CARE OF SERIOUSLY WOUNDED AFTER INPATIENT CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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

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CONTENTS

March 13, 2008

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THURSDAY, MARCH 13, 2008

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 340, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Space, Walz, Brown-Waite, Stearns, Bilbray.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning. This hearing will come to order. This is the Subcommittee on Oversight and Investigations and the hearing today is on the care of seriously wounded after inpatient care.

We are here today to hear from veterans, their families, and the U.S. Department of Veterans Affairs (VA) about the long-term care of our most severely wounded Afghanistan and Iraqi veterans.

We do know that the U.S. Department of Defense (DoD) and VA provide excellent inpatient healthcare for these warriors, but many of the most seriously injured require extensive outpatient care, some for the rest of their life. Their families need care and assistance as well.

Unfortunately, once these veterans leave the hospital, the care they receive does not seem to be on par with what they receive directly following their injury. And I think we can do better.

Planning for veterans health care was not planned very well at the outset of this war. The need to provide care and assistance to wounded servicemembers and their families in significant number and for the long term has been largely ignored.

We will hear today what it has been like for some of them. Their stories are inspiring, but also discouraging. They are inspiring because even after they suffered terrible injuries, they carry no bitterness, only pride from their service, discouraging because they have been left to fend for themselves for too long.

The DoD and the VA are large organizations with an overwhelming bureaucracy. Their care and services often overlap in messy, unpredictable ways. At a time of enormous stress, this bureaucracy only hurts the injured warrior and his family.

When our troops return from theater with serious injuries, they are met with a dozen seemingly unrelated people with different services. We addressed much of these problems last year with the passage of the Wounded Warrior provisions in the Defense bill, but there is obviously still more to be done.

We need to realize that families are an integral part of treatment and recovery and have their own needs. Unfortunately, the VA is restricted from providing the many services families need and deserve when their sons and daughters, siblings, and parents return with service-connected injuries.

We have been playing catch-up since the beginning of this war. It is irresponsible that the only support structure available to a 19-year-old wife of an injured soldier is the wife of a similarly injured soldier. We are going to hear from people that have been dealing with the difficulties of the system for a long time.

On February 14, 2004, Sergeant Ted Wade lost his right arm and suffered severe traumatic brain injury (TBI), along with many other injuries in an improvised explosive device (IED) explosion in Iraq. Sergeant Wade is here today with his wife, Sarah.

Marine Corporal Casey Owens of Houston, Texas, lost both his legs when his unarmored Humvee struck a landmine in Iraq on September 20, 2004.

Corporal Owens and Ms. Wade will tell us about the frustrations and difficulties they have faced and we look forward to their testimony.

Sarah and Ted Wade have devoted themselves to helping hundreds of other injured servicemembers and their families.

Just 2 weeks after he was injured, Casey Owens told his family that he wanted a camcorder so he could document his progress from start to finish. He could only communicate by writing at the time of his request. He wanted to show his future children how far he had come and how good he had it. Today you can find Casey gliding down the slopes at Aspen.

We owe Corporal Owens and Sergeant Wade a great debt. We cannot repay that debt, but we can make sure that Corporal Owens and Sergeant Wade, their families, and everyone like them get long-term care and services that are also world class.

[The prepared statement of Chairman Mitchell appears on p. 49.]

Mr. MITCHELL. Before I recognize Ranking Republican Member for her remarks, I would like to swear in our witnesses. And I would ask all witnesses if they would please stand, and raise their right hand.

[Witnesses sworn.]

Mr. MITCHELL. Thank you.

Next I would like to ask unanimous consent that Mr. Lampson be invited to sit at the dais for the Subcommittee hearing today. Hearing no objection, so ordered.

Mr. Lampson, please join us at the dais.

I would now like to recognize Ms. Brown-Waite for opening remarks.

[Microphone technical difficulties.]

OPENING STATEMENT OF HON. GINNY BROWN–WAITE

Ms. BROWN-WAITE. Let us hope this works a little bit better. I am sorry.

Good morning. Mr. Chairman, I thank you for holding this hearing and also for yielding. I am going to keep my comments short because I am looking forward to hearing from our witnesses on how we can make the system better.

Over the past several years, this Committee has watched over the development of the Polytrauma Rehabilitation Care (PRC) units throughout the VA system. It has seen good work including one in my own neighborhood in Tampa, Florida.

