SERVICEMEMBERS' SEAMLESS TRANSITION INTO CIVILIAN LIFE—THE HEROES RETURN

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MARCH 8, 2007

Serial No. 110–7

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

34–309 WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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CONTENTS

March 8, 2007

POST-HEARING QUESTIONS FOR THE RECORD

SERVICEMEMBERS' SEAMLESS TRANSITION INTO CIVILIAN LIFE—THE HEROES RETURN

THURSDAY, MARCH 8, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:43 p.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Space, Walz, Rodriguez, and Brown-Waite.

Also Present: Representatives Filner, Hare, Buyer, Bilirakis, and Lamborn.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Welcome to the Oversight and Investigations Subcommittee of the Committee on Veterans' Affairs March 8, 2007, hearing entitled, Servicemembers' Seamless Transition into Civilian Life—The Heroes Return. I want to thank everyone for being here today. Two weeks ago, the American people learned that some of the most seriously wounded warriors were recovering in dilapidated conditions at the Walter Reed Medical Center, supposedly the Army's premier medical facility.

These conditions are absolutely unacceptable and the American people are rightly outraged. Sadly, it appears the buildings are just the tip of the iceberg. Reports have been filtering in about a labyrinth of bureaucratic red tape our returning soldiers are having to navigate to get the basic health care benefits they need and deserve. These problems have a direct impact on these men and women as they transition from the military's health care system to the VA. We have a responsibility to investigate how issues at the Department of Defense affect soldiers as they become veterans. We have a responsibility to make sure that the Department of Veterans Affairs is doing its job to make the transition as easy as possible.

I am not convinced that the U.S. Department of Veterans Affairs (VA) is doing its part. Last night, ABC News reported that a proposal to keep seriously wounded vets from falling through the cracks of the bureaucracy was shelved in 2005 when Jim Nicholson took over as VA Secretary. I am deeply troubled when wounded soldiers say in news reports that the VA has made them feel horrible. That is unacceptable and embarrassing and the American people

deserve answers. Today, we hope to get to some of them. In today's hearing, we will hear from witnesses who have seen and experienced firsthand the difficulties veterans face when they transition from the DOD health care system to the VA. Their stories are compelling, and I am eager to learn how the VA is responding to their concerns as well as the health care needs of their fellow veterans who have taken time to come to observe our hearings.

In particular, I would like to recognize Specialist Greg Williams, Corporal Noel Santos, Sergeant Frank Valentine, Staff Sergeant Danny Vega. We are honored to welcome these young heroes here today. At this time, I ask unanimous consent that Mr. Filner, Mr. Buyer, Mr. Hare, Mr. Lamborn, and Mr. Bilirakis be invited to sit at the dais for the Subcommittee hearing today. Hearing no objections, so ordered.

[The prepared statement of Chairman Mitchell appears on pg. 55.]

Mr. MITCHELL. Before I recognize the ranking Republican Member for her remarks, I would like to swear in all of our witnesses. And at this time, if you would please stand, we will swear you in.

[Witnesses sworn.]

Mr. MITCHELL. Thank you. Now I would like to recognize Ms. Brown-Waite for her opening remarks.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. I thank the Chairman. And I apologize both to the Chairman and to the Members for my tardiness. It was an issue relating to a sexual predator in my district who was found guilty yesterday, and I was speaking to the family and to some Members of the press about it. And I thank the gentleman for yielding. The Committee on Veterans' Affairs has been conducting oversight reviews of the seamless transition issue for our Nation's servicemembers for the past several Congresses.

In the last Congress alone, the Committee and its Subcommittee held 10 hearings on the transition of our servicemembers. I believe that I speak for all of us when I say that this is a top priority issue, that despite our best efforts has not always been entirely resolved. Congress codified the concept of DOD–VA sharing, now known as seamless transition, in 1982, with the passage of the Veterans Administration and the Department of Defense Health Resources Sharing an Emergency Operation Act. This Act created the VA Care Committee to supervise and manage opportunities to share medical resources. Now, 25 years later, we are still discussing this issue. Some progress has been made in the area of transitioning servicemembers back to the workforce.

Last Congress, Public Law 109–461 was enacted which included various transition assistance initiatives ranging from health care needs to education and employment needs. During the last Congress, Members and staff from the Committee conducted numerous field and site visits at the VA and military treatment facilities and military bases to review efforts on the seamless transition, and held oversight hearings in May and September of 2005. The transition and integration back into civilian life should be transparent and effortless for our servicemembers.

However, this apparently does not always seem to be the case. More often than not, the handoffs have been fumbles. In a GAO report prepared for this Subcommittee on June 30, 2006, it was found that the VA has taken many aggressive actions to provide timely information to OEF and OIF servicemembers and their families, especially in their critical time of need. The report also noted the positive steps taken to increase the awareness training and sensitivity of staff and medical providers on the needs of OIF and OEF servicemembers and veterans. The report also found the VA continues to have problems assessing real-time medical information from DOD treatment facilities. Mr. Chairman, I ask unanimous consent that a copy of this report be inserted in the official hearing record, and I will be happy to hand that to you.

Mr. MITCHELL. So ordered.

[The referenced GAO Report entitled, "Vocational Rehabilitation—More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers," (GAO–06–79R), appears on pg. 78.]

Ms. BROWN-WAITE. I appreciate that.

We know that we have witnesses from Walter Reed Army Medical Center, and I want to make it clear that today's hearing is not about the conditions at Walter Reed, but about the transition of our servicemembers and how they are making it from DOD to VA care, how the process works, are there any gaps in care, and is VA getting the information that it needs from DOD in a timely manner to ensure the continuity of care for these new veterans, so that waiting periods for care do not extend for months after separation from active duty. And why to this day is information on DOD personnel being cared for at the VA's polytrauma centers still not being electronically transmitted? Is there a difference between DOD electrons and VA electrons? Again, Mr. Chairman, I thank you and I yield back the balance of my time.

[The statement of Congresswoman Brown-Waite appears on pg. 55.]

Mr. MITCHELL. Thank you. At this time, I am asking Members to submit their opening statements. We have 13 people on three panels that we are going to hear today. So it will take quite a while. If you could submit them for the record, I would appreciate that.

We will now proceed to panel one, we are pleased to welcome Dr. Michael Kussman, the acting Under Secretary of Health for VA. Dr. Kussman has had a long and distinguished military career beginning with his service in the 7th Infantry Division in Korea. He has held leading medical positions at multiple facilities while on active duty, such as serving as commander of the Walter Reed health care system.

As the Director of Health care at the GAO, Ms. Cynthia Bascetta provides our Subcommittee with a major service not only in her ability to provide independent assessment of VA program performance, but also to place the performance of VA's seamless transition programs in a historical context. As many of you are aware, last night, Mr. Paul Sullivan appeared on ABC News to discuss a data tracking system, which would have made the seamless transition of new veterans much more efficient. We are pleased to welcome

him here today to answer questions and share his knowledge and experience on this issue.

Finally, Private First Class Kimberly Lain who has recently gone through the transition process to the VA from the Walter Reed Medical Center is here to share her experiences with us.

STATEMENTS OF MICHAEL J. KUSSMAN, MD, MS, MACP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. MITCHELL. Dr. Kussman, if you would please. If everyone could please, in front of you is a little clock with a green light, a yellow light and a red. And if we could keep that, keep it in line with that, I would appreciate it. Dr. Kussman?

STATEMENT OF MICHAEL J. KUSSMAN

Dr. KUSSMAN. Good afternoon Mr. Chairman and Members of the Subcommittee. I would like to submit the written record for the record if that is okay, Mr. Chairman. Thank you for this opportunity to comment on VHA's seamless transition efforts. Before I begin, however, let me address an issue with which was discussed in the news media last night. In 2003, VA developed a contingency tracking system to meet the Veterans Benefits Administration, not the VHA's immediate need to track their benefits, assistance activities in support of seriously injured servicemembers as they transition from MTFs to our health care facilities.

The VA employees who worked on the system hoped that it would evolve to meet the VHA. Unfortunately, it could not meet VHA's needs or even all of VBA's needs without additional development costs, and in February 2005, our Department decided to consider other ways to accomplish this task.

Because VHA's case management needs were not met by the system, we developed our own tracking system which is known as the MTFs to VA. Last summer, we were briefed on DOD's joint patient tracking application, or JPTA system, which provides a great deal of information on the progress of seriously injured veterans through DOD's health care system.

Together, DOD and VA realized that enhancing DOD system was our best option, providing both departments with a much better tool to track case management issues. DOD provided us with the capability to look at their records toward the end of last year, and earlier this month, we developed the ability to enhance the system to enable VA case managers to add their own notes and information about phone calls they have made to patients.

Our vision is to create a continuous clinical record of transfers and case management activities for all seriously injured patients as they progress through both DOD and VA systems of care. VHA will continue to use the MTF to VA system until JPTA can create such a record for seriously injured patients.

One other thing, before I leave this subject, contrary to what was erroneously reported last evening, the decision to use one system which was felt better met our needs over another one was made appropriately at the administrative level. This was a programmatic

decision and not one made by the Secretary. VHA's efforts to create a seamless transition for men and women as they leave the service and take up the honored title of veteran begins early on. Our outreach network ensures that returning servicemembers receive full information about VA benefits and services.

In each of our medical centers and benefits offices now has a point of contact designed to work with veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom. VHA has coordinated the transfer of other 6,800 injured or ill active duty servicemembers and veterans from the Department of Defense to the VA.

Our highest priority is to ensure that those returning from the global war on terror who transition directly from DOD military treatment facilities or MTFs to VA medical centers continue to receive the best possible care available anywhere. This month, we are attempting to call each of these severely injured servicemembers and veterans to see if they need additional support. And we are directing facilities to provide OIF/OEF care coordinators at each facility.

VA social workers benefits counselors and outreach coordinators advise and explain the full array of VA services and benefits to servicemembers while they are still being cared for by DOD. These employees assist active duty servicemembers as they transfer to VA medical facilities from MTFs.

In addition, our social workers help newly wounded soldiers, sailors, airmen, and marines and their families plan a future course of treatment for their injuries after they return home. Currently, VA social work and benefits counselors are located at 10 military treatment facilities. One important aspect of coordination between DOD and VA to a patient's transfer to VA's access to clinical information. The Bi-Directional Health Information and Exchange, BHIE, allows VA and DOD clinicians to share text space clinical data in a number of sites, including Walter Reed and National Naval Medical Center and the two military treatment facilities that refer them, they are the two military treatment facilities that refer the majority of polytrauma patients to the VA.

Mr. Chairman, case management for our patients begins at the time of transition from the military treatment facility and continues as their medical and psychological needs dictate. Patients suffering severe injuries or those with complex needs receive ongoing case management at the VA facility where they receive most of their care. VHA has recently determined that every medical center will have a full-time case manager for OIF/OEF veterans needs and we are in the process of hiring a hundred new OIF/OEF veterans to serve as ombudsmen to support severely wounded veterans and their families.

Each VA NC also has a designated point of contact to coordinate activities locally for OIF/OEF veterans and to ensure the health care and benefits needs of the returning servicemember and veterans are fully met. VA has distributed specific guidance to field staff to ensure that the roles and functions of the points of the contact and case manager are fully understood and that proper coordination of benefits and services occur at the local level. To ensure that all eligible veterans are aware of the services they are entitled

to, VA's developed a vigorous outreach education and awareness program for our returning veterans and their families.

To allow us to provide coordinated transition services and benefits for National Guard and Reservists, a memorandum of agreement was signed with the National Guard in May 2005. Similar memorandums are under development with the United States Reserve and the United States Marine Corps. These new partnerships will increase awareness of and access to VA services and benefits during the demobilization process as former servicemembers return to their local communities.

VA is also reaching out to returning veterans whose wounds may be less apparent. VA's a participant in the DOD's post-deployment health risks and assessment program. We provide information about VA care and benefits, enroll interested Reservists and Guardsmen in the VA health care system and arrange appointments for referred servicemembers.

As of December 2006, an estimated 68,800 servicemembers were screened under the provisions of this program resulting in more than 17,000 referrals to the VA. Finally, VA provides outreach to our newest veterans through our readjustment counseling service, commonly known to veterans as the Vet Centers Program. Vet centers were created by Congress as the outreach element in VA's health administration. The approximate number of OIF/OEF combat veterans served by vet centers today is 180,000. Vet centers have provided bereavement services to the families of over 900 fallen warriors. VA plans to expand the Vet Center Program. We will open 15 new vet centers and eight new vet center outstations at locations throughout the Nation by the end of 2008. At that time vet centers will total 232.

We also expect to add staff to 61 existing facilities to augment the services they provide. Seven of the 23 new centers will be opened during calendar year 2007. Mr. Chairman, this concludes my presentation. At this time I would be pleased to answer any questions that you may have. Thank you.

Mr. MITCHELL. Thank you, Dr. Kussman, for your presentation.

[The statement of Dr. Kussman appears on pg. 57.]

Mr. MITCHELL. The others are here just for questions. We will not have an opening statement. But I do have some questions I would like to ask of you to start with. I am going to ask about the complaint system that is in place that the VA has. When a patient approaches the VA with a complaint about treatment they have received, how is that complaint handled?

Dr. KUSSMAN. Sir, there would be multiple ways. We have patient advocates at every facility. There are signs up that tell the patients that if they are unsatisfied with what they have they can go to the patient advocate. They could call the IG, they could call our Office of Medical Inspection. They could go directly to the hospital director or they could send an e-mail directly to me, which people do, as well as the Secretary.

Mr. MITCHELL. And is there someone who follows up with this after they have made a complaint?

Dr. KUSSMAN. Yes, sir. Personally, if it is to me.

Mr. MITCHELL. And to follow up with this, the follow-up, who follows up with the facility to make sure that they correct whatever

is wrong? Does anybody follow up? Because it seemed to me, you know, when we hear about Building 18 and some other buildings out there—I am sorry, that was Walter Reed, not under your control. But let's say that there was a facility that someone complained about, is there anybody who follows up with the facility?

Dr. KUSSMAN. Yes, sir. Our assistant, I mean, our Deputy Under Secretary for Operations and Maintenance, Mr. Bill Feeley, is responsible for the upkeep and the services at all the facilities and through him and the hospital directors we would be sure that things were corrected. We also have a lot of inspection teams that come and visit us. If there was an issue like that, not only the joint commission, but we have what we call our own supports, there are a mini joint commission that we do on ourselves. The IG comes and reviews us with their CAP reports. We have other outside agencies that review, CARF which reviews rehabilitation centers. So there is a lot of review and follow up if there is identified a deficiency in any of our facilities.

Mr. MITCHELL. What kind of records do you keep on patients' complaints?

Dr. KUSSMAN. Again, I think that would be at the facility level. But we also have very elaborate patient satisfaction surveys that are done when patients come in, they fill out a form, and those are reviewed and kept that, I believe at the facility. They are tracked at the facility as part of the performance measures for the leaders of the facilities to be sure, but we also have the University of Michigan do a consumer satisfaction review service every year, and thank goodness every year that we have done very well on that is a customer satisfaction, and have actually been 10 points higher than civilian facilities.

Mr. MITCHELL. What is the process you use for taking valid complaints and taking corrective action?

Dr. KUSSMAN. Well, as I said, sir, hopefully that would be handled at the facility level, that if somebody raised a complaint about something, that through the patient advocate or anybody else who took the complaint, the facility director and associate directors would act on that. If the patient doesn't get satisfaction, it could be raised through the division level or to the central office through an 800 hotline call to the Secretary, the IG, or the Office of Medical Inspection.

Mr. MITCHELL. How often do you review these surveys or these complaints? Are they done every day? Once a month? Every 3 months? How often do you review these complaints or these satisfaction surveys? Once a year?

Dr. KUSSMAN. The survey, the large survey, as I mentioned from the University of Michigan, is done once a year, but other surveys are done on a rotating basis. The IG does—rotates through our facilities.

Mr. MITCHELL. Besides surveys about satisfaction, what about complaints about service or the care they are getting? How often are those reviewed and are there records of those?

Dr. KUSSMAN. Well, as I said, I think it depends on whether the complaint got up to the central office or not, but the complaints are generally handled at the local level if they can be handled. If the individual doesn't get satisfaction, it would bubble up, but that is

an ongoing thing. They review those complaints and see if there is any pattern.

Mr. MITCHELL. If a patient doesn't feel they have gotten satisfactory compliance or haven't had their complaint satisfactorily answered, what happens then?

Dr. KUSSMAN. Well, I would encourage them and they would be encouraged to take it to the higher level. They can come to the division or they can come to the central offices if they don't get satisfaction. That is our job, to take care of veterans and if they are not satisfied with what they want, we would encourage them to call us.

Mr. MITCHELL. Do you have any idea about how many complaints you might get a month?

Dr. KUSSMAN. No, sir, but I can go back and ask and get it to you.

Mr. MITCHELL. All right. Thank you. I yield my time.

Mr. BUYER. Mr. Chairman, I ask for a parliamentary inquiry.

Mr. MITCHELL. Yes.

Mr. BUYER. My inquiry is that the witnesses sitting with the Acting Under Secretary, the individuals sitting there, are they witnesses or are they sitting there in an individual capacity?

Mr. MITCHELL. Mr. Buyer, they were sworn in. So they are here to answer questions as we try to further this.

Mr. BUYER. Further parliamentary inquiry. Is it the intention of the Chairman to follow rule XI of the House Rules when it comes to the rules and procedures of the Committee?

Second, Mr. Chairman, in the 15 years I have been here in Congress, I have never seen a Committee or a Subcommittee ever treat an official of the administration without respect and dignity of their position and station. And I have been here through Republican and Democratic administrations. This is a very curious manner in which you are treating the Under Secretary of Health for the VA. So I, again, ask you, is it the intention of the Chairman to follow the rules and protocols of the House under rule XI?

Mr. MITCHELL. We will take a five-minute recess on that.

[Recess.]

Mr. MITCHELL. We will reconvene. Mr. Buyer recommends that having Mr. Sullivan and Ms. Lain appear with Dr. Kussman on the panel does not show proper respect. So, we will ask Ms. Lain and Mr. Sullivan if they would step down and join the second panel. If you would do that, please.

Mr. SULLIVAN. Yes, Mr. Chairman.

Mr. MITCHELL. That's the only way I guess we can get proper respect. Thank you.

Mr. BUYER. I thank the Chairman.

Mr. MITCHELL. Ms. Brown-Waite?

Ms. BROWN-WAITE. I would address this to Dr. Kussman. Today I received a letter from Secretary Nicholson addressing what the VA has done and what they are doing, and what they're going to do in the future to ensure that the wounded veterans receive everything that they need as a transition from DOD medical facilities to the VA. If you would please talk about that, I'm sure that you were involved in that letter. Is that correct?

Okay. If you would just please discuss that, and I think that every Member here does plan, you know, holding the Secretary's

feet to the fire to make sure that those promises made in the letter, and I think everyone received one, I think the Chairman received a letter today, that that really does take place. I think regardless of the party affiliation, every Member here wants to make sure that our veterans are well taken care of, and in response to the Chairman's question about what happens when the number of complaints pile up, I can just tell the Chairman that I'm aware of at least one hospital administrator who was removed from that post in my district, and I am sure that the freshman Members here will learn and that we will be also contacted when the VA is not responsive.

The families and/or the veterans and military people won't hesitate to also let us know. So if you would just elaborate a little bit on that letter, I would appreciate that very much.

Dr. KUSSMAN. Congresswoman, I don't have the letter right in front of me, so I didn't have it memorized, but obviously I am aware of the content of the letter. We believe very strongly in our responsibility to veterans and their families for care, and I believe that we have done that, as mentioned with the satisfaction surveys that we have. But I believe this was just another way of energizing and reminding our people and our facilities of our obligation to do the things that we need to do. We are hoping we will accept responsibility when things don't go well, and we pledge to fix them when they're not, and so we want to be sure that we've assessed everything that we are doing, and be sure that we can raise the bar as appropriate.

Ms. BROWN-WAITE. You know, when I first ran for office, I thought it was a really good idea to virtually have the veterans be able to go to non-VA hospitals. I really thought that was a good idea until I really got to know the veterans population both in my district and the organizations that are represented up here. And I learned what a very high satisfaction level that the clear majority of veterans have and also the very good survey results that the virtual—the customer satisfaction survey that takes place. I know I don't have a VA hospital in my district.

I have three great ones around me, and we're going to hear later from the head of the polytrauma unit there. But I get great results and the veterans who aren't happy also contact us, you know, I would be interested in the number of complaints. I think maybe we should—every Member should have that information available, and how many of them were resolved. You know, so that we can also assure the veterans that if they do have a question, or a complaint, that their complaint is taken seriously, and is resolved.

Dr. KUSSMAN. Yes, ma'am.

Ms. BROWN-WAITE. Mr. Chairman, I would also request that Secretary Nicholson's March 7 letter addressed to me and to you regarding the VA's efforts to ensure the seamless transition into the VA system from DOD, that that can be also submitted for the record.

Mr. MITCHELL. Without objection, so ordered.

[The March 7, 2007, letter from Secretary Nicholson appears on pg. 73.]

Ms. BROWN-WAITE. I appreciate that. In the letter it also said that every VA medical center now has specialty PTSD treatment

capability. Would you elaborate a little bit on that? And how recent is it that the PTSD treatment availability has been available?

Dr. KUSSMAN. Thank you for the question. The VA, as you know, has been the leader in the treatment evaluation and research of PTSD ever since the diagnosis was first used in 1980, and we have a national center in White River Junction and other research sites that are seen as international resources for the treatment research and evaluation of PTSD. We, in 2004, developed a very thorough and elaborate mental health strategic plan to look at where we were at the time and what are the things that we could do better. And one of those things we realized that we could do better was to be sure there was PTSD treatment teams at all our facilities and there are over 200 of them and that is more than just our facilities, because as you know, we have about 155 hospitals. We've also put PTSD treatment teams in large clinics as well to meet the needs of people who have PTSD or are being looked at for PTSD. And so this is really part of our mental health strategic plan to enhance the services available.

Ms. BROWN-WAITE. I thank the Doctor, and I yield back the balance of my time.

Mr. MITCHELL. Thank you, and just one follow-up question real quick. What is the waiting time for a person to receive treatment in these centers?

Dr. KUSSMAN. Sir, obviously our goal, first of all, if anybody has urgent or emergent care, they get in right away. Our goal is that if it is not urgent or emergent the person should be seen within 30 days of the request.

Mr. MITCHELL. How long?

Dr. KUSSMAN. 30 days.

Mr. MITCHELL. Thank you. Mr. Space?

Mr. SPACE. Thank you, Mr. Chairman. I understand that Ms. Bascetta is available for questioning?

Mr. MITCHELL. Right.

Mr. SPACE. I hope I have pronounced your name correctly.

Ms. BASCETTA. Bascetta.

Mr. SPACE. Thank you. And I apologize.

Ms. BASCETTA. That's okay.

Mr. SPACE. Ms. Bascetta, you, in your work for the GAO, obviously have invested many hours in researching, in documenting matters concerning seamless transition. My question is to what extent—I am assuming you have made recommendations. And I am curious to what extent those recommendations have been followed, and if there have been matters that you have recommended, issues that you have suggested that have been ignored.

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. I wouldn't say that the VA has ignored any of our recommendations in this regard. I can't say, however, that the two departments working together have followed our recommendations so far to the extent that we'd want them to. And the one that I'm most concerned about is that VA and DOD do a better job collaborating on rehabilitation so that veterans or servicemembers, for that matter, who need services get them as early as possible. Our work has shown that if there is a delay in getting rehabilitation,

there can oftentimes be deficits that can't be made up. And one of our most significant concerns is that, of course, all veterans start in the DOD system. And if they don't work together early, meaning that DOD at times would have to let VA in early, it could happen that when VA has a veteran arrive for care in their system, you know, there could be deficits that VA can't make up.

I'd also say that with regard to the seamless transition, it remains a work in progress rather than a fully implemented reality, but I think that because of the complexity of the process, there will always be room for continuous improvement. When we reported on it in 2006 to this Committee, we did not make recommendations because in the course of our work when we found problems to VA's credit, they corrected them while we were completing our work. Most of those were problems with regard to individual patients. So we would have to do more work at this time to look systematically to reassess how well it is working.

[The statement of Ms. Bascetta appears on pg. 59.]

Mr. SPACE. Thank you. Have you made specific recommendations concerning the fashion in which these delays can be eliminated, specifically with respect to rehabilitation? And if so, can you provide us with a copy of those specific recommendations?

Ms. BASCETTA. I can submit our report for the record. The recommendation was a conceptual one that the two departments collaborate to come up with a plan and an agreement as to when it would be appropriate for VA to have data about servicemembers. And that through the course of them working out the details early intervention could become a reality.

[The GAO report (GAO–05–167) reference by Ms. Bascetta appears on pg. 94.]

Mr. SPACE. Thank you. I yield back the balance of my time.

Mr. MITCHELL. Thank you. Mr. Buyer?

Mr. BUYER. Mr. Chairman, I will follow the protocols of the Committee and I will go at the end of the sitting Members of the Committee for questions. Thank you.

Mr. MITCHELL. Thank you. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman. And thank you, Dr. Kussman, for being here. Ms. Bascetta, I appreciate the opportunity to speak with you, and I want to thank you for the work you've done for our veterans. I said I do think that is critically important that we keep that in mind, and having spent a lot of time in our polytrauma center in Minneapolis, I know the quality of care and the professionalism there is something that I am very proud of.

My constituents demand that we get this right and we're here today to question and to look ahead and I think that is a healthy exercise, I think it is one we need to do and we can get this right. We must get it right. I would associate myself with the Ranking Member Ms. Brown-Waite when she said, that this is a priority. This is one that we have to get right. I feel it is a moral imperative to take care of our wounded warriors when they return home, but I also think that it is a national security issue.

We need to make sure this is part of what we're doing so soldiers know they're being taken care of. Results matter in this, and it is one of these situations that I think we have to shoot for. You're

right, it is always going to be a continuing process. But this is a zero sum proposition. One mistake is too many in this. One soldier left untreated is too many.

And I think all of us agree with that, and the goal is to try to get it to zero. If we ever get there, we must continue to try. So just a couple of questions, Mr. Kussman. How long have you been with the VA—I'm not sure if I got that—have you been working in your current position, sir?

Dr. KUSSMAN. In my current position? Since 12 August 2006.

Mr. WALZ. How long have you been with the VA in general, Dr. Kussman.

Dr. KUSSMAN. I first came to the VA on 24 September 2000.

Mr. WALZ. Very good. My first question on this is do you believe there were substantial changes made or substantial preparations made starting in about March of 2003 when this current conflict in Iraq got started? Were there preparations made for the influx of wounded veterans that we would see?

Dr. KUSSMAN. We always, sir, are ready to take whatever we need. I think that the thing that surprised everybody was the type of injuries that we were seeing, not necessarily the volume, although no one could predict how long the war was going to go on, and that is a different issue. But what we have seen is that there are certain signature injuries of this war. One is PTSD, particularly for the National Guard and Reserves because I am not trying to minimize the active component, but they do have a cocoon around them, and in my previous life I appreciated that. But what do you do with the people who then, when they get discharged, don't have that same type of cocoon?

The other thing is because of the body armor and the far-forward surgical care, servicemembers are surviving with much more complicated wounds. So that was one of the things that drove us very quickly to build on our four TBI centers that we have in Palo Alto, Minneapolis, Tampa and Richmond. And we have two of the directors here that will be on a follow-up panel. We put in place there, the full multidisciplinary approach for things, not just TBI. But TBI is another signature injury that is occurring, partly because I think when we went into the war, we thought that we would see the more traditional types of casualties, gunshot wounds, shrapnel, the usual thing.

The enemy is taking a different tact in using IEDs and car bombs that create blast injuries, and one of the blast injuries among others is the traumatic brain injury which is—not to minimize it, it is head rattle that occurs inside the helmet, the brain floats and things in the brain, it is not locked in. So there is a whole spectrum of mild to moderate traumatic brain injuries to severe traumatic brain injuries.

Mr. WALZ. And just using the last bit of my time, do you feel like we're prepared for the large number that are going to be diagnosed as we start to check everyone now the traumatic brain injury? Sometimes it's not so visible, vision, different things like that, and PTSD. Do you feel like we're prepared? And you are absolutely right, in my former life, it was 24 years in the National Guard. And I know when they go out to rural Minnesota, it is a lot different than when we're on an active military base. Are we prepared

for these soldiers today, tomorrow and 5 years and 50 years down the road?

Dr. KUSSMAN. Sir, as you know, I can't read a crystal ball, but I think right now we put in place the procedures and processes that we can take care of this group of patients. As you know, of the 613,000 servicemembers that have transitioned out of the active component since the OIF/OEF started, some are active component people who have left, others are transitioned back to the National Guard or Reserve or just get out of that as well. We've seen 205,000 of those people with a myriad of differing complaints. We see—we project that number—that was out at the end of FY 06. We project that number in FY 08 to be 263,000.

We project that we will see 5.8 million veterans. So it is a relatively small number of our total force, but they have certain needs, and we believe with our four polytrauma centers, our 17 additional level two centers and teams and all our facilities, we are ideally poised to be able to take care of the patients as they transition out.

Mr. WALZ. Thank you. And I yield back, Mr. Chairman.

Mr. MITCHELL. Mr. Rodriguez?

Ms. BASCETTA. Mr. Chairman, may I add something? I'm sorry.

Mr. MITCHELL. Go ahead, ma'am.

Ms. BASCETTA. I would just like to elaborate a little bit on what Dr. Kussman said. And that is, we did some budget work for this Committee last year and reported in September 2006 that one of the factors that caused one of the problems in VA's budget estimation was underestimating the cost of serving veterans returning from Iraq and Afghanistan. And part of that was due to the fact that their data largely predated the conflict. But the other part was—and I can't make this point too strongly—that they have had trouble getting data from DOD that they need for planning purposes. So it is another example of the need for these two agencies to work together.

Mr. MITCHELL. Thank you. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you very much. I wanted to follow up with the GAO. And you answered one of my questions because I recall some time back, we pushed an effort in terms of trying to get both the active-duty soldier and the VA working together more and it seems based on the GAO report that there are still some serious problems in communication and, in fact, some even questioning the part of the DOD about the fact that they have concerns that they might even provide services to them while they're still in the military. And I was wondering, why would they be concerned about that?

Ms. BASCETTA. They told us—and this was about a year and a half ago now—that they were concerned about their retention goals.

Mr. RODRIGUEZ. They were concerned about their retention goals?

Ms. BASCETTA. Yes.

Mr. RODRIGUEZ. And not necessarily concerned about their health, I gather.

Ms. BASCETTA. They didn't say that.

Mr. RODRIGUEZ. They didn't say that.

Ms. BASCETTA. They were worried about VA coming in too early and giving servicemembers the idea that they might want to leave the military. And our concern was that these servicemembers needed rehabilitation from VA, from DOD, from the private——

Mr. RODRIGUEZ. Whoever can provide it, I agree.

Ms. BASCETTA. So they could fully recover both medically and vocationally and have the option to, you know, work to their fullest potential, either in the military or in the private sector, in the civilian sector and many of them, I think, might have opted to stay in the military and many are because it is their career, and they're dedicated to it. Others have told us that they don't want to leave the military because their families need health care, health insurance.

Mr. RODRIGUEZ. And I know that doesn't have anything to do with VA, but you also, in the GAO report, talk about our military soldiers having difficulty paying, or when creditors go after them, when they're unable to get their loans, unable to buy a car, and mainly, because they're being harassed by credit agencies and going after them for fees?

Ms. BASCETTA. Yes, sir. There are long-standing problems with the military pay system that have not been fixed. And it aggravates an already antiquated system. If I might add too, there are other problems that we noted in the course of the seamless transition work. It was done for the VA Committee. So we didn't report these findings in the report, and we didn't make recommendations to DOD because they weren't within the scope of our reporting. But some of them had to do with other bureaucratic problems that the family members and the servicemembers get caught up in.

For example, in one case, a disabled servicemember was to be discharged from a PRC to a VA nursing home. And DOD refused to pay to have the wheelchair transported. It didn't fit in the ambulance, and they refused to have it transported separately until a cost analysis could be done. They told the VA social worker that would take several weeks. The VA social worker, to her credit, found donated post funds, not appropriated funds, and used them to have the wheelchair shipped to the nursing home so the servicemember would not be confined to his bed.

Mr. RODRIGUEZ. My God. You know, and I know that, you know, I had left for 2 years from Congress, but I remember prior to leaving, we were working hard at trying to establish a system where the soldier automatically leaves the military and can be picked up as quickly as possible. Now you also mention that the VA is still having difficulty getting the prognosis and diagnosis, and the medical history, because it isn't electronically done?

Ms. BASCETTA. That's correct.

Mr. RODRIGUEZ. What can we do from the VA perspective in terms of trying—because that is part of—you know, and the other part, and I know you have only been there a short time and I know the responsibility falls with all of us. I don't like the idea of coming down—this I am referring to the administration—firing the commander at Walter Reed who has only been there for 6 months when in all honesty, that responsibility falls with all of us in ensuring that they have the resources that are needed, and I know that we haven't provided that, and I know that with a large number,

some 23,000 soldiers that are coming back seriously injured, we need to beef up on funding. I was pleased to see on the CR, that $3.6 million, and I want to get your feedback on it, and we're hoping to add some additional supplemental funding, but not only to the VA, but also to the active soldier.

And in saying that, we had talked about seeing how we can, you know—and maybe you can guide us from the VA perspective. What do we need to do to make sure that we accomplish that goal that when that soldier leaves the military and the VA picks him up, how can we make sure we don't have to reduplicate everything and retest everything in terms of the soldier?

Dr. KUSSMAN. Sir, is that a question to me?

Mr. RODRIGUEZ. Yes, sir.

Dr. KUSSMAN. We are working very closely with DOD, particularly with the more seriously injured people. And let me just add to what Ms. Bascetta said. The two health care systems, by their nature, have been complementary, that the VA does some things and DOD does others. I mean, we don't do pediatrics and things of that sort. She is exactly right, that when people have multidisciplinary problems, you need to get at them all quickly because you can then lose some momentum with one thing if you are only focused on one. So we have moved to put a blind rehabilitation specialist into Walter Reed, a spinal cord specialist coming out of the Washington VA, because those are the two things that——

Mr. RODRIGUEZ. If I can, what else do we need to do to try to correct some of those things that were mentioned by the GAO from the VA perspective?

Dr. KUSSMAN. Well, I think that we have done a lot of the things that the GAO mentioned, and Ms. Bascetta said that. What we did is we realized that we have those four wonderful centers that we have, and I think they're state of the art and multidisciplinary, but people leave those centers. They don't live near there, so we put 17 additional—there are really 21 level II sites, one for each of our divisions. But the 17 are additional. The four that we already have in VISNs, we didn't see any reason to duplicate on top of the level I. So there is a total 17 new, but a total of 21 centers as well as putting resources at our facilities to try to provide the full depth and breadth of services close as we could.

Mr. RODRIGUEZ. Did I hear you saying that we don't need to do anything else, that you have established the things that are there in order for us to—for the service person to be able to be picked up? Is that what I am hearing?

Dr. KUSSMAN. We can always do better. We appreciate your assistance.

Mr. RODRIGUEZ. The question is how can we do better? What do we need to do to help to you do better? Because apparently we're not doing——

Mr. MITCHELL. Mr. Rodriguez, your time has expired.

Mr. RODRIGUEZ. Thank you.

Mr. MITCHELL. Thank you. Mr. Buyer?

Mr. BUYER. Thank you very much. Ms. Bascetta, I was sitting here trying to think how many years we have been on this issue. I can't even remember. It has to go back 12 or 13 years. It is not nice to talk about age with a lady, but it has been a long time. I

can't even begin to count the number of GAO studies you've done and supervised over the years. You know, this is 20-plus years in the making, trying to get DOD and VA to coordinate and cooperate.

And Dr. Kussman, I've got history with you too, even back when I was on the Armed Services Committee and you were a commander at Walter Reed, which a lot of people may not even realize, back in the nineties. And you know what—pardon?

Mr. FILNER. Now we know who is responsible.

Mr. BUYER. Well, if you want to know who is responsible, let's go back and do a little history. I remember—let's do this, Dr. Kussman, because you were a senior officer then in the medical corps. In the nineties, we would come out of two rounds of base closures, back then the defense budgets were about $270 billion, and we were doing everything we could to try to downsize everything from wings and ships and divisions, and were trying to make it work, and then that is when I had the supervision over the military to help the delivery system.

So what was the response? The response was that if we had less dollars, we'd create centers of excellence. Remember? So we created Brooke, Bethesda, and Walter Reed as centers of excellence because there weren't enough dollars to go around out of those budget years to fund all of those hospitals at all the ports or all of the bases and forts. So we create the three centers of excellence. And we had this belief coming out of the first gulf war that, gee, we weren't going to have as many wounded, we wouldn't be in a continuous war for a long period of time. It was challenging for me when Walter Reed came out on the BRAC. I was pretty surprised by that. I knew it was an aging facility. But at a time of war, for us to put one of our centers of excellence on the BRAC was bothersome to me.

