specialty centers of excellence in collaboration with VA centers. Centers dedicated to wounded warrior care include the Walter Reed Army Medical Amputee Care Center and Gate Laboratory, the National Naval Medical Centers National Intrepid Center of Excellence for Traumatic Brain Injury and Psychological Health, the Center for the Intrepid in Brooke Army Medical Burn Center at Fort Sam Houston, Naval Medical Center San Diego Comprehensive Combat Casualty Care Center, the Defense Centers of Excellence for Traumatic Brain Injury and Psychological Health, and the Centers of Excellence for Vision, Hearing, and Traumatic Extremity Injuries and Amputations.

We have made tremendous progress in combat, trauma, and rehabilitative care of our injured combatants over the last 9 years. The medical personnel of our combined services are working very hard to develop and implement the MHS programs necessary to return our severely injured servicemembers to duty or to a protective civilian life.

Thank you for your continued support of our servicemembers and their families, and I would be pleased to respond to any questions. [The prepared statement of Dr. Smith appears on p. 55.]

Mr. MICHAUD. Thank you.

Dr. Beck.

STATEMENT OF LUCILLE B. BECK, PH.D.

Dr. BECK. Good Morning, Chairman Michaud and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs' full complement of specialty, rehabilitative services for severely injured veterans and servicemembers.

I am accompanied today by Deborah Amdur, Chief Consultant for Care Management and Social Work Services, Dr. Margaret Hammond, Chief Consultant for Spinal Cord Injuries and Disorders, and Dr. Billie Randolph, Deputy Chief Consultant for Prosthetics and Sensory Aid Service.

My testimony will discuss how VA supports and facilitates the transition and care management of Operation Enduring Freedom and Operation Iraqi Freedom veterans. I will highlight the specialty rehabilitation services provided by VA for severely injured veterans and servicemembers since 2003 for four program areas: Blind Rehabilitation, Spinal Cord Injury, Polytrauma Traumatic Brain Injury, and Amputation, Prosthetics, and Sensory Aids.

VA and DoD partnered to create the Federal Recovery Coordination Program in order to facilitate access to VA for severely injured veterans and servicemembers and to assure that these veterans and servicemembers receive the benefits and care they need to recover.

Currently, 556 clients are enrolled in the FRC program and another 31 individuals are being evaluated, 497 have previously received assistance.

The VA care management and social work service coordinates care for 5,800 severely injured servicemembers and veterans.

Additionally, VA has placed liaisons at military treatment facilities and developed an OEF/OIF team at each VA medical center to help coordinate the care for returning servicemembers and veterans.

The first specialty rehab program I want to discuss is VA's blind rehabilitation service which assesses, recommends, and trains visually-impaired veterans in the use of technology and assisted devices such as computers, personal digital assistance, and global positioning systems.

Blind rehabilitation services are delivered at every medical center and select outpatient rehabilitation clinics and in-patient centers. These services are structured and geographically located for visually-impaired veterans and servicemembers to access the care they need.

A total of 1,098 OEF/OIF veterans and servicemembers are tracked to ensure ongoing coordination. Of this total 126 servicemembers have attended in-patient blind rehabilitation centers due to severely disabling visual impairment.

Second, VA's spinal cord injury system of care is internationally regarded for its comprehensive and coordinated services for rehabilitation, surgical, medical, preventive, ambulatory, long-term, and home-based care.

VA promotes activity based therapies at SCI centers, and recently enhanced the rehabilitation and training environments to

offer the latest and most effective interventions for newly injured servicemembers and veterans.

VA has treated 503 servicemembers in its SCI units.

Third, the VA's polytrauma system of care is an integrated tiered system that provides specialized interdisciplinary and comprehensive care, including treatment by teams of rehabilitation specialists, specialty care management, patient and family education and training, psychosocial support, and advanced rehabilitation and prosthetic technologies.

New programs at each polytrauma rehabilitation center include transitional rehabilitation programs, emerging consciousness care, and assisted technology laboratories.

VA has treated 1,792 patients at the PRCs: 907 servicemembers, and 885 veterans with severe injuries.

Finally, VA's Amputation and Prosthetic's and Sensory Aid Program provides veterans with the full spectrum of commercially available rehabilitation and prosthetic equipment to maximize their independence and health.

Prosthetics currently serves 657 OEF/OIF amputee veterans and servicemembers. Specialized prosthetic devices are provided to meet the unique needs of returning veterans, and this program has pioneered the use of best practices for management of prosthetic devices and care through its clinical management program.

Thank you again to the opportunity to appear today and discuss VA's work in providing our OEF/OIF veterans with timely access to the specialty care services they need. We appreciate Congress's support in provides the resources we need to serve our veterans.

My colleagues and I look forward to answering your questions. Thank you.

[The prepared statement of Dr. Beck appears on p. 58.]

Mr. MICHAUD. Thank you very much, Dr. Beck.

Mr. Bilirakis.

Mr. BILIRAKIS. In the interest of time I will submit my questions for the record.

Mr. MICHAUD. Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman, I will submit most of mine, but I do have a couple questions.

First of all, Dr. Smith, could you just give me a short answer on what is the status on the eye trauma registry that Tom brought up earlier?

Dr. SMITH. Sure. We worked very closely with the VA in establishing the clinical requirements for the registry. Those requirements have been established at this point. They were in the process of putting together a model to build for that.

Meanwhile, we are utilizing our clinical data repository and case management systems to identify the patients who need care so that we can communicate and refer those to the VA.

We are also working on an eye forum in our joint theater trauma registry, which begin to give us more visibility on patients who have sustained injuries in the theater.

So there are multiple avenues we are pursuing, including the registry, which is going to take a little more time to build because of its need to draw information from the various clinical reposi-

tories that we talked about and our ongoing effort to establish and improve our electronic health record.

Mrs. HALVORSON. And speaking of that, real quick. You know, you say that you are working on a seamless transition, but yet I hear from all my veterans that the VA can't talk to the DoD. When the young service man leaves the theater, they get medical records that the VA can't talk to the DoD.

Why can't they—when the servicemember leaves the DoD that they can just get a CD of all their records or you can put it on a USB and hand it to them and say here you go, you have your medical records all to yourself?

Dr. SMITH. We have for patients who are being transferred to the polytrauma centers full copies of records go, including imageries and—

Mrs. HALVORSON. Where do they go?

Dr. SMITH. They go to the polytrauma center.

Mrs. HALVORSON. Which everybody loses something somewhere, because that is what they tell me when they come to me.

Dr. SMITH. Yeah. Well everything is scanned at the time they are transferred from DoD to the VA.

We also have the Bi-Directional Health Information Exchange which makes visible to VA doctors anything that is in our electronic health record, and certainly I am not going to tell you—

Mrs. HALVORSON. But doesn't that servicemember own his own record? You can't just give it to him?

Dr. SMITH. Well, if he is being medically evacuated out of the theater—

Mrs. HALVORSON. No, no, no. Just when he leaves theater can't he say I want my medical records, put it on a USB, a little thing and it is mine?

Dr. SMITH. We don't currently have that process. We do give an electronic copy of the health record to the VA at the time that people separate from the military.

Mrs. HALVORSON. But they can't read it. You don't have the same system so it is not seamless.

Dr. SMITH. We do have interoperability ability initiatives under way and the Bi-Directional Health Information Exchange I believe is working.

Mrs. HALVORSON. But it is not simple. Our office works all day long trying the figure out the medical record issues.

I am just saying, and I am not going to belabor the issue, we have to figure out the VA member—this is an issue, this is a bad issue, and VA—the men and women who served our country who worked so hard, their medical records should be something that they own and that we shouldn't have this kind of problem every day. When they leave they should own their own records that they—because there is a problem with trust. And you guys give them to the VA or you do something with them, but they own them and then there is problems, and the VA can't read them.

So this is something that we need a whole Subcommittee on just that. So something better be done so the VA can read your records. Because I was in Landstuhl and they showed us a system that should be seamless. And again, I don't want to get on my high

horse, but I am supporting and protecting my veterans, and they are not happy.

So Mr. Chairman, I yield back.

Mr. MICHAUD. Thank you. Mr. McNerney.

Mr. MCNERNEY. Well, thank you, Mr. Chairman. Thank you for your testimony, Dr. Beck and Dr. Smith.

Dr. Beck, how would you respond to the Legioneer's claims or comments that the returning soldiers get the best rehabilitative treatment for amputations, but the long-term prognosis is not that good or not that clear? In other words, they are going to get the best possible treatment from the DoD, but the long-term treatment is not as clear.

Dr. BECK. Thank you, Congressman.

We are working very closely with the Department of Defense with the three centers who are providing the primary amputation rehabilitation. Brooke Army Medical Center at the Center for the Intrepid, Navy at Balboa, and at Walter Reed. We are sharing staff at those centers. We have VA staff at the Center for the Intrepid. We now have VA staff who are at Walter Reed and at the DC VA Medical Center. We are working at all levels to integrate and communicate all of the services. We are training together. The military and the VA are training our staffs, our interdisciplinary team of physicians and physical therapists and occupational therapists and our clinical prosthetics.

Mr. MCNERNEY. Okay. I mean there is no doubt in my mind that the intention is good.

I guess what I am trying to get at is that they get out of Walter Reed or Bethesda, they are in pretty good physical shape, but they need long-term guidance—

Dr. BECK. Yes, sir.

Mr. MCNERNEY [continuing]. In some way to make sure that they don't fall off the cart, you know, and get into problems.

Dr. BECK. Yes, sir. And what the VA is doing and has developed in the last 3 years is a refreshed amputation some of care, and in my written testimony we provided the information.

We have stood up seven regional amputation centers in the VA around the country that are specialized centers providing the full compliment of medical and rehabilitative care for our amputees. We also have amputee specialty care at 21 of our network sites, the Veterans Integrated Service Network sites, and we have amputation clinic teams around the country. And the intention and the effort is to manage and care for all of VA's amputees. We have approximately 43,000 amputees already in the VA system being served and are now addressing the need—their needs as well as the needs of our OEF/OIF traumatic amputees.

So we are providing the latest in prosthetist equipment, artificial limbs, and services through our network of private prosthetist providers as well.

Mr. MCNERNEY. Okay, thank you.

I am going to yield back, Mr. Chairman.

Mr. MICHAUD. Thank you very much. I have just a couple quick questions for Dr. Smith.

Yesterday we had a Roundtable discussion in which we discussed hyperbaric therapies that I know the DoD has been using. There

is a DoD report on hyperbaric therapy that has never been submitted.

Could you provide the Committee with a copy of that report? That is my first question.

[The DoD subsequently provided the following information:]

To our knowledge, the DoD participants at the House Veterans' Affairs Committee Roundtable held the day before this hearing did not reference any Hyperbaric Oxygen (HBO) report. The only HBO report referenced that day was of another panelist and the Department does not have an association with or knowledge of the other panelist's report.

However, there is a separate HBO report which may be of interest to the Committee. As requested by the Joint Explanatory Statement for H.R. 3326, the Department of Defense Appropriations Bill, 2010, DoD is currently working on a final report to Congress on HBO due in September 2010.

Mr. MICHAUD. And my second question is, Congress passed legislation requiring the DoD to perform a baseline evaluation when soldiers go to Iraq and Afghanistan and an evaluation when they come back. It is my understanding that they have stopped doing that evaluation and that is a big concern. Is it because in the evaluation that has been done that traumatic brain injury issues are coming up and you don't want to face what our soldiers are going through?

I do not want another Agent Orange with our veterans in Iraq and Afghanistan, so please provide that report on hyperbaric therapy, or what has been done on the report if it is not completed, and also address in writing why the DoD is not evaluating the soldiers when they come back.

[The DoD subsequently provided the following information:]

The Department of Defense (DoD) does not perform routine, population-based, post-deployment neurocognitive assessments on its returning servicemembers. Neurocognitive assessments are focused exclusively on assessing cognition. At present, research does not support the use of computerized neurocognitive assessments tools such as Automated Neuropsychological Assessment Metrics (ANAM) for post-deployment population-based concussion screening. There are many reasons (e.g. sleep deprivation, depression, concussion, etc.) there could be changes in cognitive scores between pre- and post-deployment.

However, DoD completes an overall screening post-deployment with the goal of identifying all servicemembers who may have persistent symptoms from a concussive injury obtained during deployment. DoD screens the post-deployment population for the entire spectrum of symptoms associated with concussion rather than only evaluating symptoms of cognition. Because a concussion can produce a variety of symptoms (with or without cognitive dysfunction) such as headache, dizziness, insomnia, irritability, mood and anxiety disturbances, in addition to isolated cognitive disturbances, the tool used for post-deployment screening is an adaptation of the Brief TBI Screen that was recommended by the Institute of Medicine for this purpose in its December 2008 report. Those servicemembers who screen positive for having possible symptoms associated with a concussion receive further medical evaluation to include assessments of cognition with ANAM or other formal neuropsychological assessments.

This process works to provide the comparative information necessary for post-injury care of mild traumatic brain injury in the acute phases of injury and identify cases that may not have been evaluated in theater or have persistent symptoms. The Department continues to look for the best methods for delivering quality, evidence-based care to our servicemembers.

Mr. MICHAUD. Also for the VA, Dr. Beck, please provide to the Subcommittee information on VA's progress in implementing the caregivers legislation that was recently passed, including when we can expect it to be fully implemented.

There will be additional questions from the Subcommittee as well.

Unfortunately, the vote is open. We have 7 minutes to get over there to vote, so I will provide additional questions for the record from the rest of the Committee.

I want to thank both Dr. Smith and Dr. Beck and those who you who are accompanied by, for coming today, as well as the first panel for your enlightened testimony.

As you can tell from the questions both for the first panel and that I know we would have asked on this panel had we had the time, this is a very important issue that we have to deal with. And some of the other questions that will come forward, particularly of VA, as we heard from the Iraq and Afghanistan folks, is there is still a concern about the time frame, and about some of the concerns with VA having to put veterans on hold for 45 minutes, and a public relations problem within the veterans' community. Hopefully we will be able to address some of those questions and we will be asking additional questions of this panel as well.

So once again, I want to thank you all for coming. I really appreciate it.

If there are no other questions, we will adjourn the hearing.

So thank you.

[Whereupon, at 11:41 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Opening Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I would like to thank everyone for attending this hearing.

The purpose of today's hearing is to explore how we can best serve our veterans who have sustained severe physical wounds from the wars in Iraq and Afghanistan. Today, we will closely examine VA's specialized services for the severely injured, which include blind rehabilitation, spinal cord injury centers, polytrauma centers, and prosthetics and sensory aids services.

With advances in protective body armor and combat medicine, our servicemembers are surviving war wounds which otherwise would have resulted in casualties. Many servicemembers who are severely injured in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) will require sophisticated, comprehensive, and often lifelong care. We know that blast injuries from improvised explosive devices are the most common causes of injury and death among our OEF and OIF servicemembers. Blast injuries often include combinations of TBI, blindness, spinal cord injuries, severe burns, and damage to the limbs which results in amputations.

Today, we will examine whether VA is meeting the needs of the severely injured and whether veterans have access to the most current therapies for treating their physical war injuries. We will identify what VA is doing well and what areas are in need of improvement. We will also explore how VA ensures that the quality of care is consistent and standardized across the VA health care system so that veteran receive the same high quality care regardless of which VA facility they visit. Finally, we will review VA's current efforts to coordinate specialized services for the severely injured with the DoD and how we can achieve improved coordination between the two departments.

I look forward to hearing from our witnesses today.

Opening Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman, and good morning.

Yesterday, we reached a milestone. It was eighty years ago—on July 21, 1930—that President Herbert Hoover first established what we now know as the Department of Veterans Affairs (VA).

Since that day, VA has endeavored to fulfill their mission to “care for those who have borne the battle”. For those who return from battle carrying the very worst wounds of war, including spinal cord injury (SCI), traumatic brain injury (TBI), amputation, and blindness the VA has developed specialized services to meet their unique rehabilitative needs. Providing these types of services to our very highest priority veterans is the backbone of the Department.

Since 1996, Congress has mandated that the VA maintain capacity for these specialized rehabilitative services. And, in 2004, Congress enacted legislation to provide comprehensive services for severely injured servicemembers suffering with complex injuries resulting from blast injuries. This came to be called VA's Polytrauma System of Care.

More than 2.1 million servicemembers have been deployed since October 2001. As of April 3, one thousand five hundred and fifty two have suffered amputations in Iraq or Afghanistan. Countless others have suffered TBI, SCI, eye trauma, hearing loss, or other severe combat wounds. These young heroes are going to require a lifetime of rehabilitation and highly skilled medical services and support. They risked life and limb in our name and in return it is our responsibility to provide them with the care they require and so dearly deserve.

As the battles in Iraq and Afghanistan persist, the specialized care given in VA Medical, Polytrauma, Spinal Cord Injury, and Blind Rehabilitation Centers continue to take on increased importance.

We must diligently prioritize investment in specialized services, medical research, and recruitment to have all the tools necessary to provide all veterans and especially our most severely wounded veterans with an active and full life characterized by independence, functionality, and achievement.

I'm grateful to all our panelists and audience members for being here this morning and I yield back.

**Prepared Statement of Thomas Zampieri, Ph.D., Director
of Government Relations, Blinded Veterans Association**

INTRODUCTION

Chairman Michaud, Ranking Member Congressman Brown, and members of the House Veterans Affairs Subcommittee on Health, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our testimony today on "Healing the Physical Injuries of War." BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families for over 65 years. Today, as U.S. forces remain engaged in two wars and with the surge into Afghanistan resulting in more wounded returning from the battlefields, this hearing is important in reviewing the current systems specialized services and what works and does not work well. While the media often covers the signature injury of the wars, "Traumatic Brain Injuries" and the mental health problems like Post Traumatic Stress Disorders (PTSD) it is important to note that most wounded return with several injuries "polytrauma" and they should all be considered in planning for VA specialized care and benefits they require.

SEAMLESS TRANSITION ISSUES

During the past couple years, BVA has worked extensively with the members of the Committee and tried to get the House Armed Services Committee (HASC) to hold DoD more accountable for the many organizational problems associated with the Seamless Transition process involving the battle eye-injured and those with visual complications associated with Traumatic Brain Injury (TBI). Many severely eye-injured OIF and OEF wounded servicemembers are not centrally tracked, making the implementation of the Eye Trauma Registry vital. This tracking failure negatively affects some in their access to the full continuum of VA Eye Care Service, Blind Rehabilitation Service (BRS), and Low-Vision outpatient programs that these committees helped establish. BVA again stresses that, according to DoD data compiled between March 2003 and December 2009, DoD reported 10 percent of all combat-injured casualties evacuated from OIF and OEF had associated mild, moderate, or severe eye injuries, considering that 38,497 U.S. servicemembers have been evacuated from being wounded or injured this is obviously a significant number. Fortunately, due to advanced combat surgery teams, and the rapid evacuation military aero-medical system, the severely eye injured in these wars have had their vision sometimes fully or partially restored, but approximately 124 blinded have required treatment at one of the ten VA Blind Rehabilitation Centers (BRCs) and there are large numbers with TBI low vision problems. There has been insufficient governance or oversight of the Vision Center Excellence (VCE) by the Joint Executive Council (JEC) and some failure of both agencies to provide detailed budgets, necessary for VCE joint staffing, implementing the Eye Trauma Registry has been delayed, and the planned construction renovation for 3,870 square feet of office space for the VCE at the National Naval Medical Center in Bethesda is not expected to be completed until April FY 2011. BVA requests that no further delays for the immediate operational implementation plans for the VCE in FY 2010 are acceptable and they should not be tolerated.

BVA points to the frustrating fact that despite the MILCON/VA Appropriations including \$6.8 million for FY 2009 for VA implementation of its portion of the VCE initiative, it was April 2010 before VA had a total of four **staff appointed** to the VCE. Members found that the funding had been reprogrammed over five years instead of utilizing the funds to urgently start the VCE operations. BVA requests that Congress include \$9,350,000 in the Defense Appropriations FY 2011 and require that VHA and DoD Assistant Secretary Defense for Health Affairs (ASDHA) report

quarterly on VCE joint staffing plans, the status of the Eye Trauma Registry, and expenditures of the MILCON/VA appropriations provided to HVAC and HASC.

BVA believes that the VCE and its Eye Trauma Registry are where improved coordination to ensure availability of eye care and vision rehabilitation services, best outcome practices, and evidence-based clinical research measures can be developed and refined for the TBI-wounded who face vision dysfunction and those suffering penetrating eye wounds. Research coordinated with the Defense Veterans Brain Injury Centers (DVBIC) and the Defense Intrepid Center of Excellence (NICOE) for TBI, along with VA Polytrauma sites, can be facilitated, data-analyzed, and published to improve both acute injury care and long-term vision rehabilitation. We predict that the number of TBI-injured will continue to rise as a result of the troop surge into Afghanistan this year.

VA's Full Continuum of Care

A very positive note is that VA continues to build on a now 62-year history of successful blind rehabilitation programs, which include 10 residential Blind Rehabilitative Centers (BRC's) throughout the United States and construction on two new BRC's is occurring now. At present, the implementation of a sweeping \$40 million, three-year Full Continuum of Care plan has been completed that this committee supported. While the plan was originally initiated to serve the projected aging population of veterans with degenerative eye diseases requiring specialized services, the new 55 intermediate and advanced low vision blind rehabilitation outpatient programs also have specialized staffing in place to provide the full range of basic, intermediate, and advanced vision services essential to the new generation of eye injured veterans from OIF and OEF. In addition, VA continues to emphasize medical vision research and the latest advances in prosthetic adaptive equipment, with access to new vision technology through a coordinated team approach that is designed to benefit both low vision and blinded veterans of all eras.

VA Blind Rehabilitative Centers

BRCs are especially important for the returning OIF and OEF service personnel because they often suffer from multiple traumas that include TBI, amputations, other neurosensory losses, and limb injuries. One VA research study found PTSD in 44 percent of TBI patients, 22 percent suffer depression, 40 percent had acute and chronic pain management issues. Mild TBI was found in 44 percent of these 433 patients, with 56 percent diagnosed with moderate to severe TBI with 12 percent of those had penetrating brain trauma. The Defense Veterans Brain Injury Center (DVBIC) reports that an analysis of the first 433 TBI wounded found 19 percent had concomitant amputation of an extremity. The VA BRC can deliver the entire array of highly specialized care needed for them to optimize their rehabilitation outcomes and successfully reintegrate within their families and communities. Mr. Chairman, we wish to strongly emphasize that private agencies may lack all of the highly specialized consultant services, and prosthetics expertise, that our residential blind centers have now developed, and they all have Commission on Accreditation of Rehabilitation Facilities (CARF) approval. Only the inpatient VA Blind Centers have all the various specialized consultant services needed such as prosthetics, orthopedics, neurology, rehabilitative medicine, surgery, ophthalmology and low vision optometry, and psychiatry to treat these polytrauma servicemembers.

There is no environment of which we are aware that better facilitates the initial emotional adjustment to the severe problems associated with the traumatic loss of vision than full, comprehensive VA blind rehabilitation. One BVA recommendation though is that VHA BRS should have more central control over VA blind center staffing resources and the funding levels because BRS will be better able to track demand for workload across all centers, monitor waiting times, and improve the overall allocation of critical resources in meeting new staffing demands.

VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

The mission of each Visual Impairment Service Team (VIST) program is to provide blinded veterans with the highest quality of adjustment to vision loss services and blind rehabilitation training. To accomplish this mission, VIST has established mechanisms to maximize the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. The VIST concept was created in order to coordinate the delivery of comprehensive medical and rehabilitation services for blinded veterans. VIST Coordinators are in a unique position to provide comprehensive case management and Seamless Transition services to returning

OIF/OEF service personnel for the remainder of their lives. They can assist not only the newly blinded veteran but can also provide his/her family with timely and vital information that facilitates psychosocial adjustment.

The VIST system now employs 114 full-time Coordinators and 43 who work part-time. The average caseload is 375 blinded veterans. VIST Coordinators nationwide serve as the critical key case managers for some 49,269 blinded veterans, a number that is projected to increase to 52,000 within a couple of years. The VIST teams are able to coordinate local services when a veteran requires them and follow blinded veterans who attend a BRC and later require any additional training due to improvements in adaptive equipment or technology.

BLIND REHABILITATIVE OUTPATIENT SPECIALISTS (BROS)

VA BRS established several new Blind Rehabilitative Outpatient Specialists positions during FY 2009 in facilities throughout the system, bringing the total of BROS to 73 working full-time, triple the number from 2004 largely due to the efforts of this committee and Chairman Michaud. The creation of the positions placed VA in a better position to deliver accessible, cost-effective, top-quality outpatient blind rehabilitation services.

While the BROS is a highly qualified professional who, often is dually certified; that is, he/she has a dual masters science degree both in Orientation and Mobility (living skills and manual skills) and Rehabilitation Teaching and is credentialed and privileged in VA medical centers there is problem within DoD medical treatment facilities (MTF). The defense health care system has never before credentialed BROS professionals because for sixty years blinded servicemembers were sent to VA BRC's. While DoD credentials other occupations with similar master's degrees for example, occupational and physical therapists, DoD has no policy for credentialing of VA BROS. We credit VHA and VCE director, COL Gagliano, for trying over the past year for DoD MTF's to credential these VA BROS into selected MTF's to begin early blind rehabilitative training skills for the severely wounded that may be pending being transferred to VA BRC. Walter Reed Med Center and Navy Medical Center currently have been unable to credential the local VA BROS so they can provide this training. Such training prepares these individuals to provide the full range of mobility, living, and adaptive manual skills that are essential early skills in recovery and return to the veteran's home environment and BROs provide reassurance to family members that the training will lead to independence. Today in several DoD and VA medical centers there are wide number of clinical providers, social workers, and other staff working together within each department's facilities to improve transition and clinical care. BVA would strongly recommend that the VA Committee working with HASC provide "NDAA report language" that VA credentialed and privileged BROS shall be granted MTF clinical privileges as VA clinical consultants representing VA Blind Rehabilitative Service and that DoD and VHA report back to the committees on the implementation of this privileging process.

ADVANCED BLIND REHABILITATION PROGRAMS

Pre-admission home assessments, individualized evaluations, and outpatient training, all of which are complemented by a post-completion home follow-up, are part of the new three year expansion of VA's Advanced Outpatient Blind programs. These programs have been referred to historically as VISOR (Visual Impairment Services Outpatient Rehabilitation Program). They consist of a nine-day rehabilitation experience, offering Living Skills Training, Orientation and Mobility, and Low-Vision Adaptive Devices Therapy with appropriate prosthetics while staying in *Hoptel* bed at a medical center with nursing care as necessary during the stay. A VIST Coordinator with low-vision credentials manages the program with other key staff members consisting of certified BROS, Orientation and Mobility Specialists, Rehabilitation Teachers, Low-Vision Therapists, and Low-Vision Ophthalmologists. These new programs considerably improve access, provide new rehabilitation services of the highest quality, reduce waiting times, and decrease veteran travel across networks.

INTERMEDIATE LOW-VISION OPTOMETRY PROGRAMS: VICTORS

Another important model of service delivery that does not fall under VA BRS is the Visual Impairment Center to Optimize Remaining Sight (VICTORS), an innovative program operated by VA Optometry Service. It consists of special services to low-vision veterans who, although not legally blind, suffer from severe visual impairments. Veterans must usually have a visual acuity of 20/70 through 20/200 to

be considered for this service. The program, entirely outpatient, typically lasts three days. Veterans undergo a comprehensive, low-vision optometric evaluation and then appropriate low-vision prosthetics devices are then prescribed. The Low-Vision Optometrists employed in Intermediate programs are ideal for the highly specialized skills necessary for the assessment, diagnosis, treatment, and coordination of services for returnees from Iraq or Afghanistan with TBI visual dysfunction and who also require low-vision services. These new low-vision programs assist veterans with some residual vision from conditions such as macular degeneration, diabetic retinopathy, glaucoma and other degenerative eye diseases in maintaining independence and functional status at home or work.

PRIVATE AGENCIES AND POLY TRAUMA REHABILITATION SERVICES

BVA objects to finding that private agencies for blind are asking for members to earmark various ‘centers of excellence’ and private agencies trying to initiate new independent programs to “manage these new OIF and OEF combat wounded,” adding to the confusion and negatively impacting transition between DoD and VA. Recent combat blinded servicemembers often suffer from multiple traumas that include TBI, amputations, neuro-sensory losses, PTSD, pain management, and depression. The New England Journal of Medicine’s January 31, 2008 article on the experience of mild TBI wounded found even mild cases were significantly more likely within three to four months after injury to develop altered mental status, depression, headaches, emotional distress in up to 30 percent of cases, again evidence that without neurology, neuro-psychology or psychiatry staff, the specialized treatment necessary for recovery will be missed. Only VA Blind Rehabilitation Centers (BRC’s) can deliver the entire full array of these inpatient medical-surgical and psychiatric specialized care often needed for veterans to fully optimize their rehabilitation outcomes and successfully reintegrate into their families and communities. They need the specialized VA mental health services with coordinated multidisciplinary health care teams that the VA medical centers are capable of providing.

We caution that residential private agencies for the blind do not have the full specialized nursing, physical therapy, pain management, speech pathology, pharmacy services, and lab or radiology support services, along with subspecialty surgery specialists, to provide the clinical care necessary for the wounded. The lack of electronic health care records in the private agencies would make things worse when veterans returned into DoD or VA medical services. BVA requests that any private agencies should demonstrate peer reviewed quality outcome measurements that are a standard part of VHA BRS and they also must be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and blind rehabilitation instructors must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). They should also have the specialized medical staffing necessary for complex wounds.

BVA believes that the DoD–VA Seamless Transition process for eye trauma cases must include the sharing of outcome studies, clinical guidelines, and joint peer reviewed research projects on vision care and vision loss prevention through the exchange of electronic medical records and clinical specialized consultation. These components are not present in private agencies for the blind.

RECOMMENDATIONS

- Congress must ensure the full establishment and budget of the Vision Center of Excellence VCE and Eye Trauma Registry must become operational. Joint DoD/VA staffing resources available now is critical for successful Seamless Transition of eye injured. Request DoD appropriations include \$9,350,000 for FY 2011 for operations and staffing for the VCE. Section 1624 of NDAA FY 2008 must be modified and specific organizational governance alignment for the VCE Director and VA Deputy Director shall report directly to the Assistant Secretary of Defense for Health Affairs and to the Under Secretary of Health (USH) in VHA.
- BVA would strongly recommend that the VA Committee with HASC provide “NDAA report language” that VA credentialed and privileged Blind Rehabilitative Outpatient Specialists (BROS) ‘shall be granted MTF clinical privileges as VA clinical staff’ for VA Blind Rehabilitative Service (BRS) and that DoD and VHA shall report back to the committees on the implementation of this privileging process for BROS.
- The new, specialized VA programs for blinded and low-vision veterans Continuum of Care must be utilized by DoD and to ensure that continuing edu-

cation of DoD staff about this must occur along with the various VA Case Managers, the Federal Recovery Coordinators (FRCs) and the Vision Center of Excellence (VCE). Veterans and their families must know where these resources are located so that they continue to receive the high quality VA vision health care.

- BVA supports the National Alliance for Eye Vision Research's (NAEVR) position that extramural defense vision research funding through the dedicated Peer Reviewed Medical Research-Visionline item in the DoD's Congressionally Directed Medical Research Program (PRMRP) is essential. BVA urges that PRMR-Vision be funded at \$10 million in FY2011 defense appropriations and BVA also appreciates the dear colleague letter of Congressman Walz dated July 15, 2010 requesting members support this level of funding.

CONCLUSION:

Once again, Mr. Chairman, and Members of the subcommittee, BVA appreciates this opportunity to present our testimony on Specialized VA Health Care services confronting the newly injured returning from OIF and OEF. I will answer any questions you have.

Prepared Statement of Carl Blake, National Legislative Director, Paralyzed Veterans of America

Chairman Michaud and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to present PVA's views on how the Department of Veterans Affairs (VA) is caring for the severely injured Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. The challenges the VA has faced in delivering care to OEF/OIF veterans have been unique as this generation of servicemembers has experienced new and different actions in combat, such as the wide-spread use of improvised explosive devices (IED). And yet, the delivery of specialized health care is something that the VA has greatly improved upon over the years and has established itself as a world leader.

The wars in Afghanistan and Iraq have now continued for an extended period of time. The number of casualties and new veterans being created has had a significant impact on the VA. PVA appreciates the Subcommittee's continued efforts to sufficiently fund the care for this growing number of veterans. VA has done a great many things to provide for the care of our newest generation of veterans. The open enrollment of OEF/OIF veterans into the VA health care system for up to five years after these servicemembers leave the service, creation of multiple polytrauma centers to address the complex and severe disabilities that some servicemembers are experiencing as a result of their service, the expansion of mental health programs as well as programs targeted at women veterans, and other efforts to ensure the proper care of these men and women demonstrates VA's willingness to go the extra distance to provide timely and sufficient care.

It is important to emphasize that specialized services are part of the core mission and responsibility of the VA. For a long time, this has included spinal cord injury care, blind rehabilitation, treatment for mental health conditions—including post-traumatic stress disorder (PTSD)—and similar conditions. Today, traumatic brain injury (TBI) and polytrauma injuries are new areas that the VA has had to focus its attention on as part of their specialized care programs.

Specialized services were initially developed to care for the unique health care needs of veterans. The VA's specialized services are incomparable resources that often cannot be duplicated in the private sector. With this in mind, we believe that the VA must be given the opportunity to show what it is capable of doing in addressing TBI and polytrauma conditions for this newest generation of veterans.

The provision of specialized services is vital to maintaining a viable VA health care system. Specialized services are part of the primary mission of the VA. The erosion of these services would lead to the degradation of the larger VA health care mission. With growing pressure to allow veterans to seek care outside of the VA, the VA faces the possibility that the critical mass of patients needed to keep all services viable could significantly decline. All of the primary care support services are critical to the broader specialized care program provided to veterans with spinal cord injury. If primary care services decline, then specialized care is also diminished.

As such, we are pleased to see that the VA has applied the spinal cord injury care model to treatment for polytrauma and TBI. PVA believes that the hub-and-spoke model used in the VA's spinal cord injury service serves as an excellent model for how this network of polytrauma centers can be used. Second level treatment centers (spokes) refer spinal cord injured veterans directly to one of the 23 spinal cord injury centers (hubs) when a broader range of specialized care is needed.

Treatment of polytrauma and TBI can function in the same fashion. The new level two polytrauma centers (spokes) being established will better assist VA to raise awareness of the complex medical issues that severely injured servicemembers and veterans are facing. These increased access points will also allow VA to develop a system-wide screening tool for clinicians to use to assess TBI patients. When more comprehensive treatment is needed, a veteran can be referred to the level one polytrauma center that serves as the hub. Unfortunately, the ability of VA to provide this critical care has been called into question. PVA recognizes that the VA's ability to provide the highest quality TBI care is still in its development stages; however, it continues to meet these veterans' needs while continuing to expand its capabilities.

While VA has gone to great lengths to provide appropriate care for OEF/OIF veterans, there have been several recent media reports indicating problems with proper identification and treatment of servicemembers suffering from TBI. This has occurred despite increased attention to the problem. Those with significant cases of TBI are being identified and well cared for. It is those with less severe cases of TBI that seem to be falling through the health care cracks. In most cases, this is not VA's fault. Instead, the identification and treatment by Department of Defense (DoD) personnel on the scene or at the initial care sites are not making this identification. This is leading to a lack of continued care when those veterans who may suffer from mild to moderate, but undiagnosed, TBI injuries leave the service and seek care at VA facilities. We expect VA will continue to work closely with DoD to ensure TBI care is provided to all veterans who have suffered this often debilitating injury.

But for PVA, there is an ongoing problem that has not received a similar level of appropriate media coverage. Some active duty soldiers with a new Spinal Cord Injury/Dysfunction (SCI/D) are being transferred directly to civilian hospitals in the community and bypassing the VA health care system. This is particularly true of newly injured servicemembers who incur their spinal cord injury in places other than the combat theaters of Iraq and Afghanistan. This violates a Memorandum of Agreement between VA and DoD that was effective January 1, 2007 requiring that "Care management services will be provided by the Military Medical Support Office (MMSO), the appropriate Military Treatment Facility (MTF) and the admitting VAMC as a joint collaboration" and that "whenever possible the VA health care facility closest to the active duty member's home of record . . . should be contacted first." In addition, it requires that "To ensure optimal care, active duty patients are to go directly to a VA medical facility without passing through a transit military hospital," clearly indicating the critical nature of rapidly integrating these veterans into an SCI health care system.

This is not happening. For example, servicemembers who have experienced a spinal cord injury while serving in Afghanistan and Iraq are being transferred to Sheppard Spinal Center, a private facility, in Atlanta when VA facilities are available in Augusta. When we raised our concerns with the VA regarding Augusta in a site visit report, the VA responded by conducting an information meeting at Sheppard to present information and increase referrals. However, reactionary measures such as this should not be the standard for addressing these types of concerns.

Of additional concern to PVA, it was reported that some of these newly injured soldiers receiving treatment in private facilities are being discharged to community nursing homes after a period of time in these private rehabilitation facilities. In fact, some of these men and women have received sub-optimal rehabilitation and some are being discharged without proper equipment. PVA is greatly concerned with this type of process and treatment. There is a serious need to reinforce compliance by DoD regarding the Memorandum of Agreement toward the treatment of soldiers with new SCI/D at VA SCI centers.

Ensuring that these men and women gain quick access to VA care in spinal cord injury centers is critically important because it begins what will become a lifelong treatment process. SCI/D care in the VA is unique from private care for spinal cord injury rehabilitation because of the care coordination that the veteran receives for the remainder of his or her life. Care coordination begins as soon as a new injury enters the VA SCI service. Failure to transfer new injuries into the VA only serves to deny these men and women the world-class specialized care the VA will provide. While we understand that local VA medical centers and DoD facilities are taking

actions to improve this process, we ask that the Subcommittee work with your colleagues of the House Committee on Armed Services to ensure our SCI/D veterans are getting the complete, proper and appropriate care for their sacrifices.

VA has historically been the best provider of care for our injured veterans. They are familiar with the wounds of war and the physiological and psychological conditions that accompany them. It is unacceptable that DoD might move its disabled warriors to sub-standard care and we can only believe that this is because some individuals within the DoD health care system do not understand the complexities of SCI/D care and the multitude of conditions that require attention for veterans with spinal cord injuries.

PVA also remains concerned that the VA must maintain its capacity for the provision of SCI/D care as mandated by P.L. 104-262, the "Veterans Health Care Eligibility Reform Act of 1996." This law required the VA to maintain its capacity to provide for the special treatment and rehabilitative needs of veterans with spinal cord injury, blindness, amputations, and mental illness. The baseline of capacity for spinal cord injury was established based on the number of staffed beds and the number of full-time equivalent employees assigned to provide care on the date of enactment of the law.

Ultimately, we cannot emphasize enough that any reduction in staffed beds can have a direct negative impact on the newest generation of veterans as well as veterans of previous generations. Unfortunately, the single biggest accountability measure—an annual capacity reporting requirement—expired in April 2004. This allows the VA to make changes to its SCI/D capacity in a less than transparent manner. In accordance with the recommendations of *The Independent Budget* for FY 2011, PVA calls on this Subcommittee to approve legislation to reinstate this vitally important reporting requirement.

Additionally, the SCI/D programs of the VA face a common challenge with the larger health care system—a shortage of qualified nurse staffing. As a result, VA is experiencing delays in admissions and bed reductions at its SCI centers. In order to meet this challenge head on, some SCI centers in the VA have offered recruitment and retention bonuses to enhance their nurse staffs. Unfortunately, this is not a uniform national policy and these actions are subject to the budget decisions of local VA medical center and Veterans Integrated Service Network (VISN) directors. In accordance with recommendations of *The Independent Budget*, we believe it is time for the Veterans Health Administration (VHA) to centralize policies and funding for systemwide recruitment and retention of SCI nurse staffing. Additionally, we believe Congress should establish a specialty pay provision for nurses working in the SCI service, and should consider extending similar provisions to the other VA specialized services.

PVA appreciates the emphasis this Subcommittee has placed on reviewing the care being provided to the most severely disabled servicemembers and veterans returning from OEF/OIF. It cannot be overstated that the VA is the best option for these men and women when it comes to provision of specialized services. And yet, we have only touched on a small segment of this population—SCI/D veterans—in our testimony today. There are many more severely injured servicemembers and veterans who are dealing with TBI, vision impairment, amputations, and serious mental illness. We would encourage the Subcommittee to review *The Independent Budget* for FY 2011. This comprehensive policy document includes significant discussion about the challenges of providing care to this generation of war-wounded veterans, as well as the individual issues with the different segments of specialized services.

PVA would like to thank the Subcommittee once again for allowing us to provide testimony on these important health care issues facing OEF/OIF veterans, as well as other severely disabled veterans. We certainly appreciate the continued attention this Subcommittee has placed on these issues. I would be happy to answer any questions that you might have. Thank you.

**Prepared Statement of Joy J. Ilem, Deputy National
Legislative Director, Disabled American Veterans**

Mr. Chairman, Ranking Member Brown, and Members of the Subcommittee:
Thank you for inviting the Disabled American Veterans (DAV) to testify at this hearing of the Subcommittee on Health, titled "Healing the Physical Injuries of War." We appreciate the Subcommittee's leadership in enhancing the Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely, and to comment on how the VA is caring for the severely

injured servicemembers and veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) through its specialty programs. We also appreciate the Subcommittee's interest in identifying any gaps in care or services that may exist within these programs. We are specifically focusing our testimony on VA's Polytrauma/Traumatic Brain Injury (TBI) System of Care.

According to VA's June 2010 Queri Fact Sheet on Polytrauma and Blast Related Injuries more than 37,000 OEF/OIF servicemembers have been wounded in action, and of those, more than 20,000 were unable to return to duty within 72 hours, presumably because of the severity of their injuries. Blasts were listed in the Fact Sheet as the most common cause of injury. In combat, sources of blast injury includes artillery, rocket and mortar shells, mines, booby traps, aerial bombs, improvised explosive devices (IEDs), and rocket-propelled grenades

According to VA, from March 2003 through March 2010 a total of 1,792 inpatients with *severe* injuries have been treated at Polytrauma Rehabilitation Centers.¹ Within this total group of patients, 774 were injured in OEF/OIF with the remaining injured in non-combat, non-deployed incidents.² Blast injuries are often polytraumatic, meaning they affect multiple body systems or organs, resulting in physical, cognitive, psychological, and psychosocial impairments and functional disabilities.³ As a result of these blasts, servicemembers and veterans who are classified as polytraumatic often experience a combination of amputations, spinal cord injury (SCI), visual and auditory impairments, brain injury, post traumatic stress disorder (PTSD) and other catastrophic medical conditions. Patients presenting with these types of injuries require a high level of provider coordination, interdisciplinary clinical support and a wide range of specialized services.

As reported by the Army Office of the Surgeon General, from September 2001 to January 12, 2009, there were 1,184 amputations in personnel deployed to OIF and OEF, nearly three-quarters of which were major amputations. IEDs caused 55 percent of the 1,184 OEF/OIF amputations.⁴ Through our research we have found it difficult to come up with a firm number representing the total number of *severely* wounded from OEF/OIF as it appears that VA and Department of Defense (DoD) track veterans and servicemembers separately, with VA using only the number of servicemembers or veterans who have been treated in one of its Polytrauma Centers. We suggest that VA and DoD collaborate to provide an accurate accounting of the number of severely wounded, how they classify a person in this category, where they were treated, as well as their active duty or veteran status at time of accounting.

In 2005, due to the number of polytrauma casualties from the wars in Afghanistan and Iraq, VA expanded the scope of services available at its existing VA TBI Centers to establish a more integrated, tiered system of specialized, interdisciplinary care for polytrauma injuries and TBI. Currently, VA operates four regional Polytrauma/TBI Rehabilitation Centers (PRCs) that provide specialized inpatient rehabilitation treatment and expanded clinical expertise in polytrauma. The PRCs are located at VA medical centers in Minneapolis, Palo Alto, Richmond, and Tampa, and a fifth PRC is currently being established in San Antonio. These PRCs are the hub of the Polytrauma/TBI System of Care, which includes four Polytrauma Transitional Rehabilitation Programs that are co-located within the PRCs; 22 specialized outpatient and subacute residential rehabilitation programs referred to as Polytrauma Network Sites (PNS) that are geographically distributed within each of the VA's 21 integrated service networks (VISNs) including one at the VA medical center in San Juan, Puerto Rico. VA has also reportedly designated Polytrauma Support Clinic Teams at smaller, more remote VA facilities; and has established a point of contact and referral at all other VA facilities.^{5, 6}

Today's injured military servicemembers are experiencing higher survival rates than in previous wars, with the overall survival rate among wounded troops being about 90 percent. This increase is attributed to the widespread use of body armor,

¹R. Jesse, M.D., Ph.D., Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Armed Services*; June 22, 2010.

²D.X. Cifu, M.D., Acting National Director VHA PM&R Services, Chief of PM&R Richmond VAMC; *VA Polytrauma System of Care*; PowerPoint Presentation, November 3, 2009.

³VA QUERI Fact Sheet; *Polytrauma & Blast-Related Injuries*; June 2010.

⁴Institute of Medicine; *Preliminary Assessment of Readjustment Needs of Veterans, Servicemembers, and Their Families*; Ch. 5, March 31, 2010.

⁵Wade, Sarah, Statement before House Veterans' Affairs Subcommittee on Oversight and Investigations, April 28, 2009.

⁶Lynch, Cheryl, Statement before House Veterans' Affairs Subcommittee on Oversight and Investigations, April 28, 2009.

improved battlefield triage procedures and expedited medical evacuation.⁷ For a majority of our wounded servicemembers, the first level of complex intervention on their journey to a VA PRC normally occurs at the Landstuhl Regional Medical Center in Germany, operated by the U.S. Army. Up until 2009, VA received little to no information about wounded servicemember transport, the full extent of the acute care process that servicemembers had undergone, or the stress that these patients had experienced before arriving at a VA PRC. However, in October of 2009, a team of two VA physicians and two nurses from VA's Polytrauma System of Care spent four days at Landstuhl to gather information and put a system in place to establish a regular exchange of information between medical teams in the military and VA's PRCs. The PRCs are now able to track patients from the beginning of their journeys and can identify medical complications much earlier. This system of coordination has established a continuum of care that is not proprietary to the DoD or VA, and has aided them to develop one system that benefits our wounded personnel and veterans.⁸ We are pleased with this relatively new development and believe it addressed one key area where gaps in care were evident for those who were treated before its implementation at VA PRCs.