We are happy that we are doing better on inpatient care for our severely wounded servicemembers. What we have observed during our oversight visits is a dedicated staff and resources that are necessary to make sure that the care given to our veterans is second to none.

However, this Subcommittee is concentrating its focus on what happens after the servicemember or veteran is discharged from the VA. How are these severely injured veterans and their families actually integrating back into their communities and back with their families? What kind of post hospitalization care and support services are they receiving? What avenues do they find opened or closed to them? Basically, what are the challenges that the veterans are facing?

We are all looking forward to hearing from our first panel as to what they have encountered since their discharges. Hearing their stories is not only important to the Committee but also to the VA as they develop their Federal Care Coordinator Program to reach out to our severely injured veterans and assist them whenever and however they need it.

Those who are serving on the front lines of battle do not consider where their actions will take them in the future. Our Nation's heroes have sacrificed their time, energy, and often physical health to secure freedom and democracy throughout the world.

And I think every American believes that they deserve the best possible care that we can give. Our obligation to care for severely injured servicemembers does not end when they leave the PRC but continues long after the discharge care process.

Again, Mr. Chairman, thank you for holding this hearing and I yield back my time. And I apologize for the problematic microphone here and it is not my Blackberry because I handed it over.

Mr. MITCHELL. Thank you.

Congressman Walz.

Mr. WALZ. I will reserve my time.

Mr. MITCHELL. Congressman Stearns.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Yeah. Let us see if this works. Thank you, Mr. Chairman, for holding this hearing.

Obviously today we are addressing a very critical issue facing our heroic wounded warriors and their families and, of course, their transition back into civilian life.

A recent article in which former U.S. Department of Health and Human Services (HHS) Secretary Shalala commented, she indi-

cated if we are asking people to risk their lives and their future, then we ought to be willing to make this investment. And that is what we are trying to do here.

Families are the most important factor in the successful transition back to civilian life for our warriors. Obviously they deserve all the support we can provide for them.

I am very glad that on our first panel of witnesses, we will hear the personal testimonies from two individuals who have experienced these issues firsthand, Corporal Casey Owens, and Ms. Sarah Wade will be speaking on behalf of herself and on behalf of her heroic husband, Sergeant Edward Wade.

And I want to thank both of them for traveling the distance to come here and take the time to testify before us.

My colleagues, since 2003, I have been pleased at some of the initiatives that the VA has established to serve wounded warriors and their families.

In June of 2005, the VA issued a directive expanding the scope of care it would provide to include psychological treatment for family members. This is very important. In addition, the VA has expanded their team of caseworkers, but we do need more.

Intensive clinical and social work case management services have been created for the four regional traumatic brain injury rehabilitation centers now named the polytrauma rehabilitation centers. VA also established joint programs with the Department of Defense to ease the transfer of injured servicemembers to the VA medical facilities.

In August of 2003, VA and DoD established a program assigning VA social workers to select military treatment facilities to coordinate patient transfers between DoD and the VA medical facilities. The social workers make appointments for care, ensure continuity of therapy and medications, and followup with the patients after their discharge.

But I am concerned, first of all, that caseworkers seem to have too large a caseload which may inhibit the amount of time and focus they are able to spend with each and every family. Particularly when servicemembers are discharged from the VA polytrauma rehabilitation centers, most, if not all, still require followup care at the VA, at DoD, or private-sector facilities.

I want to know if this transition system functions smoothly, whether the patient is going back to the military or is the patient going back to the private sector.

In addition, most of the most severely wounded patients require long-term care and will become veterans eligible for VA care when discharged from active duty.

So I look forward to this hearing, Mr. Chairman.

I have had the opportunity, as I am sure many members have, to participate in the VA winter sports clinic out at Snow Mass, Colorado, and seeing the enormous energy disabled veterans put into that skiing clinic and to see how successful they are and it is inspiration for all of us. And so I welcome our witnesses today and I look forward to their testimony, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Space.

[No response.]

Mr. MITCHELL. Thank you.

I ask unanimous consent that all Members have five legislative days to submit a statement for the record. Hearing no objection, so ordered.

At this time, I would like to recognize Congressman Nick Lampson of Texas who is here to introduce his constituent, Corporal Casey Owens.

Congressman Lampson.