Now I no longer had served on the Armed Services Committee, so I have a void in my background in intellect here as to exactly what happened and transpired over the last 5 years. But even to say we're going to transition it all over to Bethesda is a pretty heavy burden. So as we had a surge of wounded and other than hospitals were not able to accept those capacities, we had a problem.

And I also, then, add to this Congress, GAO, and Inspectors General have put a lot of pressure on commanders of bases that have been BRAC'ed about what moneys you are going to spend on facilities that are about to be closed. And so, what an untenable and difficult position we put a commander in at Walter Reed by squeezing him from both ends. We're going to maintain the standard and quality of care, and at the same time, by golly, you'd better be careful what dollar you spend, and the worst, horrible things that happened is, I can almost see an individual thought they would make a well-intentioned decision by saying, let's keep these unmarried soldiers in close proximity to the care giver and they made a bad judgment by putting them in an unhealthy building.

So when they talk about who is responsible, well, Congress is on the list. Because what did we do BRAC'ing one of our centers of excellence during a time of war? So I'm going to turn it over to you. I have a lot of history with you, General, and Dr. Kussman, and

I would, from a historical perspective, be interested in your comments on mine.

Dr. KUSSMAN. Well, sir, I think—thank you for the question. And Mr. Filner said maybe I am responsible for what happened. It was 10 years ago, Mr. Filner. So thank you. But having been a commander of other facilities when they were targeted to be closed, it wasn't when I was at Walter Reed, but I've been there at other times. It is a big challenge because psychologically, the place closes very quickly with the ability to do the nonrecurring maintenance, the other things that you would like to have done as well as maintaining an adequate work force, because if people look ahead and they know there is a good chance that they will not have a job 2, 3 years from now, the real good ones in particular start looking for new things. So it is a great challenge to be in charge of a facility that has been earmarked to close.

Mr. BUYER. So with the personnel challenge, then what commanders have to do is do contracting, try to fill in the gaps or holes where they can. And now we have soldiers waiting on their disability ratings and therein lies the tremendous challenge that we have for them, as that begins to back up and now that they gain rehab and convalescent care. Well, thank you very much. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you. Mr. Filner?

Mr. FILNER. Thank you, Mr. Chairman. And thank you for allowing those of us who are not on this Subcommittee to visit with you today. It is a very important issue, and I appreciate your leadership on this, and I appreciate the job you are doing. I apologize, Dr. Kussman. I did not hear your opening statement, but I did hear answers to some questions. What I was surprised about when Mr. Walz asked are you prepared? I think it was in the context of the traumatic brain injury. But I probably enlarged that to PTSD also. And you said, we are ideally poised. Those were your words.

I find that, that kind of—I don't know, misplaced optimism or defense of where we are to be at the cause of a lot of things we are hearing today, whether it was at Walter Reed, whether—if you read the cover story from Newsweek on veterans falling through the cracks, to see the situation that Bob Woodruff portrayed on ABC, I don't believe we're ideally poised. I don't think we're handling what we're doing now, let alone the tens of thousands, maybe several hundred thousand returning vets. This injury, as you, I assume, pointed out is not always recognizable at the beginning. You said that. So, we got probably thousands of kids coming back that have brain injuries that we don't know about, they don't know about, that it is our obligation to follow as long as they are alive. The stress on this system right now is very tough.

I mean, we are not handling the veterans who get out today and who have been out. We have a 600,000 claim backlog. Does that mean we're ideally poised? We have got veterans waiting weeks and weeks, if not months, for their first appointment. Is that ideally poised? We have people sitting in waiting rooms for hours because there is not enough doctors or there is not enough nurses. Is that ideally poised? Come on. Let's be frank and candid about the situation. The VA is being stressed to the limits. I'm not blaming you.

I'm blaming you for the defensiveness and the cheery optimism you have instead of telling us the truth. Because we are asking you to do more and more with fewer and fewer resources. It is our job to give you the resources, but if you say you don't need them, I mean, that is ridiculous. I will tell you, by the way, by the work of the people from Mr. Mitchell and Mr. Space, Mr. Walz, Mr. Rodriguez, and Mr. Hare and myself, and a couple people who aren't here, we convinced our leadership to add in the supplemental that is coming to the floor, $3.5 billion of additional resources, primarily aimed at traumatic brain injury and PTSD. That is going to be a big item.

But you will probably give it back because you are so ideally poised to deal with these issues. Listen, we have an incredible obligation here. We have an incredible obligation. There are so many with brain injuries, there are so many with PTSD, we are not diagnosing them. Kids want to get home. They're not checking anything. Marines say if you check anything, that is a weakness. The American public doesn't understand PTSD, doesn't understand traumatic brain injury. We got a lot of work to do.

You guys had the nerve last year, when there were sudden upticks of diagnoses of PTSD, you had the nerve to say—instead of saying to Congress, we need more resources to handle all these diagnoses, you said, let's investigate these doctors and why they're giving out this diagnosis so freely. That is the problem. You guys keep not saying what—that we have an extensive situation. We have got to take—our obligation, these kids have done everything we've asked them to do. It is our job to treat them with the—to extent worthy of the sacrifices they have made. And I will tell you, we're not doing it, Dr. Kussman. And you are not doing us any good with this cheery optimism saying that, "we can handle it." We are not handling it today. You tell me how we are handling it if a young Marine goes to one of your facilities in Minnesota who says he thinks he has PTSD and he has suicidal thoughts and they tell him he is 26th on the waiting list. Come back in a few months and he goes home and commits suicide. Are we ideally poised, Dr. Kussman?

Dr. KUSSMAN. Sir, can I respond to that particular case?

Mr. FILNER. No. Respond to the whole thing.

Dr. KUSSMAN. No one is more committed than I am of taking care of veterans. I am a veteran and a retiree and I am very proud of it. So I wasn't trying to be glib when I said ideally suited. I meant from a clinical perspective, when we have the resources, we are looking at TBI. No one really knows how common mild to moderate TBI is. We put in a screen that we are going to evaluate everybody who comes in, and we do that same thing with PTSD, our outreaches.

Mr. FILNER. You tell me you are diagnosing every single returnee with PTSD and TBI? You are telling me you are doing that right now? You are not doing it. Let these guys tell me if they are doing it. They check a questionnaire, and that is what the thing is.

Dr. KUSSMAN. That is not what I am talking about, sir. I am talking about when somebody comes to the VA not some screen that is being done someplace. This is part of when——

Mr. FILNER. Oh, they have to come in first. Well make that clear.

Dr. KUSSMAN. When they come in to the VA for whatever their problem is, they get screened for PTSD and now we're screening for TBI as well.

Mr. FILNER. Thank you.

Mr. MITCHELL. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Dr. Kussman, GAO testimony last Monday at the Walter Reed field hearing indicated medical information of patients being transferred to the VA is less than adequate. I want to know why there is no transfer electronically. It requires a very time-consuming process of multiple phone calls and faxes. Doesn't this become a safety issue, a serious safety issue?

Dr. KUSSMAN. I think there is more progress that needs to be done, obviously in the transfer of information. We are working together, our IT people, to develop that seamless flow of information. As you are probably aware of, it recently was announced last month that we are going to move toward a single inpatient electronic health record that would be the same in DOD and VA.

Mr. BILIRAKIS. Okay. Thank you. Ms. Bascetta, TBI patients and their families at the polytrauma centers complained that while they were on lengthy administrative hold, awaiting military disability process up to 6 months, no brain rehabilitation was given until they arrived at the VA. I understand early intervention would help, most definitely. Can you comment on this, please?

Ms. BASCETTA. Absolutely. That is one of our biggest concerns. I should emphasize, we don't have work on the DOD rehabilitation side of the story, medical or vocational. But we have heard this repeatedly, and, you know, it is great that VA is going to start screening for PTSD and brain injury, but it has to start earlier. It has to start at DOD. And that information has to be shared with VA as early as possible. Otherwise, I don't understand how servicemembers or veterans will get the care that they need when they need it.

Mr. BILIRAKIS. Thank you. I yield back.

Mr. MITCHELL. Thank you. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman. I don't know really where to begin here. I share Congressman Filner's anger and frustration. I have been sitting here during this hearing. I look out and I see those brave people sitting there, and for the life of me, I cannot understand why we cannot get two agencies to talk to each other to do something that makes some sense to help these people out. And I know that might be oversimplification on my part. But you know, this is another VA hearing that I sit in, and I listen to testimony about things that have been going on for years, and I'm not blaming the witnesses even for this.

I am talking—I think this problem is just built in, inherent, and I don't see any movement on it or I see discussions on it, and I see a lot of rhetoric. But you know, it is like the old commercial, "Where's the Beef?" There has to come a time, it seems to me, where we have to make treating these people, our finest, in the finest possible fashion that we can. I am just so incredibly tired of what I consider to be lip service.

I think the hammer has got to be dropped, and I think this Walter Reed thing is just systemic. I think we fight like—sometimes

like children on a playground to figure out if we're going to have funds, to be able to give the kind of care that we have while we spend $11 million an hour on a war, and we're not nearly prepared for the people that are coming back, not nearly prepared to take care of them.

And we shrug our shoulders and wonder, well, we hope we can get some continuity and some cooperation between DOD and the VA, and in the meantime, while that goes on, we have people going home that are hurt, people, you know, I don't even know—I'm beyond the point of being angry about this.

And just when you think it gets bad, it keeps getting worse. I think we have to put our money where our mouth is. I'm glad that we got the additional funds, but I share this frustration. I have a vet center two blocks from my district office. They do a wonderful job and you're right, we need more of them. And we need to do everything we can, and we have to back up what we're doing with a lot more—I think—I think maybe you folks ought to be angry, if you are not already there, maybe a little bit more.

Maybe we have to figure this out because what we've been doing hasn't been working, quite candidly. I said this before, I'm the new kid on the block. I'm a veteran and a freshman on this Committee, but you know, I don't get it. And perhaps maybe you folks can enlighten me at another point. I just wanted to say a couple things. Why is it the case that servicemembers who are transitioning to veteran status still have to make hard copies, if that is the case, of the medical records and hand-deliver them to the VA? Is that still the practice? Do they still have to do that?

Dr. KUSSMAN. I believe for the benefits, that is true, sir.

Mr. HARE. Okay. How long do you folks see an integration of these two systems so that we can put an end to this once and for all? And from your perspective, what can we do? What can I do or what can this Committee do or what can this Congress do to move this along and put an end to this once and for all to put an end to it and to do what needs to be done from your perspective, I would be very interested in hearing what you think.

Dr. KUSSMAN. I think there are several things that are being done, as I hope you know that we have VA personnel full time in the military facilities. We have military people in the VA facilities. I think Congressman Filner and the Secretary just visited north Chicago as an example of partnering. We hope to be able to do more things like that in a more integrated system. There are a lot more things to be done.

Mr. HARE. Can you maybe describe what actions are being done to improve the sharing the medical records between the VA and the DOD. I think you did. I apologize if I didn't get it.

Ms. BASCETTA. We characterize it really as a work in progress. They clearly are better off at the polytrauma centers than elsewhere because they do have some access to the electronic records. DOD actually installed computers in the VA. They're not VA computers that have access to DOD computers. What bothers us is that, you know, a year ago when we showed up in one of the PRCs to make sure that the electronic access was working, it wasn't.

As recently as 3 weeks ago DOD unilaterally cut off the access of the physicians in one of the PRCs because the two bureaucracies

had failed again to reach a data sharing agreement. That is inexcusable. And the potential adverse effect on patient care could have been a significant problem. In a larger sense, sometimes I think that if the servicemembers on medical hold were not discouraged and were getting the kinds of rehabilitation services that they needed, maybe the mold in Building 18 wouldn't have caused as much of a problem.

And where I've seen VA and DOD sharing work the best it has been when the two departments or the people in the departments at the local level have taken the approach of focusing on the patient, not their own bureaucratic rules and regulations.

Mr. HARE. Hopefully that is—I know my time is up, and I thank you, but hopefully that is something we can all improve on and get that cooperation. So that the men and women that are sitting here are the beneficiaries of that cooperation. I yield back. Thank you.

Mr. MITCHELL. Thank you. I would like to ask Dr. Kussman just a couple of other questions. Are you familiar with the contingency tracking system that has been talked about?

Dr. KUSSMAN. Yes, sir.

Mr. MITCHELL. And one of the purposes of that tracking system was to supposedly track the status of wounded soldiers throughout their medical treatment in Defense and VA facilities. In your view, why was this canceled?

Dr. KUSSMAN. It is my understanding, sir, that when the program was developed it was tried to be used. It didn't meet the needs of particularly the VHA. It was a system that was localized to a military treatment facility, and the input would have had to be done at the military treatment facility. It didn't integrate itself with the CPRS Vista or the DOD system, and it was felt it wouldn't meet the needs of particularly VHA in the longitudinal following of patients, because when they transferred out of the MTF, the data didn't go anywhere.

Mr. MITCHELL. Okay. One last question. Did social workers who are liaisons at Walter Reed, did they ever report any concerns about the conditions that the servicemembers were living under at Walter Reed?

Dr. KUSSMAN. Are you talking specifically, sir, about Building 18?

Mr. MITCHELL. That or any other buildings, any of your social workers.

Dr. KUSSMAN. They didn't report that to us. Actually when I heard about it, I called them over to have a meeting of what was their assessment of what was going on. You know, they don't have the visibility of the actual physical plant. They're working generally in the hospital with servicemembers who are transitioning.

Mr. MITCHELL. They were not working with those who were outpatients, for example?

Dr. KUSSMAN. Well, the individuals, as they're working through the disability process in the military, they would be talking to them as needed to be sure that if they chose to use the VA when they left then some of them are direct transfers, others would be patient that are going back home and we would get them enrolled in appointments at a local VA but we're not involved the MEB/PEB process that is going on in the military.

Mr. MITCHELL. So if you know that someone who is a multiple amputee is obviously not going to be in the military very long, and will be transitioned into your service, you don't do anything with them until they report back home to the hospital?

Dr. KUSSMAN. No, sir. The people who are entering into the disability process, someone like you just described, we then approach them and work with them to determine what their benefits might be and where they would like to get their health care. As you know, someone who is leaving the military, particularly if they're being medically discharged have basically three options of their care. They can come to the VA if they choose and we would encourage them to do so and have them seen. They can use TRICARE or they can use the military treatment facility. The more severely injured ones, as you go from Walter Reed to Bethesda or Brooke to one of our four polytrauma centers.

Mr. MITCHELL. Thank you. Yes, Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you Mr. Chairman. I have another question for Ms. Bascetta and I know also that Mr. Buyer has a question also.

Ms. Bascetta, were you able to ascertain why the joint patient tracking application system was turned off so that the VA did not have information about the patients?

Ms. BASCETTA. My understanding is that a decision was made at TMA and DOD by their attorneys that the data sharing agreement had not been signed, and that is why the access was cut off.

Ms. BROWN-WAITE. Are you aware if any efforts are ongoing to resolve any issues so that that access can be turned on so that there can be continuity of care and information sharing?

Ms. BASCETTA. I don't know what was done systemically, and I am not current on whether they have a data sharing agreement at this point. But I know that the access was restored. I think it was cut off on a Friday and it was restored that Saturday morning.

Ms. BROWN-WAITE. Doctor, could you respond?

Dr. KUSSMAN. Yes. There is a data sharing agreement, and it was restored.

Ms. BROWN-WAITE. So it has been fully restored?

Dr. KUSSMAN. Yes, ma'am.

Ms. BROWN-WAITE. Thank you.

Mr. MITCHELL. Thank you. Mr. Buyer, you had a question?

Mr. BUYER. Yes. Thank you, Mr. Chairman. What I realize quickly is that, you know, many soldiers, Dr. Kussman, they will be very complimentary of their care for the military treatment facilities or the actual medical care at the VA. But they have real challenges when they're facing the discharge. Over the years, we talked about this in doing the Benefits Delivery at Discharge (BDD), identified the 142 sites. Ms. Bascetta, you went out there and visited some of those a couple of years ago, you identified 20, went to 10 I think. And so, as we try to do this, one physical that will apply to that VA disability, Dr. Kussman, right there is the sandpaper to the skin. I think that is the beginning of a lot of irritation for soldiers in "how my government is treating me, do they appreciate my sacrifice, am I being fairly treated with regard to my rating," and it just rips them from the inside of their gut.

And I think that is where this one really begins to identify itself. And so, if there is a weakness that I see in our system in the total chain of mercy, it is right here. And so let me ask now, Ms. Bascetta, whether or not you have looked at this. Since you looked at it 2 years ago, have you had any advance look with regard to the BDD and the sites and whether or not we've improved ourselves?

Ms. BASCETTA. No. Unfortunately we don't have updated work on that, but we have overall work on modernizing disability, which is at a much higher level than you were talking about, but I think it speaks volumes that if soldiers are feeling as though they're discouraged, they don't really want to be boarded out, and the system becomes more adversarial than it's intended. It's not surprising we have these kinds of outcomes. And the systems are geared in VA, DOD, Social Security, you name it, the Federal disability programs are cash benefit programs. And the incentive is to minimize the payments, and that is part of what creates the adversarial atmosphere.

Our view is that a better system would focus on rehabilitation first because it is in the interest of the government, if not the servicemembers, to get everybody rehabilitated so that they can work either in the military or in the civilian labor force to their fullest potential. If we had a system that focused on rehabilitation, what people can do instead of what they can't do, and compensated them afterward for their residual impairments, it could really help reduce a lot of the animosity.

Mr. BUYER. Dr. Kussman, your thoughts?

Dr. KUSSMAN. Sir, I am aware—we've had this discussion before. Right now, we have two types of seamless transition. There is the little seamless transition that we've been talking about about patients who are severely injured or going from one facility to another. The large—what I call big seamless transition, is the average servicemember who is getting out through the BDD process. And we have, as you know, worked for a long time to focus on a single physical exam. I think the thing that we've learned is that it is really a comp and pen exam because routine discharge physicals are not actually done in the military.

And so what we have to do is be sure that we start with this process at these 144 sites up to 6 months before if somebody is getting out to help them work through the process, encourage them if they have a problem to request a CMP exam, and the whole idea is to get that done expeditiously so that when they do separate, because as you know, we can't provide anything for anybody until they get a DD–214 from a disability perspective, that we would be prepared to provide them that disability for whatever it is determined to be.

Mr. BUYER. All right. Thank you, Dr. Kussman. Thank you for your courtesy, Mr. Chairman. Okay.

Mr. MITCHELL. If there are no other questions, we want to move to the second panel. Thank you for coming today. We appreciate you answering questions and your statements. Thank you.

Ms. BASCETTA. Thank you.

Dr. KUSSMAN. Thank you, sir.

Mr. MITCHELL. At this time we'll take a 5-minute recess. And let me just mention that I will read the panel as they get their name tags up there. Go ahead. Thank you.

[Recess.]

Mr. MITCHELL. If everyone will be seated, we can get started. If those witnesses that were not sworn in at the very beginning, if they would please rise and raise their right hand.

[Witnesses sworn.]

Mr. MITCHELL. Let me just very quickly introduce this panel, and I will reintroduce two that were on the last panel. As many of you may be aware, last night, Mr. Paul Sullivan appeared on ABC News to discuss a data tracking system which would have made the seamless transition of new veterans much more efficient, and we're pleased to welcome him here today to answer questions. He shares his knowledge and experience on this issue. Also Private First Class Kimberley Lain who has recently gone through the transition process to the VA from Walter Reed Medical Center is here to share her experience with us.

We also have Ms. Kathy Dinega and Ms. Sherry Edmonds-Clemons, who are VA social work liaisons to Walter Reed Medical Center and Bethesda Naval Hospital. We have asked Mr. Dinegar and Ms. Edmonds-Clemons and what the options are once they transition into the system at the local level. Dr. McNamee is the director of VA Polytrauma Center in Richmond, Virginia, and we welcome his input on the challenges facing the VA as it attempts to move seriously wounded servicemembers into these facilities. At this time—let me—I want to defer to Ms. Brown-Waite and ask her to introduce Dr. Scott, and let me do that now. I'm sorry.

Ms. BROWN-WAITE. I thank the Chairman very much. It is my very distinct pleasure to introduce Dr. Steven Scott. Dr. Scott heads up the polytrauma unit at Haley Hospital, and there is something we didn't know until today when I actually had time to fully read his resume, and that is, he is graduate of Springfield College from Springfield, Massachusetts, where he got his original bachelor's degree, and I taught at Springfield, but at the Tampa campus. And he went on to Pennsylvania State University, did his graduate school of medicine at Mayo Clinic in Rochester, Minnesota with a residency in physical medicine.

He also was recently nominated to be the VA employee of the year. We don't know yet, the votes aren't counted, but that certainly is a great honor for him to be nominated. And I visit the hospital regularly, and talk to the family members, and also to some of the patients and let me just tell you that Dr. Scott is held in very high esteem. He is passionate about quality care for those who need the polytrauma rehabilitation center. And I thank the gentleman for allowing me to introduce him.

STATEMENTS OF SHANE MCNAMEE, MD, DIRECTOR, HUNTER HOLMES MCGUIRE RICHMOND VETERANS AFFAIRS MEDICAL CENTER, RICHMOND, VA; STEVEN G. SCOTT, MD, MEDICAL DIRECTOR, TAMPA POLYTRAUMA REHABILITATION CENTER, JAMES A. HALEY VETERANS' HOSPITAL, TAMPA, FL; PAUL SULLIVAN, CEDAR PARK, TX (FORMER PROJECT MANAGER, U.S. DEPARTMENT OF VETERANS AFFAIRS); AND PRIVATE FIRST CLASS KIMBERLY LAIN, MILLERSVILLE, MD (RECENTLY TRANSITIONED VETERAN FROM WALTER REED AND DISABLED AMERICAN VETERAN)

Mr. MITCHELL. Thank you. We're going to have two statements, five minutes each. Dr. McNamee, is that how you pronounce it?

Dr. MCNAMEE. It is McNamee, sir.

Mr. MITCHELL. Thank you. And if you would start, I would appreciate it.

STATEMENT OF SHANE MCNAMEE

Dr. MCNAMEE. Good afternoon, Mr. Chairman and Members of the Committee. Thank you for the opportunity to discuss the transition of our wounded heroes with the Veterans and Health Administration. My name is Dr. Shane McNamee, and I will be testifying from the perspective of a clinician as well as in my role as the medical director of the Richmond polytrauma program. To frame the issue appropriately, I will describe the typical transition process of severely wounded heroes and their family Members in the military treatment facilities through our programs and into their communities. It is my firm belief that this highly coordinated effective system is unparalleled in this Nation's medical system for those who have suffered a traumatic brain injury.

The key concepts of seamless transition I will be discussing are as follows: Number one, the significance of medical record access, the continuum of care; number two, the importance of relationship-based medicine; and number three, the recognition of the family as part of the injury complex and the integration of families into the therapeutic plan of care. Our four polytrauma rehabilitation centers are consulted by the military treatment facilities when a wounded hero screens positive for a traumatic brain injury. The referrals that come to Richmond are processed by our nursing admissions coordinator. Following collection and analysis of clinical and family information, we provide the military treatment facility a decision on the referral within 24 hours of the DOD's original request for this referral.

At the earliest possible time, the family Members of the severely wounded are contacted by myself, the nursing admissions coordinator, and the social worker assigned to the case. This step has proved essential for several reasons. For the family, the transition of a wounded hero between medical facilities creates anxiety due to the unknown. Importantly, this contact provides an early opportunity to build a relationship with key family Members. This relationship with the patient and the family Members forms the basis of a successful rehabilitation plan. The family also serves as an invaluable resource in the recognition of personality and cognitive changes that are common after a traumatic brain injury. Numerous systems are used to develop an individualized plan of care prior to

admission to our polytrauma rehabilitation center. Medical records are obtained through our direct access of Walter Reed Army Medical Center and Bethesda national Naval Medical Center.

Up-to-date information about medications, laboratory studies, results of imaging and daily progress notes are reviewed to determine the individual case parameters. We access the Web-based joint patient tracking application to gain further understanding of the patient's clinical status, specifically the field notes from Balad, Iraq, and follow up at Landstuhl, Germany, are indispensable in determining severity of TBI and associated injuries.

Our nursing admissions coordinator also takes specific documentation through the DOD liaison personnel stationed at both Walter Reed Army Medical Center and Bethesda national Naval Medical Center. As medical director, I contact referring physicians and discuss the particulars of the case. Our facilities have scheduled video teleconferences to discuss the referral and to meet the wounded hero and family Members face to face. These are essential in developing intensive individualized rehabilitation medicine plan for each wounded hero before admission. This also includes coordination of resources necessary for the family including housing, transportation, meals and psychosocial supports. Upon admission to our facility, each Member of our rehabilitation team individually evaluates the wounded hero within 24 hours and pays particular attention to the functional needs.

Our team meets three times weekly to discuss each patient and continually adjust the therapeutic plan of care. Each patient undergoes 3 to 6 hours of therapy a day tailored specifically to their functional and cognitive needs, we actively work to reinstitute the roles that previously defined our wounded heroes. As mentioned earlier, it is not just an individual who suffers a traumatic brain injury, rather, the entire family's structure is affected and requires attention. The literature relating to TBI is very clear on the fact that those individuals with strong psychosocial supports are more successful over time.

Our support is multi-modal and includes health information through site specific literature, informal education sessions, formalized lecture series and intensive discharge planning. We also provide professional support, emotional support, logistical support, involvement in the care processes, and the support of a military liaison officer.

To further support the families, we have instituted a pager and cell phone system that are covered 24 hours a day by Members of our social work team. This allows yet another level of support for our families. And importantly, in a very real sense, the family Members become an integral part of our team. This program serves to educate families, decrease their anxiety of the unknown and prepare them to care for their loved one. In recognition of this, we have developed the model of care appropriately referred to as relationship-based medicine.

We have found that it is this relationship with those involved in the continuum of care that drives our success. Initially, we intensively worked with the families and patients to gain their trust and instill recognition that we are on their side indeed. Once this level of trust has been established, we can develop an effective treat-

ment plan and approach. It is important to point out that this relationship does not end once discharged from our facility. Patients are followed at regular intervals by the social work case manager along with the physiatrist.

Intensive discharge planning is the cornerstone of any successful rehabilitation plan. Our discharge plans are initiated the moment a patient is admitted to our facility. On a weekly basis, we discuss the discharge needs and timelines necessary for success. These are communicated with the family and aligned with their needs. Once a disposition is provided by the family, we begin to contact necessary resources in the community. Based upon location, a consult is opened either with one of the polytrauma network sites or——

Mr. MITCHELL. Doctor, could you summarize very quickly?

Dr. MCNAMEE. The integrated transition plan of care from the military treatment facility to the PRC into the community is paramount to the success of our wounded heroes and families. The systems set up throughout the VA is world-class and has no equal for those suffering from traumatic brain injury. Across the system, we continually monitor and incorporate improvements. I am proud to be a part of an exceptional rehabilitation staff who are fully dedicated in their mission to serve those who sacrifice so much. Thank you, Mr. Chairman and members of the Subcommittee for your time.

[The statement of Dr. McNamee appears on pg. 65.]

Mr. MITCHELL. Thank you. Dr. Scott?

STATEMENT OF STEVEN G. SCOTT

Dr. SCOTT. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss our experience as it relates to the Servicemember's Seamless Transition Into Civilian Life, Our Heroes Return. My name is Dr. Steven Scott, and I have been a specialist in physical medicine rehabilitation since 1980. I have been employed at the James A. Haley Veterans Hospital in Tampa, Florida, since 1990 and have directed both the spinal cord and traumatic brain injury programs.

I would like to provide you with a brief history of the development of polytrauma rehabilitation care. In the summer of 2003, we began to receive these unique patients who had been evacuated from the battlefield following improvised explosive devices blasts and injuries.

Due to tremendous advancement in military care, we now have the opportunity to rehabilitate young men and women who in years past would not have survived. These patients are medically complex and have sustained numerous injuries which are complicated by serious TBI or traumatic brain injury. The primary focus of the polytrauma system of care has been to provide rehabilitation care to the most seriously injured. A typical patient has traumatic brain injury, vision or hearing loss, pain, wounds, burns, orthopedic problems including amputations. We deal with extended families in crisis including spouses, children of all ages, parents and siblings, as well as care givers.

The stress and the sacrifice of these families frequently takes its toll, sometimes resulting in conflict and serious marital issues.

The complexity of injuries of these combat veterans wasn't like those seen previously. The unique needs of these patients required rapid realignment of our delivery of health care systems to routinely include such things as our multidisciplinary team of medical specialists. In addition to our team of physiatrists or rehabilitation doctors, specialists in the areas of surgery, neurosurgery, internal medicine, psychiatry, infectious disease, prosthetics, orthotics, and spinal cord injury are a part of the day to day planning and patient care treatment program. The physiatrist or rehab doctor also runs the interdisciplinary team which is quite large and includes speech therapists, kinesiotherapists, vocational therapists, social workers, neuropsychologists, psychologists, advanced nurse practitioners, wound care nurses, respiratory therapists, recreational therapists, rehabilitation counselors, military liaisons, chaplains, blind occupational therapy case managers, physical therapists amputation case managers, social worker case managers, educational specialists, and veteran benefit specialists.

Each one of these medical specialists and health care disciplines have a specialized expertise in caring for the polytrauma patient and their family and are essential to be sure that their comprehensive care results in excellent outcomes.

As we developed the program it became quite apparent that we needed to establish a mechanism to exchange medical information. Initially we established physician to physician phone conferences to the National Naval Medical Center in Bethesda and the Walter Reed Army Medical Center in Washington. Videoconferencing with the patient and family in attendance was established with Brooke Army in San Antonio, National Naval and Walter Reed. A military treatment referral form was completed by the military and sent to our onsite case manager DOD VA military liaison social worker.

This form initiates the referral to the polytrauma system of care. Medical records and exchanges occur between the Tampa VA and the military treatment facilities.

This practice was new to us, and we have progressively improved this practice over the years. We continue to work on improvements in the transfer of radiological images and microbiology lab results. The VA polytrauma rehabilitation centers have been an active participant in videoconferencing with the DOD Trauma of Continuing Care that has been established to improve practices in care and transportation of trauma patients.

In addition, we've been able to connect and actually participate with the joint patient tracking system that allows us to get more detailed medical information.

Most polytrauma patients remain on active duty during the entire stay at the Tampa Polytrauma Center. Therefore, ongoing sharing of information between the VA and DOD is necessary. The military liaisons assigned to our center assist the patient and family with military issues and assist with maintenance of nonmedical orders for the family.

Patients are frequently referred back to the military treatment facilities from the VA for follow-up surgery and placement in medical hold.

When the individual comes to Tampa, a military greeting team and case manager meets the patient and their family. Community

volunteers arrange free housing and transportation for families through the Haley House Fund. Our 7-day a week program for both patients and families always has the emphasis of community re-entry as our primary goal. Our staff and volunteers provide family educational classes, family support groups, planned family activities such as spouses day out, trips to NASA and to the space shuttle, and others. Our Internet Cafe provides activities outside our structured therapy program and recreational therapy provides community re-entry such as shopping and recreational activities. As the patients and families advance in rehab, they go to day passes, then overnight passes to practice their independent living skills. We also have——

Mr. MITCHELL. Dr. Scott, could you wrap it up?

Dr. SCOTT. I will wrap it up for you. In summary, basically we work on a continuing care to get the individual home, that is our goal. And it is in my conclusion that I am honored to serve these courageous young men and women and their families. And I look forward to working with DOD, Congress, our VA leaders, advocacy groups and private citizens to continue to provide the excellent care and improve the function of their future lives throughout the lifespan of the American wounded heroes. Thank you.

[The statement of Dr. Scott appears on pg. 67.]

Mr. MITCHELL. Thank you very much. I have a couple questions. First to Dr. Scott. It has been reported recently in the news that VA physicians have been cut off from relevant DOD data on injured patients and the VA inspector general, the GAO have reported that there have been incomplete transfers of medical records when soldiers are transferred from DOD to the VA medical centers. Do you currently have any reliable access to relevant DOD medical records for the OIF and the OEF veterans and active duty men and women who are in your wards?

Dr. SCOTT. Presently this morning in Tampa we have access to Bethesda, Walter Reed, as well as Brooke Army and also have access with the Joint Patient Tracking System. The only system that was down that I am aware of is the Patient Joint Tracking System. When I became aware of it I called the help line and within 12 hours—I think 24 hours that was back online. So that was the only down time that I experienced during this time.

The record system itself is cumbersome in the military, to get into those cumbersome records, but we can do it on a regular basis, we have done it, and it is working at the present time.

Mr. MITCHELL. Dr. Scott, you were reading all of the different kinds of therapists and the specialists. There is a whole list of them. Do you have a proper mix of all of these specialties?

Dr. SCOTT. Presently based on our outcomes it appears that we have a proper mix. But as the injuries change and as individuals and new things come up, we may need different and newer specialists in the future. This is an ongoing change. As we follow the war, the injury patterns sometimes change. We have seen where the injuries were first fairly minor and then more complex. We saw mild burns, now there are major burns.

So sometimes our team management has to change according to the needs of the patient. All this program is and all this team structure is, is focused to meet the needs of those injured from the

war. Whatever those needs are, we try to meet them directly with the highest quality of care.

Mr. MITCHELL. One follow-up. Have you had to turn anybody away because you just didn't have the space or the beds?

Dr. SCOTT. In my 16 years at the James A. Haley Veterans Hospital I have never turned a patient away, and I never will in the future. I will always find space for that individual, wherever that might be. And with these returning individuals I will also find space wherever that might be within our facility.

Mr. MITCHELL. Thank you. I have a question for Mr. Sullivan. Could you please explain to us your role in the Seamless Transition Task Force? Not only your role but what did you do on the task force and what data did you brief your supervisors on while you were at the VA?

STATEMENT OF PAUL SULLIVAN

Mr. SULLIVAN. Yes, Mr. Chairman. Thank you for having me here today. My role on the Seamless Transition Task Force created by Secretary Anthony Principi in 2003 was as staff support to one of the full Members of the Committee. That was my Assistant Director, Susan Perez.

I attended the task force meetings with her and when we were requested to create the contingency tracking system, I became the project manager for that system. There was a person also for a while who was the project manager on this before me. He was deployed to Afghanistan. That is the other reason why I picked up the project. That was my role with the Seamless Transition Task Force.

What did I report to my supervisors regarding what was going on and what was I seeing with the data? I can tell you, Mr. Chairman, that one of my other responsibilities at the Veterans Benefits Administration was to monitor the claims, health care and counseling use of gulf war veterans and thus I was asked to monitor the claims activity of the new Iraq and Afghanistan war veterans.

So what I did is designed along with the team of computer programmers and analysts a method to use the Pentagon data to see how many Iraq and Afghan war veterans had filed claims. Then we would take that information and sort it. We would sort it and see how many of those claims were still pending, how many were approved, and how many were denied. Then I would prepare reports and I would brief my supervisor, the Assistant Director, as well as other executives within VBA about our findings.

I can tell you that starting in March of 2005, we started to notice some very significant events and if you would like I can actually read you some of the e-mails that I sent issuing what I thought were warnings that there would be a surge in disability compensation claims among the Iraq and Afghanistan war veterans. I made those concerns known several times in several briefings.

[The additional information from Mr. Sullivan was supplied in a March 27, 2007, letter, and the attachments are being retained in the Committee files.]

Mr. MITCHELL. My time has expired. Maybe somebody else will follow up on that.

Ms. Brown-Waite.

Ms. BROWN-WAITE. I would encourage Mr. Sullivan to submit the information to the Subcommittee so that we could all have it. I think that would be appropriate, Mr. Chairman.

Dr. Scott, I know from talking to so many families that the reputation that James Haley Polytrauma Unit has is superior, and Dr. McNamee, I am sure it is the same with your facility. I just have a little more familiarity with the facility in Tampa.

I would like to know what else can we do here, including appropriating more money, to make your job a little bit easier when you see the young people coming back with these traumatic brain injuries and I know the great work that is done, the great rehab work that is done. Tell us what we can do. I know last year, Dr. Scott, for the Haley Hospital I think we provided more money for spinal cord injury, and are you going to be—so that they could expand. Are you going to get some more beds also when that expansion takes place? I know the funding was there but it takes a while for that construction to take place.

Dr. SCOTT. Presently we do have a space problem on our polytrauma unit. The VA leadership is trying to do its best to create more space for our unit at the present time as well as expand the bed situation too. Our space problem is serious. I would have to say this because I have a strong compassion to those who come back. We basically put them in rooms 10 by 10, about 100, 110 square feet. That is just not—we should not do that. We need to change that, and I think we will change that very shortly and with the support of our leadership.