Recently DAV National Commander Roberto "Bobby" Barrera visited VA's PRC in Tampa, Florida. In meeting with injured servicemembers, veterans and their families, our Commander received very positive feedback about the level and coordination of care provided to severely injured patients, and remarked on the high regard these families held for the dedicated medical staff caring for their loved ones.

In preparing for this hearing, I had the opportunity to talk with the father of a severely disabled servicemember who was injured nearly nine months ago in Afghanistan and is now an inpatient at the Tampa PRC. I was very pleased to learn that his impression, from the date of his son's injury to the present, the care provided—initially in Afghanistan, then in Landstuhl and subsequently in VA's PRC in Tampa, was *seamless*. This father commented on the high level of coordination of care and expert staff, in both VA and DoD, that was necessary and existed every step of the way as his son was transported to the United States and from Tampa to Walter Reed Army Medical Center (WRAMC) for surgeries and returned to the Tampa PRC.

DAV was very pleased to hear this stellar report about DoD/VA collaboration and coordination of care and acknowledge the dedicated staff who created this critical system—to optimize care coordination and transition of complex patients across the DoD and VA health care systems. This helps to ensure every severely injured servicemember and disabled veteran has the best care available, and reduces the burden that families must endure during these extreme circumstances post-injury of a loved one. I was pleased to learn that this particular veteran is now beginning to communicate and walk—although it was apparent that his recovery will be slow and he likely will require years of surgeries, comprehensive rehabilitation, family support—and a lifetime of attendance by VA.

In a March 2010 report, the Institute of Medicine (IOM) suggested that more research and program development are needed to substantiate the potential usefulness and cost-effectiveness of protocols in use for the long-term management of TBI and polytrauma, including:

- Prospective clinical surveillance to allow early detection and intervention for health complications;
- Protocols for preventive interventions that target high-incidence or high-risk complications;
- Protocols for training in self-management aimed at improving health and well-being;
- Access to medical care to treat complications; and
- Access to rehabilitation services to optimize functional abilities.⁹

According to the IOM, the array of potential health outcomes associated with TBI suggests that injured servicemembers and veterans will present long-term medical and psychosocial needs from the persistent physical disability as well as cognitive deficits and psychosocial problems that may develop in later life. Access to rehabilitation therapies are essential—including psychological, social, and vocational services. Although VA has established a comprehensive system of rehabilitation services for polytrauma and severe TBI patients that addresses acute and chronic needs that

⁷ Institute of Medicine; *Preliminary Assessment of Readjustment Needs of Veterans, Servicemembers, and Their Families*; Ch. 5, March 31, 2010.

⁸ Vanguard; *Better Care for Wounded Warriors*; Winter 2009/2010.

⁹ Institute of Medicine; *Preliminary Assessment of Readjustment Needs of Veterans, Servicemembers, and Their Families*; Ch. 5, March 31, 2010.

arise in the initial months and years after injury—protocols and programs to manage the devastating lifetime effects that many of these veterans must live with are not in place and have not been studied for either military or civilian populations. We concur with IOM that as in other chronic health conditions, long-term management of TBI may be effective in reducing mortality, morbidity, and associated costs of VA’s caring for this extraordinary population.¹⁰

VA testified that in 2007 it developed and implemented Transitional Rehabilitation Programs at each PRC. These facilities consist of 10-bed residential units with a home-like environment to facilitate community reintegration. The average stay is approximately 3 months in one of these rehabilitation units. Other specialized services developed by VA include the establishment of an Emerging Consciousness care path at the four PRCs for severe TBI patients that are slow to recover consciousness as well as a program to evaluate ocular health and visual function.¹¹ According to VA it has also developed policies regarding comprehensive long-term care for post-acute TBI rehabilitation that includes residential, community and home-based components utilizing interdisciplinary treatment teams.¹² However, in some cases it may be difficult to find appropriate residential placement options for OEF/OIF veteran patients who are ready for discharge from acute rehabilitation but unable to return home. For many of these severely disabled young men and women medical foster care or nursing home placement is not an appropriate option. However, we are not aware of any age-appropriate, government sponsored facilities for this unique younger patient population with polytraumatic injuries and brain injury. These types of facilities for long-term placement only exist in the private sector, but again, they may not be appropriate placement options for a variety of reasons. In this connection, DAV National Commander Barrera heard about an extraordinary proposal called “Heroes Ranch” while on his visit to the Tampa PRC.

We understand that 85 acres of land is available for the proposed Tampa-area Heroes Ranch—and would serve as a post-acute long-term care residential brain injury facility for active duty military servicemembers and veterans. The location of the land for the proposed Ranch is approximately 15 miles from the Tampa VA PRC. This cutting edge residence would serve the most severely injured—including individuals in a vegetative state, patients with neurobehavioral problems, and those persons that require a structured day program for ongoing recovery after completing acute inpatient rehabilitation. According to the proposal a three-tiered program would include:

1. Post-acute long-term care for patients in a state of emerging consciousness who have completed twelve weeks of acute inpatient TBI rehabilitation and whose families are not ready, or are unavailable, to care for them at home;
2. Sub-acute residential rehabilitation in a safe environment to treat patients with residual neurobehavioral issues; and
3. Outpatient day rehabilitation in a structured environment for brain injured, neurologically and cognitively impaired veterans.

To meet the long term needs of this unique population and the goal of an interdisciplinary approach, resources would be needed to staff the facility with a Medical Director to guide a team consisting of psychiatrists, neuropsychologists, psychologists, physical therapists, speech/cognitive therapists, recreational therapists, occupational therapists, vocational counselors, psychosocial counselors, nursing staff, nurse practitioners, physician assistants, living skills advisors, social workers, administrative personnel, and family therapists as well as support personnel, equipment and supplies.

We understand this proposal is pending consideration within VA but not yet formally approved or funded. We ask that the Subcommittee inquire about this exceptional idea in order to clarify VA’s intent. Clearly, an offsite VA therapeutic residential facility of this type is needed to ensure the ongoing recovery of this uniquely and catastrophically disabled veteran population, and as an aid to their families. VA’s mission is to provide leadership excellence for therapeutic, rehabilitative, vocational, and recreational services to sick and disabled veterans, and as a nation, it is our duty to ensure that a proper life-time age appropriate care center is estab-

¹⁰ Ibid.

¹¹ R. Jesse, M.D., Ph.D., Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Armed Services*; June 22, 2010.

¹² L. Beck, Ph.D., Chief Consultant, Office of Rehabilitation Services, Office of Patient Services, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Veterans Affairs*; May 5, 2010.

lished within VA for these men and women who courageously served the nation and nearly made the ultimate sacrifice. DAV has testified in the past before this Committee to support VA's development and deployment of therapeutic residential care facilities for our newest war generation. On May 7, 2007, Adrian Atizado, DAV Assistant National Legislative Director, gave the following testimony:

Mr. Chairman, when we think of long-term care, we assume that these programs are reserved for the oldest veterans, near the end of life. Today, however, we confront a new population of veterans in need of specialized forms of long-term care—a population that will need comfort and care for decades. These are the veterans suffering from poly-traumatic injuries and traumatic brain injuries as a consequence of combat in Iraq and Afghanistan. In discussion with VA officials, including facility executives and clinicians now caring for some of these injured veterans, it has become apparent to DAV and others in our community that VA still needs to adapt its existing long-term care programs to better meet the individualized needs of a truly special and unique population. VA's existing programs will not be satisfactory or sufficient in the long run. In that regard, VA needs to plan to establish age-appropriate residential facilities, and additional programs to support these facilities, to meet the needs of this new population. While the numbers of veterans sustaining these catastrophic injuries are small, their needs are extraordinary. While today they are under the close supervision of the Department of Defense and its health agencies, their family members, and VA, as years go by VA will become a more crucial part of their care and social support system, and in many cases may need to provide for their permanent living arrangements in an age-appropriate therapeutic environment.

We are very pleased to see that at least one PRC, such planning for these unique therapeutic residential facilities is now underway. We strongly endorse the development of the facility in Tampa as well as the establishment of similar facilities in other areas of the country with concentrated populations of severely injured veterans with polytrauma and TBI.

Another issue DAV is concerned about relates to family caregiver needs and VA's pending implementation of the family support provisions of Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010. We ask the Subcommittee to provide oversight at regular intervals to ensure VA is making progress to fully implement all of the provisions in this important Act, and especially to move forward rapidly on provisions that are uncomplicated (more flexible and expanded respite services, for example). Caregivers of the severely wounded have waited years for this important and comprehensive package of services mandated in this precedent-setting legislation.

Likewise, although much of the knowledge DoD and VA have gained on TBI is likely to transfer to the care of polytrauma patients, the information needs of caregivers of patients with catastrophic injuries may be distinct from those with TBI because the context, number and severity of the injuries and the amount and type of medical information required to treat them are more vast and complex. Similarly, administrative information is complex because patients are often involved in two, or sometimes three, health care and benefit systems simultaneously, including DoD and TRICARE, VA, and private, contract hospitals or clinics in their home communities. Research is needed to assess the specific information needs of caregivers who face these complexities.¹³

Furthermore, researchers suggest that few studies have been conducted to determine the information needs of families based on severity of injury, to determine the best timing and approach to communicate information based on the patient's level of cognitive functioning, or the best training for providers on communicating with families who are grieving or angry about their loved one's conditions and often-changing prospects for survival and recovery—especially early on in this process. Family caregivers respond and adjust differently depending on family composition, kinship to patient and other factors. No research exists today that addresses different information needs of family members, according to caregiver gender, on polytrauma or TBI cases.¹⁴ We believe such research should be done on a priority basis.

As required by section 1702 of Public Law 110-181, the National Defense Authorization Act of 2008, and according to VA in testimony earlier this year, VA has developed and implemented a national template to ensure that it provides every vet-

¹³J. M. Griffin, PhD, G. Friedemann-Sánchez, PhD, et al; JRRD; *Families of Patients with Polytrauma: Understanding the Evidence and Charting a New Research Agenda*; Vol. 46, No. 6, pp 879-892, 2009.

¹⁴Ibid.

eran receiving inpatient or outpatient treatment for TBI who requires ongoing rehabilitation, an individualized rehabilitation and community reintegration plan. VA integrates this national template into its electronic health record, and includes in the record results of the comprehensive assessment, measurable goals that were developed as a result of the plan, and recommendations for specific rehabilitative treatments. The patient and family participate in developing the treatment plan and are provided a copy of the plan. According to VA, since April 2009, in consonance with this mandate, 8,373 of these individualized plans have been completed and filed for veterans who receive ongoing rehabilitative care in VA.¹⁵

Intervention studies that test the effectiveness of communication strategies for families and caregivers of those with a TBI are almost entirely absent, and these same gaps, therefore, probably occur in cases of caregivers of patients with polytrauma. Currently, no evidence-based guidelines have been developed on best practices for communication and education to support the adaptation and adjustment of families of patients with polytrauma across the continuum of treatment, rehabilitation, and lifelong services.¹⁶ DAV believes these studies should be done and the results of them distributed across the Polytrauma System of Care.

While DAV believes great strides have been made over the past two years, VA recently acknowledged embracing opportunities for further improvement in its Polytrauma System of Care, and states the Department's ongoing goals as follows:

1. Ensuring that blast-exposed veterans receive screenings and evaluation for high-frequency, invisible sonic wounds that may produce mild TBI, PTSD, and other psychiatric problems, or pain and sensory loss;
2. Promoting identification and evaluation of potentially the best practices for polytrauma rehabilitation, including those that optimize care coordination and transition across care systems and settings such as DoD and VA;
3. Optimizing the ability of caregivers and family members to provide supportive assistance to veterans with impairments resultant from polytrauma and blast-related injuries;
4. Identifying and testing methods for improving process of care and outcomes, even when the evidence base is not well established; and
5. Identifying and testing methods for measuring readiness to implement and sustain practice improvements in polytrauma care.¹⁷

Historically, VA has focused its health care system on individual veterans, often to the exclusion of the needs of their family members, even including family caregivers. Thus, family-centered care is relatively new in VA. In that regard we were pleased to learn that the Minneapolis PRC, located at the Minneapolis VA Medical Center, has participated in a six-month pilot program designed to embrace the principles of family-centered care, and to include families as partners in care delivery of their wounded loved ones. As a part of this pilot program, a "Family Care Map" was created. The Family Care Map is a web-based resource that helps families navigate the many layers of information, ranging from where to find temporary lodging to locating sources of personal counseling. Soon this Web site is expected to be migrated to the main VA Web site for the VA Polytrauma System of Care so that all PRC-involved families may benefit from access to consolidated information to help them cope with these extraordinary circumstances.¹⁸

We appreciate VA's efforts to standardize family-centered care and improve communications for this population and urge VA to move forward quickly to make this important information available to these families. Overall, based on our monitoring of their progress and as reviewed in this testimony, we believe that in most cases DoD and VA PRCs are collaborating well with respect to the most severely injured and are providing comprehensive, coordinated care in PRCs for this relatively small population. However, DAV remains concerned about the gaps that exist in the Federal Recovery Coordination Program and social work case management essential to coordinating complex components of care for polytrauma patients and their families.

¹⁵L. Beck, PhD., Chief Consultant, Office of Rehabilitation Services, Office of Patient Services, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Veterans Affairs*; May 5, 2010.

¹⁶J. M. Griffin, PhD, G. Friedemann-Sánchez, PhD, et al; JRRD; *Families of Patients with Polytrauma: Understanding the Evidence and Charting a New Research Agenda*; Vol. 46, No. 6, pp 879-892, 2009

¹⁷VA QUERI Fact Sheet; *Polytrauma & Blast-Related Injuries*; June 2010.

¹⁸C. Hall, RN, PhD, CCDOR, Minneapolis VAMC; Second Annual Trauma Spectrums Disorders Conference; *VA Polytrauma Rehabilitation Centers' Family Care Collaborative*; December 10, 2009.

These gaps were highlighted by disabled veterans and their families in hearings held by the House Veterans' Affairs Subcommittee on Oversight and Investigation in 2009 and 2010 and warrant continued oversight and evaluation.

In testimony VA, reported the development and implementation of its "TBI Screening and Evaluation Program" for all OEF/OIF veterans who receive care within VA. According to VA, from April 2007 through March 2010:

- 408,474 OEF/OIF veterans were screened for possible TBI;
- 56,161 who screened positive were evaluated and received follow-up care and services appropriate to their diagnosis and their symptoms;
- 30,368 were confirmed with a diagnosis of mild TBI; and
- Over 90 percent of all veterans who were screened were determined not to have TBI, but all who screened positive and completed a comprehensive evaluation were referred for appropriate treatment.¹⁹

In 2009, VA and DoD collaboratively developed a clinical practice guideline for mild TBI and deployed this methodology to health care providers in both systems, and provided other recommendations as well in the areas of cognitive rehabilitation, driver training, and the management of the comorbidities of mild TBI, posttraumatic stress disorder (PTSD) and pain. Also, the 2009 VA-led collaboration with DoD and the National Center for Health Statistics produced revisions to the International Classification of Diseases, Clinical Modification (ICD-9-CM) diagnostic codes for TBI, resulting in significant improvements in the identification, classification, tracking, and reporting of TBI and its associated symptoms.²⁰ These are late-arriving, but welcome, improvements during the sunsetting of our wars overseas. As more and more veterans are being identified with mild to moderate TBI, some several years after-the-fact, VA appears to be making progress, but we are concerned it may still lack a robust universal system of treatment and care for this population.

Although there are not definitive numbers on how many veterans may need specialized services for mild to moderate TBI in the next five years—the findings from initial studies, articles and reports on these conditions, including PTSD and other post-deployment mental health issues, and VA's current workload based on preliminary mental health and TBI screening numbers for OEF/OIF veterans indicate that in the near future, VA will likely be confronted with a significant population seeking care. To this regard, DAV remains concerned that screening and treatment of veterans with mild-to-moderate TBI in medical centers outside the five designated VA PRCs may not be receiving a commensurate level of additional VA resources they may need to *fully* assess and care for these injured veterans. Based on our discussion with VA staff some non-PRC sites may struggle to provide timely access to care, comprehensive evaluations, treatment and support for this particular patient population. We ask the Subcommittee through its oversight of VA's specialized programs to make inquiry to ensure that sufficient resources and staff to accomplish this mission has been provided to non-PRC sites for treatment of mild-to-moderate TBI cases.

We also ask the Subcommittee to evaluate VA's current approaches and plans to ensure the care for those with mild-to-moderate TBI receive commensurate attention from VA, in contrast to the overwhelming response to the severely injured being cared for in PRC sites. We believe the situation and potential demand warrants an independent evaluation of its outpatient TBI programs. VA TBI specialists with whom we have consulted believe a new "dual track" specialized program is necessary to meet the *individualized* needs of veterans with mild-to-moderate TBI residuals accompanied by PTSD. It is likely more resources, staffing, training, research and education will be necessary to stand up effective programs to reliably deliver this type of appropriate interdisciplinary care.

Mr. Chairman, in summary, DAV has concluded that DoD and VA have done a commendable job in saving the lives of, and addressing the catastrophic medical, surgical and rehabilitative needs of a new generation of severely disabled American war veterans, but we note that recent progress was years in the making. We hope VA will now turn its attention to the unmet needs of thousands of veterans with less life threatening but troubling injuries to the brain caused by war that are still little understood but in need of appropriate attention. We also urge VA to move forward swiftly in establishing needed therapeutic residential rehabilitation facilities modeled on the Tampa proposal for the sustained and unique care of the most se-

¹⁹ R. Jesse, M.D., Ph.D., Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Armed Services*; June 22, 2010.

²⁰ *Ibid.*

verely injured OEF/OIF veterans who will not easily or possibly ever be able to return to their homes.

Mr. Chairman, this concludes my statement on behalf of DAV. I would be pleased to address your questions, or those of other Subcommittee members.

Prepared Statement of Tom Tarantino, Legislative Associate, Iraq and Afghanistan Veterans of America

Mr. Chairman, Ranking Member, and members of the subcommittee, on behalf of Iraq and Afghanistan Veterans of America's one hundred and ninety thousand members and supporters, I would like to thank you for allowing us testify before your subcommittee on "Healing the of Physical Injuries of War."

"Veterans need to know that their country will continue to take care of their service-related injuries. A servicemember's body pays a heavy toll from the high physical demands of deployments. It's more than just paying disability claims, it's a back or knee that starts to cause problems for a middle-aged man because he spent four years humping with a pack and patrolling with 60 lbs of gear."— IAVA Veteran

My name is Tom Tarantino and I am a Legislative Associate with IAVA. I proudly served 10 years in the Army beginning my career as an enlisted Reservist, and leaving service as an Active Duty Cavalry Officer. During these ten years, my single most important duty was to take care of other soldiers. In the military they teach us to have each other's backs. And although my uniform is now a suit and tie, I am proud to work with this Congress to continue to have the backs of America's servicemembers and veterans.

Over the past few years this Committee has helped secure impressive improvements to the VA health care system. For the first time in over twenty years, the VA now has a timely and fully funded budget that will end the practice of rationing health care services. The VA is developing a virtual lifetime service record that will seamlessly transition a veteran's health record from DoD to the VA, ensuring a higher quality of care. Female veterans can now receive postnatal care for their newborn babies, and family caregivers of severely wounded veterans will have the training and assistance they need to support their loved ones. Thank you for all the work this Committee has done and will continue to do in the months and years to come.

Specifically, we look forward to the work this Committee will do to continue to improve VA health care. The VA is the largest health care provider in the nation, and overall, it provides much higher quality of care than the nation's private sector hospitals. The pressing problem with the VA health care system is not the quality of care, but a lack of access to the system. In order to continue to improve on both the quality of care and access to the system, IAVA fully supports all of the recommendations contained in this year's Independent Budget that address issues related to specialized services, access to care, invisible wounds, prosthetics, long term-care, finance and administration. IAVA would like to focus our testimony on just few of those key issues as they relate to Iraq and Afghanistan veterans seeking treatment for combat injuries, especially Traumatic Brain Injury.

We asked our members what they thought of the treatment they were receiving at the VA and we received a wide range of opinions, both complimentary and critical. However, several common themes appeared: 1) Long waits for quality appointments 2) Rude administrative staff 3) Growing distrust of VA health care 4) Long drives to VA facilities. We received only a few complaints about the actual quality of care at the VA.

I. Rethink and adapt the VA's rehabilitation practices for wounds of the wars in Iraq and Afghanistan

Traumatic Brain Injury (TBI) is the signature wound of the wars in Iraq and Afghanistan. To properly treat these returning combat veterans with mild to severe TBI, the VA must completely rethink and adapt their medical rehabilitation practices just as the DoD has had to adapt to fight an unconventional war against insurgents.

"I suffered a TBI in Iraq and now have PTSD. Due to my symptoms, I lost my job, my family, my self-respect and for a time, my freedom! I have had to swallow my pride and accept Government assistance. I would rather work but the jobs I might be able to hold for a short time pay so little I would not be able

to visit and take care of my sons. At times I feel like a complete failure.”—IAVA Veteran

As our friends over at Wounded Warrior Project (WWP) have stated, any successful rehabilitation of a veteran suffering from TBI “must be veteran-centered.” This means ensuring that all TBI patients are given a thoughtful individualized rehabilitation plan that is thorough and honest about what the VA can and cannot provide. Any rehabilitation plan must include the veteran’s family as a core component to rehabilitation.

“After my wife straightened out the VA doctors and fired a few, I finally got a doctor that truly listens and does what needs to be done to make sure I have what I need. She spends time talking with me and my wife. Some of the doctors have a problem talking with my wife, but I have a TBI and I don’t understand things well and she explains them to me and makes sure I do as I am suppose to. She is my caregiver and my best friend. She advocates for me and does whatever she has to, to make the doctor understand me, and vice versa.”—IAVA Veteran

IAVA is concerned that the VA has limited or denied access to some veterans seeking recovery services for Traumatic Brain Injury. Current statute requires that the VA provide services to “restore” function to wounded veterans.¹ Full recovery should always be the desired outcome for a rehabilitation plan. However, sustaining current functions or preventing future harm should also warrant access to VA services. I have no doubt that the members of this committee agree that the VA’s role isn’t just to help those who might get better, but it also to help those who might get worse. IAVA recommends adjusting these statutes to embrace the realities of injuries like TBI. Veterans should be able to focus more on recovery then fighting with the VA.

“I have a possible traumatic brain injury or it could be PTSD but whatever it is, there is no way I could sit there and try and read through 10 pages of legal speak. Believe me I tried. Even if I read through all of it, I have no idea what I am reading cause I can’t focus on anything.”—IAVA Veteran

II. I have to wait how long to see a VA doctor?

Among IAVA members seeking services at the VA, the single most common complaint is how long it takes to schedule an appointment.