OPENING STATEMENT OF HON. NICK LAMPSON

Mr. LAMPSON. Thank you, Mr. Chairman. Hopefully this one works.

I want to thank Chairman Mitchell and Ranking Member Brown-Waite and Members for allowing me to come and sit in on this hearing with you today. I am honored to join you on this distinguished Subcommittee and very proud to introduce Corporal Casey Owens of Missouri City, Texas.

Casey is an extremely exemplary young man and I commend him for his willingness to continue to serve his country and his fellow veterans. We are proud of his service to this Nation in many, many ways.

I was impressed when we met yesterday for the first time by all of his accomplishments. A graduate of May Creek High School, he went to the University of Texas. But following the attacks on September 11, he decided to join the Marines.

He was deployed twice, the first time from February 2003 to October of 2003 and the second time from August of 2004 until September 20, 2004, when he sustained his injuries. During this time in the Marine Corps, he received several medals in recognition of his distinguished service.

Less than a year after sustaining his injuries, Casey successfully completed the Marine Corps marathon in 2005 using a hand-cranked wheelchair with a time of approximately 2½ hours, probably better than any of us here could do. I know better than I could do.

He is currently training as a member of the competitive ski team in Colorado that has been recognized by the Paralympics and the VA as an official training center.

Even more impressive than the three accomplishments, than all of these accomplishments in my opinion, is Casey's advocacy for veterans' care. He has worked with Mayor Bill White, Houston Mayor Bill White's Veterans Task Force which was established last year to address the needs of Houston's veterans, both young and old, when it comes to housing, health and mental care, job training, and other issues.

And he has come here today to testify before Congress about the challenges new veterans in this country continue to face as they transition from DoD to the VA system and try to navigate it.

The most impressive, though, is the concern for his fellow veterans and those that will come after him. He is here today to ensure that our Nation's future wounded warriors will not go through the same frustrations and feelings of neglect that he and his friends have experienced at the DoD and the VA and have struggled to adapt to a new breed of patients as they have struggled to

adapt. So they deserve much more in return for their service. And I commend Casey for his advocacy on their behalf.

And, again, I thank the Subcommittee for allowing me to sit in and I yield back my time, Mr. Chairman.

[The prepared statement of Congressman Lampson appears on p. 50.]

Mr. MITCHELL. Thank you.

At this time, I would like to recognize our first panel, Corporal Owens, Ms. Wade, and Sergeant Wade.

And I just want to say that last evening, I met with all three in my office and we had a great visit. And I hope that you convey in a very matter-of-fact way what you told me yesterday because I think it is a very compelling story and everyone should hear it.

So thank you very much. And we will start with Corporal Owens.

STATEMENTS OF CORPORAL CASEY A. OWENS, USMC (RET.), HOUSTON, TX (U.S. MARINE CORPS COMBAT VETERAN); AND SARAH WADE, CHAPEL HILL, NC, ON BEHALF OF SERGEANT EDWARD WADE, USA (RET.) (U.S. ARMY COMBAT VETERAN)

STATEMENT OF CORPORAL CASEY A. OWENS, USMC (RET.)

Corporal OWENS. Good morning. Thank you, Chairman Mitchell and Members of the Subcommittee, for coming.

I was injured September 20, 2004. I was serving with the 1st Battalion, 7th Regiment Weapons Company. I was in Al Anbar Province out west on the Syrian border. We were on a reconnaissance mission, dropped off a reconnaissance team. Minutes later, we got a call to pick them back up for a medivac mission. A Sergeant from reconnaissance had been shot in the throat who later succumbed to his injuries.

On the way back to base, we were engaged again and ran over two anti-tank mines, which resulted in the loss of both my legs. I was flown to a field hospital in Iraq, stabilized, treated there, and to Landstuhl, Germany. I was there for 3 to 4 days and then flown to the Bethesda, Maryland Naval Hospital.

I woke up about a month later from a coma to find my legs were missing. I had suffered two collapsed lungs, a pulmonary embolism, serious head trauma, broken my clavicle and my jaw, which now has a metal plate, and my teeth were knocked out, several shrapnel wounds to my neck and torso.

From there, I had several surgeries over the next 2 to 3 months to stabilize me and was transferred to Walter Reed to join the amputee program there and to walk again.