But we also probably need to expand more beds than we currently have because of the increased amount of attention, awareness of traumatic brain injury. We are not sure exactly what numbers they are, we are not sure exactly how many are out there. We know this is an invisible, hidden type of wound. We know that by creating more attention and more awareness this is going to create more individuals referring not only the active duty individuals but also our veteran population who also sustained TBI or have had previous TBIs in the past. I might add there is an unknown population group that we haven't really——

Ms. BROWN-WAITE. Doctor, I am confused. When the Chairman asked you, you said that you never turned anybody away, and I believe that because I have been there. But is the issue that you don't turn anybody away in a response to the Chairman, but you are telling me that they are in inadequate rooms for the equipment that is needed. That is question number one. And question number two is: Making room for somebody, and, Dr. McNamee, you probably have exactly the same problem and I would like to hear from you too, making room for somebody and making sure that the room is adequate are really two different things.

So, Dr. Scott, could you just clarify that?

Dr. SCOTT. We do make room, it may not be adequate, as you mentioned. One of the lessons learned is that our whole hospital is involved in the polytrauma system and so we use all the hospital beds in our facility, and so when we run out of rehab beds we will use medical/surgical beds.

Another one of the lessons learned, we also have done, is we admit people right on our medical/surgical floors directly and make

sure that they are medically and surgically stabilized before we move them to rehab. If we don't have rehab beds at that time, we keep them off-floor and we start the rehab off-floor. That allows us to again keep that open door and be able to serve those in need.

Ms. BROWN-WAITE. How many in Haley are not on the polytrauma unit floor, but rather are elsewhere in the hospital?

Dr. SCOTT. We usually have several over in the spinal cord unit that we use and we may have one or two in our intensive cares or even off-floor because of the nature of these complex injuries. So when we make our multi-disciplinary rounds, it is almost like hospital rounds because we are all over the hospital. And that is why we do it in a multi-service type fashion, not just one service. We have all the services involved because we basically cover most areas of the hospital.

Ms. BROWN-WAITE. I thank the doctor.

Mr. MITCHELL. Thank you. Mr. Walz.

Mr. WALZ. Thanks, Mr. Chairman. I would say I am lucky enough in Minnesota, we have one of the four polytrauma centers in Minneapolis and in my district the Mayo Clinic. I would argue that we have two of the finest medical facilities in the world. So I am very familiar with the polytrauma centers.

The work that has been done there has been nothing less than stellar. That is verifiable, that is not anecdotal. We are seeing some incredibly impressive work being done there. So, see, I do applaud you on that and we are here to be proactively preparing for the needs of our returning veterans to make sure that we are carrying forward lessons learned maybe over at Walter Reed and the DOD system and making sure we are getting them into the VA system.

I want to make very clear especially to the two directors the work you are doing is absolutely stellar in that regard. We need to make sure the work that Congress is doing in oversight is equally stellar in preparing for that. That is part of our leadership responsibility.

I have two questions, the first one was to Mr. Sullivan, I know you are going to submit it to the record, about this data you are providing to the VA. I want to know a bit about it if you could summarize that quickly and when you were giving that to the VA, what you knew about what was coming.

Mr. SULLIVAN. Here is a briefing from August 2005 and it is just a couple of sentences of summary: In summary, these analyses that I gave provide a strong warning of a current and future increase in the surge of claims activity among global war on terror veterans. VBA is now beginning to observe the initial yet tremendous and sustained impact of more than 1.1 million recent war servicemembers discharging from the military and promptly filing substantial numbers of complex multi-issue disability compensation claims. The risk of an increased claim workload and delays in processing claims based on the continuing surge in VBA claims activity among new war veterans can be mitigated with immediate and proper staffing, training and funding at central office and at regional offices.

That is my summary.

Mr. WALZ. That is what we are here to do. What was done with this data as far as you know?

Mr. SULLIVAN. I am not aware of anything that was done.

Mr. WALZ. Is it possible, do you think this data is solid enough that you could extrapolate and project needs into the future that we would have then an idea of what we could see on maybe a yearly basis or specifically a monthly basis? Is that possible?

Mr. SULLIVAN. Yes, Congressman. I was fortunate enough to use the Freedom of Information Act to get this information and provide it to Harvard Professor Linda Bilmes, who prepared and delivered a report that estimated the number of patients and the cost of the war. She was estimating hundreds of thousands of claims and patients and she estimated between $350 billion and $700 billion in costs for VA for the war for the next 40 years.

Mr. WALZ. In your mind, Mr. Sullivan, how was the VA making these projections if they are not using quantifiable data? How are they making projections on needs when the President tells us how much he needs in the future? How are they doing it?

Mr. SULLIVAN. That wasn't done in my office, Congressman. You would have to ask the Department of Veterans Affairs actuary. You may want to ask the former chief actuary, Mr. Steven Meskan, about what he was trying to do at VA to make those kinds of projections, sir.

Mr. WALZ. Because their projections are quite a bit lower than what you are projecting and what the Harvard study is projecting.

Mr. SULLIVAN. That is correct.

Mr. WALZ. We will look at those, you can rest assured. My last question is to PFC Lain. First, I would say as a retired enlisted soldier I know they moved you off that first panel; I would proudly sit with you on that panel. So there was no disrespect there sitting with a PFC in a military uniform.

I would ask as comfortable as you are, I know these are private matters, if you could summarize just briefly from your impact in your wound to where you are at today, how would you summarize your care?

STATEMENT OF KIMBERLY LAIN

Ms. LAIN. Actually, I just joined the military back in July of 2005 and I was injured in basic. I ended up here at Walter Reed in September of 2005 and the care—the doctors are great. There's awesome doctors there. When I was finally discharged from the hospital and sent on my way, I grew up in Baltimore so I knew the area, I ended up at home with family, and when I finally ended up back for checkups and everything, I really—there was no direction on where to go from the doctor to med hold. I eventually did find my way to med hold and then from there it was one appointment after the other until eventually they said okay, we are going to discharge you, and then once I was told that, I had to start the MEB process.

The MEB process was—I wasn't very involved in it, it was basically give your documents to your counselor, they will get them to where they need to go. The problem with the documents is we are moving into a paperless society. There is no physical documents unless you ask your doctor for them, and a lot of the soldiers aren't told that so they go back and ask for these documents that the doc-

tor can't access any more because they have been filed and gone wherever they need to go.

Once I finally did get my MEB back I was given 3 days to look over it and decide whether or not I agreed with the findings or wanted to submit something else. Actually, I agreed with mine and I submitted them to the PEB as they were and once they finally made it over to the PEB I was given a rating according to their standards, and it came back and I was told that I then had 10 days to decide whether I agreed with the PEB findings of what they were going to discharge me with, either medical separation or medical retirement, depending on the severity of what they felt my injuries were.

Once I had decided that I didn't agree with what they had rated, they had rated a condition that I didn't have, that there was a mix up somewhere in paperwork, and so I submitted an appeal for that. When I first decided to submit my appeal, I had no idea how to go about doing it. I didn't know who to go to.

Luckily, in my platoon I had been hearing the phrase DAV being thrown around and I finally was put in contact with the DAV. There's one person on post operating from the DAV, and he submitted my appeal, he started my VA claim. Actually, he's helped me through the entire process of the PEB. Actually, I signed it this morning for a medical retirement. And I have already—with his help submitting my information to the VA I have already seen all of the initial doctors I need to see for the VA. They just have to wait for my orders to finally get me completely into the VA system to be discharged from the military.

Mr. WALZ. Thank you.

Mr. MITCHELL. Mr. Rodriguez.

Mr. RODRIGUEZ. We have large caseloads of veterans that we do the casework for because the VA doesn't have sufficient workers to help them out in the process of doing the casework that is needed. I know we have handled a large number of VA requests, and it is unfortunate.

Let me ask the two social workers, do you all have the tools that are necessary, and the staffing that is required to handle the so-called surge or the injuries that I know has got to be there because there have been some 23,000 soldiers that have been seriously injured that have been coming in and I wanted to see if you could react to that.

Ms. DINEGAR. I think so. Our program has really grown. We started with one VA at Walter Reed.

Mr. RODRIGUEZ. One?

Ms. DINEGAR. We started with one back in August of 2003. We now have two full time at Walter Reed, one full time at Bethesda, and I think it is 12 VA social work liaisons at 10 MTFs across the country. So the resources have been given to us to grow and try and meet the need of the servicemembers who are returning and getting off of active duty.

Mr. RODRIGUEZ. What's your caseload?

Ms. DINEGAR. We have transferred out of—well, I can speak to Walter Reed and Bethesda, we have transferred, transitions health care, about 11,000 referrals out of Walter Reed and I believe Bethesda's number is somewhere around 500, just transitioning of

health care from those two facilities. I know Dr. Kussman had some more numbers about how many nationwide we have transitioned through our social work liaisons at the MTFs.

Mr. RODRIGUEZ. The most common problems that you see coming toward you, and the question is to both of you, the most common problems that you see coming to you in terms of from the soldiers. Do you want to react?

Ms. DINEGAR. In terms of injuries and illnesses?

Mr. RODRIGUEZ. Yes.

Ms. DINEGAR. Sir, that varies from a broken foot, an injury in basic training, to your most severe traumatic brain injury, to your triple amputee. We see all ranges of severity of illnesses and injuries.

Mr. RODRIGUEZ. Now you heard the comments by the soldier in terms of her difficulty. As social workers do you have a responsibility there?

Ms. EDMONDS-CLEMONS. Can you repeat that, sir?

Mr. RODRIGUEZ. You heard the soldier talk about her difficulties in terms of trying to figure out what you needed to do next and where she was going to get access to services and those kind of things. Is that part of the role of the social worker in terms of helping out?

Ms. EDMONDS-CLEMONS. Yes. We become involved with the soldiers at the point that they are referred to us from their treatment team, and that would be their teams at, say, Walter Reed or Bethesda. The part that she was involved in with the MEBs, we generally are not directly involved in that until which time the case manager or one of the treatment team Members refers the soldier to the VA.

Mr. RODRIGUEZ. Do you know what kind of caseloads the case managers might have? No?

Go ahead, ma'am.

Ms. LAIN. The case managers that we have, in the active duty med hold side, we have one case manager per platoon and the platoons usually have 55 to 60 soldiers in the platoon and that one case manager is responsible for coordinating all their doctors visits, their meetings with their PEBLO counselors, any other kind of meeting they have. The case manager keeps track of them and it is their responsibility to make sure the soldier gets there.

I know with the med holdover, which is the Reserve/National Guard component, the med holdover side, which is Reserve/National Guard component they—I believe they have six—they have six platoons and their six platoons have anywhere between 30 to 40 soldiers. The Active duty side has eight platoons.

Mr. RODRIGUEZ. I guess on the VA side in terms of casework I know that as a Member of Congress we have a large number of veterans that come to see us when they have difficulty getting access either because of the waiting list or because of a variety of different decisions are made. Is there any attempt in terms of the VA maybe taking on the responsibility? Of course they are always welcome to run to their Congressman, but is there an effort in terms of beefing up on the case managers? I am talking to the two directors of the hospitals.

Dr. MCNAMEE. Sir, are you specifically speaking about the case managers on the Department of Defense side or on the Veterans Affairs side?

Mr. RODRIGUEZ. Am I making a mistake on this? DOD then?

Dr. MCNAMEE. With Veterans Affairs.

Mr. RODRIGUEZ. I apologize. Because we do get the ones——

Mr. MITCHELL. Mr. Rodriguez, your time has expired. Thank you. Mr. Bilirakis.

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

Dr. Scott, I know you worked very well with my father, Congressman Bilirakis, in the 109th Congress when he Chaired the Oversight Subcommittee. I look forward to working with you as well and I will see you next week at Haley. I have a couple questions here. Are you still having problems receiving complete medical records from military treatment facilities?

Dr. SCOTT. We receive them, and I think I can say from our facility it is always an effort to get everything because we have to make sure with this complex injury that every microbiology report, every x-ray, ever—we can't miss one thing. And I think that is what makes this very complex and why the medical records system has to be a perfect system almost because if anything is lost in that exchange it could affect the outcome of that individual, and it has affected the outcome of the individual. And so we are able to get them; it takes a lot of effort. It has improved and it is going to continue to improve as we all continue to work together to make it better.

Mr. BILIRAKIS. So it is improving and you are receiving them in a timely manner?

Dr. SCOTT. I think we are like Richmond, too; we try to get a response back once the individual is referred within about a day, if possible. If we have all the medical information, we can make that response. If it's anything longer than that, then we have to get updated medical records because that morning or that last 4 hours it may change completely, the medical status. That is why it is important that we do things in a very timely, orderly way.

Mr. BILIRAKIS. Dr. McNamee, do you want to comment on that?

Dr. MCNAMEE. We definitely get full records from our DOD facilities and, as Dr. Scott and I both had mentioned, we get them in multiple different fashions. We get them through our direct access, we get them through the incredible work of our VA–DOD liaisons, we get them through the joint patient tracking application, and go figure, you can pick up a phone and call someone as well. That to me has been the piece that is probably the most appropriate because even when you look at a hospital-to-hospital transfer and if you have someone coming from one floor to another, typically the most appropriate way to understand a case and to transfer a case is for the two clinicians to sit down and discuss the complexities of the case and work it through.

As I had mentioned earlier, the term relationship-based medicine that we preach, that isn't just with the families and the patient, but that is with our referers and the clinicians on the other end.

In my cell phone in my bag I have the phone numbers of two of the major referers from Walter Reed and Bethesda and we talk on a very frequent basis. This on its own has really led to a tremen-

dous level of care and handoff and even more so the ability to plan care over time for these individuals. So yes, I do believe we get access to the data and we get it from a lot of different ways. Sometimes it takes some effort but I don't think people are being in any way cut out from the highest quality of medical care because of it.

Mr. BILIRAKIS. Thank you very much. I yield back the balance.

Mr. MITCHELL. Thank you. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. Thank you all for being here and helping us understand this issue. To the two medical directors, thank you for providing a good survey of what you are doing and the passion which you bring to the job. I have questioned the VA bureaucracy and their seeming lack of passion for the veterans because it comes through that way sometimes. So we appreciate your passion.

On the medical records, you say you are able to get them, but the two systems electronically can't communicate with each other, is that correct?

Dr. SCOTT. Yes, they do not connect. Actually, there is a two-step approach, the other one takes three different steps to go through.

Mr. FILNER. You have to go through each system to get those records. That is the kind of thing we need you to point out to us. Is there a plan to bring them into one system as far as you know?

Dr. SCOTT. My understanding from the previous testimony and my reading is there is a plan to have one medical records system. That is I think the long-term plan.

Mr. FILNER. That is very long-term, unfortunately. It is probably not going to help any of your patients in the next 10 years. It's a question of programming and software, and if we put the resources into it we could do it. It is not conceptually a difficult problem. I was at North Chicago, as one of the witnesses said, and there the military clinic and the VA are trying to figure this out and they are making some progress. But even bringing this together is difficult.

Again, I think you would be helped tremendously by having that access, and it's not just at Walter Reed; it's also what's happened on the battlefield in Iraq. In the most advanced society in the world, we can't get these two systems to communicate. It's beyond my comprehension. But it takes resources to do it. How many actual patients do you have right now, sir?

Dr. MCNAMEE. We currently have 11 on our unit, in our active unit.

Mr. FILNER. How many would you deal with in a year?

Dr. MCNAMEE. In the last year the number of specifically OIF/OEF injured on our last count was 56 for fiscal year 2006.

Mr. FILNER. Similar or more?

Dr. SCOTT. We have 11 now, we had over 100 this past year.

Mr. FILNER. In four polytrauma centers, 44 people we are treating right now. You have painted an incredibly good picture but we are doing only a couple hundred, maybe 350 a year compared to the needs that we are going to have. It seems to me that we are so far from where we need to be. You don't turn anybody away, but are there a lot more cases out there that would profit from being at your polytrauma center?

Dr. MCNAMEE. Sir, the numbers that we quoted are the individuals who are on the inpatient unit, and they are the most severely wounded of the polytraumatic injuries. The large numbers that we will see will be the mild to moderate injuries that will not need intensive neuro-cognitive and behavioral training on an inpatient unit.

Mr. FILNER. Based on what you know at this moment. Three years from now, they may.

Dr. MCNAMEE. It is from the knowledge that we have gained in the last 30 years with traumatic brain injury rehabilitation.

Mr. FILNER. If you have mild brain injuries that do not need that kind of care, they may need it in a decade.

Dr. MCNAMEE. The care we provide is in the outpatient setting. Currently, at Richmond, the outpatient caseload for these individuals is 75 and growing rapidly every month as we are beginning to screen these individuals. So this care——

Mr. FILNER. Are you in charge of the outpatient, too?

Dr. MCNAMEE. I have a large hand in the outpatient setting.

Mr. FILNER. It seems at Walter Reed the problem was in the outpatient situation, not necessarily in the hospital. It looks like to me we have much greater needs. You are doing a great job with the 11 you have, but we've got hundreds of thousands coming back and, Paul, you told me what percentage might have brain injuries?

Mr. SULLIVAN. According to a document from the Defense and Veterans Brain Injury Center, it was about 10 to 12 percent. So if you do the math on 1-1/2 million servicemembers deployed, that could be about 150,000. And most of those overwhelmingly are going to be in the mild, is that right, Doctor?

Dr. SCOTT. If you compare the report, A Mild Head Injury in 2003, and that would be a good one for everyone to review, about 75 percent of all head injuries in this country are mild head injuries. So if you just multiply basically what we have for moderate to severe and then multiply it by again times four, you can probably get just a rough estimate.

Mr. FILNER. What's the estimated number of polytrauma centers we need or will need next year? Probably dozens I would think, offhand. We've got four.

Dr. SCOTT. We just don't really know what the number is out there. We could estimate, we could draw some things here and there, but what we do know is that our troops over there are under a lot of these IED blasts and they are being redeployed multiple times. So they are going to have increased chances of having these injuries.

Mr. FILNER. One last question if I may, did you watch the Bob Woodruff interview? It seemed to me, that one of the main problems there was in the discharge to the local home area, where there was not the same expertise that you have.

Is that a legitimate concern, and how do we deal with it? Woodruff showed several people who went backward in their movement toward health because there was just not the expertise and the records got lost.

Dr. MCNAMEE. What we are doing at this point in this, and obviously there are 21 outpatient polytrauma network sites, and to develop a system of care that crosses the country for traumatic brain

injury has never been done in the history of this society and what we are doing with that is to provide the appropriate levels of education, support and direction. We have the video teleconferencing abilities with all these sites, we have frequent conferences. There is a system-awide TBI initiative to cover this as well. We are all here to cover each other, and I don't think anyone would say that any system is anywhere near perfect, particularly with one that is this wide ranging and this large, but we are doing our best to make sure that all of these individuals receive the highest level of care that we have.

That issue that you talk about is true with any system of care within this country for any specific injury. It is about building the appropriate system.

Mr. FILNER. You are ready for a promotion to the bureaucratic staff if you look at what you just said. Instead we need answers of how we are going to prepare for all these people. I need numbers of centers, number of beds, what you're telling me is not going to help in getting the job done. You have to be more simple with us.

Mr. MITCHELL. Thank you. Mr. Hare.

Mr. HARE. I am going to ask a quick question, then yield my time to Mr. Filner.

What measures and accountability practices are you implementing when you work with the Department of Defense to ensure that the rehabilitation of TBI patients is initiated when it's clinically indicated?

Dr. SCOTT. We have our own outcome and quality management that we do on every individual that enters our program. It is based on an outcome-based program. It's very comparable to the private sector, too. It is based on functional gains, accessibility, amount of disability, amount of impairment, and we can follow that individual within the hospital and also on follow-up, too, in that fashion and we roll up those data on a regular consistent basis with what we call performance improvement plan, and with that we then look at that and see which areas we can improve upon and from that improvement we can advance forward.

I am also a principal investigator of the Defense and Veterans Head Injury Program and we have regular contact every other week. We have phone conferences in which we bring up key issues on head injury management between DOD and VA, and from that we can problem solve and identify certain key areas that we can contribute and improve upon.

Also the international trauma continual care, that we actually follow the individuals. This is a V–Tel that goes from the battlefield all the way over. We also are an active participant in which we can contribute information back to those at the warfront or back to those that actually can improve and identify head injuries or problems that we see at our end that they can help at the other end, and that also improves the quality of care, too.

Mr. HARE. Let me just if I can, Mr. Filner, would you like—I am going to yield the balance of my time to Mr. Filner.

Mr. FILNER. Again, we need some help. And you are on the front lines. There is a disconnect, and it's especially pronounced when you're in the bureaucratic hierarchy here, as you saw with the pre-

vious panel. From your perspective, you are doing everything really well with what you have and the people you have to see.

Ms. Lain, did I get that right? Ms. Lain's testimony was the frustration felt from the patient end. There is a disconnect here. You are doing great work, yet we have hundreds, if not thousands, of people feeling very frustrated with the system. You have to help us bridge that and you have to be honest with us and straightforward, and if you said, "I have 11 beds but if I had 50 I could really do something," or "their caseload is 1,600," and I don't know how many social workers have to handle those 1,600 referrals. It's not just the two of you, is it?

Ms. DINEGAR. There are three of us that have transitioned 1,600. They are not all currently active.

Mr. FILNER. That is a big load. We need people to say, if I had half I could really help people. So we need to hear that. Apparently the upper bureaucrats don't want us to hear. They are instructed not to tell us.

We want to help you. We are all committed on both sides of this Committee to helping you serve our veterans better, but we've got to know what's going on. Paul has been sort of the designated guy on some of the TV shows where he's telling us what's going on. That's been very helpful watching you, Mr. Sullivan. I really appreciate what you have been saying.

But we all have to be honest and straightforward. We need to know what you want because we control the money. Help us help you because you are doing a great job with what you have. But we are going to have thousands, if not tens of thousands more to deal with.

So I'll leave it open. Anything that you would like us to know right now about what you need in the current budget?

Dr. MCNAMEE. I think one of the initiatives that the VA is working on right now, which is tremendously important, is the transitional care and the transitional living care piece for those individuals with traumatic brain injuries. These are individuals again with moderate to severe brain injuries. The things that we look at that are the greatest success for these individuals is to transition back into a community setting and potentially transition back into a work setting.

There has been a model of this developed in the community; however, there is a bit of disconnect with it over time.

Mr. FILNER. You mentioned 21 centers; what was that 21?

Dr. MCNAMEE. 21 polytrauma networks. These transitional care units will be developed at the polytrauma rehabilitation centers and will be set up to transition these individuals back into active duty to re-establish those roles I talked about or back to home with their family.

Mr. FILNER. What would you tell the veteran on the Bob Woodruff show in some rural town that didn't have access? What do they do?

Dr. MCNAMEE. We need to continue to case manage these individuals and allow them every opportunity to get back into our system and work with them and deliver the kind of care that they absolutely deserve. We are responsible for that and we are respon-

sible to deliver that care to those individuals and responsible to develop programs to support these individuals.

Mr. FILNER. Thank you, Mr. Chairman.

Ms. BROWN-WAITE. Mr. Chairman, a little bit of housekeeping. I don't believe that it was mentioned, so I would ask for unanimous consent that all members would have 10 legislative days to submit statements.

Mr. MITCHELL. Without objection, so ordered. Thank you. Thank you very much. I really appreciate you taking your time to come here and give us your expertise and your testimony. Thank you all very much.

Ms. BROWN-WAITE. Keep up the good work.

Mr. MITCHELL. As they leave would the next panel please position yourselves so we can keep going? It's getting late. We've got a few more things to hear. Thank you.

Take your seats so we can get started. Thank you all for being here and the rest of you for sticking with us. I would like to introduce panel three. Mr. William Feeley is the Deputy Under Secretary for Operations and Management; Dr. Edward Huycke, the DOD–VHA Coordination Officer; Dr. Ira Katz, the Director of Mental Health Services, are all here courtesy of the VA. I would like to also welcome their thoughts on the seamless transition process. In addition to these three gentlemen we have Mrs. Kathy Pearce, who is here to tell us exactly what she and her son have faced on the personal level in making the transition from DOD care to the VA system. We welcome her and thank her for appearing at such short notice to answer questions.

I would also like to note, due to unforeseen circumstances, Mr. Todd Bowers was unable to appear at the last minute, and we are very sorry for the confusion.

My understanding is that Mr. Feeley, Dr. Huycke and Dr. Katz have a statement, a 5-minute statement, and that Mrs. Pearce also would like to be here for questions, is that correct? Thank you.

Mr. Feeley, if you would start.

STATEMENTS OF WILLIAM F. FEELEY, MSW, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; EDWARD C. HUYCKE, MD, CHIEF DEPARTMENT OF DEFENSE COORDINATION OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; IRA R. KATZ, MD, PhD, DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND KATHY PEARCE, MESA, AZ (MOTHER OF TRANSITIONING VETERAN)

STATEMENT OF WILLIAM F. FEELEY

Mr. FEELEY. Good afternoon, Mr. Chairman and Members of the Committee. My statement is in the record but I would like to read my comments. I want to thank you for the opportunity to discuss ongoing efforts in the Veterans Health Administration to improve the quality of care we provide to veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom. VHA is com-

mitted to providing comprehensive, quality primary and specialty care to all enrollees with an emphasis on exceeding the expectations of veterans. When we don't, our leaders want to know about it and make it right.

My comments will focus on the operational facility aspects of the organization. Related to the access of care issue, the quality of care VHA provides to our veterans is widely regarded as exceptional. Offering veterans access to VA care when and where they need it is key to this excellent clinical care.

VHA monitors how long veterans must wait for appointments, including the time it takes for an OEF/OIF veteran to be seen. The waiting times are reported every 2 weeks and are distributed to network and facility leadership. Waiting times are a key performance element in network and facility directors' performance plans.

VHA has employed system improvement strategies in recent years to reduce clinic wait times and help to ensure that our clinic processes are streamlined. Some examples of these efforts include group visits. People with diabetes or congestive heart failure, rather than seen on an individual appointment are seen in group teaching sessions, extended hours in clinics, including Saturday clinics. Normal lab work, an x-ray reporting is reported to the veteran via phone rather than have them return for a medical visit.

And one of the issues that was discussed today is we have clinical office space renovation providing two exam rooms for every physician as a goal. Dr. Scott did identify space challenges at the polytrauma center in Tampa, and we are currently looking at a $7 million minor renovation project that will enable him to enlarge those rooms.

I would like to talk a little bit about the polytrauma centers. In order to meet the needs of our most severely injured veterans, VA has created this polytrauma system of care, which includes a phased approach to providing care for seriously injured veterans returning from Iraq and Afghanistan. The most intense phase, Level I, consists of four centers that provide acute comprehensive medical and rehabilitation care for the most complex and severe polytraumatic injuries. Each maintains a full staff of dedicated rehabilitation professionals and consultants from numerous specialties. The centers serve as resources for other VA facilities and are active in the development of educational programs to spread national learning across our system.

These four trauma centers are located in Tampa, Richmond, which we heard from the two physicians today, Minneapolis and Palo Alto.

In my statements there are detailed explanations of polytrauma that I am going to skip because I think Dr. Scott has adequately addressed those. I would like to comment on a point Dr. McNamee made. VHA is recognizing that severely injured veterans may require extensive rehabilitation therapy to successfully reintegrate back into the community, and thus the Department is developing four transitional rehabilitation programs collocated with the Level I polytrauma rehabilitation centers. The activation date for these four new residential transitional programs is July of 2007.

A transitional rehabilitation program offers additional time to improve a veteran's physical, cognitive, communicative, behavioral,

psychological and social functioning under the necessary scope and supervision. The goal of these programs is to return servicemembers to the most independent status possible, whether that is return to active duty, work, school or independent living in the community.

Palo Alto's transitional housing is now complete. The other three sites we are currently working on them. The Level II sites which we have heard about exist in 17 locations, one in each network. These sites are responsible for coordinating lifelong rehabilitation services for patients within each network. Level II sites provide a high level of expert care, a full range of clinical and ancillary supports, and serve as a resource for other facilities within the network. They provide continued management of patients referred from the Level I polytrauma sites and evaluate patients referred directly to the Level II sites.

Mr. MITCHELL. Could you summarize pretty quickly?

Mr. FEELEY. Yes. The last comment I would make is the extensive polytrauma network was created to adapt VHA's existing health care system to provide care for these severely wounded veterans. I would be happy to entertain any questions.

[The statement of Mr. Feeley appears on pg. 69.]

Mr. MITCHELL. Thank you. Dr. Huycke.

STATEMENT OF EDWARD C. HUYCKE

Dr. HUYCKE. Thank you, Mr. Chairman, distinguished Members of the Committee. Thank you for the opportunity to speak to you about the progress the Department of Veterans Affair and the Department of Defense have made in improving the delivery of health care and benefits to our Nation's veterans. I think you have my statement for the record, and so I will just orally talk about some of the highlights if I can in the interest of time.

Veterans Health Administration staff has coordinated the transfer of care for more than 6,800 injured or ill active duty Members and veterans from DOD to the VA, specifically those injured or ill as part of the global war on terrorism in Iraq and Afghanistan and in particular those transitioning directly from the DOD treatment facilities to the VA medical centers.

In partnership with DOD, VA has implemented a number of strategies and innovative programs to provide timely, appropriately and seamless services to the most seriously injured OEF/OIF active duty Members and veterans. The centerpiece of the program supporting the seamless transition of the seriously injured servicemembers and veterans involves the placement of the VA social work liaison, the DOD liaisons, VA benefit counselors and outreach coordinators at the military treatment facilities to educate servicemembers about VA services and benefits. These VA employees assist active duty servicemembers during their transfer to VA medical centers and ensure that returning servicemembers receive information about VA benefits and services.

Currently VA social work and benefit liaisons are located at 10 medical treatment facilities, including of Walter Reed Army Medical Center, National Naval Medical Center, the Naval Medical Center at Balboa, and Womack Army Medical Center.

In addition to the social work and benefits liaison a VA certified rehabilitation registered nurse was assigned to the Walter Reed Army Medical Center in September of 2006 to assess and provide regular updates to the VA polytrauma centers to which these patients may be transferred. They provide education to the families about VA benefits and services and prepare the active duty servicemembers for the transition to the rehabilitative phase of their recovery.

Once the MTF team notifies VHA of its plan to transfer the patient, the VA social work liaison and the certified rehabilitation nurse begin to coordinate the care and information transfer. The VHA social worker liaison begins meeting with the patient and the family to educate them about the patient's transition from the DOD health care system to the VA's health care system.

The VHA social work liaison also registers the active duty servicemember or enrolls the recently discharged veteran in the VA health care system and begins the process of coordinating a transfer to the VA health care facility most appropriate for the services they need or to a location that is closest to their home.

In the case of a polytrauma patient transfer, both the registered nurse and the social work liaison remain an integral part of the treatment team at the medical treatment facility while providing input to the VHA care plan and collaborating with the patient and the family throughout the remainder of the health care transition process. VA case management for these patients begins at the time of the transition from the medical treatment facility and continues as their medical and psychological needs dictate. Once the patient is transferred to the receiving VA medical center or reports to his or her home VA medical center for care, the VA social work liaison at the medical treatment facility follows up with the receiving VAMC to address any issues and to ensure the patient is attending appointments.

Patients with severe injuries or those that have complex needs will receive ongoing case management at the medical center where they receive most of their care.

An important part of the coordination of the care between the DOD and VA prior to transfer is the access to the clinical information, including viewing of electronic medical information using remote access capabilities. Video teleconference calls are routinely conducted between the DOD medical treatment facility team and the receiving VA polytrauma——

Mr. MITCHELL. Could you wrap it up?

Dr. HUYCKE. —enabling a face-to-face transfer, discussion of the polytrauma patient's care prior to transfer.

I think I will conclude my oral statement at this point and thank the Chairman and the Subcommittee. Meeting the comprehensive health needs and benefits of our Nation's veterans is our Nation's highest priority, and we are proud of the progress we have made in the seamless transition process.

Thank you, Mr. Chairman. I would be happy to answer any questions.

[The statement of Dr. Huycke appears on pg. 70.]

Mr. MITCHELL. Thank you, Dr. Huycke. Dr. Katz.

STATEMENT OF IRA R. KATZ

Dr. KATZ. Thank you. Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the ongoing steps that the Department of Veterans Affairs is taking to meet the mental health needs of our Nation's returning veterans. Care for Operation Iraqi Freedom and Operation Enduring Freedom veterans is among the highest priorities in VA's mental health care system.

For these veterans, VA has the opportunity to apply what we've learned through research and clinical experience about the diagnosis and treatment of mental health conditions; to intervene early; and to work to prevent the chronic or persistent courses of illness that have occurred in veterans of prior eras.

Since the start of the global war on terrorism until the end of 2006, over 631,000 veterans have been discharged. About a third have sought care from VHA; and, of these, 35.7 percent have had diagnosis of a possible mental health condition. This makes mental health second only to musculoskeletal conditions among the classes of conditions seen in returning veterans.

Somewhat less than half of the returning veterans with a mental health condition have a possible diagnosis of post-traumatic stress disorder, or PTSD, making it the most common of the mental health conditions. However, PTSD isn't the whole story. Among the diagnosable conditions, mood disorders as a group, when added together, are almost as common. Moreover, many veterans experience nonspecific stress-related symptoms that may be viewed more appropriately as normal reactions to abnormal situations in combat, rather than any disorder.

VA, in fact, has two components of its mental health care system: mental health services in medical centers and clinics and vet centers. In response to the growing number of veterans returning from combat, the vet centers have initiated an aggressive outreach campaign to welcome home and educate returning servicemembers at military demobilization and National Guard and Reserve sites. Through its community outreach and coordination efforts, vet centers provide access to other VHA and VBA programs.

To augment this effort, the vet center program recruited 100 OEF/OIF veterans in 2004 and 2005; and just last week Secretary Nicholson announced plans to hire an additional hundred to conduct outreach at both medical centers and in the community. When these outreach activities lead to identification of mental health conditions, veterans have choices. They may receive care in vet centers, medical facilities or both.

VA's approach to PTSD is to promote early recognition for those who meet formal criteria for diagnosis and those with partial symptoms. The goal is to make evidence-based treatments—psychological, pharmacological and rehabilitative—available early to prevent chronicity and lasting impairment.

Throughout VHA, there is a sense of urgency about reaching out to OIF/OEF veterans, engaging them in care, screening them for mental health conditions and making diagnoses, when appropriate. Screening veterans for PTSD and other stress-related conditions is a necessary first step to helping to heal the psychological wounds of war. In cases where there are positive screens, patients are as-

sessed and referred to mental health providers for follow-up and treatment, as appropriate.

However, we recognize that even in America, even in 2007, there can still be some degree of stigma associated with mental health conditions and their treatment. That is why we offer a number of options, for example, for care in mental health specialty services, vet centers or, increasingly, for mental health services provided in primary care settings. When veterans with severe symptoms are reluctant to enter care, we're prepared to educate them and their families and to work with them to overcome resistance. When veterans with milder symptoms are reluctant, we watch over them over time and urge treatment if symptoms persist or worsen.

We're committed to making the best available treatments available; and for advancing the nature of the care available, VA has been a leader in research as well as clinical services for PTSD. Last week, the Journal of the American Medical Association included an article based on VA research describing the benefits of a specific behavioral treatment for PTSD. Before the results were even published, VHA was beginning to establish training programs to make this intervention available throughout our system to our patients. The translation from research into practice won't be instantaneous, but it can be accomplished far more readily in VA than in any other clinical setting or system. This is how a mental health care system should be functioning.

Thank you again, Mr. Chairman, for the opportunity to be here; and I would be pleased to answer questions.

Mr. MITCHELL. Thank you, Dr. Katz.

[The statement of Dr. Katz appears on pg. 72.]

Mr. MITCHELL. Ms. Pearce, did you want to read your statement or did you just want to answer questions?

You've got a statement here. Please do it.

STATEMENT OF KATHY PEARCE

Ms. PEARCE. Thank you, Mr. Chairman and Congress, for taking your time to listen to these veterans and these people that work with our veterans.

I would like to say good morning—it is not morning. Good afternoon. My name is Kathy Pearce. I am a military mom who lives in Mesa, Arizona. I appreciate the opportunity to tell you about my story because I believe it is similar to the experiences of so many families of seriously wounded soldiers across the country.

My son, Army Sergeant Brent Bretz, was seriously wounded during his service in Iraq on December 19 of 2004. Brent was driving a supply truck at the time in his Stryker Brigade convoy when a remotely detonated IED blast blasted through his vehicle. Brent lost both of his legs in the attack. His left arm was very seriously injured, his lost his spleen, his lung collapsed, and he suffered a head injury.

But the truth is, we are lucky Brent is alive. I know that he would not be with us today without the exceptional medical care he received from military doctors in the months following his blast.