“I did visit the VA, but will not again. Sorry to say, but the process to get an appointment is impossible. I had to get an appointment to get an appointment. What I mean is this—It took 3 weeks to get an appointment to see a nurse who assessed my injury, then she made an appointment to for me to see a doctor about my injury for 3 weeks later. By the time I was able to see a doctor, it was over 6 weeks. I lost 2 days of work. It seems like the process is set up to discourage patient care.”—IAVA Veteran

When veterans began returning home from Iraq and Afghanistan, the VA was caught unprepared, with a serious shortage of staff and an exceedingly inadequate budget. Wait times varied regionally, but for some patients, lasted six months or more. The problems weren’t limited to primary care along; the backlog was especially severe for veterans seeking mental health treatment. In recent years, wait times for primary and specialty care at the VA have improved, but approximately 8 percent of patients—or more than 450,000 veterans—are still waiting more than 30 days for their desired appointments, according to the VA.² Moreover, the VA’s Inspector General suggests that wait may be even longer than the VA admits. And there are still some veterans who have “to wait on the phone for 2+ hours to speak with someone to set an appointment with [a] primary care physician that ends up being 4–6 weeks away from the date of my call.” Even when veterans are able to schedule an appointment, many times they still have to sit around the hospital for hours once they arrive because the VA “booked 20 patients during a 2 hour window.”

For veterans, long wait times mean that they may have to suffer for months until their next appointment or opt for not receiving the care they need at all.

¹“such professional, counseling, and guidance services and treatment programs as are necessary to restore, to the maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person.” 38 U.S.C. 1701(8).

²VA Performance and Accountability Report, FY 2009, p. II- 145.

“Ortho is a nightmare. I had to schedule a cortisone shot 2 ½ months in advance, even though my shoulder was in pain now.”—IAVA Veteran

Just as the VA is working to address the VA disability backlog, the VA must continue attacking the issue of long appointment wait times. As recommended in the Independent Budget, the solution involves improved tracking, a completely revamped scheduling IT system and an increase in the number of medical providers in critical areas. To this end, IAVA supports the following recommendations from the Independent Budget:

- The Veterans Health Administration should make external comparisons to measure its performance in providing timely access to care.
- The VHA should fully implement complementary aspects of the Institute for Health care Improvement’s Advanced Clinic Access principles and measures for primary and specialty care to maximize productivity of clinical care resources by identifying additional high-volume clinics that could benefit.
- VA should consider implementing complementary recommendations contained in the Booz Allen Hamilton report Patient Scheduling and Waiting Times Measurement Improvement Study.
- The VHA should certify the validity and quality of waiting time data from its 50 high-volume clinics to measure the performance of networks and facilities.
- The VHA should complete implementation of the eight recommendations for corrective action identified in the July 8, 2005 report by the VA Office of Inspector General.
- VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the OIG’s recommendations.

III. How far is too far to drive?

Some veterans have to drive for an “entire day to get to their local VA facility” and IAVA is concerned that the VA has yet to develop a consistent and humane policy for answering an age old question, “How far is too far to make a veteran drive to the VA?” About 3 million veterans, or 37.8 percent of veterans enrolled in the VA system, reside in rural areas,³ and as of 2003, “more than 25 percent of veterans enrolled in VA health care—over 1.7 million— live over 60 minutes driving time from a VA hospital.”⁴

“I have an obvious service related injury that I receive a prescription for (Celebrex for a knee that was injured by IED) . . . rather than give me a referral to a local orthopedist in town, they wanted me to drive 5.5 hours to Tucson, which I could not do because of a busy work schedule. The whole process is very slow and cumbersome.”—IAVA Veteran

IAVA acknowledges that the VA can’t always be a short drive from every veteran. However, we believe that the VA should issue clear guidelines for when a veteran lives too far from a local VA facility. These veterans should be given the choice to continue using the VA or access more convenient local medical care.

“My main concern with the VA health care system is distance. We only have an outpatient clinic here and if I need anything more than a flu shot, I have to drive 125 miles to the nearest VA hospital.”—IAVA Veteran

IAVA also believes that the VA should assist veterans who need to drive to their appointment or need a ride. IAVA recommends that that the VA should (1) Promote, oversee, and evaluate a pilot program that provides a network of drivers for veterans struggling to find transportation to the nearest VA hospital and (2) Provide a lodging stipend and mileage reimbursement for veterans forced to travel long distances for VA medical care, comparable to the stipend paid to VA employees when they travel.

“For anything dental or surgical I have to travel 2 hours and often times for appointments that don’t last 30 minutes. Additionally, because I don’t qualify for travel pay, I often have to ask social workers for gas cards. The SWs appear to be annoyed by me whenever I ask for their assistance in obtaining gas cards.”—IAVA Veteran

³ U.S. Department of Veterans Affairs, “About Rural Veterans: Common Challenges Faced by Rural Veterans,” January 6, 2010: <http://www.ruralhealth.va.gov/RURALHEALTH/AboutRuralVeterans.asp>.

⁴ GAO-03-756T, “Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs,” May 8, 2003, p. 6: <http://www.gao.gov/new.items/d03756t.pdf>.

IV. "I hear the VA is a nightmare."

Some of our members openly fear the VA. Recent media reports about HIV and Hepatitis exposure have only served to fuel that fire. A veteran returning home from Afghanistan who reads about his or her battle buddies being exposed to infectious diseases while being treated at the local VA will likely think twice before seeking the care s/he needs.

"As a Navy Hospital Corpsman who has worked in a VA hospital I am nervous about care provided by the VA."—IAVA Veteran

Whether or not these fears are warranted is a topic for another hearing, but the end result is still the same, VA health care has a public relations problem. Until the VA adequately addresses this issue many combat veterans will be weary to seek treatment. IAVA believes that the VA must address this issue head on by owning the mistake, doing everything in their power to take care of those affected and then redoubling efforts to make sure proper medical procedures are followed at other facilities.

What we don't want to see are stories like the saga of Judy Yarzebinski. After being treated at a local VA she was notified that she had been exposed to dirty equipment. Sadly she tested positive for hepatitis C and due to other medical issues cannot be treated for it. Judy will now have to live with fevers, headaches, fatigue, loss of appetite, nausea, vomiting, and diarrhea for the rest of her life. To make matters worse the VA now denies having caused the exposure in the first place. Public battles such as this are exactly what make weary veterans reluctant to seek out VA care.

IAVA believes that in order for the VA to conduct effective outreach, it must centralize its efforts between VHA, VBA, and NCA and aggressively re-brand itself as one Department of Veterans Affairs. The average veteran (and the average American for that matter) does not understand the difference between the VHA and the VBA. When I wait an entire semester for my GI Bill check to come, I'm upset with the VA, not the VBA. When I wait 2 months for a medical appointment, I'm upset with the VA, not the VHA. If the VA wants to effectively improve communications, it must speak to the veteran population clearly, and re-brand itself to the American people.

The Department of Veterans Affairs must develop a relationship with service-members while they are still in the service. Like many successful college alumni associations that greet students at orientation and put on student programs throughout their time in college, the VA must shed its passive persona and start recruiting veterans and their families more aggressively into VA programs. Once a veteran leaves the military, the VA should create a regular means of communicating with veterans about events, benefits, programs and opportunities. IAVA is encouraged by the development of the Veterans Relationship Manager. Leveraging modern technology to develop a single means of communication between all sectors of the VA and a veteran is a step in the right direction. If a veteran received half as many letters and emails from the VA, as college grads do from their alumni association, we would be getting somewhere.

To assist in building this relationship IAVA recommends automatically enrolling all troops leaving active-duty service, whether from the active or reserve component, in VA health care.

"Getting a VA card AND being vested (and what vested means) is a great way to prepare, even for those who work and have their own insurance, in case of lay off or other emergency."—IAVA Veteran

In addition to providing a more seamless transition for separating combat veterans, automatic enrollment will cement the relationship between the VA and veterans.

Overall the VA continues to provide good care to our nation's veterans. However, we must continue to strive for better. In the military, they teach us to never stop improving our fighting position and be forever vigilant. It is this proactive ethos that continues to lead to victory on the battlefield. If we are to honor the service and sacrifice of America's warriors, we must instill this spirit in all of the services that we develop to care for them. No one program or piece of technology will solve these problems, but together we can ensure that the citizens of this country have a system of care that honors the freedoms that we enjoy and care for those who have sacrificed blood and limb on our behalf.

**Prepared Statement of Denise A. Williams, Assistant
Director for Health Policy, Veterans Affairs and
Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the Department of Veterans Affairs (VA) efforts in caring for the severely injured servicemembers from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

The current Global War on Terror (GWOT) has introduced more sophisticated forms of weaponry than in previous conflicts. As a result, our servicemembers are sustaining severe and unique wounds. The Department of Defense (DoD), reports that as of April 3, 2010, a total of 8,810 servicemembers have been wounded in action during OIF and 2,038 have been wounded in action during OEF. Servicemembers are surviving their wounds in considerably higher numbers because of advancements in body armor, helmets, and improved battlefield medical care. Currently the survival rate for wounded servicemembers is about 90 percent due to these improvements in equipment and the timely and effective application of emergency medical treatment. The improvised explosive device (IED) is the weapon of choice for our enemy, and is insidious in its utilization and often even more devastating in its long-term effects than gunshots due to the multiple and terrible wounds and burns it produces. These devices have resulted in amputations, Traumatic Brain Injuries (TBI), spinal cord injuries, and blindness.

Amputation: Prosthetics and Sensory Aids

The United States military operations in Iraq and Afghanistan have produced a significant number of service men and women with amputations. According to the DoD as of April 3, 2010, there has been a total of 1552 servicemembers that suffered amputations. This unique population of younger servicemembers requires extraordinary medical care and rehabilitation. Walter Reed Army Medical Center (WRAMC), among many DoD facilities dedicated to assisting wounded warriors, has highly advanced programs to care for warriors with amputations. In addition, there is an array of specialty physicians, rehabilitation, psychological support groups, recreation sports group, and vocational counselors. Once these servicemembers transition from the military to the civilian world, their care is essentially in the hands of the Veterans Health Administration (VHA). In response to the large number of veterans with prosthetics and rehabilitative needs, VA established Polytrauma Rehabilitation Centers (PRC). The VA Polytrauma Rehabilitation Centers provide treatment through multi-disciplinary medical teams including Cardiologists, Internal Medicine, Physical Therapist, social work and Transition Patient Case managers and much more specialty medical service areas, to help treat the multiple injuries. Currently, VA maintains four VA Polytrauma Rehabilitation Centers in Richmond, VA; Minneapolis, MN; Palo Alto, CA and Tampa, FL.

However, the American Legion is concerned about VA's ability to consistently meet the long term needs of these young veterans. As stated by the *Military Medicine* Journal, rehabilitation is a crucial step in optimizing long-term function and quality of life after amputation. Although returning veterans with combat-related amputations may be getting the best in rehabilitative care and technology available, their expected long term health outcomes are considerably less clear. It is imperative that both DoD and VA clinicians seriously consider the issues associated with combat-related amputees and try to alleviate any foreseeable problems that these OIF/OEF amputees may face in the future. The *Military Medicine* Journal further cautioned that research findings indicate that traumatic lower-limb amputees, particularly bilateral transfemoral amputees, are vulnerable to a number of health risks including Cardio Vascular Disease (CVD) and Ischemic Heart Disease (IHD). Considering these facts, The American Legion recommends that VA conducts further research on this matter to stay ahead of the curve and counter any long-term issues these veterans may encounter as they get older.

The VA has made great strides in addressing the increased influx of young veterans with amputations. However, it has been reported that VA does not have the state-of-the art prostheses available in comparison to the Department of Defense. That is why it is of utmost importance that VA receives the adequate funding to ensure that *all* VA medical centers are fully equipped to address these veterans' prosthetic needs. This is especially vital for the veterans that reside in rural and highly rural areas. It would be a grave disservice to these veterans if they have to bear the burden of travelling hundreds of miles in order to receive health care in addition to enduring their debilitating condition. The American Legion applauds VA

on the establishment of the Prosthetics Women's Workgroup to enhance the care of female veterans in regard to their prosthetics requirements. Despite this implementation, there are still cases where the fitting of the prostheses for women veterans has presented problems due to their smaller physique. The American Legion urges VA to increase their focus on amputation and prosthetics research programs in order to enhance and create innovative means to address this population of veterans' health care needs.

Polytrauma Centers

The VA has designated five VA Medical Centers as Polytrauma Rehabilitation Centers (PRC). These centers provide specialized care for returning servicemembers and veterans who suffer from multiple and severe injuries. They also provide specialized rehabilitation to help injured servicemembers or veterans optimize their level of independence and functionality. In addition to the four centers mentioned above, there is a fifth center currently under construction in San Antonio, TX. In addition to the five designated sites, VA has established 18 Polytrauma Network Sites (PNS); one in each Veterans Integrated Service Network (VISNs); and approximately 81 Polytrauma Support Clinic Teams to augment the care of those with severe/multiple injuries.

The Veterans Health Administration defines polytrauma as two or more injuries sustained in the same incident that affect multiple body parts or organ systems and result in physical, cognitive, psychological, or psychosocial impairments and functional disabilities.

During our "System Worth Saving" site visits to the Polytrauma centers some facilities reported that there were staffing shortages in certain specialty areas such as: physical medicine and rehabilitation, speech and language pathology, physical therapy, and certified rehabilitation nursing. This was attributed to the competitive salaries being offered for these positions in the private sector. Considering the complex nature of these severely wounded veterans The American Legion finds this unacceptable. The Department of Veterans Affairs needs to step up their recruiting efforts in these areas so that in the future these veterans are not faced with the dilemma of going outside of the VA for care.

Blind Rehabilitation

There are currently 49,460 blind veterans enrolled in the VA health care system and that number is expected to increase because of the number of eye injuries in Iraq and Afghanistan. The Department of Defense reports that in the current conflict, eye injuries account for 13 percent of all injuries. The *American Academy of Ophthalmology* reports that eye injuries are a very common form of morbidity in a combat environment. Although effective counter measures have been developed to protect some parts of the human body against the effects of IEDs, such as body armor to protect the chest and abdomen, and helmets which protect the brain, there are no proven counter measures effective for protection of the eyes which will not impair visual requirements. Consequently, many warriors who survive blasts now face a future with terrible burns, amputations, and blindness.

The Department of Defense does not provide rehabilitation for blindness. Unlike other injuries where after rehabilitation warriors may be retained and continue service, blinded warriors are medically discharged and are relegated to utilizing the VA for their rehabilitative needs. Currently VA employs about 155 Visual Impairment Service Team (VIST) Coordinators and 73 Blind Rehabilitation Outpatient Specialists (BROS). Given the prediction that the number of blinded veterans is expected to increase over the next several years, The American Legion urges VA to recruit more specialists to fill this gap. In addition, VA has a long history of providing inpatient and outpatient care for blind veterans. However, this has been for the older veteran population with visual impairment or blindness due to their age. Mr. Chairman, The American Legion would like to encourage VA to continue to modernize their overall rehabilitation programs and approach in order to help these newly blinded and younger veterans meet and overcome the challenges of visual impairment.

Section 1623 of the National Defense Authorization Act of 2008 requires DoD to establish a Center of Excellence (COE) in the prevention, diagnosis, treatment, and rehabilitation of eye injuries and for DoD to collaborate with VA on all matters pertaining to the center. In addition, Section 1623 directs DoD and VA to implement a joint program on traumatic brain injury post traumatic visual syndrome, including vision screening, diagnosis, rehabilitative management, and vision research. Unfortunately, the center has yet to be fully established because of constant funding

delays and bureaucratic hurdles. The American Legion calls for immediate action from the Secretary of Defense and the Secretary of VA to rectify this important issue.

Spinal Cord Injury Centers

As with most serious injuries, spinal cord injury is a life-altering and chronic condition that can affect an individual's independence, sense of self worth, and create additional health problems. The Veterans Health Administration reported that since Fiscal Year 2003, they have treated a total of 503 active duty servicemembers at their Spinal Cord Injury (SCI) Centers and of that number 162 sustained their injury in combat. The Veterans Health Administration is the largest health care system to care for spinal cord injuries. VA has a total of 24 SCI centers throughout the country and they serve about 14,000 veterans annually. The *Journal of Women's Health* reports that spinal cord injury patients are at a greater risk of having chronic conditions, especially as they get older. It is important that VA receives sufficient funding to ensure adequate staffing at these facilities to provide the necessary long-term care to these veterans.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on these important issues.

That concludes my written statement and I would welcome any questions you may have.

**Prepared Statement of Jack Smith, M.D., MMM, Acting Deputy
Assistant Secretary for Clinical and Program Policy,
U.S. Department of Defense**

Introduction

Chairman Michaud, Congressman Brown, distinguished Members of the Subcommittee, thank you for the opportunity to appear here to talk to you about the Department of Defense's (DoD) medical care for physical injuries in combat. On behalf of DoD, I want to take this opportunity to thank you for your continued support and demonstrated commitment to our servicemembers, veterans, and their families. Today, I will describe some of the aspects of DoD medical care for severely injured servicemembers who have returned from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

On October 16, 2009, Secretary of Defense Gates stated "Beyond waging the wars we are in, treatment of our wounded, their continuing care, and eventual reintegration into everyday life is my highest priority. I consider this a solemn pact between those who have risked and suffered and the nation that owes them its eternal gratitude." We who work in military medicine completely agree with Secretary Gates.

Prevalence of Injuries in OIF and OEF

Over the last nine years, a new era of combat has emerged in which our servicemembers are constantly challenged by the demands of a high operational tempo. More than 2.1 million servicemembers have deployed to OEF and OIF from October 2001 to May 30, 2010. Of those, 31,882 were wounded in action in OIF, and 6,773 were wounded in action in OEF. A total of 61,874 servicemembers have been transported out of Iraq and Afghanistan to receive medical care. Of those who were transported, 18 percent were for battle injuries, 21 percent were for non-battle injuries (such as motor vehicle injuries), and 61 percent were for diseases.

DoD Care for Polytrauma

Severely injured servicemembers often require prolonged and intensive medical treatment and rehabilitative care. DoD has addressed this challenge by establishing specialty centers of excellence. DoD also has strengthened its partnership with the Department of Veterans Affairs, including with the four Polytrauma Rehabilitation Centers. Servicemembers who sustain severe injuries require complex, well-integrated care from a variety of medical specialties, which DoD provides at centers that specialize in providing care for combat trauma.

Key components of DoD health care for severely injured servicemembers include three DoD amputee care centers, the Brooke Army Medical Center Burn Center, and the Defense and Veterans Brain Injury Center. DoD has established three

major centers that specialize in the treatment and rehabilitation of combat injuries. The Military Advanced Training Center at Walter Reed Army Medical Center opened in 2007 to provide optimal amputation care and prosthetics. The Center for the Intrepid at Brooke Army Medical Center opened in January 2007 in San Antonio to provide state-of-the-art rehabilitation for servicemembers with amputations or severe burns. The Comprehensive Combat and Complex Casualty Care Center at the Naval Medical Center San Diego has a similar mission; and its mission and infrastructure were expanded in 2007. Each of these three trauma care centers provides orthopedic surgery, reconstructive plastic surgery, amputee care and prosthetics, and care for traumatic brain injuries (TBI) and post-traumatic stress disorder.

DoD has long been a leader in research on improved treatments for traumatic injuries. The U.S. Army Institute of Surgical Research (USAISR) is located at the Brooke Army Medical Center in Texas. USAISR is dedicated to both laboratory and clinical trauma research. Its mission is to discover new treatments for combat casualty care for injured servicemembers across the full spectrum of military operations. In addition, USAISR is involved in providing state-of-the-art trauma, burn, and critical care to servicemembers around the world and to civilians in the local community. Brooke Army Medical Center has a world class burn care center, and it is considered one of the world's leaders in burn care research.

The Defense and Veterans Brain Injury Center (DVBIC) was established in 1992 to provide state-of-the-art care for servicemembers who were diagnosed with traumatic brain injuries (TBIs). TBI is often part of the spectrum of polytrauma, which includes spinal cord injuries, amputations, and visual and hearing impairment. DVBIC serves servicemembers and veterans with TBI and their families, through state-of-the-art medical care, and through innovative clinical research and educational programs. DVBIC has established several specialized centers, including centers at the Walter Reed Army Medical Center, Naval Medical Center San Diego, and San Antonio Military Medical Center. For polytrauma patients who have sustained a TBI, DVBIC is part of the comprehensive medical team, coordinating and contributing to multidisciplinary treatment. Through a network of TBI Regional Care Coordinators, DVBIC also assists in coordinating servicemember transitions as they move among different systems of care, including between military medical treatment facilities, Department of Veterans Affairs (VA) Polytrauma Centers, and local community care.

DoD has established three Centers of Excellence focused on hearing impairment, vision impairment, and extremity injuries and amputations. These centers collaborate to the maximum extent practicable with VA, institutions of higher education, and other appropriate public and private entities (U.S. and international) to carry out their responsibilities. In addition, they are working together to create registries that will enable them to document injuries and follow treatments of servicemembers suffering eye, ear, or extremity injuries. These centers augment the work of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), which was established in 2007. The DCoE offers a central coordinating point for activities related to traumatic brain injuries and psychological health. DCoE focuses on the full continuum of medical care and prevention to enhance coordination among the Services, Federal agencies, and civilian medical organizations.

DoD Extremity and Amputation Center of Excellence

The DoD Extremity and Amputation Center of Excellence (EACE) was approved for establishment in May 2010 pending final agreements with VA, but it has been working since early 2009 to serve as the lead organization for identifying policy issues, providing direction and oversight of a multidisciplinary network for care, and research on traumatic amputations and extremity injuries. The EACE will promote excellence in the research, diagnosis, treatment, and rehabilitation of traumatic injuries; and its vision is to assist servicemembers as they return to the highest possible levels of physical and psychological functioning. The EACE will oversee medical care from the time of injury through definitive care and rehabilitation to reduce disability and optimize the quality of life of servicemembers and veterans. EACE services will include rehabilitation, in collaboration with the VA. EACE will include several affiliated regional centers, including the three DoD amputee centers, and the VA Polytrauma Rehabilitation Centers.

DoD Vision Center of Excellence

The DoD Vision Center of Excellence (VCE) was formally established in May 2010 with the Navy as the Lead Component, but it has been working since 2008 to pro-

vide leadership in the prevention, diagnosis, treatment, and rehabilitation of eye injuries.

VA has provided the deputy director for this center. The VCE will provide clinical support for the full scope of military eye care, treatment, and research; and it will provide clinical education programs on eye injuries in servicemembers for both the DoD and VA. Servicemembers can experience vision problems through a variety of mechanisms: trauma from explosions and projectiles, vision abnormalities secondary to TBI, and eye injuries from chemical hazards, biological hazards, or extreme environmental conditions. The VCE is working with VA to coordinate transition of medical care. For example, a collaborative process has been developed at Walter Reed Army Medical Center for servicemembers to receive blind rehabilitation care from VA while they are still receiving DoD care. The VCE is involved in several innovative research projects, including evaluating treatments for blast and burn injuries to eye structures and treatments for TBI-associated visual problems. The VCE is planning to establish four Regional Clinical Centers for Ocular Disease and Trauma at military medical centers that have ophthalmology residency training programs. The VCE recently added two VA staff members with expertise in Blind Rehabilitation and Low Vision Research; they will work closely with the VA Blind Rehabilitation Centers and Polytrauma Centers in tracking and caring for patients with eye and vision injuries across the DoD and VA continuum of care. In addition, there are several research centers in DoD and VA that are collaborating with the VCE.