Over this time, I was a patient at Walter Reed and Brooke Army Medical Center and was discharged and retired February 26 of 2006. And I did not have my right leg completed yet. I was still experiencing problems.

Upon retiring in February, I needed another surgery, about March, early April. My right leg, which is my myodesis, which is kind of the muscle flap that goes over the end of your femur, kind of gives you a padding, it had previously, once about a year earlier, had torn completely off my femur and I had my leg amputated again about an inch, and my sciatic nerve cut. They reattached it. It looked good.

Over the next year, I still had more surgeries. I had problems with heterotrophic ossification, which is a bone growth which kind of held me back with my prosthetic care, my prosthetic progress.

So when I was retired, I had a 60-day window that you are still under the Department of Defense care. So I was able to return to Brooke Army Medical Center to have it repaired. That is where it had been done the first time. I went back there. They repaired it.

Within a month, it had failed again for the third time. And when I say third time, the myodesis was performed on the initial injury. Failed the first time, second time, now third, so this would be the fourth time to fix it.

I was now enrolled in the VA as of April 1, 2006. I went to the VA, said, you know, I think it is failing again. I know it is failing again. I can feel the bone coming through the muscle this time and you could see it.

They instructed me to work with prosthetics, and that is use their standard procedure is prosthetics, you know, adjusting your prosthetics before, you know, surgery. I told them that, you know, this is the third time. I have been down this road. I know what I need.

They did not agree with me. The first day, they did not agree with me. I said, I will be back in about 4 to 5 weeks. The condition is going to be worse. Sure enough, about 5 weeks later, over the weekend, the muscle started retracting, pulling back, leg, you know, was very painful.

It was the weekend, so my choices were to go to the emergency room, which I knew would be come back Monday, see an orthopedic doctor. So I drove to Brooke Army Medical Center about 3 hours away, found one of my orthopedic surgeons that had performed the surgery the first two times. He looked at it right away and said, yes, failed myodesis. And I said, well, what are you going to do and what procedure. And he said, we will do what is called a Goshock procedure named after the doctor who invented it.

He said, well, this has failed four times now or failed three times. This will be the fourth time to do the procedure. I said, you know, I do not have any more of my leg to give, so he pretty much said, well, that is what we can do.

So I went home disappointed. I spoke to a prosthetist who told me about a new procedure, the Ertle procedure. Because he was prosthetics, he said, you know, this advice did not come from me and because in the past, he had been reprimanded for giving advice from an orthopedic because for some reason, that is not his field, even though prosthetics, orthopedics go hand in hand.

So I found it. On the Internet, I found Dr. Ertle. I went to my doctors at the VA and said I would like to get this Ertle procedure done. They did not agree with me.

So over the next 6 months, I debated with the VA until I finally got my surgery done, which the previous two times had taken me less than 72 hours to get it done.

So during this time, I cannot move forward. I cannot go to work, school. I am in pain. I got back on my pain meds which I had already gotten off of. And also my insurance, my TRICARE insurance supposedly through a clerical error, was canceled. So that was another deal to deal with.

I did not have a social worker for the first 3 months, so I sought the advocacy of a friend with Marine for Life who kind of took over my case and Marine for Life, Wounded Warrior Project and other people who just stepped up to the plate and helped me out that were not even government agencies or people from the VA.

I had the surgery done in Oklahoma. The doctor, well, he has VA benefits, so, you know, I was not really going outside the box. So, you know, I cannot understand what took so long for the approval. I never really got an answer other than sorry, we made a mistake.

And I have had the surgery done. It has performed. It is doing well. But they had to amputate two more inches of my leg and cut another 3 inches of my sciatic nerve which now I suffer from chronic phantom pain.

And I returned home. I went out to Aspen. I had to recover. I had several months before I could work with prosthetics, so I went out to Aspen. And I was invited out there to train for the Paralympics skiing, mono skiing.

I returned home early summer. I went to the VA and said I am home. I am here to work solely on my prosthetics. This is my number one goal. I am not working. I am not in school. I had appointments about once a week, you know, for an hour which was not sufficient to me, so I said, you know, I need to get this done, you know. I am technically retired from the military, but, you know, I am ready to go back to school and move on, you know, with a job and career. And I cannot do it until I have this done because it is going to take several months of rehab.