After he was stabilized in Iraq and treated at military facilities in Germany, Brent was transferred to Bethesda Naval Hospital, where he stayed for 5 months. He was then transferred to Brooke

Army Medical Center at Fort Sam Houston, where he was an inpatient for 2 months before he was transferred to outpatient status in June of 2005.

Thankfully, I was able to be with Brent from his care in Germany to his transition to outpatient status. Despite his new status as an outpatient, he still had unique needs, and I know that if I had not been available to help provide care, the transition would have been very difficult for Brent.

Unfortunately, there are many soldiers whose families cannot help during that transition; and, as a result, their needs are not always being met.

My experiences with Brent led me to believe that there may be a need for many soldiers to have an option of care that is somewhere between inpatient and outpatient status. As an outpatient, Brent had to wheel himself with one arm severely injured the length of three football fields from his barracks to his appointments at the hospital and to the mess hall. On several occasions Brent was physically unable to get himself to appointments or to the mess hall, and he missed meals and doctors' appointments accordingly.

In addition to the distance he had to travel to his appointments, he has to wade through an interminable bureaucracy that makes it difficult to get the answers he needs. Unfortunately, as he is transitioning into a status as a veteran, he has encountered the same bureaucracy and red tape at the Department of Veterans Affairs.

I don't think most people know how difficult it can be for a wounded soldier to transition into the Department of Veterans Affairs and get the benefits and care they need. The experiences Brent had with overloaded caseworkers at the Department of Defense is similar at the VA, and at times it doesn't seem like there is an adequate level of communication between the DOD and the VA. At times, the VA counselor has been inaccessible, unable to answer many of Brent's questions. He frequently fills out paperwork only to be told that he needs to secure even more documents and fill out even more paperwork to move the transition process forward. It is time-consuming and complicated, and it has been very difficult for Brent to get the guidance he needs.

Brent's experience is common for many wounded soldiers. While his initial care was world class and our family appreciates the work of these doctors, Brent has experienced many things no soldier should ever experience. His outpatient care has not always met his unique needs, and he is now dealing with significant bureaucracy gridlock at the VA.

We can do better, and our soldiers deserve better. I appreciate the Subcommittee's interest in this issue, and I hope that you can help military families like mine and soldiers like Brent get the services and care they deserve.

Thank you.

Mr. MITCHELL. Thank you very much.

Before we open up to questions, I would like to turn the gavel over to Mr. Walz. I will be back in just a few seconds, but I will have you start with the questions.

Mr. WALZ [presiding]. Well, thank you all for being here. I know it is a late hour, and I said there might be a little discomfort, but I couldn't help even thinking before Ms. Pearce spoke that I don't think it is a bad thing that America feel a little discomfort when we're talking about this issue. I think it is highly appropriate that we feel a little discomfort.

We're here today to make sure that we correct and we do what is right for these wounded soldiers and that we're proactive on this. As I have said, again, the VA and the providers inside the VA are doing what they can. They're doing a good job. But I said—when I listened to Ms. Pearce, it comes back to what I said earlier, this is a zero sum proposition. One that goes through this is too much in this Nation, and I think we have every expectation in this Nation that we should do everything possible to make sure there isn't that one.

I think it is probably good that Mr. Filner is not here at this time because I think he would raise some questions.

But I'm going to ask the question that I think is on the mind of a lot of my constituents; and that is, looking at this and looking at the administration level, higher than the gentlemen sitting in front of us, but I am going to ask your opinion, and I am going to ask what you think when I hear this from constituents. Are we getting a rosy picture painted by the VA to justify this administration's—the Presidential administration's unwillingness to put the money that was necessary into the VA and unwillingness to plan for this war?

When we were told it was weeks and not months, when we were told it was over and mission accomplished, was thought put into the implications for people like Brent and his mother? Were those types of decisions talked about at an administrative level? Were they discussed on the level of what you could do to change the infrastructure of the organization to prepare for that?

When I hear experts tell me that the numbers are going to be larger than the VA is telling me, I have to be quite honest, from this administration, I am very skeptical that they are planning based on reality. And I ask that question more out of frustration for my constituents who are asking it.

Has this discussion happened at a VA level or an administration level? Was there a preparation made? If each of you have been there for that long, was preparation made? Was it talked about, what the impact would be on the numbers that were coming?

Mr. FEELEY. I would indicate—I have been in the position 13 months, and I believe that this is a daily discussion going on the entire time I have been there, and we are constantly learning from our experiences as we go along in trying to adjust. So that is the best answer I can give to that, considering the length of time.

Now I also was a network director and a director in the field, and I think we are making every effort to treat every veteran as a family Member. I want Ms. Pearce to know that this is my card, and you can e-mail me and call me, and I will do whatever I can to make sure your son gets what he needs.

Ms. PEARCE. Thank you.

Mr. WALZ. How do I get that card to the rest of them? That is the answer I want to hear. That is the type of reaction I want to start seeing.

But I am feeling right now what I do feel at times. We're with you in this. We are partners. We need to figure out how to get this. And too many people are afraid of what the political fallout will be by admitting that we need help, we need to prepare, we need to make sure Brent's needs are met and do everything in our power to do that.

I just want to know what we can do, and I feel like we're being told it's okay.

Mr. FEELEY. I think one of the key issues that was identified here is the need for these transitional housing options that we talked about. Because people need a longer runway to heal, and the polytrauma center needs to have the ability to handle the most severe injuries. But that next phase requires additional support so that young men and women can go to school, go to vocational tech school, get a job, test their legs at independence.

This is a learning issue that we found out the hard way, and only in the past 6 months has this started to gain attention.

A conference was held in December of last year, and that is where the decision was made to build these units. It's essentially a halfway house with proper supervision allowing people to integrate back in. I think that is a little bit of what I hear Congressman Filner raise. That need may get greater. We do have options in our system, including the veterans domiciliary system, to assist young men and women; and we're going to have to gear up for that.

Mr. WALZ. My final question before I turn it over to the Ranking Member, and this is to you, Ms. Pearce. You are sitting here in front of Congress. I am sitting here as a new Member of Congress who was a command sergeant major whose total life was devoted to making sure those soldiers get taken care of. What do you have to tell us? What would make life easier for you and for Brent? What would truly honor that commitment that he made to this Nation so that this Nation can pay it back the way it should?

Ms. PEARCE. I think that these transitional houses, they are really needed. They're needed on the VA side as well as the DOD side.

Brent is still going through his med board, and he has had some dealings with the VA, but he's still with the DOD. It is a tough—there is a tough line there, and it is like they can't take hold of him until the DOD has let go of him. And to get that agreement between the DOD and the VA that those medical records, that that information, that they can have this seamless transition that we keep talking about would really help these guys.

Their everyday lives have changed. What they used to take for granted—if I can take a moment here. When Brent first got back, a reporter asked him what he missed. It was standing up to pee. I mean, that is something so simple. But, for him, it was something that he was looking forward to.

To give him back that dignity by giving them this transitional housing—they go from 24/7 care to nobody there, nobody to help him, nobody to help him with that transition. A lot of these young men and women don't have family that can stay with them and help them with that transition.

And he needs to know that the VA is going to be there for the next 20, 30, or 40 years to help him. He made his commitment to this country. He gave his all, and he just wants to know that they're going to be there to assist him.

Mr. WALZ. Thank you.

I'll recognize the Ranking Member.

Ms. BROWN-WAITE. Thank you very much.

Ms. Pearce, one of the things that I tell my daughter who has teenagers is parenting doesn't end when they're 18 or 20. And certainly you are the epitome of the world's greatest mom, and I mean that, to be there for your son.

I'm sorry that the system wasn't there to help your son. I'm sorry that DOD just doesn't work well with the VA. It has been a system since—I've been here 5 years. It was long before I ever got here that these kind of silos buildup with DOD and the VA. That's not an excuse that anyone should fall through the cracks, as obviously your son did. And thank you so much for being there. I have parents in my district, too, who are there for their son, move around the country as he transitions from James Haley to other units.

If I may, to ask this question to you, Ms. Pearce. Did you bring this to the attention of your Member of Congress? I don't even know who your Member of Congress is. But did you contact the Member of Congress' office to express these concerns and to have somebody work on the issue? And I'll let you answer that.

Ms. PEARCE. I have talked to Members of the Senate. I have not talked to my Congressman. But these are issues that I have recently noticed as I have spent more time travelling back and forth, still spending time with Brent, but I had to go back to work. But I see these young men that are in these barracks. They're at Brooke Army Medical Center. And just over the months of being away from Brent and back and forth, I have realized these needs.

So it is not something that I noticed early on, but I see that there is a need there, that they need some kind of transitional housing, and I think it needs to be on both sides of the fence. Because so many of our young men and women are spending time at Bethesda and Walter Reed and Brooke and I know Pendleton now as well as Madigan and some of the others, and they need something to help them get to the point where they can live independently. But I hope that it is something that—I did stop by my Congressman's office today. He was out voting. So I didn't get to speak with him.

Ms. BROWN-WAITE. But, please, as you come in contact with any people who have served in the military, whether they're still under DOD or whether they're in the VA, have them contact their home Member of Congress. Because until we know that there is a problem, we can't solve that problem.

I know in my instance of parents who are with their son today, they're actually out in California at a private rehab center. I know that they didn't hesitate to contact me so that I could make sure that everything that Marine needed, he got.

So, please, I implore you, let the servicemembers and their families that you come in contact with know; and that way we can work on coming up with a solution that works not just for that one person—because we are not, you know, narrow minded, just take care

of my constituent—take care of Mr. Rodriguez's constituent, too, who may be in exactly the same situation.

But when we know about the problem, there isn't a Member on either side that won't immediately go to work and try to solve the problem.

Again, I commend you for your devotion to your son. You ultimately are, you know, the mom of the year.

I would have a quick question for Mr. Feeley. That is, Secretary Nicholson's recent letter making all sorts of promises and initiatives, ultimately, you are probably going to be the one implementing it. How do you plan on operationalizing all of the health care initiatives?

And the other important question is, will you be adequately funded to do these things?

I know I'm running out of time, so you may have to submit the answer, but I think it is an important question.

Mr. FEELEY. We're committed to the transitional housing. I think that need is going to be greater; and, frankly, we have excellent cooperation with Dr. Katz to help us.

Ms. BROWN-WAITE. I think transitional housing is one of the issues, but there were far more than that in Secretary Nicholson's letter. Did you see the letter?

Mr. FEELEY. I have seen the letter, and there are a lot of deployment and execution issues we're going to face, but we're going to deal with it. The hiring of the hundred patient advocates is something we're putting a plan together on right now.

Ms. BROWN-WAITE. And you will have enough money for it? Because, if not, you need to let us know immediately. The Secretary needs to let us know.

Mr. FEELEY. I understand.

Ms. BROWN-WAITE. Dr. Katz, you need to let us know.

I thank the gentleman.

Mr. WALZ. I thank the gentlewoman.

Mr. Rodriguez, you are recognized for 5 minutes.

Mr. RODRIGUEZ. Thank you very much.

Ms. Pearce, thank you very much for your testimony, and I would want Dr. Ed Huycke, since you are responsible for—I gather you are the one who helps coordinate between VA and the DOD—in terms of some feedback from you as to what else can you do or that we have to do in order to try to have a better transition in that process.

And, number two, you know—and I was glad to hear in terms of that specific recommendation in terms of transition—I'm from San Antonio. We have Brooke Army facility there. It is a beautiful facility, and I know that we just had the private sector come in and do some—for families because we're not providing it.

I was wondering in terms of how we can begin to look at not only the soldier but the families. And in that I wanted to see if Dr. Katz, I know in the area of mental health, how it impacts the entire family, and I wanted to get your feedback in terms of what we need to do.

Once again, I think we're working hard, and I know the supplemental had—and I'll say it again—$3.6 billion additional moneys that you have for the rest of this year, and we're working hard in

trying to add another $3-point-something on the, you know, supplemental, which is probably the most you have ever had. But the key is, now how do you use those resources to respond to that?

And I would ask both of you to see if you might be able to respond.

Dr. HUYCKE. Thank you, sir, for the question.

I think at this point in time, working together, the VA and the DOD is at its—as good as it has been ever been. It is not—I think you've heard that it is not perfect at this point in time, and there is still work to do. But I think it would be important to state up front that there has been an awful lot of work between the DOD and VA to help transition those servicemen and women from active duty into veteran status.

That said, I think the issue of the medical records has been brought up. There needs to be continued work on that, and I think the departments, both of the departments, are committed to that. And that would be my answer.

Mr. RODRIGUEZ. Okay. I would hope that we would come up with something that actually makes it happen. Dr. Katz, on the mental health side for families.

Dr. KATZ. For families, that's an excellent question. We're authorized to provide care—I'm sorry. We're authorized to provide care to help the veteran. In our medical centers and clinics, we can provide services to families when it is part of the treatment plan to benefit the veteran. That is a major part of mental health care, especially with more serious mental illness.

Mr. RODRIGUEZ. Can I interrupt there?

Dr. KATZ. Sure.

Mr. RODRIGUEZ. In cases of, for example, suicide or serious situations, does that trigger the need to bring in the family?

Dr. KATZ. Yes. Yes. And I want to respond in a sidetrack to answer about suicide and then go back to talking about families.

We've been following the Joshua Omvig bill very, very closely in VA; and I am really very proud to say that, with leadership of Dr. Kussman and Dr. Cruas, we're already implementing almost all of that bill with existing legislative authority. We're committed to doing everything possible to prevent veteran suicides.

About families, working with families as a part of benefiting the veteran who is in our care is only part of the story. We've been discussing possible legislative proposals to you, and one of them is asking for authorization to work with the families of people who haven't come to us, families who might notice mental illness or suffering or behavioral difficulties, dangers. We'll be asking for authorization to work with those families to evaluate the symptoms they report, to educate them about resources, to talk with them about helping to manage the veteran at home, and to collaborate with them about a plan to help the veteran engage in care. That is a low-cost, small-ticket item, but a kind of authorization that could help us reach out and meet needs.

Mr. MITCHELL [presiding]. Thank you.

Mr. RODRIGUEZ. Thank you very much for the services you provide for us.

Mr. MITCHELL. Mr. Hare?

Mr. HARE. Ms. Pearce, let me just thank you for coming this evening. I listened to your testimony. I have a son. I can't imagine, you know, what you are going through and have gone through. And it struck me, one of the parts of your testimony is, you know, you were able to spend time with Brent and the numbers of people who may not be able to spend the kind of time and get the type of care and be around people who need them the most when they need them the most. I just wanted to tell you that, from my perspective and hopefully from this entire Subcommittee and full Committee's perspective, we've got to put an end to this.

I said this before, and I will continue to say it, as my colleague Representative Walz has said, one soldier, one person is one too many, and we have a responsibility. I would like you to convey to your son and to your entire family, A, that you have talked to a lot of congressmen here this evening and, B, these Congress people have listened.

We may be new, as I said before, but the advantage of being new is, you know, sometimes you get different ideas and you can—you know, I get a little angry, as you can probably tell—or frustrated. But I'm probably not close to what you've been through. So please understand that we're going to work on this, and we will get this thing solved one way or another. I don't know how long it is going to take, but we're going to do it because it is the right thing to do.

I want to ask Dr. Katz a question, and I'm not sure that we do this. For people who come back from the Middle East in whatever theater they served in, are all men and women tested for PTSD when they exit their tour?

Dr. KATZ. There are a couple levels, three levels at least, for testing, for screening to try to observe everyone who is suffering. There is the post-deployment health assessment just when people are leaving from deployment. There is the post-deployment health reassessment conducted by DOD and the vet centers working with them, outreach to catch symptoms that may have emerged over 3 to 6 months after deployment. When people come to us, we screen everyone for symptoms of mental health conditions, PTSD and others, and follow up on what we find.

Mr. HARE. And I would assume that by testing everybody or having everybody screened, whatever term you want to use, that would avoid someone having to feel guilty or someone, you know, the stigma that is touched with having a problem that that they can't necessarily—that they don't want their family to know about.

But isn't it true that this whole—the post-traumatic stress or the disorders people have, it affects the entire family, as you mentioned, am I correct?

Dr. KATZ. Right.

Mr. HARE. And then my other question to you—I'm sorry. I didn't want to interrupt your answer. But then the second part of that was, for those that don't have the symptoms or may be developed later, how do you identify them and reach out to them and have them come in and help them and their families?

Dr. KATZ. Yeah. You know, I think because of the experience with PTSD and returning veterans, America is learning that the strongest, best-trained and most resilient people can still be vulnerable to a mental illness. Unfortunately, the last people to learn

that lesson may be the soldiers, who all too often still feel ashamed. So stigma remains a problem, in spite of what America is learning about PTSD and other mental health conditions.

I am really proud of the 2-year eligibility without co-payment in VA. That gives people a chance to come in, to get to know us and us to get to know them, to become aware of mild or moderate symptoms or to let them grow to trust us enough to tell us what they're suffering from.

Mr. HARE. Is that 2 years enough or should that be extended in your opinion, Doctor? Is that 2-year window enough or should that be down the road?

I'm not an expert. Obviously, I wouldn't know how long symptoms are going to take before somebody has that or has a problem. But is 2 years enough or should it be longer?

Dr. KATZ. Well, symptoms can emerge at any point throughout the lifespan, but the overwhelming number will emerge within that—you know, the greatest good—the greatest number might well be 2 years, although we worry about everyone we miss.

Mr. HARE. Thank you, Doctor,

Mr. MITCHELL. Thank you.

I want to thank you all for being here and staying with us for this long period of time. What you have given us is very important. We're hoping to, as all of us are, to try to make the lives of these veterans and these soldiers better. They have given a great sacrifice, and I think it is our duty as a nation to do everything we can, our utmost, to give them the finest care that they can get, and that is the purpose of these hearings.

If there is no other business, this meeting is adjourned. Thank you.

[Whereupon, at 7:04 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Harry E. Mitchell
Chairman, Subcommittee on Oversight and Investigations

Good afternoon and thank you for being here today.

Two weeks ago, the American people learned that some of our most seriously wounded warriors were recovering in dilapidated conditions at the Walter Reed Army Medical Center, supposedly the Army's premier medical facility.

These conditions are absolutely unacceptable—..and the American people are rightly outraged.

Sadly, it appears the buildings are just the tip of the iceberg. Reports have been filtering in about a labyrinth of bureaucratic red tape our returning soldiers having to navigate to get the basic health care benefits they need and deserve.

These problems have a direct impact on these men and women as they transition from the military's health care system into the VA.

We have a responsibility to investigate how issues at the Department of Defense affect soldiers as they become veterans. We have a responsibility to make sure that the Department of Veterans' Affairs is doing its job to make that transition as easy as possible.

I'm not convinced the Veterans' Affairs Department is doing its part.

Last night, ABC News reported that "a proposal to keep seriously wounded vets from falling through the cracks of the bureaucracy was shelved in 2005 when Jim Nicholson took over as the secretary of the Veterans Affairs Department."

I am deeply troubled when wounded soldiers say in news reports that the VA has made them feel "horrible."

That's unacceptable and embarrassing, and the American people deserve answers. Today we hope to get some of them.

In today's hearing, we will hear from witnesses who have seen or experience first-hand the difficulties veterans face when they transition from the DOD health care system to the VA network.

Their stories are compelling, and I am eager to learn how the VA is responding to their concerns as well the health care needs of their fellow veterans. I am pleased to note the number of new veterans who have taken time to come and observe our hearing. In particular, I would like to recognize Specialist Gregory Williams, Corporal Noel Santos, Sergeant Frank Valentine, and Staff Sergeant Danny Vega. We are honored to welcome these young heroes.

At this time, I ask unanimous consent that Mr. Filner, Mr. Buyer, Mr. Hare, Mr. Lamborn, and Mr. Bilirakis, be invited to sit at the dais for the Subcommittee hearing today.

Hearing no objection, so ordered.

Before I recognize the Ranking Republican Member for her remarks, I would like to swear in all our witnesses.

I ask that all witnesses stand and raise their right hand.

Do you solemnly swear to tell the truth, the whole truth, and nothing but the truth?

I now recognize Ms. Brown-Waite for opening remarks.

Prepared Statement of the Honorable Ginny Brown-Waite, Ranking Republican Member,
Subcommittee on Oversight and Investigations

Thank you, Mr. Chairman for yielding.

The Committee on Veterans' Affairs has been conducting oversight reviews of the seamless transition issue for our Nation's servicemembers for the past several Con-

gresses. In the last Congress alone, the Committee and its Subcommittees held 10 hearings on the transition of our servicemembers. I believe I speak for all of us, when I say this is a top priority issue that, despite our best efforts, has not entirely been resolved.

Congress codified the concept of "DOD–VA Sharing", now known as "Seamless Transition," in 1982, with passage of the Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act (P.L. 97–174). This Act created the VA–Care Committee to supervise and manage opportunities to share medical resources. Now, twenty-five years later, we are still discussing this issue.

Some progress has been made in the areas of transitioning servicemembers back to the work force. Last Congress, P.L. 109–461 was enacted, which included various transition assistance initiatives ranging from health care needs to educational and employment training provisions.

During the last Congress, Members and staff from the Committee conducted numerous field and site visits at VA and military treatment facilities and military bases to review efforts made on Seamless transition, and held oversight hearings in May and September of 2005. The transition and integration back into civilian life should be transparent and effortless for our servicemembers. However, this does not always appear to be the case. More often than not, the hand-offs have been fumbles.

In a GAO report prepared for this Subcommittee on June 30, 2006, it was found that the VA has taken many aggressive actions to provide timely information to OEF and OIF servicemembers and their families, especially in their critical time of need. The report also noted the positive steps taken to increase the awareness, training and sensitivity of staff and medical providers on the needs of OEF and OIF servicemembers and veterans. The report also found that VA continues to have problems accessing real time medical information from DOD treatment facilities. These records are instrumental in continuing care for servicemembers and veterans receiving treatment at VA facilities.

Mr. Chairman, I ask unanimous consent that a copy of this report be inserted into the official hearing record.

Mr. Chairman, I know we have witnesses from the Walter Reed Army Medical Center. I would like to make it clear that today's hearing is not about the conditions at Walter Reed, but about the transition our servicemembers are making from DOD to VA Care. How the process works? Is there any gap in care? Is VA getting the information it needs from DOD in a timely manner to ensure the continuity of care for these new veterans, so that waiting periods for care do not extend for months after separation from active duty? And, why to this day is information on DOD personnel being cared for in the VA's polytrauma centers still not being transmitted electronically? Is there a difference between DOD electrons and VA electrons?

Mr. Chairman, I ask unanimous consent that any full Committee Members attending this hearing be recognized under the 5 minute rule to question the witnesses after the Subcommittee's Members have been recognized.

Again, thank you Mr. Chairman, and I yield back my time.

Statement of the Hon. Cliff Stearns, a Representative in Congress from the State of Florida

Thank you Mr. Chairman,

For several years now, we have held hearings, heard testimony, and listened to a number of recommendations and proposals to make the transition of service Members from active duty to the Veterans' Administration as smooth as possible. However, here we are again today, with many of the same issues outstanding.

Last year's GAO report on these issues quoted VA officials as saying that the transfer of service Members to their system from the DOD would be more efficient if the Polytrauma Rehabilitation Center (PRC) medical personnel had real time access to the service Members' complete DOD electronic medical records from the referral facility. As Yogi Berra said, this is Deja-Vou all over again!

Back in 1982, Congress identified the sharing of medical records as a critical need, and passed the "Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act" that created the first interagency Committee to supervise those opportunities to exchange information between the two departments. This was the first in a long series of new oversight Committees, interagency cooperative Committees, and special task forces that looked into this same issue. Back in 2003, President Bush established the Task

Force to Improve Health Care Delivery for Our Nation's Veterans. The first recommendation of this task force 4 years ago was that the VA and DOD should "develop and deploy by fiscal year 2005" electronic medical records that are interoperable for both systems and standards based. We are 2 years beyond that deadline and not much closer to its completion. Frankly, I am very concerned about the Information Security procedures at the VA which have not even implemented basic steps like encrypting each laptop. I would insist that those precautions are in place immediately and done before we add any more confidential information to the system.

Another concern of mine is the availability of mental health services for our service Members returning from Operation Enduring Freedom and Operation Iraqi Freedom. It is my understanding that initial screenings by both the DOD and VA are conducted in adequate time, but the concern is the long wait for follow up appointments. Some veterans receiving mental health care for PTSD could be delayed in their next appointments by up to 90 days! Currently, VA officials report that they are managing the workload of referrals for PTSD treatment, but are concerned about the influx of new returning veterans from their service overseas which could strain the VA's ability to treat them. Over 24,000 service Members have returned from these theaters so far, and many more are anticipated over the coming year. We need to look into ways to expand the capacity of the VA to provide mental health services to our returning service members in a timely and efficient manner.

Prepared Statement of Michael J. Kussman, MD, MS, MACP, Acting Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, good afternoon. Thank you for this important opportunity to comment on the Veterans Health Administration's (VHA) efforts to ensure a seamless transition process for our injured service men and women, and our ongoing efforts to continuously improve this process.

VHA's work to create a seamless transition for men and women as they leave the service and take up the honored title of "veteran" begins early on. Our Benefits Delivery at Discharge Program enables active duty Members to register for VA health care and to file for benefits prior to their separation from active service. Our outreach network ensures returning service Members receive full information about VA benefits and services. And each of our medical centers and benefits offices now has a point of contact assigned to work with veterans returning from service in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

VHA has coordinated the transfer of over 6,800 severely injured or ill active duty service Members and veterans from DOD to VA. Our highest priority is to ensure that those returning from the Global War on Terror transition seamlessly from DOD Military Treatment Facilities (MTFs) to VA Medical Centers (VAMCs) and continue to receive the best possible care available anywhere. Toward that end, we continually strive to improve the delivery of this care.

In partnership with DOD, VA has implemented a number of strategies to provide timely, appropriate, and seamless transition services to the most seriously injured OEF/OIF active duty service Members and veterans.

VA social workers, benefits counselors, and outreach coordinators advise and explain the full array of VA services and benefits. These liaisons and coordinators assist active duty service Members as they transfer from MTFs to VA medical facilities. In addition, our social workers help newly wounded soldiers, sailors, airmen and Marines and their families plan a future course of treatment for their injuries after they return home. Currently, VA Social Work and Benefit liaisons are located at 10 MTFs, including Walter Reed Army Medical Center, the National Naval Medical Center Bethesda, the Naval Medical Center San Diego, and Womack Army Medical Center at Ft. Bragg.

Since September 2006, a VA Certified Rehabilitation Registered Nurse (CRRN) has been assigned to Walter Reed to assess and provide regular updates to our Polytrauma Rehabilitation Centers (PRC) regarding the medical condition of incoming patients. The CRRN advises and assists families and prepares active duty service Members for transition to VA and the rehabilitation phase of their recovery.

VA's Social Work Liaisons and the CRRN fully coordinate care and information prior to a patient's transfer to our Department. Social Worker Liaisons meet with patients and their families to advise and "talk them through" the transition process. They register service Members or enroll recently discharged veterans in the VA

health care system, and coordinate their transfer to the most appropriate VA facility for the medical services needed, or to the facility closest to their home.

In the case of transfers of seriously injured patients, both the CCRN and the Social Work Liaison are an integral part of the MTF treatment team. They simultaneously provide input into the VA health care treatment plan and collaborate with both the patient and his or her family throughout the entire health care transition process. Video teleconference calls are routinely conducted between DOD MTF treatment teams and receiving VA PRC teams. If feasible, the patient and family attend these video teleconferences to participate in discussions and to 'meet' the VA PRC team.

I should note that one important aspect of coordination between DOD and VA prior to a patient's transfer to VA is access to clinical information. This includes a pre-transfer review of electronic medical information via remote access capabilities. The VA polytrauma centers have been granted direct access into inpatient clinical information systems from Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC). VA and DOD are currently working together to ensure that appropriate users are adequately trained and connectivity is working and exists for all four polytrauma centers. For those inpatient data that are not available in DOD's information systems, VA social workers embedded in the military treatment facilities routinely ensure that the paper records are manually transferred to the receiving polytrauma centers.

Another data exchange system, the Bidirectional Health Information Exchange (BHIE) allows VA and DOD clinicians to share text-based outpatient clinical data between VA and the ten MTFs, including Walter Reed and Bethesda.

VA case management for these patients begins at the time of transition from the MTF and continues as their medical and psychological needs dictate. Once the patient transfers to the receiving VAMC, or reports to his or her home VAMC for care, the VA Social Worker Liaison at the MTF continues to coordinate with VA to address after-transfer issues of care. Seriously injured patients receive ongoing case management at the VA facility where they receive most of their care. Since April of 2006, points of contact or case managers have been identified in every VA medical center. In response to the Secretary's request this week, VA is in the process of hiring the 100 OIF/OEF veterans to serve as case advocates to support their severely injured fellow veterans and their families.

VA has four Polytrauma Rehabilitation Centers, located at Tampa, FL; Richmond, VA; Minneapolis, MN; and Palo Alto, CA. The Army has assigned fulltime active duty Liaison Officers to each one in order to support military personnel and their families from all Service branches. The Liaison officers address a broad array of issues, such as travel, housing, military pay, and movement of household goods.

In addition, Marine Corps representatives from nearby local Commands visit and provide support to each of the Polytrauma Rehabilitation Centers. At VA Central Office in Washington, DC, an active duty Marine Officer and an Army Wounded Warrior representatives are assigned to the Office of Seamless Transition to serve as liaisons. Both the Army and the Marine Liaisons play a vital role in ensuring the provision of a wide bridge of services during the critical time of patient recovery and rehabilitation.

VHA understands the critical importance of supporting families during the transition from DOD to VA. We established a Polytrauma Call Center in February 2006, to assist the families of our most seriously injured combat veterans and service Members. The Call Center operates 24 hours-a-day, 7 days-a-week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family Members. The Center's value is threefold. It furnishes patients and their families with a one-stop source of information; it enhances overall coordination of care; and, very importantly, it immediately elevates any system problems to VA for resolution.

VA's Office of Seamless Transition includes two Outreach Coordinators—a peer-support volunteer and a veteran of the Vietnam War—who regularly visit seriously injured service members at Walter Reed and Bethesda. Their visits enable them to establish a personal and trusted connection with patients and their families.

These Outreach Coordinators help identify gaps in VA services by submitting and tracking follow-up recommendations. They encourage patients to consider participating in VA's National Rehabilitation Special Events or to attend weekly dinners held in Washington, DC, for injured OEF/OIF returnees. In short, they are key to enhancing and advancing the successful transition of our service personnel from DOD to VA, and, in turn, to their homes and communities.

In addition, VA has developed a vigorous outreach, education, and awareness program for the National Guard and Reserve. To ensure coordinated transition services and benefits, VA signed a Memorandum of Agreement (MOA) with the National Guard in 2005. Combined with VA/National Guard State Coalitions in 54 states and

territories, VA has significantly improved its opportunities to access returning troops and their families. We are continuing to partner with community organizations and other local resources to enhance the delivery of VA services. At the national level, MOAs are under development with both the United States Army Reserve and the United States Marine Corps. These new partnerships will increase awareness of, and access to, VA services and benefits during the de-mobilization process and as service personnel return to their local communities.

VA is also reaching out to returning veterans whose wounds may be less apparent. VA is a participant in the DOD's Post Deployment Health Reassessment (PDHRA) program. DOD conducts a health reassessment 90–180 days after return from deployment to identify health issues that can surface weeks or months after service Members return home.

VA actively participates in the administration of PDHRA at Reserve and Guard locations in a number of ways. We provide information about VA care and benefits; enroll interested Reservists and Guardsmen in the VA health care system; and arrange appointments for referred service Members. As of December 2006, an estimated 68,800 service Members were screened, resulting in over 17,100 referrals to VA. Of those referrals, 32.8% were for mental health and readjustment issues; the remaining 67.2% for physical health issues.

Congress created the Readjustment Counseling Service (RCS), commonly known to veterans as the Vet Center Program, as VHA's outreach element. Program eligibility was originally targeted to Vietnam veterans; today it serves all returning combat veterans. The Vet Center Program receives high ratings in veterans' satisfaction, employee satisfaction, and other measurable indicators of quality and effective care.

The approximate number of OEF/OIF combat veterans served by Vet Centers to date is 165,000 (119,600 through outreach; 45,400 seen at centers). In February of 2004, the Secretary of Veterans Affairs approved the hiring of 50 OEF/OIF combat veterans to support the Program by reaching out actively to National Guard, and Reserve service Members returning from combat. An additional 50 were hired in March of 2005. This action advanced the continuing success of our Vet Centers in their ability to assist our newest veterans and their families. VA Vet Centers have provided bereavement services to 900 families of fallen warriors.

VA plans to expand its Vet Center Program. We will open 15 new Vet Centers and eight new Vet Center outstations at locations throughout the Nation by the end of 2008. At that time, Vet Centers will total 232. We expect to add staff to 61 existing facilities to augment the services they provide. Seven of the 23 new centers will open this Calendar Year 2007.

In addition, as you know this week the President created an Interagency Task Force on Returning Global War on Terror Heroes (Heroes Task Force), chaired by the Secretary of Veterans Affairs, to respond to the immediate needs of returning Global War on Terror service Members. The Heroes Task Force, which had its first meeting on Tuesday, will work to identify and resolve any gaps in service for service Members. As Secretary Nicholson said, no task is more important to the VA than ensuring our heroes receive the best possible care and services.

Finally, The VA is partnering with the State VA Directors in the "State Benefits Seamless Transition Program" in which severely injured service Members can release their contact information to their home State VA Office to be educated about their State Benefits.

VA staff assigned to major MTFs are coordinating with Heroes to Hometown as a resource to provide to service Members returning to civilian life.

Mr. Chairman, this concludes my presentation. At this time, I would be pleased to answer any questions you may have.

Prepared Statement of Cynthia A. Bascetta, Director, Health Care, U.S. Government Accountability Office

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss health care and other services for U.S. military servicemembers wounded during Operation Enduring Freedom (OEF) or

Operation Iraqi Freedom (OIF).[1] On March 1, 2007, the Department of Defense (DOD) reported that over 24,000 servicemembers have been wounded in action since the onset of the two conflicts. In 2005, DOD reported that about 65 percent of the OEF and OIF servicemembers wounded in action were injured by blasts and fragments from improvised explosive devices, land mines, and other explosive devices. More recently, DOD estimated in 2006 that as many as 28 percent of those injured by blasts and fragments have some degree of trauma to the brain. These injuries often require comprehensive inpatient rehabilitation services to address complex cognitive and physical impairments. In addition to their physical injuries, OEF/OIF servicemembers who have been injured in combat may also be at risk for developing mental health impairments, such as post-traumatic stress disorder (PTSD), which research has shown to be strongly associated with experiencing intense and prolonged combat.[2]

While servicemembers are on active duty, DOD decides where they receive their care—at a military treatment facility (MTF), from a TRICARE civilian provider,[3] or at a Department of Veterans Affairs (VA) medical facility. From the OEF and OIF conflict areas, seriously injured servicemembers are usually brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to MTFs located in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center, both of which are in the Washington, D.C., area.[4] Once the servicemembers are medically stabilized, DOD can elect to send those with traumatic brain injuries and other complex trauma, such as missing limbs, to one of the four polytrauma rehabilitation centers (PRC)[5] operated by VA for medical and rehabilitative care. The PRCs are located at VA medical centers in Palo Alto, California; Tampa, Florida; Minneapolis, Minnesota; and Richmond, Virginia. While many servicemembers who receive such rehabilitative services return to active duty after they are treated, others who are more seriously injured are likely to be discharged from their military obligations and return to civilian life with disabilities.

Our work has shown that servicemembers injured in combat face an array of significant medical and financial challenges as they begin their recovery process in the DOD and VA health care systems. In light of these challenges and recent media reports that have highlighted unsanitary and decrepit living conditions at the Walter Reed Army Medical Center,[6] you asked us to discuss concerns we have identified regarding DOD and VA efforts to provide medical care and rehabilitative services for servicemembers who have been injured during OEF and OIF. Specifically, my remarks today will focus on (1) the transition of care for seriously injured OEF/OIF servicemembers—those with traumatic brain injuries or other complex trauma, such as missing limbs—who are transferred between DOD and VA medical facilities; (2) DOD's and VA's efforts to provide early intervention for rehabilitation services as soon as possible after the onset of a disability for seriously injured servicemembers; (3) DOD's efforts to screen OEF/OIF servicemembers at risk for PTSD and whether VA can meet the demand for PTSD services; and (4) the impact of problems related to military pay on injured servicemembers and their families.

My testimony is based on issued GAO work.[7] The information I am reporting today reflects the conditions facing OEF/OIF servicemembers at the time the audit work was completed and illustrates the types of problems injured servicemembers

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[1] OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations.

[2] Charles W. Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *The New England Journal of Medicine,* 351 (2004): 13–22.

[3] DOD provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care services provided at MTFs.