DoD Hearing Center of Excellence

The Hearing Center of Excellence (HCE) also was established in May 2010, but has been working since early 2009 to promote excellence in the prevention, diagnosis, treatment, and rehabilitation of hearing loss and injuries of the vestibular system in servicemembers and veterans. The Air Force is the Lead Component for this center. The scope of the HCE includes hearing loss, tinnitus, and problems with balance and equilibrium, which could be due to injuries from blasts, blunt trauma, barotrauma, and high noise levels. Hearing loss is very frequent in veterans, and hearing loss and tinnitus are the top two diseases in terms of VA disability compensation. In addition, vertigo and dizziness are common symptoms in patients with TBI. There is close collaboration with affiliated Regional Centers for Otologic Disease and Trauma at several military and VA hospitals, including Walter Reed Army Medical Center, Naval Medical Center San Diego, and Madigan Army Medical Center in Tacoma, WA. In addition, there are several research centers in DoD and VA that are collaborating with the HCE.

DoD Program on Spinal Cord Injuries

DoD is conducting a robust research program on spinal cord injuries that includes laboratory research on repair and regeneration of damaged spinal cords and clinical research to improve rehabilitation therapies. The program focuses on innovative projects that have the potential to make a significant impact on improving the function, wellness, and overall quality of life for servicemembers. The scientific areas include neuroprotection and repair, and rehabilitation and complications of chronic spinal cord injuries.

DoD Support Programs for Severely Injured Servicemembers and Their Families

DoD has developed many support resources to assist injured servicemembers, veterans, and their families. One important resource is the Recovery Coordination Program, which was established in 2008, to ensure that wounded, ill, or injured servicemembers receive the non-medical support they need to successfully navigate the road to recovery. A servicemember who has a serious injury would be eligible for a Recovery Care Coordinator (RCC), if the servicemember would not return to duty within a specified time determined by the Military Wounded Warrior Program or if the servicemember might be medically separated. The RCC works for one of the programs in any of the four Services, including the Army Reserve, as well as the Special Operations Command Care Coalition. The RCC develops a recovery plan, evaluates its effectiveness, and adjusts it as transitions occur. The RCC makes sure the plan meets the servicemember's and the family's goals, and works with the individual's Commander to coordinate the services included in the plan. Currently, there are 130 RCCs in 55 locations nationwide.

DoD provides outreach to servicemembers and families to promote awareness of the available resources. We conduct outreach to encourage servicemembers and families to seek help from these programs, when needed, and to ensure the most com-

plete recovery possible. One of the most important support resources is Military One Source, which provides assistance to servicemembers and their families to evaluate their needs, and coordinate referrals to other programs to provide the appropriate services. Military One Source is a central coordination point to ensure accessibility to the many available resources for servicemembers and their families.

Four service-specific programs provide assistance: the Army Wounded Warrior Program, Marine Wounded Warrior Regiment, Air Force Wounded Warrior, and Navy Safe Harbor. The wounded warrior programs assist and advocate for severely wounded, ill, and injured servicemembers, veterans, and their families, wherever they are located. The four Service-specific programs provide counseling, employment assistance, family support, and other services needed to transition to home and the community. These services are provided as long as severely injured servicemembers and their families require support.

Transition from DoD Care to VA Care for Severely Injured Servicemembers

DoD and VA are working together to improve their coordination of medical care for servicemembers and veterans, including those who were severely injured in OIF and OEF. The key objectives of our coordinated transition efforts include: ensuring continuity of medical care from DoD to VA health care providers; and providing clear and comprehensive information about available support programs to servicemembers and their families.

DoD takes advantage of the four VA Polytrauma Rehabilitation Centers (Tampa, Minneapolis, Richmond, and Palo Alto) to meet the needs of active-duty servicemembers who have experienced multiple, severe injuries, including TBI. DoD has a longstanding relationship with VA to ensure continuity of care, and DoD refers injured servicemembers to VA for long-term rehabilitation. From March 2003 to June 2010, more than 500 active-duty servicemembers who were injured in theater were treated in the four VA Polytrauma Rehabilitation Centers. In addition, 21 VA Polytrauma Network Sites nationwide provide continuing long-term care to these injured veterans.

In August 2003, DoD incorporated a VA Liaison Program at Walter Reed Army Medical Center to provide case management for combat veterans. When severely injured servicemembers need long-term medical care, VA liaison personnel work with them to coordinate VA services. This joint program has expanded to 12 more military hospitals. At these 13 hospitals, 27 VA nurses and social workers provide the linkage to follow-up care at VA facilities near the servicemembers' homes. As of June 2010, this program had made more than 10,000 patient referrals to VA to ensure continuity of care.

Conclusion

DoD is providing comprehensive, state-of-the-art care for severely injured servicemembers in collaboration with our partners at VA. We are committed to continued and more expansive collaboration and coordination with VA because we believe it is essential to our ability to provide servicemembers, veterans, and their families with consistently superior medical care and support services as well as continuity of care in the most comprehensive way.

Thank you for the opportunity to address this vital issue. I will be pleased to respond to any questions you may have and to participate in an ongoing dialogue to better serve our current and former servicemembers.

**Prepared Statement of Lucille B. Beck, Ph.D. Chief Consultant,
Rehabilitation Services, Office of Patient Care Services, and Director,
Audiology and Speech Pathology Service, Veterans Health Administration,
U.S. Department of Veterans Affairs**

Good Morning, Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee. Thank you for the opportunity to appear to discuss the Department of Veterans Affairs' (VA) work in caring for severely injured Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans and Servicemembers through our full complement of specialty, rehabilitative services. VA's mission includes ensuring we have appropriately staffed facilities that provide timely, accessible, coordinated, high quality specialty care for our severely injured Veterans. We appreciate Congress' support in providing VA the resources necessary to meet the needs of our Veterans.

VA is committed to helping Servicemembers transition from active duty to Veteran status as smoothly as possible. The Veterans Health Administration (VHA) is well-known for its integrated system of health care and its expertise in treating spinal cord injuries and disorders (SCI/D), traumatic brain injury (TBI), and blindness and visual impairment. Our provision of quality rehabilitation care is supported through a system-wide, long-term collaboration with the Commission on Accreditation of Rehabilitation Facilities (CARF) to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. VA continues to increase collaborations with private sector facilities to successfully meet the individualized needs of Veterans and complement VA care and services. This ensures that quality rehabilitation programs are offered in a timely manner that meet the unique needs of severely injured Veterans and provide a catalyst for improving their quality of life.

Our severely injured Veterans returning from OEF/OIF rightfully expect us to provide the latest in treatment, technology, and rehabilitation services. VA has established policies and supports its facilities to ensure that specialty services are structured appropriately, fully staffed, and effectively coordinated. We understand and appreciate the specialized skills required to deliver the care our Veterans need and deserve, and to that end VA has created numerous education and training opportunities for our clinical providers.

Facility capacity and bed occupancy rates are routinely monitored at the local level and are reported to the national program offices at least monthly to ensure our OEF/OIF Veterans have open access to our care and services. Any surge in demand for services are addressed with corrective actions such as temporarily increased staffing, use of additional existing authorized beds at the Polytrauma Rehabilitation Centers (PRCs), careful planning of elective admissions, and transfers within the Polytrauma System of Care (PSC) of non-traumatically disabled Veterans to ensure that the first priority for admissions remains allocated to Servicemembers and Veterans with severe injuries. Flexibility is available to provide additional resources at specific locations, if necessary.

My testimony will begin by explaining how VA supports and facilitates the transition and care management of severely injured OEF/OIF Veterans into specialty rehabilitation programs, then provide a detailed review of four major rehabilitation areas: VA's Blind Rehabilitation Service, its Spinal Cord Injury/Disorders program (SCI/D), the Polytrauma and TBI System of Care, and the Amputation System of Care and Prosthetics and Sensory Aids Service.

Transition and Care Management of OEF/OIF Veterans

VA recognizes that severely injured Servicemembers face a significant transition when returning home and becoming Veterans. In addition to treating Veterans with blindness, SCI&D, polytrauma/TBI, and amputations, VA and Department of Defense (DoD) have worked together through a Memorandum of Agreement for almost 30 years to deliver rehabilitation services to active duty Veterans and Servicemembers with such injuries.

As soon as the pre-requisites for medical stability are met, the DoD physician and the VA admitting physician at one of VA's specialty centers begin discussion on the patient's medical status and arrange for appropriate transportation and admission to the VA facility closest to the Veteran's or Servicemember's home. Each patient receives a customized rehabilitation plan designed to achieve patient-centered goals and maximal functional independence. Rehabilitation serves to improve any bodily functions affected by the injury, teach compensatory functions using remaining intact body systems, anticipate and prevent medical complications, alter the environment as needed, and educate the person to promote autonomy and to achieve their full potential and quality of life.

In order to make VA easier to access for those most in need, we have responded by partnering with DoD to create the Federal Recovery Coordination Program, and creating a Care Management and Social Work Service responsible for developing policies and deploying staff to VA and DoD facilities.

VA's Care Management and Social Work Service

In October 2007, VA established the Care Management and Social Work Service to address the needs of wounded and ill Veterans and Servicemembers. VA's Military Liaisons for Health care are social workers or nurses who serve as essential resources for transitioning injured and ill OEF/OIF Veterans and Servicemembers. VA now has 33 VA Military Liaisons for Health care stationed at 18 military medical treatment facilities (MTFs) to transition ill and injured Servicemembers from

DoD to a VA more appropriate for the specialized services their medical condition requires, or closer to home.

VA Military Liaisons are co-located with DoD Case Managers at MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. They educate Servicemembers and their families about VA's system of care, coordinate the Servicemember's initial registration with VA, and secure outpatient appointments or inpatient transfer to a VA health care facility as appropriate. VA Military Liaisons make early connections with Servicemembers and families to begin building a positive relationship with VA. Our Liaisons coordinated 5,000 referrals for health care and over 20,000 professional consultations in fiscal year (FY) 2010 through June.

Each VA medical center has an OEF/OIF Care Management team in place to coordinate patient care activities and ensure that Servicemembers and Veterans are receiving patient-centered, integrated care and benefits. Members of the OEF/OIF Care Management team include: a Program Manager, Clinical Case Managers, Veterans Benefits Administration (VBA) Service Representatives, and a Transition Patient Advocate. The Program Manager, a nurse or social worker, has overall administrative and clinical responsibility for the team and ensures that all OEF/OIF Veterans are screened for case management. Severely injured OEF/OIF Veterans are provided a case manager, and any other OEF/OIF Veteran may be assigned a case manager based upon initial assessment or upon request. Clinical Case Managers coordinate patient care activities and ensure that all clinicians providing care to the patient are doing so in a cohesive and integrated manner.

VBA team members assist Veterans by educating them about VA benefits and assisting with the benefit application process. The Transition Patient Advocate helps the Veteran and family navigate VA's system by acting as a communicator, facilitator and problem-solver. Since many returning OEF/OIF Veterans connect to more than one specialty case manager, VA introduced a new concept of a "lead" case manager. The lead case manager now serves as a central communication point for the patient and his or her family. Case managers maintain regular contact with Veterans and their families to provide support and assistance to address any health care and psychosocial needs that may arise. The OEF/OIF Care Management program now serves over 44,000 Servicemembers and Veterans, including 5,800 who are severely injured.

OEF/OIF Care Management team members actively support outreach events in the community, such as annual 'Welcome Home' events. OEF/OIF team members also participate in the demobilization process, the Yellow Ribbon Reintegration Program, Post-Deployment Health Reassessment events, and Individual Ready Reserve musters. OEF/OIF staff regularly make presentations to community partners, Veterans Service Organizations, colleges, employment agencies and others to collaborate in providing services and connecting with returning Servicemembers and Veterans. VHA and VBA officials coordinate on the full range of services and benefits to Veterans and their families to support their transition back to civilian life.

Federal Recovery Coordination Program

The needs of severely injured Servicemembers and Veterans are also met through the services provided by the Federal Recovery Coordination (FRC) Program. FRCs serve to ensure that severely injured Veterans and Servicemembers receive access to the benefits and care they need to recover. Since its creation in 2008, the FRC Program has helped Servicemembers and Veterans access Federal, state and local programs, benefits and services, while supporting the families of these heroes through their recovery, rehabilitation, and reintegration into the community. Currently, 556 clients are enrolled and another 31 individuals are being evaluated for enrollment; an additional 497 have received assistance through FRC.

Blind Rehabilitation

The VA Blind Rehabilitation Service (BRS) provides world-class comprehensive evaluation, planning, and rehabilitation treatment for OEF/OIF Veterans and Servicemembers with any level of visual impairment. BRS assesses, recommends and trains Veterans in the use of technology and assistive devices with enlarged print, Braille or speech output such as computers, personal digital assistants and global positioning systems. BRS, together with VA eye care practitioners, incorporates the latest in optical enhancing devices into rehabilitation care. This technology serves to enhance independence, social functioning, employment, and education.

Blind Rehabilitation Services are delivered at every VA medical center, with 157 Visual Impairment Service Team Coordinators who provide care management, and 77 Blind Rehabilitation Outpatient Specialists who provide in-home and in-community service. Additionally, VA has 55 outpatient blind and vision rehabilitation clinics, and 10 inpatient Blind Rehabilitation Centers; three additional inpatient centers will open in FY 2011 in Cleveland, OH, Biloxi, MS, and Long Beach, CA. VA blind rehabilitation services are structured and geographically located for visually impaired Veterans and Servicemembers to access the care they need.

The BRS database tracks OEF/OIF Veterans with visual impairment to ensure ongoing coordination of care for these patients. As of June 2010, Blind Rehabilitation Service is tracking 1,098 OEF/OIF Veterans and Servicemembers who have received blind and vision rehabilitation care, or who have been referred for screening to rule out possible visual consequences associated with TBI. Of this total, 126 active duty Servicemembers have attended inpatient blind rehabilitation centers due to severely disabling visual impairment. VA has also held several national training conferences on the visual consequences of TBI to educate our providers, and has added specific medical codes to document the visual consequences of TBI in VA's clinical patient record system. We have placed Blind Rehabilitation Outpatient Specialists at Walter Reed Army and National Naval Medical Centers, as well as at locations in VA's Polytrauma System of Care. Results indicate that patients completing VA's inpatient blind rehabilitation programs have better functional outcomes than patients from blind rehabilitation programs in the private sector.

Spinal Cord Injury

VA's Spinal Cord Injury Program is the largest single network of care and rehabilitation in the Nation for the treatment of persons with spinal cord injury (SCI). VA facilities nationwide in 2009 provided a full range of services to 27,067 Veterans with SCI/D; 13,398 of these Veterans received specialized care within the 24 Spinal Cord Injury Centers or SCI Support Clinics. For Veterans with SCI, VA provides health care and rehabilitation services, maintains medical equipment and supplies, and offers education and preventive health services. Since 2003, 503 Servicemembers have been treated in VA SCI units, and of those Servicemembers, 162 incurred a spinal cord injury in an OEF/OIF theater of operations.

VA's SCI system of care is internationally regarded for its comprehensive and coordinated services for rehabilitation, surgical, medical, preventive, ambulatory, long term, and home-based care. Interdisciplinary teams of professionals with highly specialized knowledge and experience deliver rehabilitation care, SCI specialty care, and broadly based medical services. VA is a world leader in best practices providing outstanding clinical care, customized wheelchairs, adaptive equipment, technological interventions, therapies, teaching, and training so Veterans with SCI can be as healthy and independent as possible in their homes and communities.

VA promotes activity-based therapies at its SCI Centers to improve mobility, recovery of walking and hand function. Recently, VA enhanced the rehabilitation and training environments to offer the latest and most effective interventions to fully utilize sensory patterned feedback, re-training of central pattern generators, use of body weight support, and electrical stimulation for newly injured Servicemembers and Veterans in all VA Spinal Cord Injury Centers. These services include: early standing and weight-bearing; body weight support and treadmill training; over ground training for walking; and electrical stimulation for weak and paralyzed muscles in the lower limbs for ambulation and upper limbs for hand function. There is currently a growing and integrated system of telehealth services for Veterans with SCI, and recent funding has provided telehealth systems in every SCI Center and to more than 90 percent of the SCI support and primary care teams.

VA's SCI System of Care prevents and treats co-morbid problems related to the original spinal cord injury. For example, pressure ulcers (bed sores) are a common and costly complication resulting in high rates of illness and death. Data from FY 2008–2010 demonstrate that our new prevention efforts are successful and have reduced the rate of developing a new hospital-acquired pressure ulcer to an extremely low level. The data reflects that 95 percent of patients with SCI were screened for pressure ulcer risk within twenty four hours of admission, 96 percent of at-risk patients had a documented plan of skin care within 48 hours of admission, and only 1.3 percent of patients with SCI who were hospitalized in FY 2009 developed pressure ulcers.

Polytrauma/Traumatic Brain Injury

VA also offers rehabilitation services for returning OEF/OIF Veterans and Servicemembers with polytrauma and traumatic brain injuries. "Polytrauma" is a new word in the medical lexicon that was termed by VA to describe the injuries to multiple body parts and organs occurring as a result of exposure to explosive devices or blasts to those serving in OEF/OIF. Polytrauma is defined as two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability. Traumatic brain injury (TBI) frequently occurs in polytrauma in combination with other disabling conditions such as amputation, auditory and visual impairments, spinal cord injury, post-traumatic stress disorder (PTSD), and other medical problems. Due to the severity and complexity of their injuries, Servicemembers and Veterans with polytrauma require an extraordinary level of coordination and integration of clinical and other support services.

VA has developed and implemented numerous programs that ensure the provision of world-class rehabilitation services for Veterans and active duty Servicemembers with TBI. Since 1992, VA has had four lead TBI Centers designated as part of the Defense and Veterans Brain Injury Center (DVBIC) collaboration to provide comprehensive rehabilitation for Veterans and active duty Servicemembers. In 1997, VA designated a TBI Network of Care to support care coordination and access to services across VA's system.

Beginning in 2005, VA expanded the scope of services at existing VA TBI Centers to implement an integrated nationwide Polytrauma System of Care (PSC) that provides world-class rehabilitation services, and ensures that Veterans and Servicemembers with TBI and polytrauma transition seamlessly from DoD and VA and back into their home communities. Today, the VA Polytrauma System of Care is an integrated, tiered system that provides specialized, interdisciplinary care for polytrauma injuries and TBI across four levels of facilities, including: 4 Polytrauma Rehabilitation Centers, 22 Polytrauma Network Sites, 82 Polytrauma Support Clinic Teams, and 48 Polytrauma Points of Contact. The System offers comprehensive clinical rehabilitative services including: treatment by interdisciplinary teams of rehabilitation specialists; specialty care management; patient and family education and training; psychosocial support; and advanced rehabilitation and prosthetic technologies.

Polytrauma Rehabilitation Centers (PRCs) serve as regional referral centers for the most intensive specialized care and comprehensive rehabilitation care for Veterans and Servicemembers with complex and severe polytrauma. PRCs maintain a full staff of dedicated rehabilitation professionals and consultants from other specialties to support these patients. Each PRC is accredited for Brain Injury Rehabilitation by the Commission on Accreditation of Rehabilitation Facilities (CARF), and each serves as a resource to develop educational programs and best practice models for other facilities across the system. The four regional Centers are located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA. A fifth Center is currently under construction in San Antonio, TX, and is expected to open in 2011.

The next three levels of the Polytrauma System of Care provide specialized rehabilitation services and coordinate care at locations closer to the Veterans' home communities. Polytrauma Network Sites (PNS) provide inpatient and outpatient rehabilitation care and coordinate TBI and polytrauma services throughout the Veterans Integrated Service Network (VISN). The inpatient rehabilitation units at the PNS maintain CARF accreditation for Comprehensive Inpatient Medical Rehabilitation. Polytrauma Support Clinic Teams conduct comprehensive evaluations of patients with positive TBI screens and develop and implement rehabilitation and community reintegration plans for Veterans and Servicemembers in their catchment areas. Polytrauma Points of Contact ensure that Veterans and Servicemembers needing specialized rehabilitation services are referred to the appropriate level of care within or outside of VA, if necessary. VA appreciates Congress' work in passing the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163), which will allow VA to provide specialized residential care for TBI patients and rehabilitation services for Veterans with TBI at non-Department facilities.

VA continually enhances the scope of specialized rehabilitation services available through the Polytrauma System of Care. New programs and initiatives include:

- In 2007, VA developed and implemented Transitional Rehabilitation Programs at each PRC. These 10-bed residential units provide rehabilitation in a home-like environment to facilitate community reintegration for Veterans and their families. Through December 2009, 188 Veterans and Servicemembers have participated in this program spending, on average, about 3

months in transitional rehabilitation. Almost 90 percent of these individuals return to active duty or transition to independent living.

- Beginning in 2007, VA implemented a specialized Emerging Consciousness care path at the four PRCs to serve those Veterans with severe TBI who are slow to recover consciousness. To meet the challenges of caring for these individuals, VA collaboratively developed this care path with subject matter experts from Defense and Veterans Brain Injury Center (DVBIC) and the private sector. From January 2007 through December 2009, 87 Veterans and Servicemembers have been admitted into VA's Emerging Consciousness program. Approximately 70 percent of these patients emerge to consciousness before leaving inpatient rehabilitation.
- In April 2009, VA began an advanced technology initiative to establish Assistive Technology laboratories at the four PRCs to provide the most advanced technologies related to cognitive-communication, sensory and motor impairments. This initiative allowed VA to enter into a contractual agreement with the University of Pittsburgh to develop state-of-the-art Assistive Technology (AT) labs. The goal of this initiative is to develop extensive banks of AT devices for equipment trials, a method for evaluating new AT technology, standardized evaluation procedures, and an outcomes data collection tool. AT can contribute to enhancing an individual's ability to function in their environment and achieve the highest level of independence possible for persons with disabilities.

Since March 2003, an average of 130 Servicemembers with severe polytraumatic injuries have been referred annually for acute medical, surgical, and rehabilitative care at the four PRCs, ranging from 99 (FY 2003) to 330 (FY 2008), for a total of 907 Servicemembers. Of the total 907 Servicemembers served, 754 were injured in OEF/OIF areas of operations. Thus far in FY 2010, a total of 110 Servicemembers have been treated at the PRCs. Additionally, a total of 885 Veterans with severe injuries have been admitted to the PRCs since 2003. In FY 2009, 49,207 patients were seen across VA for inpatient or outpatient services related to TBI; 46,990 patients were treated in outpatient clinics for a total of 83,794 visits. This represents a 30 percent increase over FY 2008.

VA has developed and implemented the TBI Screening and Evaluation Program for all OEF/OIF Veterans who receive care within VA. From April 2007 through April 2010, VA has screened 418,109 OEF/OIF Veterans for possible TBI; of these, 57,569 Veterans who screened positive have been evaluated and have received follow-up care and services appropriate for their diagnosis and their symptoms. A total of 31,480 Veterans have been confirmed with a diagnosis of having incurred a mild TBI. Over 90 percent of all Veterans who are screened are determined not to have TBI, but the 10 percent who screen positive and complete the comprehensive evaluation are referred for appropriate treatment. Completion of the TBI screening and evaluation for each OEF/OIF Veteran allows VA to continually assess resources and access to care.