So they outsourced me because they said they had too many patients and not enough staff to meet my needs. So they outsourced me to a prosthetist in Houston, which there is only one prosthetist there. And he did not have a technician at the time either, which even slowed the process more.

I spent the following summer, the next 8 months up until about December. And I had prior engagements with my race team starting early November and, you know, prior commitments to my sponsors for my racing.

I put it off for 2 months until January, still trying to work on my prosthetics which finally resulted in him telling me I cannot fit you. You should look elsewhere.

So I returned back to Colorado and finished my skiing. And next week I go to Oklahoma to a company, some specialists that other guys I know go to. But I am going there on the bill of the Wounded Warrior Project because it is too much of a hassle to deal with the VA and which it should be their responsibility. They are the ones who have failed to fit me.

But, like I say, at times, it gets, you know, it is not even worth dealing with the VA because it so much of a hassle and that is how it has been.

You know, I suffer from post traumatic stress disorder (PTSD) and the VA and all the problems I have dealt with have, you know, furthered it even more. And in that 6 months that I dealt with, you know, wondering why no one is helping me, why the government is not stepping up to the plate, and it just feels like I was abandoned.

And, you know, I did my duty and those that are in place are not doing theirs. And it is a very frustrating feeling to go through. And for me, it has been a harder battle coming back to the States and dealing with everything I have dealt with than it was going to the war both times. That was a cake walk compared to this.

And so here I am now and my struggles, I have gone through and done on my own or a lot of my own through the help of, you know, advocates, but I do not want others to go through it either. So here I am.

[The prepared statement of Corporal Owens appears on p. 51.]

Mr. MITCHELL. Thank you. Thank you very much.

Sarah, are you or Ted going to talk?

STATEMENTS OF SERGEANT EDWARD AND SARAH WADE

Sergeant WADE. Chairman Mitchell, Members of the Subcommittee, thank you for the opportunity to speak to you today regarding our experiences following my injury in Iraq.

My name is Edward Wade, or Ted, as I prefer to be called. And this my wife, Sarah Wade.

Ms. WADE. Hello. I am not as brave as Casey. I am going to actually read my comments because I am worried I will get off course.

Ted sustained a very severe traumatic brain injury or TBI and his right arm was completely severed above the elbow. He suffered a fractured leg, broken right foot, shrapnel injuries, visual impairment, complications due to acute anemia, hyperglycemia, infections, and was later diagnosed with post traumatic stress disorder.

Ted remained in a coma for over 2½ months and withdrawal of life support was considered. But thankfully he pulled through.

As an above-elbow amputee with severe TBI, Ted was one of the first major explosive blast polytrauma cases from Operation Iraqi Freedom that Walter Reed or the Department of Veterans Affairs had to rehabilitate.

Much of his treatment was by trial and error and there was no model system of care for a patient like Ted. And there still does not appear to be a long-term model today.

His situation was an enormous challenge as Walter Reed was only able to rehabilitate an amputee, not a TBI. The VA was able to nominally treat a TBI but not an above-elbow amputee and neither were staffed to provide appropriate behavioral healthcare for a patient with a severe TBI.

Because Ted could not access the necessary services where and when he needed them, he suffered a significant setback in 2005 that put him in the hospital for 2 weeks and would later take him probably a year to rebound from.

Ted has made a remarkable recovery, by any standards, because we strayed from standardized treatment and developed our own patient-centered path. I had to educate myself about and coordinate additional outside care. Often access to the necessary services required intervention from the highest levels of government or pressed to personally finance them ourselves.

But despite our best efforts, Ted is still unable to easily receive comprehensive care for all of his major healthcare issues due to shortcomings in the current system. And because of the time his

needs demand of me, I have been unable to return to regular work or school.

We have been blessed to have family with the means to see us through these difficult times and to help with the expenses. I was fortunate to have the education of growing up in Washington, DC, and learning about the workings of the various Federal agencies, but our situation is not typical.

We do have a few ideas to provide better long-term care for people like Ted that we would respectfully like to share.

The first one is about special monthly compensation, particularly for reasons of integration, quality of life, dependent's educational assistance, and respite care.

Individuals like Ted who required someone to be available for assistance at all times are not compensated appropriately. These veterans would require residential care otherwise, but are not granted the higher level of aid and attendance because they do not require daily healthcare services provided in the home by a person licensed to perform these services or someone under regular supervision of a licensed healthcare professional.