[4] Other MTFs that received OEF/OIF servicemembers include Brooke Army Medical Center (San Antonio, Texas), Dwight David Eisenhower Army Medical Center (Augusta, Georgia), Madigan Army Medical Center (Tacoma, Washington), Darnall Army Community Hospital (Fort Hood, Texas), Evans Army Community Hospital (Fort Carson, Colorado), and the Naval Hospital Camp Pendleton (Camp Pendleton, California).

[5] The Veterans Health Programs Improvement Act of 2004, Pub. L. No. 108–422, § 302, 118 Stat. 2379, 2383–86, mandated that VA establish centers for research, education, and clinical activities related to complex multiple trauma associated with combat injuries. In response to that mandate, VA established PRCs at four VA medical facilities with expertise in traumatic amputation, spinal cord injury, traumatic brain injury, and blind rehabilitation. A PRC addresses the rehabilitation needs of the combat injured in one setting and in a coordinated manner.

[6] See, for instance, Dana Priest and Anne Hull, "Soldiers Face Neglect, Frustration at Army's Top Medical Facility," *The Washington Post* (Feb. 18, 2007).

[7] See Related GAO Products at the end of this statement.

encountered during their healing and rehabilitation process. To complete the work for these products, we visited DOD and VA facilities, reviewed relevant documents, analyzed DOD data, and interviewed DOD and VA officials. Our work was performed in accordance with generally accepted government auditing standards.

In summary, DOD and VA have made various efforts to provide medical care and rehabilitative services for OEF/OIF servicemembers. The departments established joint programs to facilitate the transfer of injured servicemembers from DOD facilities to VA medical facilities, assess whether servicemembers will be able to remain in the military, and assign VA social workers to selected MTFs to coordinate the transfers. DOD has also established a program to screen servicemembers after their deployment outside of the United States has ended to assess whether they are at risk for PTSD. However, we found several problems in the efforts to provide health care and rehabilitative services for OEF/OIF servicemembers. For example, DOD and VA had problems sharing medical records and questions arose about the timing of VA's outreach to servicemembers whose discharge from military service was not certain. Furthermore, we found that DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need referrals for mental health evaluations receive them. Finally, problems related to military pay have resulted in overpayments and debt for hundreds of sick and injured servicemembers.

DOD and VA Have Taken Actions to Facilitate the Transfer of Servicemembers but Experienced Problems in Exchanging Health Care Information

In our June 2006 report, we found that DOD and VA had taken actions to facilitate the transition of medical and rehabilitative care for seriously injured servicemembers who were being transferred from MTFs to PRCs.[8] For example, in April 2004, DOD and VA signed a memorandum of agreement that established referral procedures for transferring injured servicemembers from DOD to VA medical facilities. DOD and VA also established joint programs to facilitate the transfer to VA medical facilities, including a program that assigned VA social workers to selected MTFs to coordinate transfers.

Despite these coordination efforts, we found that DOD and VA were having problems sharing the medical records VA needed to determine whether servicemembers' medical conditions allowed participation in VA's vigorous rehabilitation activities. DOD and VA reported that as of December 2005 two of the four PRCs had real-time access to the electronic medical records maintained at Walter Reed Army Medical Center and only one of the two also had access to the records at the National Naval Medical Center. In cases where medical records could not be accessed electronically, the MTF faxed copies of some medical information, such as the patient's medical history and progress notes, to the PRC. Because this information did not always provide enough data for the PRC provider to determine if the servicemember was medically stable enough to be admitted to the PRC, VA developed a standardized list of the minimum types of health care information needed about each servicemember transferring to a PRC. Even with this information, PRC providers frequently needed additional information and had to ask for it specifically. For example, if the PRC provider notices that the servicemember is on a particular antibiotic therapy, the provider may request the results of the most recent blood and urine cultures to determine if the servicemember is medically stable enough to participate in strenuous rehabilitation activities. According to PRC officials, obtaining additional medical information in this way, rather than electronically, is very time consuming and often requires multiple phone calls and faxes. VA officials told us that the transfer could be more efficient if PRC medical personnel had real-time access to the servicemembers' complete DOD electronic medical records from the referring MTFs. However, problems existed even for the two PRCs that had been granted electronic access. During a visit to those PRCs in April 2006, we found that neither facility could access the records at Walter Reed Army Medical Center because of technical difficulties.

DOD and VA Collaboration Is Important for Early Intervention for Rehabilitation

As discussed in our January 2005 report, the importance of early intervention for returning individuals with disabilities to the work force is well documented in voca-

[8] *GAO, VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans,* GAO–06–794R (Washington, D.C.: June 30, 2006).

tional rehabilitation literature.[9] In 1996, we reported that early intervention significantly facilitates the return to work but that challenges exist in providing services early.[10] For example, determining the best time to approach recently injured servicemembers and gauge their personal receptivity to considering employment in the civilian sector is inherently difficult. The nature of the recovery process is highly individualized and requires professional judgment to determine the appropriate time to begin vocational rehabilitation. Our 2007 *High-Risk Series: An Update* designates Federal disability programs as "high risk" because they lack emphasis on the potential for vocational rehabilitation to return people to work.[11]

In our January 2005 report, we found that servicemembers whose disabilities are definitely or likely to result in military separation may not be able to benefit from early intervention because DOD and VA could work at cross purposes. In particular, DOD was concerned about the timing of VA's outreach to servicemembers whose discharge from military service is not yet certain. DOD was concerned that VA's efforts may conflict with the military's retention goals. When servicemembers are treated as outpatients at a VA or military hospital, DOD generally begins to assess whether the servicemember will be able to remain in the military. This process can take months. For its part, VA took steps to make seriously injured servicemembers a high priority for all VA assistance. Noting the importance of early intervention, VA instructed its regional offices in 2003 to assign a case manager to each seriously injured servicemember who applies for disability compensation. VA had detailed staff to MTFs to provide information on all veterans' benefits, including vocational rehabilitation, and reminded staff that they can initiate evaluation and counseling, and, in some cases, authorize training before a servicemember is discharged. While VA tries to prepare servicemembers for a transition to civilian life, VA's outreach process may overlap with DOD's process for evaluating servicemembers for a possible return to duty.

In our report, we concluded that instead of working at cross purposes to DOD goals, VA's early intervention efforts could facilitate servicemembers' return to the same or a different military occupation, or to a civilian occupation if the servicemembers were not able to remain in the military. In this regard, the prospect for early intervention with vocational rehabilitation presents both a challenge and an opportunity for DOD and VA to collaborate to provide better outcomes for seriously injured servicemembers.

DOD Screens Servicemembers for PTSD after Deployment, but DOD and VA Face Challenges Ensuring Further PTSD Services

In our May 2006 report, we described DOD's efforts to identify and facilitate care for OEF/OIF servicemembers who may be at risk for PTSD.[12] To identify such servicemembers, DOD uses a questionnaire, the DD 2796, to screen OEF/OIF servicemembers after their deployment outside of the United States has ended. The DD 2796 is used to assess servicemembers' physical and mental health and includes four questions to identify those who may be at risk for developing PTSD. We reported that according to a clinical practice guideline jointly developed by DOD and VA, servicemembers who responded positively to at least three of the four PTSD screening questions may be at risk for developing PTSD. DOD health care providers review completed questionnaires, conduct face-to-face interviews with servicemembers, and use their clinical judgment in determining which servicemembers need referrals for further mental health evaluations.[13, 14] OEF/OIF servicemembers can obtain the mental health evaluations, as well as any necessary treatment for PTSD, while they are servicemembers—that is, on active duty—or when they transition to veteran status if they are discharged or released from active duty.

Despite DOD's efforts to identify OEF/OIF servicemembers who may need referrals for further mental health evaluations, we reported that DOD cannot provide

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[9] GAO, Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers, GAO–05–167 (Washington, D.C.: Jan. 14, 2005).

[10] We also reported on early intervention in GAO, *SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs,* GAO/HEHS–96–133 (Washington, D.C.: July 11, 1996).

[11] GAO, *High-Risk Series: An Update,* GAO–07–310 (Washington, D.C.: January 2007).

[12] *GAO, Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers,* GAO–06–397 (Washington, D.C.: May 11, 2006).

[13] Health care providers that review the DD 2796 may include physicians, physician assistants, nurse practitioners, or independent duty medical technicians—enlisted personnel who receive advanced training to provide treatment and administer medications.

[14] DOD's referrals are used to document DOD's assessment that servicemembers are in need of further mental health evaluations.

reasonable assurance that OEF/OIF servicemembers who need the referrals receive them. Using data provided by DOD,[15] we found that 22 percent, or 2,029, of the 9,145 OEF/OIF servicemembers in our review who may have been at risk for developing PTSD were referred by DOD health care providers for further mental health evaluations. Across the military service branches, DOD health care providers varied in the frequency with which they issued referrals to OEF/OIF servicemembers with three or more positive responses to the PTSD screening questions—the Army referred 23 percent, the Air Force about 23 percent, the Navy 18 percent, and the Marines about 15 percent. According to DOD officials, not all of the OEF/OIF servicemembers with three or four positive responses on the screening questionnaire need referrals. As directed by DOD's guidance for using the DD 2796, DOD health care providers are to rely on their clinical judgment to decide which of these servicemembers need further mental health evaluations. However, at the time of our review DOD had not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. Knowing these factors could explain the variation in referral rates and allow DOD to provide reasonable assurance that such judgments are being exercised appropriately.[16] We recommended that DOD identify the factors that DOD health care providers used in issuing referrals for further mental health evaluations to explain provider variation in issuing referrals. DOD concurred with the recommendation.

Although OEF/OIF servicemembers may obtain mental health evaluations or treatment for PTSD through VA when they transition to veteran status, VA may face a challenge in meeting the demand for PTSD services. In September 2004 we reported that VA had intensified its efforts to inform new veterans from the Iraq and Afghanistan conflicts about the health care services—including treatment for PTSD—VA offers to eligible veterans.[17] We observed that these efforts, along with expanded availability of VA health care services for Reserve and National Guard Members, could result in an increased percentage of veterans from Iraq and Afghanistan seeking PTSD services through VA. However, at the time of our review officials at six of seven VA medical facilities we visited explained that while they were able to keep up with the current number of veterans seeking PTSD services, they may not be able to meet an increase in demand for these services. In addition, some of the officials expressed concern because facilities had been directed by VA to give veterans from the Iraq and Afghanistan conflicts priority appointments for health care services, including PTSD services. As a result, VA medical facility officials estimated that follow-up appointments for veterans receiving care for PTSD could be delayed. VA officials estimated the delays to be up to 90 days.

Problems Related to Military Pay Have Resulted in Debt and Other Hardships for Hundreds of Sick and Injured Servicemembers

As discussed in our April 2006 testimony, problems related to military pay have resulted in overpayments and debt for hundreds of sick and injured servicemembers.[18] These pay problems resulted in significant frustration for the servicemembers and their families. We found that hundreds of battle-injured servicemembers were pursued for repayment of military debts through no fault of their own, including at least 74 servicemembers whose debts had been reported to credit bureaus and private collections agencies. In response to our audit, DOD officials said collection actions on these servicemembers' debts had been suspended until a determination could be made as to whether these servicemembers' debts were eligible for relief.

Debt collection actions created additional hardships on servicemembers by preventing them from getting loans to buy houses or automobiles or pay off other debt, and sending several servicemembers into financial crisis. Some battle-injured servicemembers forfeited their final separation pay to cover part of their military debt,

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[15] In our review we analyzed computerized data provided by DOD to identify 178,664 OEF/OIF servicemembers who were deployed in support of OEF/OIF from October 1, 2001, through September 30, 2004, and who have since been discharged or released from active duty. These servicemembers had answered the four PTSD screening questions on the DD 2796 and had a record of their completed questionnaire available in a DOD computerized database. We found that DOD data indicated 9,145 of the 178,664 servicemembers in our review may have been at risk for developing PTSD.

[16] The John Warner National Defense Authorization Act for Fiscal Year 2007 required DOD to develop guidelines for mental health referrals, as well as mechanisms to ensure proper training and oversight, by April 2007. Pub. L. No. 109–364, § 738, 120 Στατ. 2083, 2303–4.

[17] GAO, *VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services,* GAO–04–1069 (Washington, D.C.: Sept. 20, 2004).

[18] GAO, *Military Pay: Military Debts Present Significant Hardships to Hundreds of Sick and Injured GWOT Soldiers,* GAO–06–657T (Washington, D.C.: April 27, 2006).

and they left the service with no funds to cover immediate expenses while facing collection actions on their remaining debt.

We also found that sick and injured servicemembers sometimes went months without paychecks because debts caused by overpayments of combat pay and other errors were offset against their military pay.[19] Furthermore, the longer it took DOD to stop the overpayments, the greater the amount of debt that accumulated for the servicemember and the greater the financial impact, since more money would eventually be withheld from the servicemember's pay or sought through debt collection action after the servicemember had separated from the service.

In our 2005 testimony about Army National Guard and Reserve servicemembers, we found that poorly defined requirements and processes for extending injured and ill reserve component servicemembers on active duty have caused servicemembers to be inappropriately dropped from active duty.[20] For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these servicemembers and their families.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

Contacts and Acknowledgments

For further information about this testimony, please contact Cynthia A. Bascetta at (202) 512–7101 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Michael T. Blair, Jr., Assistant Director; Cynthia Forbes; Krister Friday; Roseanne Price; Cherie' Starck; and Timothy Walker made key contributions to this statement.

Related GAO Products

High-Risk Series: An Update. GAO–07–310. Washington, D.C.: January 2007.

VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans. GAO–06–794R. Washington, D.C.: June 30, 2006.

Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers. GAO–06–397. Washington, D.C.: May 11, 2006.

Military Pay: Military Debts Present Significant Hardships to Hundreds of Sick and Injured GWOT Soldiers. GAO–06–657T. Washington, D.C.: April 27, 2006.

Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members. GAO–06–362. Washington, D.C.: March 31, 2006.

Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers. GAO–05–322T. Washington, D.C.: February 17, 2005.

Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers. GAO–05–167. Washington, D.C.: January 14, 2005.

VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services. GAO–04–1069. Washington, D.C.: September 20, 2004.

SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs. GAO/HEHS–96–133. Washington, D.C.: July 11, 1996.

(290621)

GAO HIGHLIGHTS

DOD AND VA HEALTH CARE

Challenges Encountered by Injured Servicemembers During Their Recovery process

Why GAO Did This Study

As of March 1, 2007, over 24,000 servicemembers have been wounded in action since the onset of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), according to the Department of Defense (DOD). GAO work has shown that servicemembers injured in combat face an array of significant medical and financial

[19] We found that after voluntary allotments and other required deductions, many times there was no net pay due the servicemember.

[20] GAO, *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers,* GAO–05–322T (Washington, D.C.: Feb. 17, 2005).

challenges as they begin their recovery process in the health care systems of DOD and the Department of Veterans Affairs (VA).

GAO was asked to discuss concerns regarding DOD and VA efforts to provide medical care and rehabilitative services for servicemembers who have been injured during OEF and OIF. This testimony addresses (1) the transition of care for seriously injured servicemembers who are transferred between DOD and VA medical facilities, (2) DOD's and VA's efforts to provide early intervention for rehabilitation for seriously injured servicemembers, (3) DOD's efforts to screen servicemembers at risk for post-traumatic stress disorder (PTSD) and whether VA can meet the demand for PTSD services, and (4) the impact of problems related to military pay on injured servicemembers and their families.

This testimony is based on GAO work issued from 2004 through 2006 on the conditions facing OEF/OIF servicemembers at the time the audit work was completed.

What GAO Found

Despite coordinated efforts, DOD and VA have had problems sharing medical records for servicemembers transferred from DOD to VA medical facilities. GAO reported in 2006 that two VA facilities lacked real-time access to electronic medical records at DOD facilities. To obtain additional medical information, facilities exchanged information by means of a time-consuming process resulting in multiple faxes and phone calls.

In 2005, GAO reported that VA and DOD collaboration is important for providing early intervention for rehabilitation. VA has taken steps to initiate early intervention efforts, which could facilitate servicemembers' return to duty or to a civilian occupation if the servicemembers were unable to remain in the military. However, according to DOD, VA's outreach process may overlap with DOD's process for evaluating servicemembers for a possible return to duty. DOD was also concerned that VA's efforts may conflict with the military's retention goals. In this regard, DOD and VA face both a challenge and an opportunity to collaborate to provide better outcomes for seriously injured servicemembers.

DOD screens servicemembers for PTSD but, as GAO reported in 2006, it cannot ensure that further mental health evaluations occur. DOD health care providers review questionnaires, interview servicemembers, and use clinical judgment in determining the need for further mental health evaluations. However, GAO found that 22 percent of the OEF/OIF servicemembers in GAO's review who may have been at risk for developing PTSD were referred by DOD health care providers for further evaluations. According to DOD officials, not all of the servicemembers at risk will need referrals. However, at the time of GAO's review DOD had not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. Although OEF/OIF servicemembers may obtain mental health evaluations or treatment for PTSD through VA, VA may face a challenge in meeting the demand for PTSD services. VA officials estimated that follow-up appointments for veterans receiving care for PTSD may be delayed up to
90 days.

GAO's 2006 testimony pointed out problems related to military pay have resulted in debt and other hardships for hundreds of sick and injured servicemembers. Some servicemembers were pursued for repayment of military debts through no fault of their own. As a result, servicemembers have been reported to credit bureaus and private collections agencies, been prevented from getting loans, g1 months without paychecks, and sent into financial crisis. In a 2005 testimony GAO reported that poorly defined requirements and processes for extending the active duty of injured and ill reserve component servicemembers have caused them to be inappropriately dropped from active duty, leading to significant gaps in pay and health insurance for some servicemembers and their families.

Prepared Statement of Shane McNamee, MD, Director, Hunter Holmes McGuire Richmond Veterans Affairs Medical Center, Richmond, VA, U.S. Department of Veterans Affairs

Good afternoon, Mr. Chairman and Members of the Committee. Thank you for the opportunity to discuss the transition of our Wounded Heroes through the Veterans Health Administration. My name is Dr. Shane McNamee and I will be testifying from the perspective of a clinician as well as in my role as the Medical Director of the Richmond Polytrauma program. To frame the issue appropriately I will describe the typical transition process of severely Wounded Heroes and their families from the Military Treatment Facilities (MTF), through our programs and into commu-

nities. It is my firm belief that this highly coordinated, effective system is unparalleled in this Nation's medical system for those who have suffered a Traumatic Brain Injury (TBI).

The key concepts of Seamless Transition I will be discussing are as follows:

1. The significance of medical record access across the continuum of care;
2. The importance of Relationship Based Medicine: and
3. The recognition of the Family as part the injury complex, and integration of family into the therapeutic plan of care.

Our four Polytrauma Rehabilitation Centers (PRC) are consulted by the MTFs when a Wounded Hero screens positive for a TBI. The referrals that come to Richmond are processed by our Nursing Admissions Coordinator. Following collection and analysis of clinical and family information, we provide the MTF a decision on the referral within twenty 4 hours of DOD's request for referral. At the earliest possible time the family Members of the severely wounded are contacted by myself, the Nursing Admissions Coordinator and the Social Worker assigned to the case. This step has proved essential for several reasons. For the family, the transition of a Wounded Hero between medical facilities creates anxiety due to the unknown. Importantly, this contact provides an early opportunity to build a relationship with key family Members. This relationship with the patient and family Members forms the basis of successful rehabilitation. The family also serves as an invaluable resource in the recognition of personality and cognitive changes that are common after TBI.

Numerous systems are used to develop an individualized plan of care prior to admission to our PRC. Medical records are obtained through our direct access of Walter Reed Army Medical (WRAMC) and Bethesda national Naval Medical Center. Up to date information about medications, laboratory studies, results of imaging studies and daily progress notes are reviewed to determine the individual case parameters. We access the web based Joint Patient Tracking Application (JPTA) to gain further understanding of the patient's clinical status. Specifically the field notes from Balad, Iraq and follow up at Landstuhl, Germany are indispensable in determining the severity of the TBI. Our Nursing Admissions Coordinator also obtains specific documentation through the VA/DOD liaison personnel stationed at both WRAMC and Bethesda. As Medical Director, I contact the referring physicians and discuss the particulars of the case. Our facilities have scheduled Video Teleconferences (VTC) to discuss the referral and to meet the Wounded Hero and family Members "face to face". These tools are essential in developing an intensive, individualized rehabilitation medicine plan for each Wounded Hero before admission. This also includes the coordination of resources necessary for the family; including housing, transportation, meals and psychosocial supports.

Upon admission to our facility, each Member of our rehabilitation team individually evaluates the Wounded Hero within twenty 4 hours and pays particular attention to the functional needs. Our team consists of a Physiatrist (Rehabilitation Physician), Rehabilitation Nurses, Physical Therapists, Occupational Therapists, Speech and Language Pathologists, Recreation Therapists, Kinesiotherapists, Neuropsychologists, Psychologists, Dieticians, Social Work/Case Managers (SW/CM), Military Liaisons and Blind Rehabilitation Therapists. Our team meets three times weekly to discuss each patient and to continually adjust the therapeutic plan of care. Each patient undergoes three to 6 hours of therapy each day tailored specifically to their individual functional and cognitive needs. We actively work to reinstitute the roles that previously defined activities of our Wounded Heroes.

As mentioned earlier, it is not just an individual who suffers a TBI. Rather, the entire family structure is affected and requires attention. The literature relating to TBI is very clear on the fact that those individuals with strong psychosocial support structures are more successful over time. Our support is multimodal and includes health information through site specific literature, informal education sessions, a formalized lecture series and intensive discharge planning. Traditionally we provide professional support, emotional support, logistical support, involvement in the care processes and the support of the Military Liaison Officer. To further support the families, we have instituted a pager and cell phone that are covered 24 hours a day by Members of our Social Work team. This allows yet another level of support of our families. Importantly, in a very real sense, the family Members become an integral part of our team. This programming serves to educate the family Members, decrease their anxiety of the unknown and prepare them to care for their loved one over time.

In recognition of this need we have developed a model of care appropriately referred to as Relationship Based Medicine. We have found that it is the relationships with those involved in the continuum of care that drives the success. Initially, we intensively work with the families and patients to gain their trust and instill the

recognition that we are on their side. Once this level of trust has been established, we can develop an effective treatment plan and approach. It is important to point out that this relationship does not end once discharged from our facility. Patients are followed at regular intervals by the SW/CM staff along with the Physiatrist.

Intensive discharge planning is the cornerstone of any successful rehabilitation plan. Our discharge plans are initiated the moment a patient is admitted to the facility. On a weekly basis we discuss the discharge needs and timelines necessary for success. These are communicated with the families and aligned with their needs. Once a discharge disposition is provided by the family, we begin to contact necessary resources in their community. Based upon location, a consult is opened either with one of the Polytrauma Network Sites (PNS) or appropriate level of private care within the patient's community.

The consultation process includes a VTC or teleconference between our team, the consulting team, the family and patient. These conferences allow for a smooth handoff of the plan of care and specific questions. Because many patients are still an Active Duty Service Member, the Military Case Managers (MCM) are responsible to obtain authorizations from the Military regarding orders and follow up care based upon our team's recommendations.

Each family and patient is trained prior to discharge in medical and nursing care appropriate for the patient. At the time of discharge each of them are encouraged to evaluate our system. Their recommendations for improvement are always implemented if possible. After discharge our SW/CM follows each patient at prescribed intervals. As the Medical Director, I continue to follow their medical issues from afar and advocate for them when appropriate.

The integrated transition plan of care from MTF to PRC and into the community is paramount in the success of our Wounded Heroes and families. The system set up throughout VA is world class and has no equal for those suffering from TBI. Across the system we continually monitor and incorporate improvements. I am proud to be a part of the exceptional rehabilitation staff who are fully dedicated in their mission to serve those who have sacrificed so much.

Thank you Mr. Chairman and members of the Committee for your time.

Prepared Statement of Steven G. Scott, M.D., Medical Director, Tampa Polytrauma Rehabilitation Center, James A. Haley Veterans' Hospital, Tampa, FL, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss our experience as it relates to the "Service Members Seamless Transition into Civilian Life—our Hero's Return." My name is Dr. Steven Scott and I have been a specialist in Physical Medicine and Rehabilitation since 1980. I have been employed at the James A. Haley Veterans Hospital in Tampa, Florida since 1990 and have directed both the spinal cord and traumatic brain injury (TBI) programs.

Polytrauma Rehabilitation Care

I would like to provide you with a brief history of the development of polytrauma rehabilitation care. In the summer of 2003, we began to receive these unique patients who had been evacuated from the battlefield following Improvised Explosive Device (IED) blast injury. Due to tremendous advancements in military care, we now have the opportunity to rehabilitate young men and women who in years past would not have survived. These patients are medically complex and have sustained numerous injuries which are complicated by serious TBI. The primary focus of the polytrauma system of care has been to provide rehabilitation care to the most seriously injured. A typical patient has TBI, vision and/or hearing loss, pain, wounds, burns and orthopedic problems (including amputations). We deal with extended families in crisis, including spouses, children of all ages, parents, siblings as well as other care givers. The stress and sacrifice of the family frequently takes its toll, sometimes resulting in conflict and serious marital issues.

The complexity of injuries to these combat veterans was unlike those seen previously. The unique needs of these patients required rapid realignment of our delivery of care to routinely include a multidisciplinary team of medical specialists. In addition to our team of physiatrists or physicians who specialize in physical medicine and rehabilitation, we also have specialists in surgery, neurosurgery, internal medicine, psychiatry, infectious disease, prosthetics, orthotics, and spinal cord injury as part of the day-to-day planning and patient care. Physiatrists also lead an interdisciplinary rehabilitation team consisting of physical therapists, occupational thera-

pists, speech therapists, rehabilitation nurses, kinesiotherapists, vocational therapists, social workers, neurophysiologists, psychologists, advance nurse practitioners, wound care nurses, respiratory therapists, recreational therapists, rehabilitation counselors, military liaisons, chaplains, blind occupational therapy case managers, physical therapy amputee case managers, social worker case managers, education specialist and veteran benefit specialist. Each one of these medical specialties and health care disciplines has specialized expertise in caring for the polytrauma patient and family and are essential to be sure that their comprehensive care results in excellent outcomes.

Transition Between DOD and VA Polytrauma

As we developed the program, it became essential to establish a mechanism to exchange medical information. Initially we established physician to physician phone conferences to National Naval Medical Center in Bethesda, Maryland, and at the Walter Reed Army Medical Center (WRAMC) in Washington, DC. Videoconferencing with patient and family Members in attendance was established with Brooke Army Medical Center in San Antonio, Texas, and the National Naval and WRAMC. A military treatment referral form is completed by the military and sent to the on-site case manager DOD–VA military liaison social worker. This form initiates the referral to the Polytrauma System of Care. Medical record exchanges occurred between the Tampa VA and the military treatment facilities (MTFs). This was a new practice for us, and we have progressively improved the process. We continue to work on improvements in the transfer of radiological images and microbiology lab results. The VA Polytrauma Rehabilitation Centers (PRCs) have been an active participant in the video-conference Trauma Continuum of Care with the DOD which established improved practices in the care and transportation of trauma patients. In addition, we were able to connect to the Patient Joint Tracking System allowing us to get more detailed medical information.

Most polytrauma patients remain on active duty during their entire stay at the Tampa PRC. Therefore, ongoing information sharing between VA PRCs and DOD is necessary. The military liaison assigned to the PRC assists the patient and family with military issues and assists with the maintenance of non-medical attendant orders which pay for family Members to stay at the bedside. Patients are frequently referred back to the MTF for follow-up surgery or placement in medical hold.

Polytrauma Focus on Transition

A military greeting team and case manager meets the patient and family on arrival in Tampa. Community volunteers arrange free housing and transportation to families through the Haley House Fund. Our 7-day-week program for both patients and families always has community reentry as its primary goal. Our staff and volunteers provide family education classes, family support groups and planned family activities such as "Spouses' Day Out", trips to NASA, and so forth. Our Internet café provides activities outside structured therapy time. Recreational therapy provides community re-entry activities such as shopping and recreational activities. The patient and family advance in their rehabilitation to have day passes and eventually weekend overnight passes to practice their independence in community settings.

Transition to Home

The first step for our more independent patients is the Polytrauma Transitional Day Program. The patient and family move into private housing in the Tampa Bay area and continue to participate in group and individual therapies for three to 6 months or more depending on their needs. A comprehensive work therapy program places individuals in community jobs to help develop vocational skills. If the patient transitions to veteran status, he or she can become a candidate for the Chapter 31 Independent Living Benefits.

When the active duty individual is prepared to leave Tampa, our rehabilitation team and the patient and family meet to exchange information by video conferences with the Polytrauma Network site closest to the patient's home. Our case managers continue to follow the patient and family via phone and work closely with the MTF case manager on appropriate follow-up. The Network Site case manager and team provide progress reports to the Tampa VA on a monthly basis via video conferencing. Most patients are transitioned to home as active duty and may continue as such for up to one to 2 years. As active duty service Members, additional authorization numbers are required by Tri-Care for continued rehabilitation therapies and medical care. Patients are encouraged to return to the Tampa Polytrauma Outpatient Program at any time.

Conclusion

I am honored to serve these courageous young men and women and their families. I look forward to working with DOD, Congress, our VA leaders, advocacy groups, and private citizens to continue to provide excellent care and to improve future care throughout the lifespan for America's wounded heroes.

Prepared Statement of William F. Feeley, MSW, FACHE, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration, U.S. Department of Veterans Affairs

Good afternoon Mr. Chairman and Members of the Committee.

Thank you for this opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to improve the quality of care we provide to veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom. VHA is committed to providing comprehensive, quality primary and specialty care to all enrollees with an emphasis on meeting the specialized needs of OEF/OIF veterans. As Secretary Nicholson said on Wednesday, we must ensure that our heroes receive the best possible care and services. The VHA stands ready to do everything we can to provide top-quality health care to all returning OEF and OIF veterans. My comments will focus on the operational or facility based aspect of our efforts.

Access to Care

Recent publications have acknowledged that VA provides veterans with the best health care anywhere. Ensuring veterans have timely access to that quality VA care is equally important.

VHA monitors how long veterans must wait for appointments, including the time it takes for an OEF/OIF veteran to be seen. The waiting times are reported every 2 weeks and are a highly visible item for senior officials. Waiting times are a key performance element in Network and Facility Directors' performance plans.

VHA has employed System Improvement Strategies in recent years to reduce clinic wait times and help us ensure that our clinic processes are as efficient as possible.

Some examples of these innovations are as follows:

- Group Health Counseling in the dietetic area for diabetic and congestive heart failure;
- Extended hours in clinics, including Saturday clinics; and
- Normal Lab and x-ray reporting via phone rather than requiring the patient to make a return visit to the medical center.

Polytrauma Centers

In order to meet the needs of our most severely injured veterans, VA has created a Polytrauma System of Care which involves a tiered approach to providing care for seriously injured veterans returning from operations in Iraq and Afghanistan.

There are four tiers of acuity in the polytrauma system of care in VHA. Level I consists of four centers that provide acute comprehensive medical and rehabilitation care for complex and severe polytraumatic injuries. They maintain a full staff of dedicated rehabilitation professionals and consultants from other specialties related to polytrauma. The centers serve as resources for other VA facilities and are active in the development of educational programs and best practice models of care.

These four level one centers are located in:

- Tampa, FL
- Richmond, VA
- Minneapolis, MN and
- Palo Alto, CA

Each Level I center has social work case managers at a ratio of one for every six patients. These case managers assess the psychosocial needs of each patient and family, match treatment and support services to meet identified needs, coordinate services, and oversee the discharge planning process. The social work case managers associated with the center ensure that the combat wounded and their families receive intensive clinical and psychosocial case management and coordination of the veterans lifelong care needs.

The Level I centers offer a therapeutic environment that reflects the preferences and needs of the combat injured. Resources have been assembled nationally and locally to meet the special needs of families who accompany the seriously injured serv-

ice Members to the center. Such resources include lodging at Fisher Houses or hotel accommodations where a Fisher House is not yet available, transportation, telephone cards, and gift certificates for meals and entertainment.

Patient improvement is assessed using a standardized instrument that measures functional improvement from admission to discharge.

VHA also recognizes the severely injured may require extensive rehabilitative therapy to successfully integrate back into the community. To that end, the Department will develop four Residential Transitional Rehabilitation Programs co-located with the Level I Polytrauma Rehabilitation Centers. The activation date for these four new Residential Transitional Rehabilitation programs is July 2007. A transitional rehabilitation program is time limited and goal oriented to improve the patient's physical, cognitive, communicative, behavioral, psychological and social functioning under the necessary support and supervision. The goal of these programs is to return these patients to the least restrictive environment including, return to active duty, work and school or independent living in the community.

Level II sites provide services for veterans who do not require the intensity of care provided in Level I centers. These sites are responsible for coordinating lifelong rehabilitation services for patients within their network. Level II sites provide a high level of expert care, a full range of clinical and ancillary services, and serve as resources for other facilities within their Network. They provide continued management of patients referred from the Level I Polytrauma sites and evaluate patients referred directly to the Level II sites. Services include proactive case management as well as patient family support and education. They also consult, whenever necessary, with the level I sites through the use of telerehabilitation technologies.

Level III sites have teams of providers with rehabilitation expertise to deliver follow up services in consultation with regional and network specialists. Level III support teams treat patients with a stable treatment plan, provide regular follow-up visits, and respond to new problems that may emerge. They regularly consult with level I and II sites.

Level IV sites have at least one person identified to serve as a central referral point for consultation, assessment and referral of polytrauma patients to a facility capable of providing the level of services required. They work closely with level I and level II centers.

This extensive Polytrauma network was created to adapt VHA's existing health care system to provide care for the severely wounded and meet their complex rehabilitative needs. Each Network has a Level I or Level II center. VHA will continue to assess its Polytrauma services and adapt its approach to care for those brave men and women returning from combat.

This concludes my statement. I will be happy to answer any questions you may have.

Prepared Statement of Edward C. Huycke, MD, Chief, Department of Defense Coordination Officer, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and distinguished Members of the committee, thank you for the opportunity to speak to you about the progress the Department of Veterans Affairs (VA) and the Department of Defense (DOD) have made in improving the delivery of health care and benefits to our Nation's veterans. Improving the transition from military to civilian life for veterans and their families is a high priority at VA and I am pleased to be here today to provide you with an overview of the programs and initiatives that VA and DOD have implemented to improve coordination between our two systems.

Seamless Transition of Care and Benefits

Veterans Health Administration (VHA) staff coordinated the transfer of care for more than 6,800 injured or ill active duty members and veterans from DOD to VA—specifically those injured or ill as part of the Global War on Terrorism in Iraq and Afghanistan and in particular those transitioning directly from DOD Military Treatment Facilities (MTFs) to VA Medical Centers (VAMCs).

And in partnership with DOD, VA has implemented a number of strategies and innovative programs to provide the timely, appropriate, and seamless services to the most seriously injured Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) active duty Members and veterans. One such program enables active duty

Members to register for VA health care and initiate the process for benefits prior to separation from active service.

The centerpiece program supporting the seamless transition of seriously injured service Members and veterans involves the placement of VA Social Work Liaisons, VA Benefit Counselors, and Outreach Coordinators at MTFs to educate service Members about VA services and benefits. These VA employees assist active duty service members during their transfer to VA medical facilities and ensure that returning service Members receive information about VA benefits and services. Currently, VA Social Work and Benefit liaisons are located at 10 MTFs including Walter Reed Army Medical Center (WRAMC), National Naval Medical Center Bethesda (NNMC), Naval Medical Center San Diego and Womack Army Medical Center at Ft. Bragg, North Carolina.

In addition to the social work and benefits liaisons, a VA Certified Rehabilitation Registered Nurse (CCRN) was assigned to WRAMC in September 2006 to assess and provide regular updates to the VA Polytrauma Rehabilitation Centers (PRC) to which they may be transferred on the medical condition of the patient, educate families about VA benefits and services and prepare the active duty servicemember for transition to the rehabilitation phase of recovery.

Once the MTF treatment team notifies VHA of its plan to transfer the patient, the VA Social Work Liaisons and the CCRN begin to coordinate the care and information prior to transfer to VA. The VHA Social Worker Liaison begins meeting with the patient and/or family to educate them about the patient's transition from DOD's health care system to VA's health care system. The VHA Social Work Liaison also registers the active duty service Member or enrolls the recently discharged veteran into the VA health care system, and begins the process of coordinating a transfer to the VA health care facility most appropriate for the services they need or for a location closest to home. In the case of a polytrauma patient transfer, both the CCRN and the Social Work Liaison remain an integral part of the treatment team at the MTF while providing input into the VHA care plan and collaborating with the patient and family throughout the remainder of the health care transition process.