VA has sufficient resources to meet the needs of Veterans with TBI, and TBI is a Select Program in VA budget submissions. In FY 2010, \$231.9 million has been programmed for TBI care for all Veterans and \$58.2 million is programmed for OEF/OIF Veterans.

Amputation/Prosthetics and Sensory Aid Programs

A closely related Program is the Amputation System of Care and VA's Prosthetics and Sensory Aid Services. These two efforts complement each other in providing quality, accessible care to Veterans across the country.

Amputation System of Care

VA has an extensive program for amputation rehabilitation. In 2007, VA's Offices of Rehabilitation and the Prosthetics and Sensory Aids Service collaborated to develop an Amputation System of Care (ASC) designed to standardize care delivery, reduce variance, and increase access to state-of-the-science rehabilitation techniques and prosthetic technology. VA began deploying this System in 2009, enhancing structures within VA to create tiered levels of expertise and accessibility across four distinct components of care. Today there are 7 Regional Amputation Centers, 15 Polytrauma/Amputation Network Sites, 101 Amputation Clinic Teams, and 31 Amputation Points of Contact across the ASC. Collectively, this system delivers specialized expertise in amputation rehabilitation incorporating the latest practice in medical rehabilitation management, rehabilitation therapies, and technological advances in prosthetic components.

Regional Amputation Centers provide the highest level of specialized expertise in clinical care, technology, and rehabilitation for Veterans with the most severe extremity injuries and amputations. These Centers have clinical expertise in state-of-the-science medical and rehabilitation techniques and prosthetic components and design. These Centers provide comprehensive, holistic rehabilitation care through an interdisciplinary team that includes physiatrists, physical therapists, occupational therapists, prosthetists, social workers, case managers, nurses, psychologists and recreation therapists. These Centers also serve as a resource for other facilities in the System through the development of tele-rehabilitation for consultation, models of care, best practices, educational programs, and the evaluation of new technology.

Polytrauma/Amputation Network Sites also provide inpatient and outpatient amputation rehabilitation as well as prosthetic labs closer to the Veteran's home. These Sites provide care to Veterans with multiple impairments, including amputation, and addressing the long-term care needs and coordinating access to specialized services either directly or via consultation. These Sites also provide interdisciplinary care, with the clinical teams at these facilities well-trained in evaluation techniques, rehabilitation methods, and prescription of prostheses. In addition to providing the full range of clinical and ancillary services, the Sites serve as a resource and consultant for complex management issues to other facilities within their network.

Amputation Clinic Teams are designated at facilities with limited resources that may not provide a full scope of services, but still offer an interdisciplinary amputation care team. Facilities at this level may or may not have an in-house Prosthetic/Orthotic Laboratory or an inpatient rehabilitation bed program. Any sites without such services are augmented as necessary either through a contract, referral to a Polytrauma/Amputation Network Site, or through fee-based referral to an accredited facility in the private sector community. Finally, Amputation Points of Contact are located at smaller VA facilities and ensure that Veterans and Servicemembers needing specialized rehabilitation and prosthetic services are referred to appropriate level of care or to other non-VA services.

VA provides care to more than 43,000 amputees, many of whom are older Veterans who require amputations as a result of medical problems such as dysvascular disease or diabetes. A growing number of OEF/OIF Veterans with traumatic amputations also come to VA for services. As of June 1, 2010 there were 1,011 OEF/OIF Veterans or Servicemembers with major amputations, of which 657 (or 65 percent) have sought care in VA. Much of this care has been in the area of prosthetics where new prosthetic limbs and limb repair is provided. All Veterans with amputation seen within VA, including OEF/OIF Veterans who account for 1.67 percent of these patients, require specialty care for the rest of their lifetime. VA's Amputation System of Care will ensure that VA is able to meet their needs.

The VA Amputation System of Care works collaboratively with the Department of Defense's Amputation Centers at Walter Reed Army Medical Center, the Center for the Intrepid in San Antonio at Brooke Army Medical Center, and the Amputation Center at the Balboa Navy Medical Center to coordinate transition services, train interdisciplinary amputee teams, and develop best practices.

VA and the Amputee Coalition of America (ACA) have partnered to establish a Peer Visitation Program within VA. The ACA has trained 20 VA instructors across the Nation who can now train Veterans to be peer visitors. VA currently has over 30 Veterans certified as peer visitors, and expects to double this number in 2011. This program has been extremely successful at Walter Reed Army Medical Center and was identified by Servicemembers as the most important factor supporting their rehabilitation, second only to physical therapy with amputations. VA and ACA are currently exploring establishing a peer visitation program for caregivers of amputees.

VA and DoD partnered to develop the Amputation Rehabilitation Clinical Practice Guideline, which represents the first attempt to provide an evidence-based structure for rehabilitation in lower limb amputation. This will further assist in identifying priorities for new research efforts and allocation of resources to incorporate new technology as rehabilitation practices emerge. VA and DoD also partnered to develop the Amputation Patient Education Handbook "The Next Step." This publication has received extensive positive feedback from Veterans, Servicemembers, and clinicians in its pre-release, and will be available for distribution across VA and DoD by the end of July 2010.

Lastly, VA is developing a Telehealth Amputation Program to improve access to specialty amputation care closer to the Veteran's home. Telehealth will be used to connect all four levels of the ASC, and amputation specialty care to community based outpatient clinics.

Prosthetics and Sensory Aids

VA's Prosthetic and Sensory Aids Service (PSAS) provides Veterans with the prescribed equipment they require to maximize their independence and health. PSAS exceeds other health care organizations in providing the variety and array of equipment and services. PSAS provides everything from state-of-the-science bionic limbs, to custom wheeled mobility and seating solutions, to home and vehicle adaptations. PSAS has a national evaluation process for reviewing and approving the purchase of new or experimental technology and services that are medically prescribed by the Veterans VA health care provider. This process allows for the provision of devices that are not typically provided by DoD, Medicare, or any private health care provider.

Female Veterans particularly find the personal attention required for their specific needs through PSAS. Prosthetic devices such as breast prostheses or breast pumps, or a prosthetic style designed for women instead of men, are provided by PSAS to meet the unique needs of this Veteran population. In FY 2009, PSAS provided items and services to 116,000 female Veterans at a cost of over \$61 million. Over 40,000 female Veterans received eyeglasses through VA with timely, accurate service, and an eyeglass style with which they are comfortable. Our interdisciplinary Prosthetic Women's Workgroup provides guidance regarding new items that are available to this special population, and is assisting with developing a brochure that targets female Veterans to inform them about PSAS services. PSAS provides the personal service to ensure that every female Veteran receives the equipment and services—in the preferred style unique to women—to maximize her independence and quality of life.

Although not exclusive to the OEF/OIF Veteran, this population has helped bring to the forefront a wide range of technologies to keep this population active and engaged in their community. VA provides computers for blind as well as physically disabled Veterans to assist them in managing their lives and retaining their independence. VA also provides global positioning systems (GPS), smartphones, and the most advanced wheeled-mobility and seating solutions available. VA was the first in the U.S. to provide a microprocessor knee over ten years ago, and we have remained at the cutting edge of technology in the realm of prosthetic limbs. We are currently optimizing the DEKA arm in hopes of getting it to the market place soon so that all Americans with upper extremity amputations might benefit. VA is also receiving several of the new X-2 knees developed through a public-private endeavor to build a knee that can navigate stairs, water, and even enable the user to walk backwards.

PSAS is a pioneer in the area of standardizing care through its Prosthetic Clinical Management Program. PSAS developed national contracts that not only saved VA \$400 million over the past few years, but also elevated the level of care for all Veterans by awarding national contracts to companies that provide only the highest quality products. Interdisciplinary teams of clinical, patient safety and engineering experts rigorously review each offer to ensure only the best products are procured for our Veterans. This Program has also led the development of more than 35 clinical practice recommendations that provide guidance to clinicians for prescribing prosthetic devices. The result has been the successful elevation of the quality of devices and evaluations for Veterans.

Care to Women Veterans

The conflicts in Iraq and Afghanistan have introduced a new generation of Veterans into VA with specialized needs. One segment of this new generation is Women Veterans. Of the 1.1 million OEF/OIF Veterans, 128,397 are women Veterans; approximately 50 percent of these women Veterans utilized VA health care between FY 2002 and the first quarter of FY 2010. Our women Veterans have unique health care needs compared with the larger male Veteran population. On average, women Veterans are younger than male Veterans with over two-thirds of OEF/OIF women Veterans being in reproductive age groups. VA again thanks Congress for its work on Public Law 111-163, which has given VA the authority to provide newborn care for women Veterans. VA has enhanced its current system to transition from a disease model to a wellness model of care that assures equal access for all Veterans, and continues to deliver world-class health care for our Veterans who have served.

Conclusion

Thank you again for this opportunity to speak about VA's role in providing timely, coordinated care to our severely injured OEF/OIF servicemembers and veterans. I am prepared to answer any questions the subcommittee might have.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
 Subcommittee on Health
 Washington, DC.
July 27, 2010

Thomas Zampieri, Ph.D.
 Director of Government Relations
 Blinded Veterans Association
 477 H Street, NW
 Washington, DC 20001

Dear Dr. Zampieri:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Injuries of War", which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement.
2. Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?
3. How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?
4. Of the total number of veterans who are blind or have low vision, do you have a sense of how many of these veterans are accessing care at VA?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Blinded Veterans Association
 Washington, DC.
August 13, 2010

The Honorable Michael Michaud
 Chairman, House VA Subcommittee Health
 United States Congress
 335 Cannon House Office Building
 Washington, DC 20515

Dear Chairman Michaud,

The Blinded Veterans Association (BVA), is the only congressionally chartered veterans service organization exclusively dedicated to serving the needs of our nation's blinded veterans and their families and we appreciated the invitation to provide testimony before committee on July 21, and chance to respond to the questions. BVA is concerned that the Vision Center of Excellence established in the NDAA FY 2008 section 1623 has not had the full staffing, funding, and operational support necessary to meet the needs of ensuring that the combat eye injured have seamless transition of eye care, from DoD and VA medical treatment centers. These eye wounded require the coordination of vision services during these transitions. Visually impaired must be provided contacts with VA Visual Impairment Service Team (VIST) Coordinators and the Blind Rehabilitative Outpatient Specialists (BROS) they need. The claim that the Office of the Assistant Secretary Defense for Health Affairs (ASDHA) does not have enough operational funds to establish the VCE since January 2008 is completely absurd. The small amount spent of less than \$ 2.5 million is reflective of bureaucratic indifference and lack of governance for the eye wounded and BVA requests the VA Committee request a GAO investigation into the implementation of the VCE.

Regarding the questions you have submitted this is our responses:

1. BVA has seen tremendous effort and resources devoted to improving the outpatient services for blinded and low vision veterans in the establishment of 55 new specialized programs and addition of 276 staff since January 2007 with the Continuum of Care that VHA approved. As VA expanded the staffing, and improved access to specialized rehabilitation services for vision loss from injuries the problem has been communications between DoD medical treatment facilities eye care professionals, case managers, and transition coordinators to VA staff for those with either combat eye injuries or Traumatic Brain Injury with vision functional impairments know where these services are located.
2. BVA would request that the issue of Blind Rehabilitative Outpatient Specialists (BROS) who are employed by the VA and assigned to MTF's but are not being credentialed and privileged within DoD MTF's is significant problem. While new combat wounded are awaiting transfer into a VA Blind Center the wounded and families benefit from the training the VA BROS can provide. However, because DoD has never employed BROS as allied health occupation they have no mechanism to credential them to provide rehabilitation to servicemembers within MTF's. For two years no progress has been made on this problem despite meetings and outreach from VA. We recommend that the HVAC work with the HASC on language in NDAA that would resolve this problem with out further delays.
3. The Vision Center of Excellence is required to have joint Eye Trauma Registry to track eye injured or TBI visually impaired servicemembers with vital eye care consultant reports, surgery records, diagnostic testing results, and share this with VA eye care providers. The work on this registry started in FY 2007 and CONOPS were approved in August 2009. Defense Veterans Eye Injury and Vision Registry (DVEIVR) was tested from March 15-24, 2010 and successfully but still is not being funded with the \$ 6 million to implement the sharing of data elements between DoD and VA clinicians.
4. The VA witness during the hearing stated VA Blind Rehabilitative Services (BRS) has provided inpatient blind rehabilitative training to 126 OIF and OEF veterans. VA BRS is also following an additional 1,089 with low vision impairments, from TBI injuries mostly and we believe that there are others that have entered the system without being identified as having visual injuries that must all be screened. TBI's rarely result in legal blindness, but reports find rising numbers with vision problems diagnosed with variety visual impairments. The VA Polytrauma Centers report that 80 percent of all TBI patients have complained of visual symptoms from there blast exposure. VA research has further revealed that approximately 65 percent of those with diagnosis of visual dysfunction have at least one, and often three of the following associated visual disorders including diplopia, convergence disorder, photophobia, ocular-motor dysfunction, visual field loss, color blindness, and an inability to interpret print. One research study that examined 25 TBI veterans found none of the following visual complications during the normal medical evacuation process were diagnosed early; corneal damage 20 percent, cataracts 28 percent, angle recession glaucoma 32 percent, retinal injury 22 percent, these all would place these individuals at high risk of progressive visual impairments if not diagnosed and treated early. With 1,200 diagnosed with optic nerve damage this is a significant population of wounded requiring specialized VA services and they must be entered into the (DVEIVR) so both DoD and VA can ensure high quality care and avoid unnecessary complications and coordinate new research protocols for vision impairments.

BVA also included in our testimony concern that some private agencies are trying to get earmarks to provide specialized services for blinded veterans without having the same staffing and accreditation standards that VA provides within its specialized rehabilitation centers. We strongly object and would request that language be supported in the MILCON VA appropriations report clarifying that any private agency should demonstrate peer reviewed quality outcome measurements that are standard part of VHA BRS, and should it ever be necessary to refer a visually impaired or blinded veteran to a non VA BRC, they should be accredited by National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) and/or the Commission For Accreditation of Rehabilitation Facilities (CARF), and that the employed Blind Instructors or Specialists be Certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Private agencies without nursing, medical, and psychology staffing on site should not be allowed to provide services to acute polytrauma new injured servicemembers.

BVA appreciates your strong leadership on this important veteran's health care issue for those suffering eye injuries from the current wars and TBI visual complications, and we request that both DoD and senior VA JEC management report back to your subcommittee and move the Vision Center of Excellence quickly into full operations.

Sincerely,

Thomas Zampieri Ph.D.
Director Government Relations

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
July 27, 2010

Mr. Carl Blake
National Legislative Director
Paralyzed Veterans of America
801 18th Street NW
Washington, DC 20006

Dear Mr. Blake:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Injuries of War", which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement.
2. Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?
3. How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?
4. You noted that the growing pressure of allowing veterans to seek care outside of VA threatens the VA health care system because VA would lose the critical mass of patients that are needed to maintain specialized services at VA. What do you propose for our severely injured veterans in rural communities who do not live near VA facilities?
5. You discussed the coordination issues presented by DoD's transfer of SCI patients to a civil hospital, rather than to the VA. Do you have further information on the prevalence of this practice or the rationale for it?
6. Your testimony addressed the important of VA maintaining the SCI capacity mandated by P.L. 104-262. Given that the capacity levels set by this legislation were established prior to the current conflicts, do you believe the mandated capacity remains sufficient?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

Michael H. Michaud
Chairman

Paralyzed Veterans of America
Washington, DC.
August 31, 2010

Honorable Michael Michaud
Chairman
House Committee on Veterans' Affairs
Subcommittee on Health
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Michaud:

On behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to present our views on "Healing the Physical Injuries of War." We also appreciate the opportunity to address what the Department of Veterans Affairs (VA) is doing in caring for severely injured veterans, in particular, veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).

As we testified, specialized services are part of the core mission and responsibility of the VA, including spinal cord injury care, blinded rehabilitation, and mental health treatment, including traumatic brain injury. The VA's specialized health care programs are unmatched by private health care facilities. We appreciate the Subcommittee's interest in ensuring that these veterans receive the absolute best care available.

Attached are responses to each of the questions presented in your July 27, 2010 follow-up questions. Thank you.

Sincerely,

Carl Blake
National Legislative Director

Question 1: Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement?

Answer: VA continues to provide exceptional care for severely injured veterans of the wars in Iraq and Afghanistan. The law that allows for a veteran to receive care for up to five years following his or her return from a combat theater has been a tremendous benefit to these veterans. It has ensured that if they suffer from any health problems, including mental health issues such as PTSD, they have a place with knowledgeable professionals to seek treatment.

However, we believe that there is still an ongoing need to ensure proper delivery of care to veterans living in rural communities. Deployment of National Guard and Reserve servicemembers, a large percentage who generally come from more rural communities, has created a growing demand for health services from those same rural areas. However, we believe that VA has the infrastructure in place to provide the vast majority of care needed for these men and women through its extensive network of Community-Based Outpatient Clinics (CBOCs) and its hospital system. Additionally, the hub-and-spoke delivery system used for spinal cord injury care has allowed the VA to address the demands of the most severely disabled veterans it cares for. This same model can be applied to other specialized health care concerns.

Question 2: Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?

Answer: Based on a recent staffing survey (July 2010) of the Spinal Cord Injury (SCI) service, the VA is clearly understaffed in some critical areas. As expressed in our testimony, the most notable shortage is in the number of nurse staff. As of the July survey, the VA SCI service faced a total nurse deficit of approximately 134 nurses. This is particularly troublesome because these are the individuals who provide the majority of bedside care to SCI veterans. Additionally, while the survey is specific to SCI staffing, it may be applicable to other specialized care services.

PVA believes it is critical that a uniform national policy be established for nurse staffing and VHA should centralize policies for funding a systemwide recruitment and retention plan for SCI nurses. Additionally, as we recommended in our testimony, we believe it is time for the VA to consider a nurse specialty pay for those nurse staff working in SCI centers.

In the meantime, the VA SCI service also faces shortages in doctor, social worker, psychologist, and therapist staffing. While our veterans do have access to the most

current treatments and therapies, these staff shortages can have a severe impact on their ability to receive this critical care in a timely manner.

It is important, however, to point out that not all VA SCI centers are understaffed. In fact, several currently meet the fully staffed bed requirements that have been established. Likewise, the staffed levels of facilities are constantly changing due to the changing acuity levels of the patients that come and go from the various facilities. However, the fact remains that across the system the VA SCI service still faces shortages in all of its critical health professional areas.

Question 3: How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?

Answer: The coordination between the Department of Defense (DoD) and the VA to provide care for severely injured veterans is generally good, particularly for veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). The transfer of patients from the primary DoD health care centers, such as Walter Reed Army Medical Center, Bethesda Naval Hospital, Brooke Army Hospital, and Balboa Naval Hospital, generally works well, particularly when trying to move spinal cord injured servicemembers from those facilities to VA SCI centers.

However, as mentioned in our testimony, we have seen some complications in this transfer when it comes to servicemembers who were not injured in the combat theater, but instead at their home installations. In order to improve and enhance this coordination, we believe that continued education, particularly in DoD facilities, is critical to ensuring that the DoD facilities are aware of their responsibilities in expeditiously transferring severely injured servicemembers, particularly those with SCI and other polytrauma, to the appropriate VA medical center. Additionally, we think continued congressional oversight is necessary to ensure that DoD and VA are both fulfilling their responsibilities to care for these men and women.

Question 4: You noted that the growing pressure of allowing veterans to seek care outside of VA threatens the VA health care system because VA would lose the critical mass of patients that are needed to maintain specialized services at VA. What do you propose for our severely injured veterans in rural communities who do not live near VA facilities?

Answer: PVA's points regarding the growing pressure of outside care dealt with the challenges of maintaining capacity in the VA system. This can only be done if sufficient patients are treated at a facility, otherwise the costs per patient can rise significantly. PVA believes VA's hub-and-spoke model of Medical Centers supporting Community-Based Outpatient Clinics (CBOC) is an excellent method to maintain a critical mass of patients in an area while providing for veterans living at ever greater distances from VA hospitals.

This is perhaps most important in rural communities. We recognize the fact that veterans in rural communities have greater challenges getting care from VA facilities. But this is not only a problem for veterans. Rural communities are bereft of specialty care facilities, not only for veterans, but for all members of the community. While general care may be available, the specialized care needed by those with any type of catastrophic injury may be hundreds of miles away. PVA has worked to educate our members that due to the limited availability of some forms of specialized care, there will sometimes be the need to travel some distance to receive this care at a VA facility. Moreover, our members have come to realize that in order to receive the absolute best specialized care, they sometimes must travel significant distances to a VA facility because comparable care is simply not available in their local communities.

The success of CBOCs only confirms the need for greater expansion of these valuable resources further into the rural community. This will create a wider net of care facilities, providing ever increasing services to rural veterans. PVA strongly supports this method of providing for our severely injured veterans in rural communities.

Question 5: You discussed the coordination issues presented by DoD's transfer of SCI patients to a civilian hospital, rather than to the VA. Do you have further information on the prevalence of this practice or the rationale for it?

Answer: We cannot provide specific data on the prevalence of this occurrence. However, as we mentioned in our testimony, this coordination and transfer issue tends to be more prevalent when it involves a servicemember who was injured somewhere other than in the combat theaters of Iraq and Afghanistan, such as at their home installations. We find this particularly troublesome as it suggests a less-er priority is placed on getting these men and women to the appropriate care in the

VA as opposed to those injured in Iraq and Afghanistan. We also believe it reflects the fact that the Memorandum of Agreement that the VA has with DoD to transfer spinal cord injured servicemembers is not well-publicized beyond the major intake centers such as Walter Reed and Bethesda, and that some of the local DoD health care facilities are unaware of this responsibility.

Question 6: Your testimony addressed the important of VA maintaining the SCI capacity mandated by P.L. 104–262. Given that the capacity levels set by this legislation were established prior to the current conflicts, do you believe the mandated capacity remains sufficient?

Answer: With the length of the wars in Afghanistan and Iraq and the anticipation that the current conflicts may continue well into the future, PVA believes in is necessary for VA to reevaluate its mandated capacity levels to reflect changes since 9/11. It is PVA's experience that VA is generally meeting the needs of veterans with Spinal Cord Injury (SCI). However, capacity is a function of available beds and staff. Staffing challenges, particularly nursing shortages, continue to plague VA.

In addition, the demographics of the veteran population have changed with the increased numbers of National Guard and Reserves serving, a military population generally older than regular Active Duty forces. With approximately 160 new combat injured SCI veterans and hundreds more non-combat related injuries since the beginning of the war, and the possibility of increasing numbers as the weapons used increase in destructive power and availability, there is a real possibility of even higher rates of catastrophic disabilities. Considering these conditions and the fact that the nature of health care delivery has changed since enactment of P.L. 104–262, it would make sense for VA to look forward and anticipate these effects on future capacity.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
July 27, 2010

Ms. Joy J. Ilem
Deputy National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Ms. Ilem:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Injuries of War", which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement.
2. Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?
3. How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?
4. You raised concerns about the gaps that exist in the Federal Recovery Coordination Program. What are these gaps, why do you think they exist, and what can we do to eliminate them?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

Michael H. Michaud
Chairman

**POST-HEARING QUESTIONS FOR JOY J. ILEM, DEPUTY
NATIONAL LEGISLATIVE DIRECTOR OF THE DISABLED AMERICAN
VETERANS, FROM THE COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH, HEARING, HEALING THE PHYSICAL
INJURIES OF WAR, JULY 22, 2010**

Question 1: Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement?