I would be more than willing to be supervised if that is what it took. But we feel the criteria should be clearly outlined so appropriate compensation may be granted in the case of an individual whose needs of assistance are managing their care and personal affairs or they require support outside of the home to rehabilitate and integrate into their community or to achieve a better quality of life.

Both in the past and at present, we have paid someone to assist Ted outside of the home. This allows him the flexibility to hire a peer of his choice to provide community support and accompany him on sightseeing outings he has researched and planned with his therapist as part of his community reintegration, to provide transportation to the store to purchase books for homework assignments, go to the community center to swim laps, or help him balance his checkbook at the end of a day.

Not only has this enabled Ted to come closer to achieving independence, but it has greatly improved symptoms of depression by restoring hope and self-confidence, allowed him to attain fitness goals and control his blood sugar without insulin injections, all while providing much needed respite care for me.

Unfortunately, the current VA respite programs are not appropriate for a veteran like Ted. My option for that is to put him in an extended care facility for 30 days a year or, as my husband says, I could kennel him and the dogs and go on vacation. And that is not really something that I am interested in doing. I would rather go on vacation with him, or I could also have someone come provide care in the home, but they cannot take him to the places he needs to go and do the things he needs to do.

And with better resources, I might be able to access the dependent's educational assistance for which I qualify, but under the circumstances, I cannot use. And I think one of my great concerns is that these benefits do expire and I am, you know, already probably 4 years into the expiration time.

I would like to see a change maybe in that, but also someone provide the assistance we need for me to go to school because not only

would it give me the education that I have available to me, but I think it would also help increase the standard of living for Ted by increasing my earning capacity.

Another suggestion we have is about the Compensated Work Therapy Program in the VA system. Largely due to the success of the program we have created for Ted, the next phase of his recovery will probably include some sort of vocational rehabilitation. He has already had the opportunity to participate in volunteer work through counseling and job coaching provided by a private practice near our home where he attends a day treatment program for behavioral health and TBI.

But now he is ready for the next stepping stone to employment. The current Department of Veterans Affairs' vocational rehabilitation and employment service is more of a challenge than is healthy for someone like Ted, with significant cognitive deficits and significant emotional needs.

VA work therapy programs, while developing work tolerances and promoting effective social skills for more seriously impaired patients, are set in insulated environments. A work therapy program expanded to other community settings to accommodate patients like Ted who are better served outside of a sheltered atmosphere would be more effective.

Volunteer internship positions or later a part-time job that sparks his interest would be more therapeutic. Not only would this help him acquire the confidence and independence he needs to someday become gainfully employed, but it would also aid in his reintegration by providing constructive, meaningful activities for him to participate in outside of the home.

I think my last comment will be about counseling and life skills for patients like Ted with TBI and really patient-specific case management.

Although many basic therapies are offered, rarely do they include teaching socially appropriate behaviors which are commonly an issue after TBI. This task often falls on the veteran's family member or spouse, increasing the responsibility of the caregiver, and causing conflict with the veteran who feels like they are being treated like a child.

Ted has had the advantage of a community support peer, but also a counselor at the private practice I previously mentioned to help him redevelop age-appropriate social skills and allow me to be his spouse while maintaining his dignity.

She has also worked with Ted to develop healthy coping skills, to manage cognitive deficits, improve mental health, and develop patient-centered treatment plans, which focus specifically on his unique challenges.

Again, our situation is not typical, though. This is something difficult to provide in an institutional care environment like the Veterans Health Administration without greater flexibility and more resources to provide increased face time with the patients and better injury-specific expertise.

The challenges we have faced are the same as countless other veterans, many of whom have not had the resources Ted has had available to him or an advocate capable of negotiating the system.

A veteran I often think about who had a young wife with a newborn baby and nothing more than a high school education should have received the same world-class care as my husband but sadly did not nor will not. Despite my best efforts to be a support to his spouse, who is overwhelmed by motherhood while trying to negotiate a seemingly impossible system, she eventually left him because it was more than she could handle. I think it is a lot to ask any mother to neglect their child.

A veteran's care should not depend on what family they were born into, who they married, or whether or not family obligations allow their loved one to advocate for them, but sadly it does.

Though we will never be able to fully compensate seriously wounded veterans for the sacrifice they have made on our behalf, we can certainly do a better job of managing their care, rehabilitating them to the fullest potential in a timely manner, and providing the necessary resources to maximize their quality of life.