VA case management for these patients begins at the time of transition from the MTF and continues as their medical and psychological needs dictate. Once the patient is transferred to the receiving VAMC or reports to his/her home VAMC for care, the VHA Social Worker Liaison at the MTF follows up with the receiving VAMC to address any issues and to ensure the patient is attending appointments. Patients with severe injuries or those who have complex needs will receive ongoing case management at the VAMC where they receive most of their care.

An important aspect of the coordination of care between DOD and VA prior to transfer is access to clinical information including the viewing of electronic medical information using remote access capabilities. Video teleconference calls are routinely conducted between the DOD MTF treatment team and the receiving VA PRC enabling a face-to-face discussion of a polytrauma patient's care prior to transfer. If feasible, the patient and family may attend a video teleconference in order to meet the team at the receiving VA PRC. Utilizing the Bidirectional Health Information Exchange (BHIE), VA and DOD clinicians are able to share text-based clinical data from WRAMC and NNMC, the two MTFs that refer the majority of the polytrauma patients. In addition, VA clinicians at the four Polytrauma Rehabilitation Centers (PRCs)have access to DOD's Joint Patient Tracking Application (JPTA) which tracks service Members from the battlefield through Landstuhl, Germany and to MTFs in the states. JPTA provides demographic and clinical information vital for the continued care and treatment of these severely injured service Members.

In addition to the transition of health care, Veterans Benefits Administration (VBA) counselors assigned to MTFs provide VA benefits information and assistance in applying for these benefits. These counselors are often the first VA representatives to meet with the service member and his or her family to provide information about the full range of VA services including readjustment programs, and educational and housing benefits. Service Members and their families are assisted in completing their claims and in gathering supporting evidence.

While service Members are hospitalized, they are routinely informed about the status of pending claims and given the VBA counselor's name and contact information should they have any questions or concerns. Compensation claims taken for the seriously disabled are expedited to the appropriate VA Regional Office (VARO) with a clear indication that they are for an OIF/OEF seriously disabled claimant. Although benefits are not payable prior to discharge from service, work may begin on the claim, and service Members may be informed about the status of their claim while they are hospitalized.

Each VAMC and VARO has designated a point of contact (POC) to coordinate activities locally and to assure that the health care and benefits needs of returning service Members and veterans are met. A VBA OIF/OEF Coordinator is designated for all OIF/OEF outreach activities and acts as the primary VBA point of contact for seriously disabled servicemembers who first arrive in the RO's area of jurisdiction as medical patients. For each compensation claim received for a seriously disabled OIF/OEF servicemember, a VBA Case Manager is also assigned. The Case Manager then becomes the primary VBA point of contact for claims processing. The VBA Counselors at the MTF may continue to be involved if the servicemember is still a patient at the MTF.

VA has distributed guidance to field staff to ensure that the roles and functions of the POCs and case managers are fully understood and that proper coordination of benefits and services takes place at the local level.

VAMCs also host DOD representatives. In March 2005, the Army assigned full time active duty liaison officers to the four VA PRCs located at Tampa, FL; Richmond, VA; Minneapolis, MN; and Palo Alto, CA. The Army Liaison Officer supports service members and their families from all branches of the Service with a broad array of issues such as travel, housing, military pay, and movement of household goods. In addition, Marine Corps representatives from nearby local Marine commands visit and provide support to each of the four PRCs. In the VA Central Office, an active duty Marine Officer and an Army Wounded Warrior representative are assigned to and are part of the VA Office of Seamless Transition staff. All of the DOD liaisons have played a vital role in ensuring the provision of a bridge to services during the critical time of recovery and rehabilitation.

Recognizing the need to provide assistance and support to families during the tumultuous time of transition, VA established a PolytraumaCall Center in February 2006 to assist our most seriously injured combat veterans and service Members. The Call Center is operational 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and their families. The Call Center provides patients and families with a source of information, enhances coordination of care, and elevates system problems to VA for resolution.

Post Deployment Health Reassessment

VA is also reaching out to returning veterans whose wounds may be less apparent. VA is participating in the DOD's Post Deployment Health Reassessment (PDHRA) program for returning deployed service Members. In addition to DOD's pre- and post-deployment assessments, DOD is now conducting an additional health reassessment 90 to 180 days after returning home from deployment to identify health issues that may surface weeks or months after service Members return home. VA is actively participating in the administration of PDHRA at Reserve and Guard locations by providing information on VA care and benefits, by enrolling these Reservists and Guardsmen in the VA healthcare system and by arranging appointments for referred service Members. As of December 2006, an estimated 68,800 service Members were screened resulting in more than 17,100 referrals to VA. Of the referrals, 32.8% were for mental health and readjustment issues with the remaining 67.2% for physical health issues.

Closing

Meeting the comprehensive health care and benefit needs of our Nation's veterans is VA's highest priority. We are very proud of the progress we have made in the area of seamless transition as recognized by both the IG and GAO. Mr. Chairman, this concludes my statement. I thank you and Members of this Committee for your outstanding and continued support of our service members, veterans and their families.

Prepared Statement of Ira R. Katz, MD, PhD, Deputy Chief Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the ongoing steps that the Department of Veterans Affairs (VA) is taking in order to meet the mental health care needs of our Nation's returning veterans.

Care for Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans is among the highest priorities in VA's mental health care system. For these veterans, VA has the opportunity to apply what has been learned through research and clinical experience about the diagnosis and treatment of mental health

conditions; to intervene early; and to work to prevent the chronic or persistent courses of illnesses that have occurred in veterans of prior eras.

Since the start of the Global War on Terror (GWOT) until the end of FY 2006, over 631,000 veterans have been discharged. Approximately 32.5 percent have sought care from the Veterans Health Administration (VHA) medical facilities, and, of these, 35.7 percent have had diagnosis of a possible mental health condition or concern. This makes mental health second only to musculoskeletal conditions among the classes of conditions seen most frequently in these returning veterans.

Somewhat less than half of the returning veterans with a mental health condition who are seen in our medical facilities have a possible diagnosis of post-traumatic stress disorder (PTSD), making it the most common of the mental health conditions. However, PTSD is not the whole story. Among the diagnosable conditions, mood disorders as a group, when added together, are more common. Moreover, many veterans experience non-specific stress-related symptoms that may be viewed more appropriately as normal reactions to abnormal situations in combat, rather than any disorder.

In response to the growing numbers of veterans returning from combat in OIF/OEF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning service Members at military demobilization and National Guard and Reserve sites. Through its community outreach and coordination efforts, the Vet Center program also provides access to other VHA and Veterans Benefits Administration (VBA) programs. To augment this effort, the Vet Center program first recruited and hired 50 OEF/OIF veterans in February 2004 to provide outreach to their fellow veterans. An additional 50 were hired by March of 2005. When outreach leads to identification of mental health conditions, veterans have a choice. They may receive care in Vet Centers, medical facilities, or both. Last week Secretary Nicholson announced plans to hire an additional 100 OEF/OIF veterans to conduct outreach at both Vet Centers and VA medical facilities.

VA's approach to PTSD is to promote early recognition of this condition for those who meet formal criteria for diagnosis and those with partial symptoms. The goal is to make evidence-based treatments (i.e., psychological, pharmacological, and rehabilitative) available early to prevent chronicity and lasting impairment.

Throughout VHA, there is a sense of urgency about reaching out to OIF/OEF veterans, engaging them in care, screening them for mental health conditions, and making diagnoses, when appropriate. Screening veterans for PTSD and other stress related conditions is a necessary first step toward helping veterans recover from the psychological wounds of war. In cases where there is a positive screen, patients are further assessed and referred to mental health providers for further follow-up and treatment, as necessary.

We recognize that even in America in 2007, there can still be some degree of stigma associated with mental health conditions and their treatment. That is why VA offers a number of options, for example for care in mental health specialty services, Vet centers, or, increasingly for mental health services provided in primary care settings. When veterans with severe symptoms are reluctant to enter care, we are prepared to educate them and their families, and to work with them to overcome resistances. When veterans with milder symptoms are reluctant, we watch them over time, and urge treatment if symptoms persist or worsen.

VA has been a leader in research as well as clinical services for PTSD. Last week, the Journal of the American Medical Association (JAMA) included an article describing the benefits of a specific behavioral treatment for PTSD. Before the results were even published, VHA was establishing training programs to make this intervention available to our patients. The translation from research into clinical practice will not be instantaneous, but it can be accomplished more rapidly in VA than in any other clinical setting.

Thank you, again, Mr. Chairman, for the opportunity to be here.

U.S. Department of Veterans Affairs
Washington, DC, 20420
March 7, 2007

The Hon. Ginny L. Brown-Waite
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Brown-Waite:

In the past few weeks, questions have been raised about the ability of the Department of Defense (DOD) and the Department of Veterans Affairs (VA) to provide the world-class health care our service members and veterans earned through their service and sacrifices. Many of these questions are focused on conditions at Walter Reed Army Medical Center, a DOD facility. Concerns have also been raised about VA's ability to care for our returning Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans. So, I am writing to tell you what VA did, is doing, and will do in the future to care for these heroes, who share the honored title of "American veteran."

VA provides exceptional health care for veterans at more than 1,400 locations throughout our Nation. This year, we estimate more than 5.8 million patients will be cared for at our 154 hospitals, 135 nursing homes, 45 domiciliaries, and 881 outpatient clinics. Approximately 209,000 of those veterans will have served in Iraq or Afghanistan. The VA health care system is rated by many as the best health care system in the country and a failure to provide our absolute best to even one veteran is inexcusable.

I will not tolerate conditions within the facilities of the Department of Veterans Affairs that do not meet our high standards. I directed that all facilities for which I am responsible be inspected by management to assure that they are up to par. Moreover, I directed that VA focus all possible resources on providing priority service to our returning OIF/OEF veterans and streamlining their access to that service.

I am concerned some service Members may not have experienced a seamless transition as they move from active military service to care administered by VA. Often that transition takes a severely injured service member from a military treatment facility (MTF) to a VA polytrauma center, which is equipped to deal with the multiple injuries we see in those patients, to include traumatic brain injury (TBI) and amputations. The transition also includes the service Member's move from the polytrauma center to his or her home, which may be distant from our facilities. If even one of these young men or women does not receive needed care, that is one too many, and we will do all within our power to ensure such a situation is rectified.

Toward that end, I would like to tell you about a number of changes I directed to further improve the way VA provides health care to these heroes:

- We expanded our network of polytrauma centers from the original 4 to 1 in each of our 21 Veterans Integrated Service Networks. Enclosed is an information paper describing our Polytrauma System of Care.
- All VA health care professionals are being trained to recognize and care for patients with TBI.
- We will be screening all patients who served in the combat theater of operations for TBI and post-traumatic-stress disorder (PTSD).
- Every VA medical center now has specialty PTSD treatment capability.
- We are adding 23 new Vet Centers to our existing 209, each with the professional capacity to intervene on PTSD and other mental health issues.
- We will engage a panel of outside clinical experts to review and evaluate our Polytrauma System of Care.
- We will establish a VA Advisory Committee on OIF/OEF Veterans and Their Families. Membership will include severely wounded combat veterans who have experienced VA care, family Members and care givers of wounded veterans, and survivors. They are to help us identify where we can, and must, do better.

Earlier this week, 1 directed that each of our polytrauma patients be provided an advocate who will Work with that patient and his or her family to ensure everything possible is done to minimize the strains on the family and to assist them in navigating the VA system of care and benefits. To expedite this, I directed the hiring of 100 additional people, most of whom will be veterans of the Global War on Terror, to be the personal advocates for these severely injured young men and women and their families. These advocates will be available to the veterans and their families around the clock, whether the patients are at polytrauma centers, other VA medical facilities or their homes.

As service Members leave active duty, many will receive VA disability compensation for injuries received. Since the onset of combat operations in Iraq and Afghanistan, VA has expedited the claims of seriously injured OIF/OEF veterans and their families. I have now directed the Veterans Benefits Administration (VBA) to move the claims of all combat veterans who have served in Iraq or Afghanistan to the head of the line so processing their claims is a top priority. To support expedited processing of all OIF/OEF claims and reduce the claims backlog, I directed VBA to immediately begin an aggressive hiring program to increase our on-board staffing level in the regional offices by over 400 benefits employees between now and the end of June.

The President announced the creation of a bipartisan *Commission on Care for America's Returning Wounded Warriors* to review the care of wounded service men and women from the time they leave the battlefield through their return to civilian life as veterans. The President has asked me to chair his new interagency *Task Force on Returning Global War on Terror Heroes.* We are charged to respond to the President in 45 days with a report and recommendations to address the immediate needs of those making the transition from active military to veteran status.

I invite you to visit our VA facilities in your district or elsewhere as soon as your schedule permits. When you do, I am confident that you will be impressed with the care and commitment of those serving our veterans. I would like to hear your reactions following such visits. Certainly, if you find there are any situations you consider unacceptable, I ask you to contact me. I can assure you I will take immediate corrective action.

I have enclosed a separate fact sheet concerning the many VA initiatives under way to assist OIF/OEF veterans. Further, to ensure your concerns can be conveyed to me expeditiously, I have asked Tom Harvey, Acting Assistant Secretary for Congressional Affairs, to establish a separate phone number (202) 368–8895 for Members to call at any time. That line will be monitored by him or by one of his senior staff to assure your concerns about our Nation's veterans receive the prompt attention they deserve. Thank you for your support of our veterans.

Sincerely yours,

R. James Nicholson
Secretary

Enclosures

Department of Veterans Affairs (VA) Fact Sheet

Poly trauma System of Care

- VA established a Poly trauma System of Care for veterans and active duty personnel with lasting disabilities due to poly trauma and traumatic brain injury (TBI).
- The mission of the Poly trauma System of Care is to provide the highest quality medical, rehabilitation, and support services to veterans and active duty service Members injured in service to our country.
- Development of the Poly trauma System of Care followed three fundamental principles:
  - Geographic distribution of specialty rehabilitation programs to facilitate transitioning veterans into their home communities.
  - Use an interdisciplinary model of care delivery where specialists from several medical and rehabilitation disciplines work together to develop an integrated treatment plan for each veteran.
  - Provide lifelong services for veterans with severe impairments and functional disabilities resulting from poly trauma and TBI.
- The Poly trauma System of Care is currently comprised of 21 network sites, including 4 regional centers. Local polytrauma/TBI support teams are under development at all other VA facilities.
- VA is improving coordination of care for veterans with poly trauma and TBI by assigning a social work case manager to every patient treated at the poly trauma centers. The assigned case manager handles the continuum of care and care coordination, acts as the point-of-contact for emerging medical, psychosocial, or rehabilitation problems, and provides psychosocial support and education.
- A Poly trauma Telehealth Network (PTN) links facilities in the Poly trauma System of Care and supports care coordination and case management. The PTN provides state-of-the-art multipoint videoconferencing capabilities. It ensures poly trauma and TBI expertise are available throughout the system of care and that care is provided at a location and time most accessible to the patient.
- From the experience of the Poly trauma Rehabilitation Centers, we have learned that inpatient rehabilitation is only the beginning of a long road toward recovery for many poly trauma patients. Efforts are under way to develop a full spectrum of rehabilitation services to include transitional rehabilitation and programs for patients who are slow to recover or have long-term care needs.

Polytrauma System of Care Sites

Polytrauma Rehabilitation Centers	VISN	*Polytrauma Network Sites*
McGuire VAMC Richmond, VA	1	VA Boston HCS—West Roxbury Campus
	2	Syracuse VA Medical Center
	3	Bronx VA Medical Center
	4	Philadelphia VA Medical Center
	5	Washington DC VA Medical Center
	6	Richmond VA Medical Center
James A. Haley VAMC Tampa, FL	7	Augusta VA Medical Center
	8	Tampa VA Medical Center
	9	Lexington VA Medical Center
	16	Houston VA Medical Center
	17	VA North Texas Health Care System—Dallas VA Medical Center
Minneapolis VAMC Minneapolis, MN	10	Cleveland VA Medical Center
	11	Indianapolis VA Medical Center
	12	Hines VA Medical Center
	15	St. Louis VA Medical Center
	23	Minneapolis VA Medical Center
Palo Also VAMC Palo Alto, CA	18	VA Southern Arizona Health Care System—Tucson VA Medical Center
	19	VA Eastern Colorado Health Care System—Denver VA Medical Center
	20	VA Puget Sound Health Care System—Seattle VA Medical Center
	21	VA Palo Alto Health Care System—Palo Alto VA Medical Center
	22	VA Greater Los Angeles Health Care System—West LA VA Medical Center

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Department of Veterans Affairs (VA) Fact Sheet

Initiatives to Enhance Care and Service to Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) Veterans

Summary

- VA is committed to its veterans. These courageous men and women serving in Iraq, Afghanistan and elsewhere in the Global War on Terror are *Priority One.*
- In a system that is rated by many as the *"best health care system in the country,"* not providing our absolute best to even one veteran is unacceptable.
- VA wants veterans, and all Americans, to know that it can and will do better.
- President Bush has made the administration's priority very clear: There should be no excuses, only action.

- On March 5, 2007, Secretary Nicholson directed the immediate hiring of 100 patient advocates. These new hires will serve as "ombudsmen" for seriously injured returning service Members and their families, helping them cut through red tape and navigate the system—24/7.
- Secretary Nicholson will also be working closely with President Bush's new Presidential Commission tasked to review the care provided to our wounded servicemen and women—from the time they leave the battlefield through their return to civilian life as veterans.
- Secretary Nicholson will head an interagency *Task Force on Returning Global War on Terror Heroes,* charged to respond to the President in 45 days, to address the immediate needs of those making the transition from active military to veteran status.
- Secretary Nicholson is establishing an advisory committee to focus on the concerns and needs of our returning OIF/OEF veterans and their families. Veterans and their families will be represented on the panel, and they will help us identify where we can do better.

Funding

- Earlier this month, VA announced the Administration is requesting a landmark budget of nearly $87 billion for VA in FY 08.
- This budget proposal represents a 77-percent increase in the overall budget since the President took office in FY 01, and more than 83 percent more for health care spending.
- With the continued support of Congress, the administration's FY 08 budget will provide VA with the resources it needs to continue its important mission.

Health Care

- Combat veterans have access to free health and dental care from VA for 2 years—bypassing the normal rules that require determinations of service-connected injuries or income levels.
- VA operates the largest integrated health care system in the country. VA treats patients at over 1,400 sites of care, including 154 hospitals, more than 800 outpatient clinics and 135 nursing homes.
- To care for severely injured veterans, VA established 4 regional Polytrauma Rehabilitation Centers (Palo Alto, CA; Minneapolis, MN; Richmond, VA; and Tampa, FL), staffed with the full range of specialists needed to treat these veterans. VA has expanded the polytrauma system of care to include 21 Polytrauma Network Sites (the 4 regional Polytrauma Rehabilitation Centers serve as the Polytrauma Network Site for their respective Networks) and Polytrauma Support Clinic Teams across the country to care for these veterans as they return to their homes and communities.
- VA has mandated traumatic brain injury (TBI) training for all VA health care professionals.
- VA is implementing a program to screen all patients who served in the combat theaters of Iraq or Afghanistan for TBI.
- VA is also establishing a panel of outside experts to review its complete Polytrauma System of Care, including TBI programs. More than half of the physicians practicing in the United States received some of their professional education at VA medical centers.
- VA health care facilities help train students from 107 medical schools, 55 dental schools and more than 1,200 schools of allied health.

Mental Health

- VA is the largest provider of mental health services in the country. VA employs more than 9,000 frontline mental health workers— psychologists, psychiatrists and social workers— up more than 15 percent since 2003.
- Last year, VA provided mental health care to about 1 million patients.
- VA's FY 08 budget request calls for nearly $3 billion in mental health services, plus another $100 million for the operation of its Vet Centers.
- VA's health care system currently features more than 200 specialized hospital-based Post-Traumatic Stress Disorder (PTSD) programs. Every VA medical center now has specialty PTSD capability.
- On February 7, 2007, Secretary Nicholson announced plans to open 23 new community-based "Vet Centers," which are an important part of VA's mental health program, especially the treatment of PTSD. These will augment the more than 200 Vet Centers already operating.
- VA is the recognized leader in the study and treatment of PTSD. The National Center for PTSD operated by VA is an internationally recognized resource for

research and clinical improvement in treatment of PTSD and other combat-related mental health problems.

Seamless Transition

- VA is reaching out to ensure our newest generation of combat veterans is aware of benefits available to them. Over the past 4 years, VA has provided 29,000 briefings about VA benefits to over 1 million active duty and reserve personnel.
- VA has hired 100 veterans to serve as "outreach specialists" in the Vet Center program to provide outreach and educational services to their fellow veterans returning from OIF/OEF. VA has been working aggressively to make contact with our newest generation of veterans at military demobilization and National Guard and Reserve sites.
- To date, VA has seen nearly 350 veterans at its polytrauma centers and has coordinated the transfer of 6,869 seriously injured and ill service Members directly from Department of Defense Military Treatment Facilities (MTFs) to VA hospitals throughout the Nation.
- On February 12,2007, Secretary Nicholson announced a collaborative effort between VA and the states. It will use VA staff to put the most severely injured veterans still in MTFs in contact with the veterans affairs departments in their home-states.
- Secretary Nicholson is establishing the position of Special Assistant to the Under Secretary for Health for OIF/OEF Health Issues to begin the process of offering polytrauma patients and their families "second opinions" from private rehabilitation facilities on their treatment plans and to continue the Secretary's policy of meeting regularly with small groups of GWOT veterans and their families to listen to concerns and resolve these issues quickly.

U.S. General Accounting Office
Washington, DC, 20548
June 30, 2006

The Hon. Michael Bilirakis
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Subject: *VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans*

Dear Mr. Chairman:

As of the end of March 2006, over 1.3 million[1] U.S. military servicemembers had served or were serving in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF).[2] These servicemembers, including Members of the reserves and National Guard, may be eligible to receive health care from the Department of Veterans Affairs (VA) while serving on active duty or upon separating from active duty. Although the Department of Defense (DOD) provides health care services to servicemembers under TRICARE,[3] legislation passed by the Congress in May 1982 authorized VA to provide health care services to servicemembers in time of war or national emergency, when DOD may have insufficient resources to care for casualties.[4] Through December 16, 2005, DOD had arranged for 193 active duty servicemembers with serious injuries—traumatic brain injuries and other complex trauma, such as missing limbs—to receive medical and rehabilitative[5] care at VA polytrauma reha-

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[1] DOD's Contingency Tracking System Deployment File for Operations Enduring Freedom and Iraqi Freedom reported that as of March 31, 2006, the total number of servicemembers ever deployed was 1,312,221.

[2] OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations.

[3] DOD provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care services provided at military treatment facilities.

[4] The Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Pub. L. No. 97–174, § 4(a), 96 Stat. 70, 74–75.

[5] Most servicemembers receive medical care from DOD providers. However, DOD does not typically provide long-term rehabilitative services and looks to VA to be a provider of these services.

bilitation centers (PRC).[6] In addition, about 30 percent (over 144,000) of the servicemembers who had separated from active duty following service in OEF or OIF have sought VA health care, including over 4,000 who received inpatient care at VA medical facilities.

In September 2005, we testified on VA's collaboration with DOD to provide seamless transition of care for servicemembers between DOD and VA health care systems—that is, no interruption of care as the person moves from being a DOD patient to being a VA patient.[7] We reported that VA has developed policies and procedures that direct its medical facilities to provide OEF and OIF servicemembers with timely access to care but that the sharing of health information between DOD and VA was limited. You asked us to update the information we provided in our testimony by reviewing the efforts VA is making to inform servicemembers and veterans about VA health care services and to help ensure that there is a seamless transition of care for servicemembers from DOD's to VA's health care system. We addressed the following questions:

1. What outreach efforts has VA made to inform OEF and OIF servicemembers and veterans about the VA health care services that may be available to them?
2. What actions has VA taken to facilitate the seamless transition of medical and rehabilitation care for seriously injured OEF and OIF servicemembers who are transferred between DOD medical treatment facilities (MTF) and PRCs?
3. What special educational activities or clinical tools is VA using to help ensure its medical providers are aware of and recognize the needs of eligible OEF and OIF servicemembers and veterans?

To determine outreach efforts VA has made to inform OEF and OIF servicemembers and veterans about the VA health care services that may be available to them, we interviewed, and collected supporting documentation from, VA officials on their efforts and programs that have been established to inform servicemembers and veterans about VA health care services. We also observed briefings given by VA representatives at two military installations[8] to active duty and reserve servicemembers about VA health care services for which they may be eligible.

To identify actions VA has taken to facilitate the seamless transition of care between MTFs and PRCs for servicemembers seriously injured in OEF and OIF, we reviewed VA directives, policies, and handbooks governing access to VA health care by OEF and OIF servicemembers and veterans. We also visited the two MTFs that treat most of the seriously injured OEF and OIF servicemembers—Walter Reed Army Medical Center and the National Naval Medical Center, both located in the Washington, D.C., area—and the four PRCs that treat them. The PRCs are located at VA Medical Centers in Palo Alto, California; Tampa, Florida; Minneapolis, Minnesota; and Richmond, Virginia. During those visits, we interviewed medical providers and reviewed the VA electronic medical records of the 193 seriously injured servicemembers who were admitted to the PRCs from January 7, 2002,[9] through December 16, 2005. In addition, we attended a discharge planning conference for an OIF servicemember being discharged from a PRC to document the information provided to the servicemember about his follow-up health care from VA and DOD. We made subsequent visits to the Richmond and Tampa PRCs to observe the capability of PRC providers to access DOD electronic medical records.

To identify the special educational activities or clinical tools that VA is using to help ensure its medical providers are aware of and recognize the needs of eligible OEF and OIF servicemembers and veterans, we interviewed, and collected supporting documentation from, VA officials. While we were at the Naval Station Norfolk conducting audit work, we also visited the VA Medical Center in Hampton, Virginia, to obtain information on the educational activities and clinical tools VA uses when treating OEF and OIF servicemembers and veterans. We also obtained this

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[6] The Veterans Health Programs Improvement Act of 2004, Pub. L. No. 108–422, § 302, 118 Stat. 2379, 2383–86, mandated that VA establish centers for research, education, and clinical activities related to complex multiple trauma associated with combat injuries. In response to that mandate, VA established PRCs at four VA medical facilities with expertise in traumatic amputation, spinal cord injury, traumatic brain injury, and blind rehabilitation. The PRCs address the rehabilitation needs of the combat injured in one setting and in a coordinated manner.

[7] GAO, VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited, GAO–05–1052T (Washington, D.C.: Sept. 28, 2005). Also see Related GAO Products at the end of this report.

[8] VA provides briefings at hundreds of MTFs. We attended briefings at two judgmentally selected installations—the Naval Station Norfolk, Norfolk, Virginia, and Fort Benning Army Base, Columbus, Georgia.

[9] Although OEF began in October 2001, the earliest recorded date that a servicemember injured in OEF was admitted to a PRC for treatment was January 7, 2002.

information from the four PRCs. Further, we determined the number of VA medical providers and other staff who completed online educational courses developed by VA.

Our review was conducted from May 2005 through June 2006 in accordance with generally accepted government auditing standards.

Results in Brief

VA has made a variety of outreach efforts to provide OEF and OIF servicemembers and veterans and their families with information on VA health care services. VA reported that from October 1, 2000, through May 31, 2006, it provided about 36,000 briefings to almost 1.4 million active duty, reserve, and National Guard servicemembers about VA health care services that may be available to them. In some cases, family Members also attended these briefings, which were provided at over 200 sites, including 70 sites outside the United States. VA also maintains a Web site containing health information focused on OEF and OIF servicemembers and veterans, distributes brochures and pamphlets to provide information about topics of interest to OEF and OIF servicemembers and veterans and their families, and sends letters and newsletters to veterans about VA health care services and health issues specific to veterans.

VA has taken several actions to facilitate the transition of medical and rehabilitative care for seriously injured servicemembers who are being transferred from MTFs to PRCs. In April 2003, the Secretary of VA authorized VA medical facilities to give priority to OEF and OIF servicemembers over veterans, except those with service-connected disabilities. In April 2004, VA signed a memorandum of agreement (MOA) with DOD that established the referral procedures for transferring injured servicemembers from DOD to VA medical facilities. VA and DOD also established joint programs to ease the transfer of injured servicemembers to VA medical facilities, including a program that assigned VA social workers to selected MTFs to coordinate patient transfers to VA medical facilities. Nevertheless, problems remain in the process for electronically sharing the medical records VA needs to determine whether servicemembers are medically stable enough to participate in vigorous rehabilitation activities. According to VA officials, the transfer could be more efficient if PRC medical personnel had real-time access to the servicemembers' complete DOD electronic medical records from the referring MTFs. VA and DOD reported that as of December 2005 only two of the PRCs had requested and been granted real-time access to the electronic medical records maintained at Walter Reed Army Medical Center. One of these PRCs had also been granted access to the electronic medical records at the National Naval Medical Center. However, problems continue to exist with the PRCs' ability to access DOD electronic medical records. During a visit to the two PRCs in April 2006, we found that neither facility could access the DOD electronic medical records at Walter Reed Army Medical Center because of technical difficulties. Furthermore, while VA's electronic medical record system captures a wide range of patient information, we found that at the time we conducted our audit work it did not always contain a complete record of information related to the patient's discharge from the PRC, such as dates and times of follow-up medical appointments—information that could be useful for maintaining continuity of care or responding to a patient inquiry about future appointments. In response to our concerns about this problem, VA has taken corrective action. The department has developed a template that identifies the information given to servicemembers at discharge from PRCs. The template has been included in VA's electronic medical record for use systemwide.

VA has developed a number of educational activities and online clinical tools to help ensure that VA medical providers and other staff are aware of and recognize the health care needs of OEF and OIF servicemembers and veterans. Examples of VA's educational efforts include developing online courses on infectious diseases of Southwest Asia; holding conferences on brain injuries; conducting conference calls, each of which provided more than 100 VA staff with information on transferring servicemembers from DOD to VA health care services; and developing publications on the long-term effects of using an antimalarial drug. VA has also provided educational activities at two East Coast centers targeting medical professionals (such as physicians, nurses, and social workers), including conferences on topics such as physical and mental health issues, infectious disease issues, and health care services provided by VA. Furthermore, VA has developed clinical tools to help its staff be aware of and responsive to the needs of OEF and OIF servicemembers and veterans. For example, it has added reminder screens to its electronic medical records that pop up when staff are accessing patients' records and prompt them to ask questions about OEF- and OIF-related medical and psychological conditions, such as in-

fectious diseases and depression. VA and DOD have also developed guidelines to assist clinicians in providing medical care to OEF and OIF veterans.

We provided a draft of this report to VA and DOD for comment. VA concurred with the information presented in our draft report. DOD commented that the report portrays the numerous efforts that have been made to improve the efficacy of programs designed to ensure a smooth transition and continuity of care as servicemembers transition back and forth between DOD and VA health care systems. DOD also stated that the report contained several inaccuracies; however, we maintain that the information contained in the report accurately presents the results of our audit work.

Background

DOD has reported that as of June 26, 2006, over 19,000 servicemembers have been wounded in action since the onset of OEF and OIF. Some of these servicemembers are surviving injuries that would have been fatal in past conflicts. In World War II, about 30 percent of American servicemembers wounded in combat died. Because of medical advances, this proportion has dropped to 3 percent for OEF and OIF servicemembers, but many of them are returning home with severe disabilities, including traumatic brain injuries and missing limbs. In 2005, DOD reported that about 65 percent of the OEF and OIF servicemembers wounded in action were injured by blasts and fragments from improvised explosive devices, land mines, and other explosive devices. More recently, DOD estimated in 2006 that the percentage of those injured by blasts and fragments who have some degree of trauma to the brain ranged from less than 20 percent to 28 percent. These injuries may require comprehensive inpatient rehabilitation services to address complex cognitive, physical, and mental health impairments.[10]

While servicemembers are on active duty, DOD manages where they receive their care—at an MTF, a TRICARE civilian provider, or a VA medical facility. Once discharged from the military or demobilized from the reserves or National Guard, veterans may be eligible to receive care from VA's health care system.

From the OEF and OIF conflict areas, seriously injured servicemembers are usually brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to MTFs located in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center. Once seriously injured servicemembers are medically stabilized, DOD can elect to send those with traumatic brain injuries and other complex trauma, such as missing limbs, to one of the four PRCs for rehabilitative services.

The transfer of injured servicemembers from MTFs to VA medical facilities for medical care requires the exchange of health information between DOD and VA. In August 1998, the President issued a directive requiring VA and DOD to develop a computer-based patient record system that would accurately and efficiently exchange information between the departments. The directive stated that VA and DOD should define, acquire, and implement a fully integrated computer-based patient record available across the entire spectrum of health care delivery over the lifetime of the patient.[11]

Since receiving the President's directive, VA and DOD have been working to exchange patient health information electronically and ultimately to have interoperable electronic medical records. VA and DOD have begun to implement applications that exchange limited electronic medical information between the departments' existing health information systems. One of these applications—the Bidirectional Health Information Exchange—is a project to achieve the two-way exchange of health information on patients who receive care from both VA and DOD. The application has been implemented at all VA sites and at 14 DOD sites to exchange information such as pharmacy and allergy data, but as we testified in September 2005, the goal of systemwide two-way electronic exchange of patient records remains far from being realized.[12] As a separate effort, VA and DOD have undertaken an initiative to allow the four PRCs to electronically access medical records at Walter Reed Army Medical Center and the National Naval Medical Center to obtain information

[10] Traumatic brain injuries may cause problems with cognition (concentration, memory, judgment, and mood), movement (strength, coordination, and balance), sensation (tactile sensation and vision), and emotion (instability and impulsivity).

[11] National Science and Technology Council, A National Obligation: Planning for Health Preparedness for and Readjustment of the Military, Veterans, and Their Families After Future Deployments, Presidential Review Directive 5 (Washington, D.C.: Executive Office of the President, Office of Science and Technology Policy, August 1998).

[12] GAO, Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information, GAO–05–1051T (Washington, D.C.: Sept. 28, 2005).

on seriously injured OEF and OIF servicemembers. The capability for electronic access was requested by the Richmond and Tampa PRCs in 2005 and by the Palo Alto and Minneapolis PRCs in 2006. This capability will be limited to a small number of providers at each of the PRCs.

Apart from joint efforts to share medical information, VA and DOD separately have developed electronic systems for recording and accessing patient health information. VA's electronic medical records are maintained in a system that captures a wide range of patient information, including doctors' progress notes, vital signs, laboratory results, medications dispensed, drug allergies, radiological images, and clinical reminders. VA's system also allows the patient's complete medical record to be accessed from any VA medical facility. While DOD's electronic medical record system also captures information such as doctors' progress notes, vital signs, medications dispensed, and laboratory results, it does not include radiological images, vision and hearing tests, or anesthesia notes. In addition, DOD does not have a systemwide approach to electronic medical record management since the information is maintained and stored at individual MTFs or, in some locations, in networks that service multiple MTFs within a small geographic area. Under DOD's approach, all medical information cannot be electronically accessed by providers throughout DOD's health care system. For example, providers at Walter Reed Army Medical Center and the National Naval Medical Center can access each other's electronic medical records but cannot access medical records from Landstuhl Regional Medical Center in Germany.

VA's Outreach Includes Briefings, Web Sites, and Newsletters

VA has taken a number of actions to provide OEF and OIF servicemembers and their families with information about VA health care services, such as the cost of the services, how to register for VA health care, and where to obtain VA health care. VA reported that from October 1, 2000, through May 31, 2006, it held about 36,000 briefings for almost 1.4 million active duty, reserve, and National Guard servicemembers. These briefings were held at over 200 sites, including 70 sites located outside the United States. VA reported that over 8,000 family Members attended some of these briefings from October 1, 2005, through May 31, 2006. In addition, under a May 2005 MOA between VA and the National Guard, VA has trained staff hired by the National Guard to provide VA health and benefit information to National Guard units in each state.

For both servicemembers and veterans, VA has also created a Web site[13] that provides information for those who served in OEF and OIF, such as information on VA health and medical services, dependents' benefits and services, and transition assistance from military to civilian life. The Web site contains information about VA benefits available to active duty military personnel, including a page that briefly describes these benefits. VA has also developed a variety of informational materials, including a wallet-sized card with relevant toll-free telephone numbers and Web site addresses, fact sheets and pamphlets summarizing VA benefits, and a monthly video magazine called The American Veteran. VA reported that almost 1.4 million of the wallet-sized cards have been distributed during briefings. Fact sheets and pamphlets are sent to VA medical facilities for distribution to veterans and are also available on VA's Web site. The video magazine reports information about VA services on a VA Web site[14] and on the Pentagon Channel, which is available online[15] and on cable television.

VA also has outreach efforts designed specifically for active duty, reserve, and National Guard OEF and OIF veterans. The Secretary of VA sends new veterans a letter thanking them for their service to the country and informing them about VA health care services and assistance in their transition to civilian life. As of May 15, 2006, the Secretary had sent letters to over 530,000 OEF and OIF servicemembers who had left active duty. These letters include information about the VA health care services available to veterans and a toll-free number for obtaining additional health care information. In addition, from December 2003 through March 2006 VA sent four newsletters to OEF and OIF veterans with information on health issues of interest to these veterans.