Answer: It appears to DAV that the Department of Veterans Affairs (VA) four regional Polytrauma/TBI Rehabilitation Centers (PRCs), designed to provide specialized inpatient rehabilitation treatment and expanded clinical expertise in polytrauma, are meeting the needs of severely injured servicemembers from Iraq and Afghanistan. These PRCs are the “hub” of the VA’s Polytrauma/TBI System of Care, which includes four Polytrauma Transitional Rehabilitation Programs that are collocated within the PRCs—established to help patients transition from the acute post-injury phase into a rehabilitation mode aimed at restoring as much independence and functional capacity as possible so they can return home. The reports DAV has received from veterans and their families during these initial stages of care and recovery have for the most part been positive, including high regard for VA staff and satisfaction with their coordination of care.

As the Subcommittee is aware, the VA has also established a specialized outpatient and sub-acute residential rehabilitation program, referred to as a Polytrauma Network Site (PNS) within each of the VA’s 21 integrated service networks (VISNs), plus one at the VA Medical Center in San Juan, Puerto Rico. VA has also reportedly designated Polytrauma Support Clinic Teams at smaller, more remote VA facilities; and has established a point of contact for polytrauma referrals at all other VA facilities.^{1,2}

DAV has expressed concern about these secondary sites of specialty care, noting that we are less confident that VA has attuned their available services to achieve consistency of polytrauma care throughout the system nationwide. Although we believe at the national program level appropriate directives and policies have established that consistency, it is not clear if these mandates are actually being carried out in all sites of care. We have received continued reports from veterans seeking VA care for what they believe is a mild TBI—but not being satisfied with the limited cognitive testing and seemingly fragmented services offered by VA at those sites. Two veterans who contacted DAV recently expressed concern that VA staff did not offer a well-rounded comprehensive program to initially educate patients about TBI and cohesively treat symptoms such as memory deficit, anger control issues, and depression or provide family education, marital or mental health counseling. In one case the veteran requested and was authorized care in the private sector at VA expense and was very impressed with the holistic “TBI program” and services that were available at a local facility specializing in head injuries. He further commented that he received care at VA for his other service-related conditions, was satisfied with that care and could not understand why VA (in his opinion) was unable to properly screen, diagnose and treat him for his mild TBI condition, a condition that had greatly impacted his job, family and his own self-esteem.

Additionally, these veterans appeared to be labeled as “difficult patients” and reported having had trouble getting the services they needed from VA. Having worked with TBI patients in the private sector before I joined DAV, I can attest that issues related to mood, behavioral problems and difficulty managing anger are common symptoms and behaviors associated with TBI patients. We believe appropriate VA medical personnel should be trained and equipped to handle these challenges to ensure patients are treated properly for the symptoms that are associated with head injuries—regardless if they are mild, moderate or severe. In such cases we have contacted VA staff at VA’s Central Office or the local facility involved and asked that the various specialty coordinators reach out to these veterans and help resolve their issues.

DAV believes these types of reports warrant investigation and oversight of VA’s secondary system of TBI care, and recommends an independent review by GAO or another qualified entity to determine the effectiveness of these services and patient satisfaction levels.

Question 2: Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?

¹ VA QUERI Fact Sheet; *Polytrauma & Blast-Related Injuries*; June 2010.

Answer: As noted above, DAV remains concerned about veterans' access to current therapies at *all* secondary VA TBI/Polytrauma Network Sites of care. Likewise, we are concerned about sufficient staffing levels and availability of specialists and other resources at all VA Polytrauma primary and secondary sites. We recommend the Subcommittee survey the four regional sites to address this issue, as well as a sample from the secondary sites. Because of the medical complexity and severity of these patients' injuries these positions are often associated with a high level of stress, staff burn-out and elevated turnover rates.

Access to current therapies remains important to TBI patients. Several veterans have expressed their desire to be able to access more holistic, comprehensive programs to treat TBI symptoms to include education for themselves and family members about brain injuries, access to mental health and marital counseling, and to be seen by specialists who work as a team to address all of these patients' issues and most of all compassionate medical personal that understand the associated behaviors and challenges TBI patients face. In addition, as we noted in our testimony during the hearing, we strongly believe that a gap exists between VA's acute polytrauma and TBI programs and a severely injured veteran's optimal long-term rehabilitation and stabilization. Today, VA is able to offer limited options, primarily nursing home placements. The "Heroes Ranch" concept being developed at the Tampa VA PRC is one that we embrace and that we believe offers a good model of age-appropriate therapeutic residential care that could begin to fill that gap.

As noted in our testimony, VA has developed and implemented a national template to ensure that it provides every veteran receiving inpatient or outpatient treatment for TBI who requires ongoing rehabilitation, an individualized rehabilitation and community reintegration plan. VA integrates this national template into its electronic health record, and includes in the record results of the comprehensive assessment, measurable goals that were developed as a result of the plan, and recommendations for specific rehabilitative treatments. The patient and family participate in developing the treatment plan and are provided a copy of the plan. These are all positive steps; however, we encourage VA to periodically survey patients and family members in these programs about their experiences in care and treatment programs and settings to gauge if there are any improvements that can be made and to ensure consistency and effectiveness of treatments.

Finally, as noted in our statement, while DAV believes great strides have been made over the past two years, VA recently acknowledged embracing opportunities for further improvement in its Polytrauma System of Care, and states the Department's ongoing goals as follows:

1. Ensuring that blast-exposed veterans receive screenings and evaluation for high-frequency, invisible sonic wounds that may produce mild TBI, PTSD, and other psychiatric problems, or pain and sensory loss;
2. Promoting identification and evaluation of potentially the best practices for polytrauma rehabilitation, including those that optimize care coordination and transition across care systems and settings such as DoD and VA;
3. Optimizing the ability of caregivers and family members to provide supportive assistance to veterans with impairments resultant from polytrauma and blast-related injuries;
4. Identifying and testing methods for improving process of care and outcomes, even when the evidence base is not well established; and
5. Identifying and testing methods for measuring readiness to implement and sustain practice improvements in polytrauma care.³

DAV fully supports VA's goals, and we ask the Subcommittee, through oversight, to monitor VA's progress in achieving them for this deserving population with the most severe physical wounds of war.

Question 3: How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?

Answer: As noted in our testimony DAV gives VA high marks for coordination of care between the two Departments at VA's four regional PRCs and associated military treatment facilities. VA has made new inroads to improve communication between the agencies' medical systems to ensure polytrauma patient care is truly

³L. Beck, PhD., Chief Consultant, Office of Rehabilitation Services, Office of Patient Services, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Veterans Affairs*; May 5, 2010.

seamless from the time of injury throughout all stages of transition and care. From what we have read, seen and heard—there have been significant improvements over the years in this regard; however, we encourage VA and DoD to continue to collaborate and improve on this very complex network of highly specialized care. We do understand that compatibility of IT systems and access to electronic health records between the Departments is a continuing challenge and needs significant additional improvement. In that connection, we were pleased that VA announced on August 23, 2010, the establishment of a very progressive pilot program of interactive electronic health record portability among VA, DoD and private facilities in the Richmond-Tidewater area of Virginia (but also involving the San Diego, California area facilities as well). We hope the Subcommittee will closely monitor this effort because we believe, if it is successful, it may serve as a model of responsive IT interactivity, not only for polytrauma patients, but for all forms of VA health care for sick and disabled veterans.

Question 4: You raised concerns about the gaps that exist in the Federal Recovery Coordination Program. What are these gaps, why do you think they exist, and what can we do to eliminate them?

Answer: As noted in our testimony, DAV remains concerned about the gaps that exist in the Federal Recovery Coordination Program and social work case management essential to coordinating complex components of care for polytrauma patients and their families. These gaps were highlighted by disabled veterans and their caregivers in hearings held by the House Veterans' Affairs Subcommittee on Oversight and Investigation in April 2009 and January 2010 and warrant continued oversight and evaluation by the full Committee and its Subcommittees.

Prior to the establishment of the Federal Recovery Coordination (FRC) Program, veterans and their families reported a complex and frustrating bureaucracy requiring them to try to navigate the DoD and VA systems "on their own." One witness described it as, ". . . a journey of blind exploration." There were complaints of a lack of continuity, coordination of care and communication between DoD and VA during a servicemember's transition from active duty, the return home, veteran status and VA health and benefits systems. Likewise, families complained they felt they were carrying the burden of a servicemember's recovery and reintegration back into civilian life and had little guidance or support from VA or DoD. One witness at the hearing noted that lost paperwork, confusing processes and lack of information were common occurrences. This witness also reported that he had had a total of 13 social work representatives within VA and DoD—but none of them communicated regularly with each other to make sure everything was covered in his case.⁴

Another witness, the spouse of a severely disabled veteran, reported a similar experience prior to the establishment of the FRC program but noted that, once the program was up and running, things began to go more smoothly until a new FRC was assigned to their case—after only four months—requiring them to start all over again. High personnel turnover rates appeared to be a trend early on in the program for other families as well—and hope for a single point of contact that was fully knowledgeable about her husband's injuries and case as well as a complete understanding of all their benefits and a comprehensive "life plan" were dashed.⁵

One witness said it best when referring to the life-altering nature and responsibility of caring for a brain injured veteran—"The responsibility is daunting, the stress is never ending, and we need a lifeline." Although the hearing witnesses all agreed that the FRC program was needed and had the potential to be beneficial, there still seems to be a number of issues that need to be addressed including better communicating, educating, promoting visibility of the program and streamlining the referral process. It appears some family members are not aware they have an option to request an FRC and are sometimes confused about the roles of the multitude of advocates, program managers, and DoD and VA social workers and case managers to their wounded loved ones. The FRC's level of knowledge about catastrophic injuries and their impact on patients and families—as well as being knowledgeable about DoD and VA health and benefits systems and community services are of vital importance to family members and caregivers alike. They also want to be able to rely on the FRC to help address the need of lifelong care and caregiving for their injured loved ones should these veterans outlive their parents, spouses or other

⁴Brogan, Mark A. (Capt., USA, Ret.), Statement before House Veterans' Affairs Subcommittee on Oversight and Investigations, April 28, 2009.

⁵Wade, Sarah, Statement before House Veterans' Affairs Subcommittee on Oversight and Investigations, April 28, 2009.

caregivers, or in cases where their caregivers become unable to continuously care for these veterans.⁶

The Executive Director of the FRC Program, Dr. Karen Guice, acknowledged there are ongoing challenges for the program and that there have been many lessons learned and adjustments in the program to improve its overall effectiveness. For these reasons, we again urge continued Congressional oversight of this extremely important program and recommend the FRC program be continually monitored and that families and veterans be surveyed periodically to make needed adjustments and improvements to the program.⁷

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
July 27, 2010

Mr. Tom Tarantino
Legislative Associate
Iraq and Afghanistan Veterans of America
308 Massachusetts Avenue, NE
Washington, DC 20002

Dear Mr. Tarantino:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Injuries of War," which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement.
2. Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?
3. How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?
4. You noted that you "received only a few complaints about the actual quality of care at VA." This may be the case for the veterans enrolled in VHA, but do you believe that there is a perception problem out there for our OEF and OIF veterans who view VA health care as substandard care, and therefore not even enroll in VHA?
5. You raised some concerns about VA limiting or denying access to some veterans who seek recovery services for TBI. Can you expand on this point and give us some examples of the types of care that VA is limiting or denying?
6. In your testimony you discussed the often lengthy drive times faced by veterans seeking VA care. Have you found this issue to be of particular relevance to veterans seeking specialty care, and especially for those with particularly severe injuries?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

Michael H. Michaud
Chairman

⁶Lynch, Cheryl, Statement before House Veterans' Affairs Subcommittee on Oversight and Investigations, April 28, 2009.

⁷Guice, Karen, M.D., MPP, Executive Director, Federal Recovery Coordination Program, Department of Veterans Affairs, Statement before House Veterans' Affairs Subcommittee on Oversight and Investigations, April 28, 2009

House Veterans' Affairs Subcommittee on Health, "Healing the Physical Injuries of War." Questions for the Record for Tom Tarantino, Iraq and Afghanistan Veterans of America (IAVA)

Question 1: Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement?

Response: The VA is meeting many of the needs of servicemembers and veterans who are severely injured, however there is much left to be desired. VA has some of the brightest Doctors and best protocols for handling combat injuries, but access to that level of care can be limited at best.

Question 2: Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?

Response: The VA is still understaffed across the board, hence the long wait times for appointments. We've heard numerous complaints from veterans who have not been able to see a physical therapist for months at a time, nor come in for routine check-ups on past VA care.

Question 3: How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?

Response: We would rate the coordination as significantly improved, but nowhere near seamless. Seamless transition will be when a veteran walks into the VA and doesn't have to prove that they served in the military and their military medical records are available immediately to both the health care and benefits staff.

Question 4: You noted that you "received only a few complaints about the actual quality of care at VA." This may be the case for veterans enrolled in VHA, but do you believe that there is a perception program out there for our OEF and OIF veterans who view the VA health care as substandard care and therefore not even enroll in VHA?

Response: As we stated in our testimony the VA has a huge perception issue among returning veterans. Many veterans think of the VA as a health care of last resort and avoid the VA altogether. One particular quote Questions for the Record, HVAC Health Tom Tarantino, IAVA "Healing the Physical Injuries of War" 2 of 2 from our members sticks out in my mind, "You get what you pay for." The implication is that the service at VA is substandard because it is supposedly free. The truth of the matter is that many veterans pay a hefty price to earn access to VA health care. We believe that VA must do a better job showing veterans why VA health care is safe, accessible and high quality.

Question 5: You raised concerns about VA limiting or denying access to some veterans who seek recovery services for TBI. Can you expand on this point and give us some examples of the types of care that VA is limiting or denying?

Response: As we put together our testimony for this hearing we consulted with several other veterans groups on what they felt needed to be discussed. This particular issue regarding TBI was brought up by the Wounded Warrior Project in a Senate Hearing on May 5th, 2010. They listed a number of examples including a veteran suffering from TBI in Tampa where the VA "refused [the wife's] requests for further therapy to prevent reversal in the gains he had made." The end result was the veteran seeking help through Medicare and being discharged from the VA. The veteran then "moved into his own apartment, but—without structure and supervision, and with a condition marked by impulsivity and lack of insight—he spun out of control, and has struggled since then with PTSD, depression, and substance—use complicating his TBI problems." Only after being admitted at Navy Bethesda Hospital and receiving a thorough and helpful care plan was this veteran put back on the right track and the Tampa VAMC finally acquiesced. .

Question 6: In your testimony you discussed the often—lengthy drive times faced by veterans seeking VA care. Have you found this issue to be of particular relevance to veterans seeking specialty care, and especially for those with particularly severe injuries?

Response: Long wait times and longer drives to get to VA care has been continually relayed to us by our members. The issue of lengthy drives seemed to apply to both general and specialty care.

Committee on Veterans' Affairs
 Subcommittee on Health
 Washington, DC.
July 27, 2010

Ms. Denise A. Williams
 Assistant Director for Health Policy
 Veterans Affairs and Rehabilitation Commission
 The American Legion
 1608 K Street, NW
 Washington, DC 20006

Dear Ms. Williams:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Injuries of War", which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan? What is VA doing well and what areas are in need of improvement.
2. Is VA properly staffed to care for severely injured veterans and do our veterans have access to the most current therapies?
3. How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

Michael H. Michaud
Chairman

American Legion
 Washington, DC.
September 8, 2010

Honorable Michael H. Michaud, Chairman
 Subcommittee on Health
 Committee on Veterans' Affairs
 335 Cannon House Office Building
 Washington, D.C. 20515

Dear Chairman Michaud,

The American Legion appreciates the opportunity to submit responses in reference to your July 27 letter from the "Healing the Physical Injuries of War." testimony held on July 22, 2010.

1. Do you believe that VA is meeting the needs of our servicemembers and veterans who are severely injured from the war in Iraq and Afghanistan?

The American Legion has noted improvements in recent years by both the Department of Defense (DoD) and Department of Veterans Affairs (VA) in the treatment of severely injured and transitioning servicemembers but gaps still exist.

Some of the positive steps DoD and VA undertook included implementation of the Federal Recovery Coordinators, VA Polytrauma Rehabilitation System of Care, VA Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) case management teams and establishing directives for Traumatic Brain Injury (TBI) screening, clinical reminders and a new symptom and diagnostic code for TBI. The American Legion believes most of the visible wounds of Iraq and Afghanistan are adequately being addressed by VA's interdisciplinary medical team at the VA Polytrauma Rehabilitation Centers. However, some of the concerns we have include: shortages of specialty medical providers and the influx of the two million returning troops overburdening the capabilities of access and quality of care.

In addition, The American Legion continues to be concerned about prevention, screening, diagnosis and treatment and combat-related research for the invisible wounds of war such as TBI and Post Traumatic Stress. The American Legion believes TBI and PTS are interrelated and DoD and VA are treating the symptoms of these injuries and not the diagnosis. During an Improved Explosive Device (IED) explosion, a servicemember can experience a penetrating wound or have an undetected mild, moderate or severe case of TBI. From this experience, it is very likely that the veteran may develop PTS leading to substance abuse, depression and regrettably, suicide.

2. Is VA properly staffed to care for the severely injured veterans and do our veterans have access to the most current therapies?

The American Legion believes VA health care is the “best care anywhere,” and is the model for the national health care. The VA Health care system is a system designed to meet unique and complex needs of our nation’s veterans. In order to ensure quality of care for veterans, The American Legion developed a System Worth Saving program in 2003 to report on best practices and challenges in the delivery of VA Health Care as well as to obtain feedback from veterans on their level of care. In the 2010 System Worth Saving site visits, it was noted that there is a shortage of specialty providers across the country in areas such as Psychiatrists, Gastrointestinal (GI), Cardiology physicians, Radiation and Hematology Oncologists and Anesthesiologists, Audio and Speech Pathology, Dietetics, Social Work, Rehabilitation Medicine, Physical Therapists, Nurses, Pharmacists and many other critical areas.

As a result of shortages in these critical staffing areas and rural location challenges, VA’s Fee-Basis or Purchased Care costs have doubled in the last four years. In FY 2005, approximately 496,885 veterans were fee-based into the community for their health care needs at an expense of \$1.6 Billion and in FY 2009, 920,404 veterans were fee-based into the community at a cost of \$3.8 Billion. In most of the facilities visited, their Fee-Basis budget was between 15–25 percent of their hospital operating budget which significantly impacts the medical center’s ability to prioritize other medical center needs and projects.

The American Legion recommends Congress designate specific funding to address recruitment and retention and rural health incentives. In addition, The American Legion was pleased that the House Veterans Affairs Committee recently held a hearing on Innovative Treatments for TBI and PTS to discuss new technologies, research and treatment for these injuries. The American Legion has continued to recommend that Congress exercise oversight and appropriate the necessary funding for DoD and VA to fully explore and fund research and studies to prevent, diagnose and treat these complex injuries.

3. How would you rate the coordination between DoD and VA in providing medical care for severely injured OEF/OIF Veterans? What are your recommendations for enhancing coordination efforts between VA and DoD?

The American Legion would rate the coordination between DoD and VA as improved but gaps still remain. As highlighted in our testimony, DoD reported that as of April 3, 2010, there were a total of 8,810 servicemembers wounded in action during Operation Iraqi Freedom (OIF) and 2,038 have been wounded in action during Operation Enduring Freedom (OEF). Of the two million servicemembers currently deployed, The American Legion is concerned that VA does not have a capacity and number of specialty providers necessary to accommodate for an increase in demand of these returning soldiers. Due to medical advances on the battlefield in the current conflicts in Iraq and Afghanistan, our nation’s heroes are surviving life threatening injuries at a higher rate but will require significant lifelong care in the VA.

VA’s Seamless Transition process targets the severely injured servicemembers and the Military Treatment Facilities (MTFs) have VA Nurse Liaisons and VA Social Workers on site to ensure a warm handoff into one of the four lead Polytrauma Rehabilitation Centers. In addition, VA established Polytrauma Network sites at each of their 22 Veteran Integrated Service Networks (VISNs), 82 Polytrauma Support Clinic Teams and 48 Polytrauma Points of Contact to provide case management close to the transitioning servicemember’s home.

While the case management process has improved, a major impediment still needing to be resolved is the bilateral record exchange between DoD and VA. Both agencies will never truly have seamless transition if their medical records are not interoperable. The American Legion has fully supported the Lifetime Electronic Medical Record Initiative which will create a bilateral record exchange from DoD into VA.

Since 2007, The American Legion has continued to advocate for this improvement because every day without a bilateral record, a potential veteran can fall through the cracks and need access their needed medical care.

The American Legion was pleased to see passage of the Caregiver and Veterans Omnibus Health Services Act which will train and pay a stipend to a family member caregiver in the homes of our severely wounded soldiers. The American Legion's only concern with the Caregiver law is that only OEF/OIF caregivers will receive a stipend when many other veterans from previous conflicts do not receive this benefit and are taken care of by a family member in their homes for many injuries or illnesses.

The American Legion recommends that Congress exercise its oversight to ensure VA provides an annual Mental Health Strategic Report, to make transparent, the agency's efforts in appropriations and where these funds are spent, as well as services provided through research, screening and treatment for all Mental Health illnesses.

Once again, The American Legion appreciates the opportunity to provide recommendations to improve DoD and VA's efforts to ensure both agencies are prepared to meet the long-term and complex health care needs of our nation's veterans.

Thank you for your continued commitment to America's veterans and their families.

Sincerely,

Tim Tetz
Director, National Legislative Commission

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
July 27, 2010

Honorable Robert M. Gates
Secretary
U.S Department of Defense
1400 Defense Pentagon
Washington, DC 20301

Dear Secretary Gates:

Thank you for the testimony of Dr. Jack Smith, Acting Deputy Assistant Secretary for Clinical and Program Policy at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Wounds of War", which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. How does DoD define severely injured servicemembers? How does DoD track the number of and the types of severe injuries? Do you share this data with VA, and is it made available to the public?
2. Does DoD offer the same types of specialized services as VA? Are there certain specialized services that DoD offers, but which VA does not?
3. Where is DoD headed in terms of further enhancing coordination efforts with VA in caring for the severely injured?
4. Why is it that VA's Blind Rehabilitation Outpatient Specialists do not have clinical privileges at military treatment facilities?
5. In PVA's testimony, they expressed concern that some mild TBI cases are falling through the cracks because of DoD's failure to diagnose and treat mild TBI? What can DoD do to improve on this front?
6. During their testimony, PVA raised concerns about some active duty soldiers with spinal cord injury and dysfunction bypassing the VA health care system and being transferred directly to civilian hospitals in the community. Why is this happening? What is DoD's rationale for bypassing the VA health care system?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

Michael H. Michaud
Chairman

Hearing Date: July 22, 2010
Committee: HVA
Member: Congressman Michaud
Witness: Dr. Smith

Question 1: How does DoD define severely injured servicemembers? How does DoD track the number of and the types of severe injuries? Do you share this data with VA, and is it made available to the public?