VA Activities Facilitate the Transition of Care for Seriously Injured OEF and OIF Servicemembers Transferred to PRCs

VA has taken a number of actions to facilitate the transition of medical and rehabilitation care for servicemembers who have been seriously injured in OEF and OIF

[13] See http://www.seamlesstransition.va.gov.
[14] See http://www1.va.gov/opa/feature/amervet/index.htm.
[15] See http://www.pentagonchannel.mil.

and are being transferred between DOD and VA medical facilities. These actions focus on establishing and expanding internal initiatives for providing care to this population as well as VA's efforts to electronically share medical records with DOD.

In April 2003, when the President declared a national emergency with respect to the Iraq conflict, the Secretary of VA issued a memorandum authorizing VA medical facilities to give priority to servicemembers who sustained injuries in OEF and OIF over veterans and others eligible for VA health care, except those with service-connected disabilities. In October 2003, VA issued a directive requiring its medical facilities to designate a point of contact to receive and expedite transfers of servicemembers from DOD to VA medical facilities. In April 2004, VA signed an MOA with DOD to provide health care and rehabilitation services to servicemembers who sustain spinal cord injury, traumatic brain injury, or visual impairment. The MOA established the referral procedures for transferring active duty inpatient servicemembers from DOD to VA medical facilities.[16] In June 2005, VA issued a directive expanding the scope of care it would provide to include psychological treatment for family Members and intensive clinical and social work case management services [17] at its four regional traumatic brain injury rehabilitation centers and renamed these facilities PRCs.

VA has also established joint programs with DOD to ease the transfer of injured servicemembers to VA medical facilities. In August 2003, VA and DOD established a program that assigned VA social workers to selected MTFs [18] to coordinate patient transfers between DOD and VA medical facilities. The social workers make appointments for care, ensure continuity of therapy and medications, and follow up with patients after discharge. By late February 2006, VA reported that the social workers had received requests for transfer of care for over 6,000 patients, and over three-fourths of them had been transferred to VA facilities; the rest of the requests were pending.[19] Under another program, a uniformed servicemember was stationed at each PRC beginning in March 2005 to assist servicemembers being admitted to the PRC. The uniformed servicemembers serve as liaisons among injured servicemembers and their families, the MTFs, the PRCs, and the servicemembers' units. For example, they assist with reimbursement for travel and lodging costs for immediate family Members.

In January 2005, VA established the Seamless Transition Office to enhance servicemembers' transition back to civilian life by improving coordination within the Veterans Benefits Administration and the Veterans Health Administration,[20] as well as between DOD and VA. The goals of the Seamless Transition Office related to health care include improving communication, coordination, and collaboration within VA and with DOD concerning health care, educating VA staff about OEF and OIF veterans' health care, and other needs. The office has been active in areas such as coordinating efforts of the VA social workers assigned to MTFs to help servicemembers transfer their health care from MTFs to VA health care facilities and issuing a handbook on the policy and procedures for PRCs, including recommended staffing levels for the different types of medical providers caring for patients.

There are also a number of routinely scheduled teleconferences and videoconferences within VA and between VA and the military medical facilities to coordinate medical care for injured servicemembers and to discuss and resolve medical issues. Topics include issues that are general in nature and would apply to a number of servicemembers or that are specific to individual servicemembers. For example, monthly, and as needed, VA's Seamless Transition Office and PRC staff hold teleconferences to discuss such issues as obtaining DOD medical records and how

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[16] In addition to outlining DOD's and VA's responsibilities in the transfer process, the MOA also established the reimbursement rate between the two departments for inpatient care that VA would provide.

[17] Case management includes assessment of the individual's health care needs, care planning and implementation, referral coordination, monitoring, and periodic reassessment of the individual's health care needs.

[18] Five MTFs were originally selected because they received most of the OEF and OIF casualties. These facilities were Walter Reed Army Medical Center (Washington, D.C.), Brooke Army Medical Center (San Antonio, Texas), Dwight David Eisenhower Army Medical Center (Augusta, Georgia), Madigan Army Medical Center (Tacoma, Washington), and the National Naval Medical Center (Bethesda, Maryland). In 2004 and 2005, three additional MTFs—Darnall Army Community Hospital (Fort Hood, Texas), Evans Army Community Hospital (Fort Carson, Colorado), and the Naval Hospital Camp Pendleton (Camp Pendleton, California)—were added to care for returning OEF and OIF servicemembers.

[19] According to VA, patients remain in pending status until DOD determines that the patient is ready for transfer to a VA facility and VA determines the patient's medical condition is stable.

[20] The Veterans Benefits Administration provides benefits and services, such as disability compensation, to veterans. The Veterans Health Administration's primary responsibility is the delivery of health care to veterans.

to provide follow-up medical care once the servicemember is discharged from the PRC. Further, on a bimonthly basis, PRCs hold teleconferences or videoconferences with Walter Reed Army Medical Center and the National Naval Medical Center to discuss issues arising during the transfer of injured servicemembers from their facilities to the PRCs, such as obtaining military medical records. Servicemembers and their families sometimes participate in the videoconference to meet PRC staff prior to transfer. Also on a monthly basis, VA and DOD hold videoconferences to discuss medical and logistical issues that arise with injured servicemembers. These videoconferences include DOD medical providers from Landstuhl Regional Medical Center in Germany and combat medical units located in Iraq. For example, during one videoconference, VA and DOD staff discussed the blood filters[21] that were being surgically implanted in injured servicemembers in Iraq.[22] Medical providers in Baghdad asked if there was a different type of blood filter that they could use that would make removal easier at the stateside MTF or PRC.

Despite coordination, we found that the departments are having problems exchanging health care information electronically between the four PRCs and the two MTFs—Walter Reed Army Medical Center and the National Naval Medical Center. While our current review focused on the electronic transfer of information among these six facilities, over 5 years ago we recommended that VA and DOD create comprehensive and coordinated plans to ensure that the departments can share comprehensive, meaningful, accurate, and secure patient health data.[23] Both VA and DOD concurred with this recommendation and are in the process of implementing it. From a systemwide perspective, we testified over 2 years ago and again last September on the need for VA and DOD to intensify their efforts to implement the capability to share health care information electronically. In those testimonies, we recognized the actions VA and DOD had taken to electronically exchange health information but also acknowledged that much work remains to attain this goal.[24]

During our visits to the PRCs from October through December 2005, we observed that none of the PRCs had real-time access to the injured servicemembers' DOD electronic medical records from the transferring MTFs. Instead, the MTF faxed copies of some of the medical information, such as the servicemember's medical history and physical and doctor's progress notes from these records, to the PRC. Because this information did not always provide enough data for the PRC provider to determine if the servicemember was medically stable enough to be admitted to the PRC and to engage in vigorous rehabilitation activities and because the PRC did not have access to the complete medical records (paper or electronic), VA developed a standardized list of the minimum types of health care information needed about each servicemember transferring from an MTF. However, after they reviewed this basic medical information PRC providers stated that they frequently needed additional information and had to ask the PRC social worker to obtain it from the VA social worker at the MTF. For example, if the PRC provider noticed that the servicemember was on a particular antibiotic therapy, the provider might request the results of the most recent blood and urine cultures to determine if the servicemember was medically stable enough to participate in strenuous rehabilitation activities.

According to PRC officials, obtaining additional medical information in this way rather than electronically was very time consuming and often required multiple phone calls and faxes between the facilities.

According to VA officials, the main barrier to PRC medical providers' getting real-time access to medical records was DOD's interpretation of the Health Insurance Portability and Accountability Act 1996 (HIPAA)[25] and the HIPAA Privacy Rule.[26]

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[21] Blood filters are filters that screen blood to remove clots that could result in death.

[22] VA officials in attendance included staff from the PRCs and the Seamless Transition Office. DOD officials in attendance included staff from Walter Reed Army Medical Center; the National Naval Medical Center; Brooke Army Medical Center; Wilford Hall Medical Center; Army Institute for Surgical Research; Landstuhl Regional Medical Center in Germany; and combat medical units located in Balad and Baghdad, Iraq.

[23] GAO, Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing, GAO–01–459 (Washington, D.C.: Apr. 30, 2001).

[24] GAO, Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data, GAO–04–402T (Washington, D.C.: Mar. 17, 2004); Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems, GAO–04–271T (Washington, D.C.: Nov. 19, 2003); and GAO–05–1051T.

[25] Pub. L. No. 104–191, 110 Stat. 1936 (1996).

[26] The Privacy Rule, which became effective on April 14, 2001, specifies how individually identifiable health information may be used and disclosed by covered entities, which include health plans, health care clearinghouses, and certain health care providers. See 45 C.F.R. §§ 164.500(a),

The HIPAA Privacy Rule permits VA and DOD to share servicemembers' health information under certain circumstances, such as for purposes of treatment or if the individual signs a proper authorization. However, DOD officials told us they initially were reluctant to provide this access to VA because they were concerned that VA would have access to health information of all servicemembers, not only the information of those being transferred to the PRC for treatment.

Since we initiated our review, the four PRCs and Walter Reed Army Medical Center and the National Naval Medical Center have reached separate agreements on the records VA would be able to access and have begun to take action to share medical records.[27] During our initial visits, two PRCs—Richmond and Tampa—were in the process of separately negotiating with Walter Reed Army Medical Center to obtain real-time access to injured servicemembers' electronic medical records. VA reported that as of December 27, 2005, PRC providers in Richmond and Tampa have real-time access to these records. The Tampa PRC also gained access to the National Naval Medical Center's electronic medical records on February 21, 2006. VA and DOD officials have not established a date when all PRCs would have real-time access to electronic records at Walter Reed Army Medical Center and the National Naval Medical Center.

In April 2006, we revisited the Tampa and Richmond PRCs and found that problems continued with access to DOD electronic medical records. Providers at both PRCs that had been granted electronic access by DOD to obtain medical information stated that they could not always access the DOD electronic records. For example, during our visits neither facility could access the DOD electronic medical records at Walter Reed Army Medical Center because of a technical problem. Furthermore, while a nurse practitioner at the Tampa PRC was able to access the electronic medical records at the National Naval Medical Center, the admitting PRC provider for rehabilitative services could not.

While VA's electronic medical records offer ready access to VA medical information for its medical providers, we found that during our site visits some information related to servicemembers' and veterans' discharge from PRCs was not always entered into the records. When servicemembers and veterans are discharged from PRCs, many still require follow-up medical care at VA, DOD, or private-sector facilities. The social worker at the PRC is responsible for arranging follow-up appointments prior to the patient's discharge from the PRC. Information on follow-up appointments and points of contact is provided to the servicemember or veteran during the discharge planning conference, along with a large amount of other medical information and discharge instructions. Our review 193 servicemembers' VA electronic medical records showed that 126 patients required follow-up medical appointments after discharge from the PRC.[28] An examination of the 126 records indicated that appointments were made for 122 of the patients, with the remaining 4 patients instructed to call their local VA medical centers for appointments. However, while the date and time for the appointment was in the electronic medical record, it was not clearly summarized in 96 of 122 of these records, nor was there evidence that it was given to the patient. In addition, 75 of the 122 records did not clearly indicate the points of contact, nor was there evidence that this information was given to the patient. If this information were clearly documented in patients' electronic medical records, it would be available to VA providers who may need it to manage future care.

In February 2006, in response to questions we raised during our review, VA developed a template for PRC social workers to complete when a patient is discharged. The social worker includes on the template information on follow-up medical appointments, contact names and telephone numbers for the medical facilities where the servicemember is going to obtain follow-up medical care, military contacts, and PRC contacts. This template is entered into the electronic medical record. During our visit to the Tampa and Richmond PRCs in April 2006, we found that the social workers had been using the templates for patients discharged since mid-March 2006.

164.502 (2005). Both TRICARE and the VA health care system are health plans. See 45 C.F.R. § 160.103 (2005).

[27] This initiative is a unique undertaking by the four PRCs, Walter Reed Army Medical Center, and the National Naval Medical Center. It is distinct from VA's and DOD's Bidirectional Health Information Exchange.

[28] The remaining 67 patients did not need follow-up outpatient appointments because they were still patients in the PRC; had been transferred to another inpatient facility, such as an MTF or VA long-term care facility; or did not need follow-up medical care.

VA Is Using Courses, Conferences, and Online Clinical Tools to Help Ensure Medical Providers Are Aware of and Recognize Needs of Eligible OEF and OIF Servicemembers and Veterans

VA has developed activities to educate its medical providers and other staff on the health care needs of those who are or have been deployed in OEF and OIF. As part of its Veterans Health Initiatives, VA produced 14 educational courses that address OEF- and OIF-related topics, such as traumatic brain injuries and infectious diseases of Southwest Asia. These courses are available on VA's intranet, over the Internet, and on compact discs. As of December 31, 2005, VA reported that nearly 2,000 courses had been completed by VA staff, including nearly 1,200 courses that were completed by physicians. Also over 12,000 courses were completed by non-VA staff, such as veterans, family Members, and staff from veterans service organizations.

VA medical centers have also used conferences and in-house presentations to train staff on the needs of OEF and OIF servicemembers and veterans. For example, the Tampa PRC sponsored blast injury conferences in 2004 and 2005 that were attended by physicians, nurses, psychologists, and social workers. In addition, from April 2005 through April 2006, VA held five 1-hour conference calls for VA social workers that focused on the transfer of care for servicemembers from DOD to VA medical facilities, including information such as ways to be proactive in working with military families as they transition from active duty to veteran status and recognizing the signs and symptoms of stress and post-traumatic stress disorder in returning OEF and OIF veterans. VA reported that attendance for the conference calls ranged from 105 to 360 social workers.

VA's educational efforts have also included publications. VA's Under Secretary for Health has issued five informational letters to VA's medical providers offering guidance on OEF- and OIF-related topics. The topics of these letters include the long-term effects of heat-related illnesses and the long-term effects of using an antimalarial drug. In addition, VA's War-Related Illness and Injury Study Centers have produced publications providing information for combat veterans and providers on topics such as management of chronic pain and the effects of exposure to depleted uranium.[29]

VA's War-Related Illness and Injury Study Centers have also provided educational activities and clinical tools to help medical professionals treat OEF and OIF servicemembers and veterans. In 2004 and 2005 the centers reported that they held three conferences, with a total attendance of more that 450 health care providers, including physicians, nurses, and social workers, that addressed such topics as physical and mental health issues, infectious disease issues, and health care services provided by VA. They also held six workshops from 2003 through 2005 on topics such as patient-provider communication and the recognition and treatment of undiagnosed illnesses, and established Web sites that provide links to their publications and to other sources of education for medical providers.

VA has also developed various clinical tools to enhance the ability of its providers and other staff to be aware of and responsive to the needs of OEF and OIF servicemembers and veterans. For example, VA has added reminder screens to its electronic medical records that pop up when a patient's record is opened if the veteran served in the military after September 11, 2001. These screens prompt providers to ask questions about medical and psychological issues related to OEF and OIF veterans, such as infectious diseases and depression. The screens continue to pop up each time the patient's medical record is opened until the information requested is entered into that record. The pop-up reminder screens were the subject of one of the informational letters issued to VA staff. Further, VA and DOD developed 25 guidelines for clinical practice,[30] which can be viewed on a VA Web site.[31] VA officials stated that any of the guidelines may be used for OEF and OIF servicemembers and veterans depending on their needs. Finally, VA's National Center for Post-Traumatic Stress Disorder and DOD developed the Iraq War Clinician Guide. It addresses the needs of veterans of the Iraq war and is available on a VA Web site.[32]

Agency Comments and Our Evaluation

VA and DOD reviewed a draft of this report and provided written comments, which appear in enclosures I and II respectively. VA concurred with the information

[29] In May 2001, VA established the two War-Related Illness and Injury Study Centers, one in Washington, D.C., and one in East Orange, New Jersey. The mission of these centers includes providing health-related educational services to veterans and health care professionals.

[30] Clinical practice guidelines are recommendations for treating specific diseases or conditions.

[31] See http://www.oqp.med.va.gov/cpg/cpg.htm.

[32] See http://www.ncptsd.va.gov/war/guide/index.html.

presented in our draft report. It also stated that PRCs' access to DOD's electronic medical records has been a significant challenge for VA in accomplishing its mission. VA further commented that it is justifiably proud of the accomplishments of its dedicated staff in successfully responding to the often overwhelming transitional needs of these young servicemembers and their families. DOD commented that the report portrays the numerous efforts that have been made to improve the efficacy of programs designed to ensure a smooth transition and continuity of care as servicemembers transition back and forth between DOD and VA health care systems.

DOD commented that the statements in the draft report concerning its lack of a systemwide approach to electronic medical record management and the inability of providers throughout DOD's health care system to access medical records is completely inaccurate. Our statements are not inaccurate. While our draft report recognizes DOD's longstanding ongoing efforts to achieve the capability to electronically share the complete medical record, we did not find that this capability exists yet at DOD. For example, in March 2006 the Chief Information Officer at the National Naval Medical Center explained to us that MTFs did not have access to electronic medical records at other MTFs across the United States. He told us that while information could be shared among providers linked by a local area network, those providers could not electronically access medical records from other local area networks. Specifically, he noted that providers at Walter Reed Army Medical Center and the National Naval Medical Center can access each other's medical records electronically, but they cannot access medical records from Landstuhl Regional Medical Center in Germany or from MTFs in San Antonio, Texas. He acknowledged that DOD's Armed Forces Health Longitudinal Technology Application (AHLTA)—a comprehensive electronic health record—will allow providers to access medical information. In its comments, DOD also cited the access that AHLTA will provide. However, DOD documentation that describes the system states that it is for outpatient care—only one part of the complete medical record. VA providers treating OEF and OIF servicemembers are in need of information concerning the inpatient care—not just the outpatient care—that servicemembers received at DOD. Furthermore, AHLTA cannot be accessed by all of DOD's providers. In its comments on our draft report DOD stated that AHLTA is not operational at 19 percent of DOD's MTFs and that full deployment is not expected until December 2006. In comparison, VA's system allows the patient's complete medical record to be accessed from any VA medical facility.

In its comments, DOD also mentioned that a section of our draft report that described the actions VA has taken to facilitate the transition of care from DOD to VA is misleading. However, the section is an accurate presentation of VA initiatives as presented to us by VA and as observed during our audit work. Furthermore, DOD stated that it transmits certain medical information to VA on a monthly basis, although VA providers told us they need ready electronic access to current medical record information for the seriously injured OEF and OIF servicemembers. We believe that in order to plan and begin appropriate treatment immediately upon a servicemember's arrival at a PRC, medical record information is best provided through direct electronic access, not through monthly transmissions. Our draft report recognized the technical advances that VA has made in that it has the capability to electronically share the complete medical record of each of its beneficiaries among all its providers at all its medical facilities. This means that all medical services provided by VA to its beneficiaries—including information such as outpatient or inpatient procedures, pharmacy, or radiology notes—are included in VA's electronic record.

VA and DOD provided technical comments that we incorporated where appropriate.

As agreed with your office, unless you publicly announced its contents earlier, we plan no further distribution of this report until 30 days after its report date. We will then send copies of this report to the Secretaries of Veterans Affairs and Defense and appropriate congressional committees. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions, please contact me at (202) 512–7101 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made

major contributions to this report are Michael T. Blair, Jr., Assistant Director; Cynthia Forbes; Roseanne Price; Shannon Slawter; and Cherié Starck.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care

Enclosures—2

Comments from the Department of Veterans Affairs

THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 19, 2006

Ms. Cynthia A. Bascetta
Director
Health Care Team
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

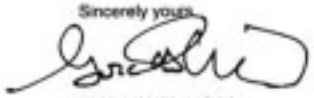
The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA AND DOD HEALTH CARE: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans*** (GAO 06-794R) and concurs with the information as presented. Your report cites many of the initiatives that VA has implemented to assure that Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) servicemembers receive timely access to benefits and high quality health care and that their transition from the military to VA is efficient and compassionate. VA and the Department of Defense (DoD) have established a collaborative relationship to respond to the special needs of these soldiers and their families.

As GAO reports, seamless transition efforts, particularly for seriously injured combat veterans, rank among VA's highest priorities. The Veterans Health Administration (VHA) has taken the lead in expanding outreach and case management efforts, to facilitate medical treatment and rehabilitation in our polytrauma rehabilitation centers (PRCs). VHA is also developing educational activities and clinical tools to assure that VA clinical staff has the information it requires to recognize the complex challenges inherent in the types of injuries these veterans sustain. Nevertheless, VHA's emphasis continues to focus on ongoing improvement recognizing that VHA must maintain the flexibility necessary to adapt to changing demand. As part of VHA's efforts to monitor its effectiveness, the Office of Seamless Transition is implementing a quality assurance program designed to assess VHA's program through in-depth review of medical records for patients transferred from military facilities to VA facilities. Because the program is still in the early developmental stages, data collection, aggregation and reporting processes are still being refined. We anticipate that valuable trend information will eventually be generated to prompt follow-up corrective actions as indicated at the national and local levels.

I agree with GAO that our PRCs' access to DoD electronic medical records has been a significant challenge for VA in accomplishing our mission. Our program managers continue to work in close coordination with DoD to resolve remaining obstacles. As reported, both the Richmond and Tampa PRCs can now access the electronic records from Walter Reed Army Medical Center and Bethesda National Naval Medical Center. The Minneapolis and Palo Alto PRCs have requested the same access, and VHA is pursuing vigorously full record sharing capability with appropriate Army and Navy officials. I anticipate that successful data transfer will be available in the near future.

VHA is justifiably proud of the accomplishments of its dedicated staff in successfully responding to the often overwhelming transitional needs of these young servicemembers and their families. I am personally committed to assure that every resource will be used to maintain the highest levels of support in any way that is needed. GAO's report has been very helpful in highlighting our strengths and priorities, and I appreciate the opportunity to comment on it. VA is also providing technical comments separately.

Sincerely yours,



Gordon H. Mansfield

Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

JUN 15 2006

Ms. Cynthia Bascetta
Director, Health Care
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

Dear Ms. Bascetta:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report, GAO 06-749R, "VA AND DOD HEALTH CARE: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans," dated June 2, 2006 (GAO Code 290463).

The Department appreciates the opportunity to provide the attached comments on the draft report.

Please direct any questions to my points of contact on this matter, Mr. Kenneth Cox (functional) at (703) 681-0039, ext. 3602 and Mr. Gunther J. Zimmerman (Audit Liaison) at (703) 681-3492, ext. 4065.

Sincerely,

William Winkenwerder, Jr., MD

Enclosures:
1. Overall Comments
2. Technical Comments

GAO DRAFT REPORT – DATED JUNE 2, 2006
GAO CODE - 290463/GAO-06-749R

"VA AND DOD HEALTH CARE: Efforts to Provide Seamless Transition of Care for OEF and OIF Service members and Veterans"

DEPARTMENT OF DEFENSE COMMENTS

This draft report provides a review of the Department of Veterans Affairs' (VA) and Department of Defense's (DoD) efforts to date to ensure continuity of care for service members injured in Operations Enduring Freedom and Iraqi Freedom.

Overall Comments:

- The report portrays the numerous efforts that have been made to improve the efficacy of programs designed to ensure a smooth transition and continuity of care as wounded and injured service members transition back and forth between the Military Health System and the Veterans Health Administration. However, the report does contain several inaccuracies that are addressed in the attached technical comments. Key examples are:

- The report states that "In addition, DoD does not have a system-wide approach to electronic medical record management since the information is maintained and stored in individual MTFs, or in some locations, in networks that service multiple MTFs within a small geographical area. Under DoD's approach, medical information cannot be accessed by providers throughout DoD's health care system."

  This statement is completely inaccurate. It does not recognize the current state of DoD's electronic health record development and implementation. DoD began implementation of a standards-based, comprehensive electronic health record, called AHLTA, in January 2004. AHLTA generates, maintains and provides worldwide, secure, round-the-clock online access to health records on our 9.2 million beneficiaries. Authorized health care providers can access patient information regardless of the location where care was provided, as evident during Hurricane Katrina. A key component to AHLTA is the centralized Clinical Data Repository (CDR) which contains electronic clinical records for over 8.04 million beneficiaries. As of June 2, 2006, AHLTA has been implemented at 113 of 139 planned Medical Treatment Facilities with 48,447 of 63,000 total users fully trained to include 16,359 health care providers. Deployment to all planned facilities is scheduled for completion in December 2006. To date, AHLTA has processed over 80,958 patient encounters daily for a cumulative total of over 21 million outpatient encounters, and continues to grow daily. At the time of this study, AHLTA was being implemented at

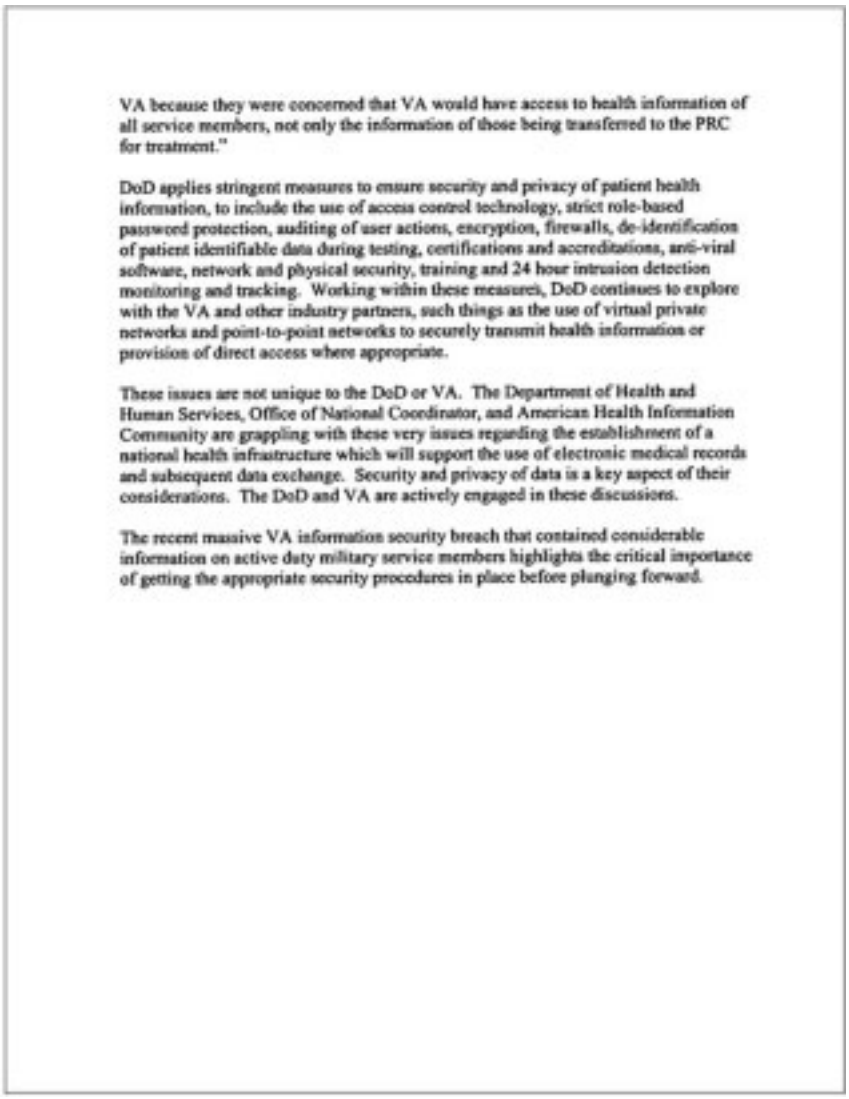
Walter Reed Army Medical Center (September 2005 – April 2006) and National Naval Medical Center Bethesda (September 2005 - May 2006).

- The report cites "VA has taken a number of actions to facilitate the transition of medical and rehabilitation care for service members who have been seriously injured in OEF and OIF and are being transferred between DoD and VA medical facilities. These actions focus on establishing and expanding internal initiatives for providing care to this population as well as VA's efforts to electronically share medical records with DoD".

  This statement is misleading. DoD transmits to VA on a monthly basis: laboratory results, radiology results, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records and demographic data on separated service members. VA providers and benefits specialists access this data daily for use in the delivery of healthcare and claims adjudication. DoD has transmitted messages to the Federal Health Information Exchange (FHIE) data repository on more than 3.5 million unique retired or discharged Service members. This number grows as health information on recently separated Service members is extracted and transferred to VA. Bidirectional Health Information Exchange (BHIE) is a joint DoD and VA initiative which enables real-time sharing of allergy, outpatient pharmacy, demographic, laboratory and radiology data between DoD BHIE sites and all VA Treatment Facilities for patients treated in both DoD and VA. As of May 2006, BHIE is operational at 14 sites (see first technical note, referring to p. 7).

  DoD also sends electronic pre- and post-deployment health assessment information to the VA. The initial historical data extraction for separated Service members was completed in July 2005 resulting in approximately 400,000 pre- and post-deployment health assessments being sent to the FHIE data repository at the VA Austin Automation Center. Monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository began in September 2005 and has continued each month since then. VA providers began accessing the data in December 2005. Beginning in March 2006, and continuing monthly, pre- and post-deployment health assessment data on Reserve and National Guard members, who were deployed and are now demobilized, is also being transferred to the FHIE data repository.

- The report states "According to VA officials, the main barrier to PRC medical providers' getting real-time access to medical records centered on DoD's interpretation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule. The HIPAA Privacy Rule permits DoD and VA to share service members' health information under certain circumstances, such as for purposes of treatment or if the individual signs a proper authorization. However, DoD officials told us they initially were reluctant to provide this access to



VA because they were concerned that VA would have access to health information of all service members, not only the information of those being transferred to the PRC for treatment."

DoD applies stringent measures to ensure security and privacy of patient health information, to include the use of access control technology, strict role-based password protection, auditing of user actions, encryption, firewalls, de-identification of patient identifiable data during testing, certifications and accreditations, anti-viral software, network and physical security, training and 24 hour intrusion detection monitoring and tracking. Working within these measures, DoD continues to explore with the VA and other industry partners, such things as the use of virtual private networks and point-to-point networks to securely transmit health information or provision of direct access where appropriate.

These issues are not unique to the DoD or VA. The Department of Health and Human Services, Office of National Coordinator, and American Health Information Community are grappling with these very issues regarding the establishment of a national health infrastructure which will support the use of electronic medical records and subsequent data exchange. Security and privacy of data is a key aspect of their considerations. The DoD and VA are actively engaged in these discussions.

The recent massive VA information security breach that contained considerable information on active duty military service members highlights the critical importance of getting the appropriate security procedures in place before plunging forward.

Related GAO Products

Information Technology: VA and DOD Face Challenges in Completing Key Efforts. GAO–06–905T. Washington, D.C.: June 22, 2006.

VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited. GAO–05–1052T. Washington, D.C.: September 28, 2005.

Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information. GAO–05–1051T. Washington, D.C.: September 28, 2005.

1Military and Veterans' Benefits: Improvements Needed in Transition Assistance Services for Reserves and National Guard. GAO–05–844T. Washington, D.C.: June 29, 2005.

Military and Veterans' Benefits: Enhanced Services Could Improve Transition Assistance for Reserves and National Guard. GAO–05–544. Washington, D.C.: May 20, 2005.

DOD and VA: Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services. GAO–05–722T. Washington, D.C.: May 19, 2005.

Vocational Rehabilitation: VA Has Opportunities to Improve Services, but Faces Significant Challenges. GAO–05–572T. Washington, D.C.: April 20, 2005.

VA Disability Benefits and Health Care: Providing Certain Services to the Seriously Injured Poses Challenges. GAO–05–444T. Washington, D.C.: March 17, 2005.

Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers. GAO–05–167. Washington, D.C.: January 14, 2005.

Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data. GAO–04–402T. Washington, D.C.: March 17, 2004.

Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems. GAO–04–271T. Washington, D.C.: November 19, 2003.

Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing. GAO–01–459. Washington, D.C.: April 30, 2001.

UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE

Report to the Ranking Democratic Member, Committee on Veterans' Affairs, House of Representatives

VOCATIONAL REHABILITATION—More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers

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Contents

Figures

Abbreviations

DOD Department of Defense

MTF Military Treatment Facility

VR&E Vocational Rehabilitation and Employment

VA Department of Veterans Affairs

U.S. General Accounting Office
Washington, DC, 20548
January 14, 2005

Hon. Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

Since the onset of U.S. operations in Afghanistan in October 2001 and Iraq in March 2003, the Department of Defense (DOD) has reported that more than 10,000 service men and women have been injured in combat. While many return to active duty after they are treated, others who are more seriously injured are likely to be discharged from their military obligations and return to civilian life with disabilities. In addition to cash compensation, the Department of Veterans Affairs (VA) offers vocational rehabilitation and employment (VR&E) services to help veterans with disabilities restore their lives and participate in the civilian work force. We have reported that intervening early after a disabling injury increases the likelihood that an individual will successfully return to work.[1] Moreover, there is growing awareness that people with disabilities can and want to work and that changes in the nature of work and advances in assistive technologies help them to do so. Further, as the U.S. work force is projected to shrink, the U.S. economy will need all who are able to participate in the paid labor force. Because federal disability programs, including VA's, lack emphasis on the potential for vocational rehabilitation to return people to work and also rely on outmoded assumptions about the relationship between impairment and work, we have designated these as "high-risk" programs.[2]

In view of the importance of early intervention in returning people who have been disabled to work, you asked that we review how quickly VA is able to provide VR&E services to seriously injured servicemembers from Afghanistan and Iraq who are likely to become veterans with disabilities. We assessed (1) how VA expedites VR&E services to these seriously injured servicemembers and (2) the challenges VA faces in its efforts to do so.

To address these objectives, we reviewed VA's formal and informal procedures for expediting VR&E services to seriously injured servicemembers returning from Afghanistan and Iraq. We reviewed applicable laws and regulations. We interviewed officials at VA's central office and at 12 of VA's 57 regional offices. Five of these offices are located near the five major Army medical treatment facilities treating the majority of the seriously injured Army servicemembers: Brooke Army Medical Center at Fort Sam Houston, Texas; Darnall Army Community Hospital at Fort Hood, Texas; Eisenhower Army Medical Center at Fort Gordon, Georgia; Madigan Army Medical Center at Fort Lewis, Washington; and Walter Reed Army Medical Center in Washington, D.C. The corresponding VA regional offices are Houston and Waco, Texas; Atlanta, Georgia; Seattle, Washington; and Washington, D.C. We selected the other seven regional offices based on Army data indicating that servicemembers injured in Afghanistan and Iraq are being treated at military treatment facilities in their regions. They are Buffalo, New York; Denver, Colorado; Muskogee, Oklahoma; Nashville, Tennessee; New Orleans, Louisiana; Wichita, Kansas; and Winston-Salem, North Carolina. Our findings for these regional offices cannot be generalized to all of VA's regional offices. We focused on Army servicemembers, including activated National Guard and Reserve, because they constituted the majority of servicemembers wounded in Afghanistan and Iraq. In addition, we visited Walter Reed Army Medical Center in Washington, D.C., where most seriously injured Army servicemembers are initially treated. We also interviewed DOD officials about their efforts to work with VA on the transition of injured servicemembers being discharged from active duty. We conducted our work between April 2004 and November 2004 in accordance with generally accepted government auditing standards.

Results in Brief

We found that VA has taken steps to expedite VR&E services for seriously injured servicemembers returning from Iraq and Afghanistan. VA has instructed its regional offices to make seriously injured servicemembers a high priority for all VA assistance and asked DOD to share data that would help VA identify and monitor them. Because most seriously injured servicemembers are initially treated at major

[1] GAO, SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs, GAO–96–133 (Washington, D.C.: July 11, 1996).
[2] GAO, High-Risk Series: An Update, GAO–03–119 (Washington, D.C.: Jan. 2003).

military treatment facilities, VA deployed staff to these sites to provide information on VA benefits programs, including VR&E services, to servicemembers injured in the conflicts in Afghanistan and Iraq. To ensure the identification and monitoring of all seriously injured servicemembers, VA initiated a memorandum of agreement proposing that DOD systematically provide information on them, including their names, location, and medical condition. Pending an agreement with DOD, VA instructed its regional offices to establish local liaison with military medical treatment facilities in their areas to learn who the seriously injured are, where they are located, and the severity of their injuries. Reliance on local relationships, however, has resulted in varying completeness and reliability of information developed by the 12 regional offices in our review. We also found that VA has no policy for VR&E staff to maintain contact with seriously injured servicemembers who do not apply for VR&E services. Nevertheless, some offices reported efforts to maintain contact with these servicemembers, noting that some who are not initially ready to consider employment when contacted about VR&E services may be receptive at a future time.

We found significant challenges to VA's efforts to expedite VR&E services. An inherent challenge is that individual differences and uncertainties in the recovery process make it difficult to determine when a seriously injured service Member will be ready to consider VR&E services. Additionally, given that VA is conducting outreach to servicemembers whose discharge from military service is not yet certain, VA is challenged by DOD's concerns that VA's outreach about benefits, including early intervention with VR&E services, could work at cross purposes to the military's retention goals. Finally, VA is currently challenged by a lack of access to DOD data that would, at a minimum, allow the agency to readily identify and locate all seriously injured servicemembers. VA officials we interviewed both in the regional offices and at the central office reported that this information would provide them with a more reliable way to identify and monitor the progress of those servicemembers with serious injuries. However, DOD officials reported that they have privacy concerns about the type of information that VA had requested and the time that VA wants it to be provided.

To improve VA's efforts to expedite VR&E services, we recommend that VA and DOD collaborate to reach agreement about information that VA needs to promote the recovery and return to work of seriously injured servicemembers and that VA develop a policy and procedures for maintaining contact with those who do not initially apply for VR&E services. VA and DOD provided written comments on a draft of this report. Both VA and DOD generally concurred with our findings and recommendations.

Background

VA's VR&E program is designed to ensure that veterans with disabilities find meaningful work and achieve maximum independence in daily living. In 2004, VA estimates that it spent more than $670 million on its VR&E program to serve about 73,000 participants. This represents about 2 percent of VA's $37 billion budget for nonmedical benefits, most of which involves cash compensation for veterans with disabilities.

VR&E services include vocational counseling, evaluation, and training that can include payment for tuition and other expenses for education, as well as job placement assistance. Interested veterans generally apply for VR&E services after they have applied and qualified for disability compensation based on a rating of their service-connected disability. This disability rating—ranging from 0 to 100 percent in 10 percent increments—entitles veterans to monthly cash payments based on their average loss in earning capacity resulting from a service-connected injury or combination of injuries. To be entitled to VR&E services, veterans with disabilities generally must have at least a 20 percent disability rating and an employment handicap as determined by a vocational rehabilitation counselor. Although cash compensation is not available to servicemembers until after they separate from the military, they can receive VR&E services prior to separation under certain circumstances.[3] To make these services available prior to discharge, VA expedites the determination of eligibility for VR&E by granting a preliminary rating, known as a memorandum rating.

VA's outreach to servicemembers who plan to apply for veterans' disability compensation has been part of its transition assistance program, which was established

[3] Hospitalized military personnel pending discharge may receive all vocational rehabilitation and employment benefits—such as counseling, evaluation, and training—except for the monthly subsistence allowance. 38 U.S.C. §§ 3102, 3104, and 3113.

in 1990.[4] Either in group sessions or in one-on-one encounters, VA provides servicemembers with information about disability benefits and services, which includes the VR&E program, and offers assistance in applying for them. In addition, VA administers a pre-discharge program that expedites the disability compensation claims processing for servicemembers who are pending discharge. This program also helps VR&E staff identify those who could benefit from vocational rehabilitation and employment services. VA has recently included activated National Guard and Reserve Members in its outreach efforts.

Servicemembers injured in Iraq and Afghanistan are surviving injuries that would have been fatal in past conflicts, due, in part, to advanced protective equipment and medical treatment. However, the severity of their injuries can result in a lengthy transition from injured servicemember to veteran. Initially, most seriously injured servicemembers, including activated National Guard and Reserve Members, are brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are transported to the appropriate U.S. medical facilities, which are usually major military treatment facilities (MTFs) but may also be VA medical centers. According to DOD officials, once stabilized and discharged from the hospital, servicemembers usually relocate to be closer to their homes or military bases and are treated as outpatients by the closest VA or military hospital. (See fig. 1.) At this point, the military generally begins to assess whether the servicemember will be able to remain in the military, a process that could take months to complete. The process can take even longer if the servicemember appeals the military's initial disability decision.

Figure 1: Seriously Injured Army Servicemembers Receive Treatment at Five Major Army Medical Facilities and Relocate to One of 57 VA Regions after Medical Stabilization

Source: GAO analysis of DOD and VA data and Art Explosion.

In response to recommendations made by the VA Vocational Rehabilitation and Employment Task Force, VA is beginning to change its approach to VR&E to better reflect contemporary views of disability. The Secretary of Veterans Affairs established this external task force in 2003 to conduct a comprehensive review of VA's

[4] GAO, Military and Veterans' Benefits: Observations on the Transition Assistance Program, GAO–02–914T (Washington, D.C.: July 18, 2002).

VR&E program.[5] In addition, faced with the immediate need to provide benefits and services to a new generation of veterans with disabilities, VA in August 2003 formed an internal task force to develop and implement policies to improve the transition of injured servicemembers back to civilian life. Known as the Seamless Transition Task Force, it included ad hoc participation from DOD.[6] Although this task force's initial priority was to ensure the continuity of medical care for injured servicemembers as they transition from military to VA health care, it has also coordinated efforts to ensure access to all other VA benefits, including VR&E services.

We have previously reported on the importance of early intervention to maximize the work potential of individuals with disabilities. We have also reported, however, that current Federal disability programs offer little opportunity for early intervention with individuals who apply for compensation. These programs require lengthy assessments in which applicants must focus on demonstrating their work limitations rather than their abilities and potential to work.[7] Consequently, vocational rehabilitation is typically introduced late in the process. Furthermore, we have designated Federal disability programs, including VA's, as high-risk programs because they lack emphasis on the potential for vocational rehabilitation to return people to work and also rely on outmoded assumptions about the relationship between impairment and work.

VA Has Taken Steps to Expedite Vocational Rehabilitation and Employment Services for Seriously Injured Servicemembers

VA has instructed its regional offices to make seriously injured servicemembers a high priority for all VA assistance and asked DOD to provide data that would ensure VA's ability to identify and monitor this population. Because many seriously injured servicemembers are initially treated at major military treatment facilities, VA has deployed staff to these sites to provide information on all veterans' benefits, including VR&E services. To ensure the identification and monitoring of all seriously injured servicemembers, VA initiated a memorandum of agreement proposing that DOD share a range of information, including the names of those with serious injuries, their medical condition, and their military status. As of December 2004, a formal agreement with DOD had not been reached. In the meantime, VA has instructed its regional offices to develop local liaison with DOD in order to identify and assist seriously injured servicemembers. The 12 regional offices we reviewed have developed information of varying completeness and reliability. However, once regional offices have identified and contacted seriously injured servicemembers, VA has no policy for VR&E staff to maintain contact with those individuals who do not apply for VR&E services while in the hospital or after they return home. Nevertheless, some regional offices reported maintaining contact with these servicemembers while others did not.

VA Has Instructed Its Regional Offices to Make Seriously Injured Servicemembers a High Priority and Asked DOD for Data to Help Identify Them

In a September 2003 letter, VA instructed its regional offices to provide priority consideration and assistance to seriously injured servicemembers returning from Afghanistan and Iraq. VA specifically instructed regional offices to focus on servicemembers whose disabilities are definitely or likely to result in military separation. Minimally, this includes servicemembers with injuries DOD has classified as "very serious," "serious," or in a "special category."[8] In this letter, VA instructed its regional offices to assign a case manager to each seriously injured servicemember who applies for disability compensation. In addition, VA noted the particular importance of early intervention for those who are seriously injured and emphasized that seri-

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[5] VA Vocational Rehabilitation and Employment Task Force. Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st century Veteran (Washington, D.C.: March 2004).

[6] DOD has supported transition assistance in various ways. For example, the VA/DOD Joint Executive Committee was established in February 2002 to further promote collaboration between the two agencies, including resolving obstacles to information sharing. The Committee is chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. In addition, the Army—in cooperation with VA—established the Disabled Soldier Support System (DS3) in April 2004 as an advocacy group and information clearinghouse to clarify the services available to disabled soldiers as they transition to civilian life.

[7] GAO, SSA Disability: Program Redesign Necessary to Encourage Return to Work, GAO/HEHS–96–62 (Washington, D.C.: Apr. 24, 1996).

[8] Army regulations classify illness and injuries as "very serious" when life is imminently endangered; as "serious" when there is a cause for immediate concern but there is no imminent danger to life; and as "special category" when the patient has a particular condition, such as loss of limb or sight, a psychiatric condition, paralysis, or a permanent disfigurement.

ously injured servicemembers applying for VR&E should receive the fastest possible service. Moreover, VA reminded VR&E staff that they can initiate evaluation and counseling and, in some cases, authorize training before a servicemember is discharged.

Since most seriously injured servicemembers are initially treated at major MTFs, VA has detailed staff to these facilities.[9] These staff have included VA social workers and disability compensation benefits counselors. In addition to these staff, at Walter Reed, where the largest number of seriously injured servicemembers has been treated, VA's Washington D.C. regional office has since 2001 provided a vocational rehabilitation counselor to work with hospitalized patients.

To identify and monitor those whose injuries may result in a need for VA services, including vocational rehabilitation, VA has asked DOD to share data about injured servicemembers. VA has been working to develop a formal agreement with DOD on what specific information to share. In the spring of 2004, VA submitted a draft memorandum of agreement to DOD's Office of the Assistant Secretary of Defense for Health Affairs proposing that DOD provide lists of all injured servicemembers admitted to MTFs. In addition, VA requested personal identifying information, medical information, and DOD's injury classification for each listed servicemember. VA also requested monthly lists of servicemembers being evaluated for medical separation from military service. Several VA officials and regional office staff we interviewed said that systematic information from DOD would provide them with a way to more reliably identify and monitor seriously injured servicemembers. As of December 2004, a formal agreement with DOD was still pending.

VA Regional Offices Have Relied on Local Liaisons with MTFs In Order to Identify Seriously Injured Servicemembers Who May Need Assistance

In the absence of a formal arrangement to ensure that DOD provides data on seriously injured servicemembers, VA has relied on its regional offices to obtain information about them. In its September 2003 letter, the agency asked the regional offices to coordinate with staff at MTFs and VA medical centers in their areas to ascertain the identities, medical conditions, and military status of the seriously injured. While VA officials reported to us that they had provided veterans' benefits information to injured servicemembers, they did not have complete and reliable data as to how many of these were seriously injured.

In response to guidance by VA's central office, every regional office has designated a coordinator to serve as a point of contact with MTFs and VA medical centers, as well as other VA regional offices, in order to monitor injured servicemembers as they relocate across the country. When servicemembers are discharged from an MTF, VA officials told us that the affiliated VA regional office coordinator notifies the coordinator in the region to which the person relocates. The new coordinator contacts the seriously injured servicemember to discuss any claims that have been filed and to provide those who have not already done so an opportunity to apply for other benefits, including VR&E services. Regional officials we interviewed reported that they have followed VA's instructions to keep updated logs of all contacts they have with seriously injured servicemembers. Regional offices are required to send these logs to VA's central office, which uses them to monitor outreach.

In our review of 12 regional offices, we found that they have developed different information sources resulting in varying levels of information on seriously injured servicemembers. The nature of the local relationships between VA staff and military staff at MTFs was a key factor in the completeness and reliability of the information that the military provided. For example, the military MTF staff at one regional office provided VA staff with only the names of new patients with no indication of the severity of their condition or the theater from which they were returning. Another regional office reported receiving lists of servicemembers for whom the Army has initiated a medical separation in addition to lists of patients with information on the severity of their injuries. Some regional offices were able to capitalize on longstanding informal relationships. For example, the VA coordinator responsible for identifying and monitoring the seriously injured at one regional office had served as an Army nurse at the local MTF and was provided all pertinent information. In contrast, staff at another regional office reported that local military staff did not until recently provide them with information on seriously injured servicemembers admitted to the MTF.

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[9] These six facilities are Brooke Army Medical Center in Texas; Walter Reed Army Medical Center in Washington, D.C.; Madigan Army Medical Center in Washington; Darnall Army Community Hospital in Texas; Eisenhower Army Medical Center in Georgia; and the Bethesda Naval Medical Center in Maryland. We focused on the five Army medical treatment facilities.

Once they have identified the seriously injured servicemembers, regional office staff reported that they are largely following outreach, coordination, and case management procedures outlined in VA's September 2003 guidance. Under these procedures, disability compensation benefit counselors usually conduct VA's initial outreach by contacting hospitalized servicemembers to provide information on all veterans' benefits, including VR&E. Traditionally responsible for taking applications and processing disability compensation claims, these staff Members are neither vocational rehabilitation experts nor are they generally trained to work with persons who have serious injuries. Accordingly, VA reported that it has begun requiring all staff Members who provide in-person or telephone outreach to receive training on how to interact with seriously injured servicemembers. VR&E staff reported that they generally rely on the benefits counselors to notify them of injured servicemembers at MTFs who are interested in or who apply for VR&E. Only then would a vocational rehabilitation counselor or counseling psychologist usually contact the hospitalized servicemember to begin counseling and evaluation. In one regional office, VR&E staff said that they do not contact injured servicemembers until they apply for services and obtain a memorandum rating establishing their eligibility.

The Washington, D.C., regional office has assigned a vocational rehabilitation counselor to be available on site at Walter Reed Army Medical Center, where a large number of seriously injured servicemembers are treated. Although VA also deployed benefits counselors to Walter Reed who are responsible for outreach activities and the provision of information on all VA benefits, the VR&E counselor works with hospitalized patients specifically to offer and provide vocational counseling and evaluation. She reported attempting to contact all patients within 48 hours of their arrival and visiting them routinely thereafter to establish rapport. Her primary mission is to work with servicemembers who will need to prepare for civilian employment, although she told us that her early intervention efforts could also help servicemembers who are able to remain in the military.

According to VA staff, many seriously injured servicemembers are not ready or able to consider VR&E services when they are first contacted. Yet, we found that VA has no policy for maintaining contact with those servicemembers who do not apply for VR&E services when they were in the hospital or when they returned to a home base or to their residence. Several regional offices reported that they do not stay in contact with these individuals while others attempt to do so in various ways. One office said it is considering contacting them after 1 year. Another regional VR&E officer reported that staff ask the servicemembers to specify when they would like to be contacted for further information or to BEGIN Program participation. Staff at this regional office noted that they are strong advocates of early intervention. They said that they try to contact servicemembers as soon as possible to establish rapport and provide VR&E program information even before the servicemembers are physically ready to begin developing a vocational rehabilitation plan. At the same time, they noted that readiness to participate in VR&E varies by individual and that professional judgment is required to balance effective outreach with an approach that could be viewed as intrusive.

VR&E program officials noted the potential value of maintaining contact with seriously injured servicemembers who may not initially be ready to participate when initially contacted by VA, but they also recognized the need to focus resources on those who do participate. Nevertheless, officials from a veterans service organization told us that it is critical to maintain contact with seriously injured veterans who do not initially apply for VR&E because they may need months or even years before they are ready. In our prior work, we have also noted that maintaining contact with individuals who have disabilities may help encourage their return to work.[10]

VA Faces Significant Challenges in Expediting Services to Seriously Injured Servicemembers

While experts and advocates for individuals with disabilities attest to the value of early intervention for returning people to work, VA is challenged to reach injured servicemembers early for several reasons. First, determining the best time to approach recently injured servicemembers and gauge their personal receptivity to consider employment in the civilian sector is inherently difficult. The nature of the recovery process is highly individualized and requires professional judgment to determine the appropriate time to begin vocational rehabilitation. Further, because VA is trying to prepare servicemembers who are still on active duty for a transition to civilian life, DOD is concerned that VA's efforts may be working at cross purposes to the military's retention goals. Finally, because VA lacks systematic information

[10] GAO, SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs, GAO/HEHS–96–133 (Washington, D.C: July 11, 1996).

from DOD on seriously injured servicemembers, VA cannot ensure that all servicemembers and veterans who could benefit from the VR&E program have the opportunity to receive services at the appropriate time.

Individual Differences in the Recovery Process Complicate the Timing of Early Intervention

Individual differences and uncertainties in the recovery process make it inherently difficult to determine when a seriously injured servicemember will be ready to consider vocational rehabilitation. Since the appropriate time to intervene depends to a large extent on the individual's medical condition and personal readiness, the time to broach the subject of a return to work, whether in the military or the civilian labor force, will vary. Regional office staff reported that many servicemembers are eager to return to military duty and do not intend to consider a career outside military service. They also reported that many injured servicemembers need time to recover and adjust to the likelihood that they may have to leave the military and prepare for civilian employment.

Because of the individual differences in receptivity to VR&E, VA staff reported needing to monitor the condition of seriously injured servicemembers and to engage them more than once during their recovery to be able to gauge their readiness for VR&E. One regional VR&E official told us that VA could benefit from more collaboration with DOD medical staff in order to make decisions on the appropriate timing of VR&E intervention. The vocational rehabilitation counselor at Walter Reed reported visiting servicemembers routinely, including evenings and weekends, so that she would be available when they were ready to discuss their need for vocational rehabilitation. For one patient, she reported visiting him 12 times before he expressed interest in VR&E. In some locations, VA staff reported participating in predischarge planning meetings with military and medical staff, which they said helped them stay informed about the servicemember's condition and likely discharge and provided an opportunity to include VR&E in their discharge planning.

VA Is Challenged by DOD's Concern that Early Intervention Could Work at Cross Purposes to Military Retention

VA is also challenged by DOD's concern that outreach about VA benefits, including disability compensation and VR&E services, could work at cross purposes to military retention goals. In particular, DOD expressed concern about the timing of VA's outreach to servicemembers whose discharge from military service is not yet certain. To expedite VR&E services, VA's outreach process may overlap with the military's process for evaluating servicemembers for a possible return to duty. According to DOD officials, it may be premature for VA to begin working with injured servicemembers who may eventually return to active duty. (See fig. 2.) With advances in medicine and prosthetic devices, many serious injuries no longer result in work-related impairments. Army officials who track injured servicemembers told us that many seriously injured servicemembers overcome their injuries and return to active duty. Recognizing this potential, both Congress [11] and the President have recently expressed interest in seeing the military provide the retraining needed to support the return of injured servicemembers to their military occupations or other occupations within the military if possible. In an attempt to enable more amputees to return to active duty, Walter Reed Army Medical Center plans to open a new rehabilitation center in 2005.

Both VA and DOD officials suggested that the earliest appropriate time for VA to intervene for regular active duty servicemembers would be when it is clear that the servicemember will not be retained by the military. Currently, VA can only provide VR&E services to active duty servicemembers who are pending discharge due to a disability. VR&E services could begin earlier for injured Members of the National Guard and Reserve since these individuals usually expect to return to their previous civilian employment. They may need VR&E services to return to their prior employment or to prepare for a different occupation in the civilian economy.

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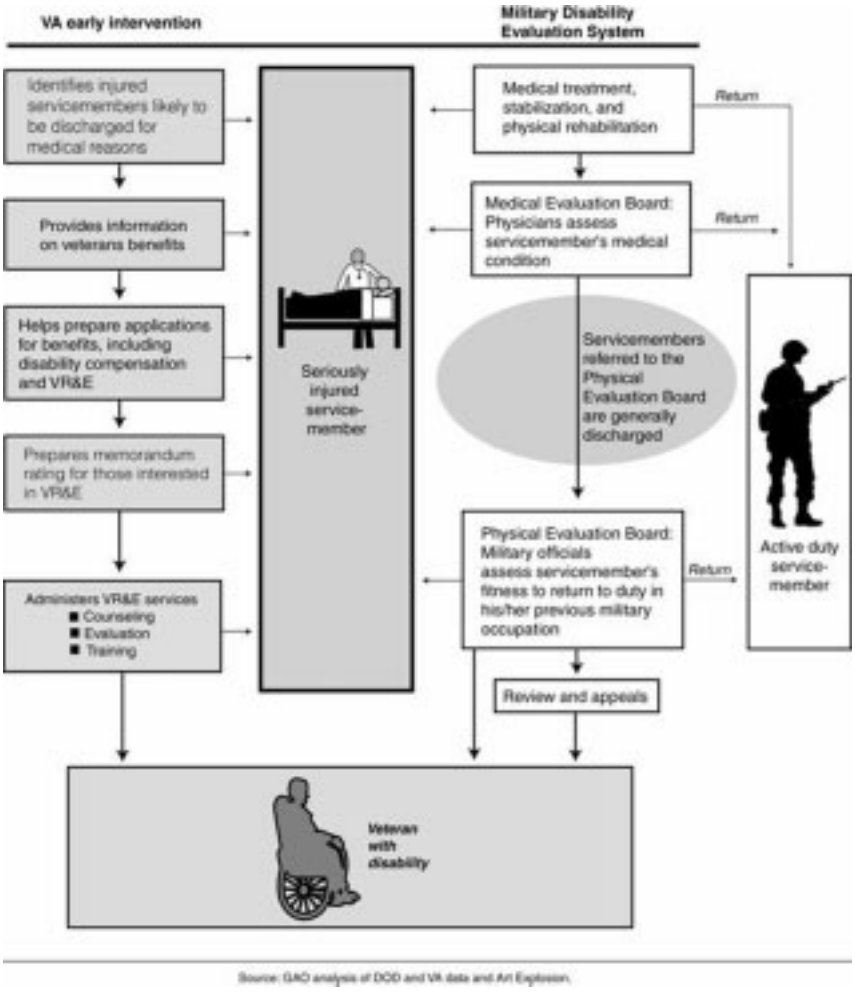
[11] Congress expressed its sense that the Secretary of Defense should develop protocols that include options for injured servicemembers who are highly motivated to return to active duty service and for them to be retrained to perform military missions fo which they are fully capable. Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Pub. L. No. 108–375, § 588, Oct. 28, 2004, the "Sense of Congress Regarding Return of Members to Active Duty Service upon Rehabilitation from Service-Related Injuries."

Figure 2: VA's Early Intervention Could Work at Cross Purposes to DOD's Retention Evaluation Process



Source: GAO analysis of DOD and VA data and Art Explosion.

VA Is Also Challenged by the Lack of Access to Systematic Data Regarding Seriously Injured Servicemembers

In the absence of a formal information sharing agreement with DOD, VA does not have systematic access to DOD data about the population who may need its services. Specifically, VA cannot reliably identify all seriously injured servicemembers or know with certainty when they are medically stabilized, when they are undergoing evaluation for a medical discharge, or when they are actually medically discharged from the military. VA has instead had to rely on ad hoc regional office arrangements at the local level to identify and obtain specific data about seriously injured servicemembers. While regional office staff generally expressed confidence that the information sources they developed enabled them to identify most seriously injured servicemembers, they have no official data source from DOD with which to confirm the completeness and reliability of their data nor can they provide reasonable assurance that some seriously injured servicemembers have not been overlooked. In addition, informal data sharing relationships could break down with changes in personnel at either the MTF or the regional office.

DOD officials expressed their concerns about the type of information to be shared and when the information would be shared. DOD noted that it needed to comply with legal privacy rules on sharing individual patient information.[12] DOD officials told us that information could be made available to VA "upon separation" from military service, that is, when a servicemember enters the separation process. At this time, servicemembers would undergo assessment by a physical evaluation board, which DOD officials said typically takes between 30 to 90 days and usually results in a medical discharge from the military. However, prior to separation, information can only be provided under certain circumstances, such as when a patient's authorization is obtained.[13]

Conclusions

VA has taken steps to help the nation's newest generation of veterans move forward with their lives, particularly those who return from combat with disabling injuries. VA has made seriously injured servicemembers a priority and, among other measures, deployed staff to major MTFs to conduct outreach to them prior to separation. However, VA benefits counselors are usually the first VA representatives to contact injured servicemembers. While they may provide an overview of all VA benefits, they may not emphasize vocational rehabilitation and employment services.

The importance of early intervention for returning individuals with disabilities to the work force is well documented in the vocational rehabilitation literature. However, the lack of an agreement with DOD for systematic data sharing impedes VA's attempt to identify all seriously injured servicemembers who might benefit from such intervention. It also poses the risk that some who are discharged with disabilities may be overlooked and not afforded the opportunity for VR&E. As VA recognizes, the current ad hoc approach of their regional offices for obtaining information is not the most efficient way to proceed. Furthermore, because individuals with disabilities vary in their readiness and need for VR&E services, maintaining contact with them would better ensure that VR&E staff know when the person is ready to participate. Because VA has no policy for maintaining contact with those who do not apply for VR&E, opportunities to rehabilitate veterans who have sustained serious injuries in Afghanistan and Iraq may be lost.

At a time when the U.S. labor force is projected to shrink, it is imperative that those who can work, whether in military or civilian jobs, are well supported in their efforts to do so. VA's early VR&E efforts, rather than working at cross purposes to DOD goals, could facilitate servicemembers' return to the same or different military occupation, or to a civilian occupation, if they were not able to remain in the military. In this regard, the prospect for early intervention with VR&E services presents both a challenge and an opportunity for VA and DOD to collaborate to provide better outcomes for this new generation of seriously injured servicemembers.

Recommendations

To improve VA's efforts to expedite VR&E services to seriously injured servicemembers, we recommend that VA and DOD collaborate to reach an agreement for VA to have access to information that both agencies agree is needed to promote servicemembers' recovery and return to work.

We also recommend that the Secretary of Veterans Affairs direct the Under Secretary for Benefits to develop a policy and procedures for regional offices to maintain contact with seriously injured servicemembers who do not initially apply for VR&E services, in order to ensure that they have the opportunity to participate in the program when they are ready.

Agency Comments

In commenting on a draft of this report, VA concurred with our findings and recommendations. VA emphasized that access to DOD information is crucial to promoting servicemembers' recovery and return to work and, to that end, is currently negotiating an agreement to allow VA to obtain protected medical information on servicemembers prior to their discharge for VA benefits purposes. In addition, VA noted that its follow-up policies and procedures include sending veterans information on VR&E benefits upon notification of a disability compensation award and 60 days later. However, we believe a more individualized approach, such as maintaining personal contact, could better ensure the opportunity for veterans to participate in the program when they are ready. VA noted that it is currently reviewing its out-

[12] Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 C.F.R. Parts 160 and 164.

[13] 45 C.F.R. § 164.508(a).

reach and follow-up procedures for injured servicemembers and will make any appropriate revisions. VA's written comments are reprinted in appendix I.

DOD also concurred with our findings and recommendations. DOD stated its commitment to retaining seriously injured servicemembers who are able and willing to return to duty. DOD also noted that a draft memorandum of agreement for information sharing between VA and DOD is under consideration by the two departments and the military services. DOD's written comments are reprinted in appendix II.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days after the date of this letter. We will then send copies of this report to the Secretary of Veterans Affairs, the Secretary of Defense, appropriate congressional Committees, and other interested parties. The report will also be available on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions regarding this report, please call me at (202) 512–7215 or Irene Chu, Assistant Director, at (202) 512–7102.

Susan Bernstein, Connie Peebles Barrow, Margaret Boeckmann, William R. Chatlos, Clarette Kim, Joseph J. Natalicchio, and Roger Thomas also made key contributions to this report.

Sincerely yours,

Cynthia A. Bascetta
Director, Education, Work force,
and Income Security Issues

Appendix I: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

January 7, 2005

Ms. Cynthia Bascetta
Director
Education, Workforce, and Income Security Issues
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VOCATIONAL REHABILITATION: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers,*** (GAO-05-167). VA concurs with GAO's findings and recommendations. Further discussion is included in the enclosure.

VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

Anthony J. Principi

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS (VA)
COMMENTS TO
GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT,
VOCATIONAL REHABILITATION: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers
(GAO-05-167)

To improve VA's efforts to expedite VR&E services to seriously injured servicemembers, we recommend that VA and DOD collaborate to reach an agreement for VA to have access to information that both agencies agree is needed to promote servicemembers' recovery and return to work.

Concur – The Department of Veterans Affairs (VA) concurs with this finding and recommendation. VA recognizes that access to DoD information is crucial to promote servicemembers' recovery and return to work. VA has been working closely with DoD with a goal of providing a seamless transition to all servicemembers who will enter the VA system. To that end, a Memorandum of Understanding is currently being negotiated that will allow VA to obtain from DoD the servicemembers' protected medical information prior to discharge from service. VA's Office of General Counsel is confident that there are exceptions in the Privacy Rule that permit service medical information to be disclosed for VA benefits purposes and has pressed the case with DoD's General Counsel.

We also recommend that the Secretary of Veterans Affairs direct the Under Secretary for Benefits to develop a policy and procedures for regional offices to maintain contact with seriously injured servicemembers who do not initially apply for VR&E services, in order to ensure that they have the opportunity to participate in the program when they are ready.

Concur – VA concurs with this finding and recommendation. VBA has developed specific policies and procedures that address outreach and follow-up activities for injured servicemembers, including those that do not file a claim for Vocational Rehabilitation and Employment (VR&E) benefits during their initial contacts with VA. That guidance is contained in Veterans Benefits Administration (VBA) Letter 20-03-36. A brief outline of those activities follows.

Enclosure

DEPARTMENT OF VETERANS AFFAIRS (VA)
COMMENTS TO
GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT,
VOCATIONAL REHABILITATION: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers
(GAO-05-167)

First, the regional office director will contact the servicemember when he or she arrives in the regional office's jurisdiction. Regional offices have Operation Enduring Freedom/Operation Iraqi Freedom coordinators and case managers. The coordinator ensures that the injured servicemember is personally provided information on all VA benefits and services. The coordinator enters information on the servicemember into a tracking log and establishes a diary for follow-up activity.

When a claim for compensation is received, a Veterans Service Center case manager is assigned to that case. The case manager contacts the veteran and again reviews all benefits and services available through VA, including VR&E benefits. Compensation is awarded after the servicemember is discharged from the military. When the veteran receives his or her first disability compensation award, VA sends another application for VR&E benefits along with information explaining the program. The case is diaried for follow-up in 60 days. If no application for vocational rehabilitation and employment benefits is received by the end of the 60 days, VR&E sends a motivation packet to the veteran.

VBA is currently reviewing all policies and procedures contained in VBA Letter 20-03-36, and will revise them as determined appropriate.

Appendix II: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D C 20301-1200

HEALTH AFFAIRS

JAN 04 2005

Ms. Cynthia A. Bascetta
Director, Health Care-Veterans'
Health and Benefits Issues
U.S. Government Accountability Office
441 G Street, N.W
Washington, DC 20548

Dear Ms. Bascetta:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report, "VOCATIONAL REHABILITATION: More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers," dated January 2004 (GAO Code 130370/GAO-05-167).

DoD appreciates the opportunity to comment on the draft report and concurs with the GAO findings and recommendations with the attached comments.

Please direct any questions to my points of contact on this matter, Mr. Kenneth Cox (functional) at (703) 681-0039, ext. 3602 and Mr Gunther J. Zimmerman (Audit Liaison) at (703) 681-3492 ext 4065.

Sincerely,

William Winkenwerder, Jr., MD

Enclosures.
1. Overall Comments
2 Technical Comments

GAO DRAFT REPORT – DATED DECEMBER 14, 2004
(GAO CODE- 130370/GAO-05-167)

"VOCATIONAL REHABILITATION: More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers

DEPARTMENT OF DEFENSE COMMENTS

This draft report provides a review of the Department of Veterans' Affairs efforts to provide rehabilitative services and employment retraining to active duty members injured in Operation Enduring Freedom/Operation Iraqi Freedom.

Overall Comments:

- The Government Accountability Office (GAO) report accurately depicts the Department of Defense's (DoD) commitment to retaining seriously injured servicemembers who have the potential and the desire to be returned to duty whenever possible.

- The GAO reports that the Department of Veterans Affairs (VA) is also challenged by lack of access to systematic data regarding seriously injured Service members. GAO recommends that the two departments "collaborate to reach an agreement for VA to have access to information that both agencies agree is needed to promote recovery and return to work for seriously injured Service members."

  DoD is collaborating with VA to develop a Memorandum of Agreement (MOA) establishing responsibilities for each department regarding the sharing of personal health information data in such a manner that it supports the seamless transition of Service members and is in compliance with applicable Health Insurance Portability and Accountability Act privacy requirements. At the time of this draft report, a draft of the MOA has been developed and is being coordinated with relevant subject matter experts in both departments and the military services.

- DoD offers the technical comments on the following page.

GAO DRAFT REPORT – DATED DECMEBER 14, 2004
(GAO CODE- 130370/GAO-05-167)

"VOCATIONAL REHABILITATION: More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers

DEPARTMENT OF DEFENSE COMMENTS

Technical Comments:

No technical comments received from the Services to date.

Related GAO Products

VA and Defense Health Care: More Information Needed to Determine if VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services. GAO–04–1069. Washington, D.C.: September 20, 2004.

VA Vocational Rehabilitation and Employment Program: GAO Comments on Key Task Force Findings and Recommendations. GAO–04–853. Washington, D.C.: June 15, 2004.

VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration. GAO–03–1172T. Washington, D.C.: September 23, 2003.

High-Risk Series: An Update. GAO–03–119. Washington, D.C.: January 2003.

Major Management Challenges and Program Risks: Department of Veterans Affairs. GAO–03–110. Washington, D.C.: January 2003.

SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity. GAO–02–597. Washington, D.C.: August 9, 2002.

Military and Veterans' Benefits: Observations on the Transition Assistance Program. GAO–02–914T. Washington, D.C.: July 18, 2002.

SSA Disability: Other Programs May Provide Lessons from Improving Return-to-Work Efforts. GAO–01–153. Washington, D.C.: January 12, 2001.

Vocational Rehabilitation: Opportunities to Improve Program Effectiveness. GAO/T–HEHS–98–87. Washington, D.C.: February 4, 1998.

Veterans Benefits Administration: Focusing on Results in Vocational Rehabilitation and Education Programs. GAO/T–HEHS–97–148. Washington, D.C.: June 5, 1997.

Vocational Rehabilitation: VA Continues to Place Few Disabled Veterans in Jobs. GAO/HEHS–96–155. Washington, D.C.: September 3, 1996.

SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs. GAO/HEHS–96–133. Washington, D.C: July 11, 1996.

SSA Disability: Program Redesign Necessary to Encourage Return to Work. GAO/HEHS–96–62. Washington, D.C.: April 24, 1996.

Cedar Park, TX
March 27, 2007

Hon. Harry E. Mitchell
Hon. Virginia Brown-Waite
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives

Dear Chairman Mitchell and Ranking Member Brown-Waite:

Please find my enclosed answers to your follow-up questions from your March 8, 2007, hearing regarding seamless transition of new Iraq and Afghanistan war veterans from the military to the Department of Veterans Affairs (VA).

From July 2000 through March 2006, I worked as a lead program analyst (GS–14) in the Office of Performance Analysis and Integrity (OPA&I), which reported directly to the office of the Under Secretary for Benefits. The team I led as a project manager was identifying, monitoring, and providing analysis on the VA disability claims activity of veterans who had been deployed to the Iraq and Afghanistan wars, often referred to as the Global War on Terror (GWOT), and Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

In addition to regular briefings to OPA&I's Assistant Director and Director, on several occasions I briefed the Deputy Under Secretary for Benefits and the Chief of Staff at the Veterans Benefits Administration. During 2004, I regularly attended then-VA Secretary Anthony Principi's Task Force on Seamless Transition and prepared the year end report in 2004, which is also attached.

Question One: In your testimony, you referenced data sent to your supervisors relating to possible surges in disability compensation claims among the Iraq and Afghanistan war veterans. Please submit this material to the Committee.

In early 2005, the Department of Defense (DOD) began providing VA with consistent and nearly complete data on service Members deployed to the war zones who had separated from active duty. Shortly thereafter, VA began matching the DOD data with VA systems in order to count the number of veterans filing VA disability claims and monitor trends. Here are three e-mails containing statistics and/or analysis.

- July 8, 2005, e-mail from Susan Perez, Assistant Director, Office of Performance Analysis and Integrity to Jack McCoy, Associate Deputy Under Secretary for Benefits, citing "concerns" about GWOT claims. There were 13 attachments with this e-mail.
- August 26, 2005, e-mail from Paul Sullivan to Susan Perez, with a "strong warning" about claims activity among GWOT veterans. There were six attachments with this e-mail.
- October 5, 2005, e-mail from Paul Sullivan to Doris Morgan containing a power point briefing describing increasing claims among GWOT veterans for the Performance Analysis (PA) staff within OPA&I. The PA staff also briefs senior VA management each month. There is one attachment for this e-mail.

Question Two: Please also provide the Committee with a copy of the report by Harvard professor, Linda Bilmes, estimating the number of patients and the cost of the war.

Attached for your review is Professor Bilmes' report about the impact of the Iraq and Afghanistan wars on veterans and VA along with two columns she wrote about her report.

- *"Battle of Iraq's Wounded," Los Angeles Times, January 5, 2007*

- "Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits," Harvard University, January 8, 2007
- "Soldiers Trapped in Limbo," Boston Globe, March 21, 2007

I thank you for the opportunity to testify on March 8. If the Subcommittee has any additional question, please contact me.

Sincerely,

Paul Sullivan

[The Attachments reference above letter are being retained in Committee files.]

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