Answer: The Department uses the following definitions:

- Seriously Ill or Injured—The casualty status of a person who has an injury; a physiological or psychological disease or condition; or a mental disorder that requires medical attention and medical authority declares that the condition is life-threatening or life-altering, and/or that death is possible, but not likely within 72 hours. This may include post-traumatic stress disorder and associated conditions. NOTE: A casualty status is assigned at a specific point in time and can be changed.
- Very Seriously Ill or Injured—The casualty status of a person whose illness or injury is such that a medical authority declares it more likely than not that death will occur within 72 hours.

The Department of Defense tracks the number of medically evacuated patients and the reason for evacuation using TRANSCOM data; collects and evaluates trauma care using the Joint Trauma Registry; collects and evaluates disease and injury trends using the Theater Medical Data System records; and collects and reports theater morbidity and mortality counts and reasons using personnel data sent to the Defense Manpower Data Center (DMDC), Data, Analysis and Programs Division.

Direct individual medical information is available to the Department of Veterans Affairs (VA) via data sharing (i.e., Bilateral Health Information Exchange and Federal Health Information Exchange). Inpatient medical records for severely injured members being transferred to VA poly-trauma centers are also scanned and forwarded to the VA. Medical information on individuals is not publicly available. However, military casualty information is publicly available on the DMDC Analysis and Programs Division Web site at <http://siadapp.dmdc.osd.mil/personnel/MMIDHOME.HTM>.

Question 2: Does DoD offer the same types of specialized services as VA? Are there certain specialized services that DoD offers, but which VA does not?

Answer: DoD does offer specialized services, as does VA. The two Departments have many MOAs regarding the sharing of specialty care. These agreements center on the core competencies of each Department in meeting the special needs of their beneficiaries. For example, there is a long standing Memorandum of Agreement (MOA) between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) associated with specialized care for Active Duty Servicemembers (ADSMs) sustaining spinal cord injuries, traumatic brain injuries, blindness, or a combination of injuries (polytrauma). The Veterans Health Administration is known for its integrated system of health care for these conditions and the VA/DoD Health Executive Council identified the need for procedures governing the treatment of ADSM inpatients, outpatients, and other related comprehensive services at VA facilities.

Question 3: Where is DoD headed in terms of further enhancing coordination efforts with VA in caring for the severely injured?

Answer: Currently, we are sustaining the momentum of DoD and VA collaboration by improving upon the existing programs as lessons are learned as well as striving to identify new opportunities for collaborative and cooperative activities with the VA. At all levels within DoD, program managers and directors are working closely with their VA counterparts to improve access, quality, and efficiency as the keys to maintaining and improving upon the firm foundation for coordinated health

care services and benefits. These efforts have been and will continue to be future high priorities for the DoD.

Question 4: Why is it that VA's Blind Rehabilitation Outpatient Specialists do not have clinical privileges at military treatment facilities?

Answer: The Veterans Health Administration (VHA) is the only medical organization that credentials blind rehabilitation specialists (BRS) and blind rehabilitation outpatient specialists (BROS) as an occupational series, which is a subgroup of an occupational group or a job family that includes all classes of positions at various skill levels in a type of work. The VHA developed an occupational series to organize, identify, and credential these professionals after World War II, when the first VHA inpatient blind rehabilitation center opened. When Medicare was deployed in the 1950's, a decision was made not to include rehabilitation for visual impairment because age-related visual impairment was not the health issue at that time that it is today. Therefore, other third party medical insurers do not currently recognize these professionals.

There has not been a similar credentialing system in place in the Department of Defense (DoD). The DoD has not provided blind rehabilitation training to Servicemembers since transferring that care from DoD to the Department of Veterans Affairs (VA) following World War II. In 1947, President Truman transferred blind rehabilitation training programs at Valley Forge General Hospital (Valley Forge, PA), Dibble General Hospital (Menlo Park, CA), and Old Farms Convalescent Hospital (Avon, CT) to the VA via Presidential Order.

Although they are not credentialed rehabilitation providers in the DoD at this time, BRS and BROS as additional occupational series' may be considered by DoD in the future. We are conducting an analysis of the requirements and courses of action for credentialing rehabilitation providers in the DoD. Currently, VA BROSs can and do support DoD credentialed providers such as optometrists, occupational therapists, and physical therapists in establishment of rehabilitation care plans for Servicemembers. DoD military treatment facilities refer to VA health care facilities and blind rehabilitation providers as needed to provide equal access to care.

Question 5: In PVA's testimony, they expressed concern that some mild TBI cases are falling through the cracks because of DoD's failure to diagnose and treat mild TBI? What can DoD do to improve on this front?

Answer: The Deputy Secretary of Defense recently signed a policy whereby mandatory medical evaluations occur in the presence of clearly defined inciting events. In addition to these mandatory medical evaluations for early detection and treatment of concussion, there are also line commander reporting requirements to ensure those who are exposed to possible concussive events undergo an evaluation.

All Servicemembers take the Post-Deployment Health Assessment and the Post-Deployment Health Reassessment at the end of their deployment cycle. Embedded within these assessments are TBI related screening questions to further identify those who may have sustained a TBI with current symptoms who may require further evaluation.

The Department of Defense (DoD) is committed to providing optimal health care to all Servicemembers. This includes all who sustain any severity of traumatic brain injury (TBI). While more severe levels of TBI are obvious and easier to diagnose than mild TBI, the DoD will continue to take steps to ensure that Servicemembers with a potential concussive injury are fully evaluated and promptly treated.

*Note: The question refers to the testimony of Mr. Carl Blake, National Legislative Director, Paralyzed Veterans of America (PVA).

Question 6: During their testimony, PVA raised concerns about some active duty soldiers with spinal cord injury and dysfunction bypassing the VA health care system and being transferred directly to civilian hospitals in the community. Why is this happening? What is DoD's rationale for bypassing the VA health care system?

Answer: Patient preference as to the location of their long term treatment is the individual's prerogative. The responsible military treatment facility (MTF) obtains the preference of the active duty Servicemember (or their guardian, conservator, or designee) for those individuals being considered for treatment under the spinal cord injury, traumatic brain injury, blindness, or polytrauma injury Memorandum of Agreement. The MTF will identify to the Servicemember or their designee the appropriate participating VA facility and make all transfer arrangements. Should the Servicemember or their designee request transfer to a TRICARE network provider or other civilian facility, the MTF will honor that request.

*Note: The question refers to the testimony of Mr. Carl Blake, National Legislative Director, Paralyzed Veterans of America (PVA).

Committee on Veterans' Affairs
 Subcommittee on Health
 Washington, DC.
July 27, 2010

Honorable Eric K. Shinseki
 Secretary
 U.S. Department of Veterans Affairs
 810 Vermont Avenue NW
 Washington, DC 20240

Dear Secretary Shinseki:

Thank you for the testimony of Dr. Lucille B. Beck, Chief Consultant, Rehabilitation Services, Office of Patient Care Services in the Veterans Health Administration at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Healing the Physical Injuries of War", which took place on July 22, 2010.

Please provide answers to the following questions by Tuesday, September 7, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Does VA track veterans by the number and types of severe injuries?
2. While OEF/OIF veterans may currently comprise a small proportion of the total number of veterans who use specialized services at VA, this is likely to change as our veterans return from Iraq and Afghanistan in increasing numbers. Given this, does VA have a good sense of the future demand for specialized services among our OEF/OIF veterans population? What is VA doing to prepare for the pending increase in demand for specialized services?
3. Dr. Beck's testimony emphasized VA's efforts in the area of prosthetics for women veterans. Are there gender differences where the needs of women veterans differ from their male counterparts for other specialized services such as blind rehabilitation, spinal cord injury centers, and polytrauma? If such difference exist, what is VA doing in these other areas to provide gender-specific care that meets the unique needs of women veterans?
4. Does VA offer the same types of specialized services as that of DoD? Are there certain specialized services that VA offers but which DoD does not offer?
5. How does VA know that they are providing the right kinds of specialized services? Also, how does VA know that they are serving severely injured OEF/OIF veterans on a timely basis at their current capacity? Can VA quickly ramp-up or ramp-down services to accommodate changes in the severely wounded veteran population?
6. How does VA ensure high quality of care for severely injured OEF/OIF veterans? In other words, how does VA know that care is consistent, standardized, and measurable across the VA health care system?
7. In their testimony, DAV brought to the Subcommittee's attention the proposed Tampa area Heroes Ranch, which would serve as a post-acute long-term care residential brain injury facility for active duty military service-members and veterans. Where is the VA in reviewing this proposal? When can we expect a formal decision from VA?
8. Where is VA in implementing the caregiver family support provisions of public law 111-163? When will caregivers have access to the supportive services provided in the recently enacted caregiver legislation?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by September 7, 2010.

Sincerely,

Michael H. Michaud
Chairman

**Committee on Veterans' Affairs, U.S. House of Representatives,
Post-Hearing Questions for Lucille Beck, Ph.D., Chief Consultant
for Rehabilitation Services, U.S. Department of Veterans Affairs
from the Honorable Michael H. Michaud, "Healing the Physical
Wounds of War," Oversight Hearing Subcommittee on Health, July 22, 2010**

Question 1: Does VA track Veterans by the number and types of severe injuries?

Response: Yes. Veterans are identified and tracked through a database appropriate for their injuries and the type of rehabilitation centers where they receive specialized services; e.g., Polytrauma Rehabilitation Centers (PRC), Blind Rehabilitation Centers, Spinal Cord Injury Centers. Additionally, VA established the Care Management Tracking and Reporting Application (CMTRA) to track Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans and to ensure appropriate care management of severely injured Veterans. Six categories of severe injuries are tracked, including: amputations, blindness/severe visual impairment, major burns, severe mental health, spinal cord injury (SCI), and severe traumatic brain injury (TBI).

Question 2: While OEF/OIF Veterans may currently comprise a small proportion of the total number of Veterans who use specialized services at VA, this is likely to change as our Veterans return from Iraq and Afghanistan in increasing numbers. Given this, does VA have a good sense of future demand for specialized services among our OEF/OIF veterans population? What is VA doing to prepare for the pending increase in demand for specialized services?

Response: VA projects demand for VA health care services by OEF/OIF Veterans for the next 20 years using a force-deployment scenario developed by the Congressional Budget Office. This allows VA to project enrollment and demand for VA health care services for OEF/OIF Veterans who will separate from the military in the future. The OEF/OIF health care utilization projections, including VA specialized services, reflect their unique morbidity and reliance on VA health care. Further, because this is a very dynamic population, VA studies evolving trends each year and makes adjustments to the projections as necessary.

There are many actions undertaken by VA to provide and plan for specialized rehabilitation services in the future, including:

- Chartered the Polytrauma Rehabilitation and Extended Care Task Force to address the long-term rehabilitative care needs of seriously injured OEF/OIF Veterans, and develop approaches to meet such needs through enhancements to current VA programs and services.
- Developed and implemented the VHA Strategic Plan for TBI, and established TBI as a select program in VA budget submissions.
- Developed and implemented the Polytrauma/TBI System of Care that provides specialized rehabilitation services within every Veteran Integrated Service Network, nationwide. This system of care consists of four levels of facilities, including 4 Polytrauma Rehabilitation Centers, 22 Polytrauma Network Sites, and 82 Polytrauma Support Clinic Teams with interdisciplinary teams of rehabilitation specialists, specialty care management, psychosocial support, and advanced rehabilitation and prosthetic technologies.
- Developed and implemented the Blind Rehabilitation Continuum of Care establishing 55 new low vision and blind rehabilitation clinics that provide the full spectrum of vision services through this one-of-a-kind National model of care for outpatient blind rehabilitation services.
- Developed and established the VA Amputation System of Care; a four component system of care that mirrors the model utilized by the Polytrauma System of Care, to provide services and expertise for Veterans with amputations.
- Developed and implemented the TBI Screening and Evaluation Program for all OEF/OIF Veterans receiving care within VA. Veterans who screen positive are referred for comprehensive evaluation and receive follow-up care and services as appropriate for their diagnosis and symptoms.
- Increase initiatives to use telehealth technology to enhance access to specialty care, coordination of care and case management, and therapeutic interventions.
- Sustain the continued development of VA's future workforce. Recruiting actions and innovative educational and academic training programs are being established to attract the best and brightest specialty providers, and to prepare these professionals to meet the specialty needs of Veterans. Maintaining the appropriate number of specialty rehabilitation providers is necessary to

support timely evaluation and services for the wide range of symptoms commonly seen following TBI and polytraumatic injuries.

Question 3: Dr. Beck's testimony emphasized VA's efforts in the area of prosthetics for Women Veterans. Are there gender differences where the needs of Women Veterans differ from their male counterparts for other specialized services such as blind rehabilitation, spinal cord injury centers, and polytrauma? If such differences exist, what is VA doing in these other areas to provide gender-specific care that meets the unique needs of women Veterans?

Response: VA Rehabilitation Services and Women's Health Care Services within each medical facility partner to accommodate the individual needs of women Veterans participating in rehabilitation with a range of disabilities including amputation, polytrauma, and spinal cord injury. Accommodation is made in fitting of prosthetic components, spinal orthoses, and adaptive equipment needed for the treatment and care of women Veterans. Certified mastectomy fitters and female Orthotists/Prosthetists are available for the specialized fitting of prostheses and orthoses. Spinal Cord Injury (SCI) primary care providers arrange for timely women's health care and gender specific screenings during the Veteran's annual evaluation, or earlier when a need arises. These services are provided by trained SCI staff in coordination with Women's Health clinical staff.

VA Prosthetic and Sensory Aids Service also formed a Prosthetics Women's Workgroup to address the unique needs of female Veterans. This Workgroup, comprised entirely of Women Veterans, developed a list of gender-specific items that are routinely available for the health and well-being of Women Veterans. Any specialized, medically indicated item can also be procured.

While the number of severely injured women who require specialized rehabilitation services is relatively small, women Veterans are an increasingly important population that VA serves; nine percent of the 1.1 million OEF/OIF Veterans who are eligible for VA care are women. To address the unique needs of this growing Veteran community, VA has implemented tools to evaluate and expand care for all Women Veterans at every site. There are now full-time Women Veteran Program Managers at our 144 medical health systems, and VHA is implementing comprehensive primary care for women at all facilities, with a completion date of 2013. In order to accomplish this, VA has provided mini-residency training to over 500 providers in women's health.

Special accommodations are further made for women inpatients to ensure privacy and safety, including: private hospital rooms, grouping female patients together in adjacent rooms with private shower facilities, and providing support for visiting families with small children. VA Women's Health Program continues to address the unique, gender-specific needs of all Women Veterans.

Question 4: Does VA offer the same set of specialized services as that of DoD? Are there certain services that VA offers but which DoD does not offer?

Response: VA offers the same set of rehabilitation services as DoD, and further provides more advanced, specialized services that are not available within DoD. DoD health care focuses primarily on short-term rehabilitation for Servicemembers with less severe injuries, and return to full military duty. VA provides the most comprehensive Rehabilitation Services for patients with more complex severe injuries and long-term consequences. Because of VA's capabilities in this area, a Memorandum of Agreement has existed between DoD and VA since 1981 for VA to provide specialized rehabilitation services for active duty Servicemembers with Spinal Cord Injury, TBI/Polytrauma, and Blindness. VA also provides the full range of rehabilitation services for patients requiring general rehabilitation.

Question 5: How does VA know that they are providing the right kinds of specialized services? Also, how does VA know that they are serving severely injured OEF/OIF Veterans on a timely basis at their current capacity? Can VA quickly ramp-up or ramp-down services to accommodate changes in the severely wounded Veteran population?

Response: VA utilizes state-of-the-science care that is evidence-based, and translates this into best practices that are defined in clinical practice guidelines and deployed to VA health care providers for use. Performance measures are established that monitor program and treatment outcomes. As examples:

- For 876 former patients with severe injuries treated at Polytrauma Rehabilitation Centers (PRCs):
 - 781 (89 percent) are living in a private residence;
 - 642 (73 percent) live alone or independently;

- 413 (47 percent) report they are retired (age, disability, other reasons);
 - 206 (24 percent) are employed;
 - 90 (10 percent) are in school part-time or full-time;
 - 59 (7 percent) are looking for a job or performing volunteer work.
- VA implemented a specialized Emerging Consciousness care path at the PRCs to serve those Veterans with severe TBI who are slow to recover consciousness. Approximately 70 percent of the 87 Veterans and Servicemembers admitted in VA Emerging Consciousness care emerge to consciousness before leaving inpatient rehabilitation.
 - For patients treated in Spinal Cord Injury Centers, new prevention efforts have successfully reduced the rate of developing a hospital-acquired pressure ulcer (which is a serious health risk for SCI patients). Only 1.3 percent of patients with SCI who were hospitalized in FY 2009 developed new pressure ulcers.

With regard to monitoring VA capacity, at no time during the wars in Iraq or Afghanistan has VA been unable to accommodate receipt of severely injured Servicemembers upon request from DoD because of capacity. Specialty units (Polytrauma Rehabilitation Centers, Blind Rehabilitation Centers, Spinal Cord Injury Centers) regularly monitor and report capacity, remaining ready and responsive in their capacity to serve patients who are severely injured, and accommodate surges in patient volume.

VA also partners with DoD to monitor and transition patients from DoD to VA health care. VA Military Liaisons are co-located with DoD Case Managers at military treatment facilities to provide onsite consultation and collaboration regarding VA resources and treatment options. They educate Servicemembers and their families about VA's system of care, and facilitate inpatient transfer to a VA health care facility as appropriate.

Question 6: How does VA ensure high quality of care for severely injured OEF/OIF Veterans? In other words, how does VA know that care is consistent, standardized, and measurable across the VA health care system?

Response: VA employs a systems approach to ensure that that VA specialty rehabilitation care programs adhere to the highest professional standards of service and effectiveness. This includes:

- **Accreditation.** VA specialty rehabilitation care programs are accredited by the Joint Commission, and by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is the internationally recognized standard of excellence for rehabilitation programs. CARF accreditation is mandatory for all VA inpatient rehabilitation programs and for all levels of rehabilitation programming at the specialty centers.
- **Outcomes Measurement.** VA collects and analyzes rehabilitation outcomes using the Functional Independence Measure (FIM), the most widely accepted functional assessment measure in use in the rehabilitation community. FIM data is collected and analyzed by the Uniform Data System for Medical Rehabilitation, which allows VA to benchmark outcomes against those of other non-VA entities. The Functional Status and Outcomes Database (FSOD) is used to track patient outcomes across the full continuum of rehabilitative care from onset of disease or injury to completion of the patient's rehabilitation goals without respect to the venue in which services are provided. VA also recently established a collaborative relationship with the National Institute for Disability and Rehabilitation Research to participate in the TBI outcome data management project with 16 TBI Model Systems centers from the private sector.
- **Translational Research.** The VA Quality Enhancement Research Initiative (QUERI) utilizes clinical practice needs to inform VA's research agenda, that in turn translates research results to identify interventions that improve the quality of patient care. Spinal cord injury (SCI), polytrauma and blast-related injuries are conditions that are part of the QUERI effort, promoting the successful rehabilitation, psychological adjustment and community re-integration of individuals who have sustained these injuries.

In order to standardize consistent delivery of quality services across VA health care system, VA Central Office provides guidance to the field regarding the structure of the specialty care services and systems, resource requirements, and the processes and procedures involved in the delivery and coordination of services. Directives, handbooks, and guidance have been issued that set policies and describe procedures for the Polytrauma System of Care, Spinal Cord Injury and Disorders, Blind

Rehabilitation Services, other specialty rehabilitation services and care management.

VA has created and provided numerous educational and training opportunities for clinical providers, and other VA staff to become familiar with the diagnosis and treatment of TBI, the continuum of rehabilitation services available through the Polytrauma System of Care, and managing other impairments associated with TBI (pain and mental health issues). Over 25 national conferences and satellite broadcasts, each with 50 to 1,200 participants, have been offered through VA Employee Education System in the last three years. Speakers have included internationally recognized experts in TBI. Prior to the implementation of the mandatory TBI screening in 2007, over 60,000 VA providers completed a mandatory four hour TBI education course.

Educational and training initiatives are also established and ongoing for VA specialty providers who work with Spinal Cord Injury and Disorders, Blind Rehabilitation Services, and Amputation System of Care (e.g., psychiatrists, neurologists, orthopedists, rehabilitation nurses, rehabilitation therapists, mental health providers, social workers, care managers, etc).

Question 7: In their testimony, DAV brought to the Subcommittee's attention the proposed Tampa area Heroes Ranch, which would serve as a post-acute long-term care residential brain injury facility for active duty military Servicemembers and Veterans. Where is the VA in reviewing this proposal? When can we expect a formal decision from VA?

Response: VISN 8 has submitted a proposal to pilot a post-acute, long term, comprehensive care facility for active duty Servicemembers and Veterans with TBI and/or polytrauma. This pilot project would be an outpatient treatment facility that would serve the most severe injuries, including those warriors in a vegetative and semi-conscious state, those patients with neurobehavioral problems, and those persons that require a structured day program for ongoing recovery after completing acute inpatient rehabilitation. The proposal is currently under review by the Deputy Under Secretary for Health for Operations and Management (DUSHOM). VA is anticipating a formal decision regarding Heroes Ranch in the first quarter of FY 2011.

Question 8: Where is VA in implementing the caregiver family support provisions of Public Law 111-163? When will caregivers have access to the supportive services provided in the recently enacted caregiver legislation?

Response: The Office of Care Management and Social Work in the Office of Patient Care Services, in collaboration with the Chief Business Office, has primary responsibility for implementing the caregiver programs required by title I of Public Law 111-163. VA has developed a Steering Committee to direct the implementation process. VA is working with the Gallup Organization to hold focus groups with Veterans who may be eligible for the program and their family caregivers; Veterans Service Organizations; and National Organizations that specialize in providing assistance to individuals with disabilities or family caregivers; the law requires that VA consult with these groups, and DoD, in developing the family caregiver program implementation plan. VA believes stakeholder feedback is critical as it moves forward with plans for implementation. DoD is providing direct input on the Steering Committee. VA is developing the plan for implementation and will begin offering the services and benefits as soon as possible.

In addition, VA has established four national Workgroups, comprised of more than 50 subject matter experts from around the country, to work on specific components of the law, including: eligibility, caregiver benefits, clinical requirements, and information technology. These Workgroups held face-to-face meetings in Washington the week of July 19 to develop recommendations for implementing key components of the law. As of the beginning of August, the Workgroups are reporting their recommendations to the Steering Committee.

This is a very complex program and will require time and regulations to implement it fully. The timeline for regulations is difficult to define specifically, but portions of the program, such as training and other supportive services, are already available for Veterans and their caregivers. VA routinely offers in-person educational support for caregivers of Veterans undergoing discharge from an inpatient stay at a VA facility and teaches techniques, strategies, and skills for caring for a disabled Veteran. Counseling for family members under 38 United States Code (U.S.C.) 1782 may also be available, and VA's respite care program has benefited Veterans for a number of years. Each VA medical center has designated a Caregiver Support Point of Contact to coordinate caregiver activities and serve as a resource expert for Veterans, their families and VA providers to assist them in locating and accessing non-VA resources.

VA clinical experts are working on developing core competencies for primary caregivers and developing a comprehensive training and support program for caregivers. Training and support services will also be integrated into a comprehensive caregiver Web site. VA will ensure public awareness of the new benefits and services, as well as the related application process through public service announcements and other forms of outreach.

VA plans to submit its implementation plan to Congress within the required 180 days.