I am very pleased to see that the Subcommittee is taking a look back to explore ways to learn from the past and address the needs of the veterans injured yesterday. I think this will make a tremendous change for the people who are being injured today.

And I want to thank you all again for having us here and look forward to answering any questions.

[The prepared statement of Ms. Wade appears on p. 52.]

Mr. MITCHELL. Thank you very much.

And let me just ask a question of all of you very quickly because we know that Congressman Walz has to leave. But yesterday in talking to all of you, you all have some individual needs. You are saying that the VA, in a way, has a number of things set up, but nothing to deal individually.

And I would just like, Corporal Owens, for you to tell the story that you told us yesterday about when you went to the methadone clinic, when they sent you out there because they did not know what else to do with you or something like that. But would you tell that story?

Corporal OWENS. During the time, I was, you know, that 6 months, waiting for my surgery, got too much to deal with anymore, so I started taking my pain meds again, still suffering from phantom pains and just the muscle tearing and just grinding against the bone and whatnot.

So I was back on them. I had my surgery done, so I was still recovering. About 2, 3 months later, went to the VA, went to my doctor, primary care doctor, said I think it is time I want to get off these, but they are very, very strong narcotic medications. So, you know, your blood pressure elevates, you know, your body goes through a lot, you know, lack of sleep, sweating, shakes.

So I said I would just like to be monitored, you know, I am ready to get off it. He said okay. So gives me an appointment. So a couple days later, I go up to see a doctor, to the floor, to the substance abuse program. First, they say, well, what are you here for. I said I do not know. I said I just want to get off my meds. I thought I was coming to see a doctor to monitor me.

So he says, no, you must have been flagged. Do you have a problem? I said no. I said call my doctor, put him on speaker phone. He calls him, asks my doctor. My doctor is saying, no, he does not

have a problem, I just do not have the time, you know, big patient load. He said he just wants to be monitored and, you know, helped and, you know, blood pressure medicine, whatnot.

So he gets off the phone. The guy says, well, we want to put you in the methadone clinic where you will come in every 6 days and you will get 6 days worth of methadone. I said I do not want any more drugs. I want to get off of them.

So I left there and, again, went to an outside nonprofit veteran group and they sent me to a doctor and to a detox center and I got off of them, have not been on them since.

But, you know, it amazed me that just a simple week-long monitoring could have taken care of it, but instead just led to more problems, more frustration, and giving me more of an attitude to not deal with the VA which I really do not do. And most of all my care since I have gotten retired has been from outside doctors and outside sources. I rarely use the VA.

Mr. MITCHELL. Thank you.

I just wanted you to kind of finish that and then we will get into our regular questions.

Mr. Walz.

Mr. WALZ. I thank the Chairman. I thank the Ranking Member for her courtesy.

I do have another appointment, but I can tell you with absolute certainty there is no place more important in this country right now than being right in this room. And I am humbled to hear your testimony. I am also ashamed that this would happen to our warriors.

We have talked about it time and time again that dealing with our wounded warriors is a zero sum proposition, that if one is not treated with all the care and all the dignity and their issues are addressed with the utmost concern, then we have failed. And that has been obvious in these cases, especially with Corporal Owens. I am not even sure what to say.

And to make matters worse even, coming to this hearing today, we just came from over in the Rotunda where we had an Iraq and Afghanistan war remembrance where a lot of people spoke and talked about a lot of nice things and you are sitting over here telling us this story.

And I think Senator Dole summed it up best when he came in and testified. He said you spent billions putting them in harm's way, do whatever is necessary to get them out of harm's way. And obviously we failed you.

And Sergeant Wade, Ms. Wade, you brought up some very good points. I just have a couple of quick questions on this.

Corporal Owens, you talked about how your TRICARE was canceled. And what is so troubling to me about this whole thing is that you have come to expect that we are going to fail you. I mean, that is obvious that your experience has showed that we are going to fail you. That means we failed. Our job is to provide that oversight. It does not matter.

Last year, we talked about how much we were able to do in the VA. It obviously did not help you and that is a concern, this Committee's primary concern.

So what happened with that, with TRICARE?

Corporal OWENS. Supposedly it was when I got my medical ID, it was supposed to be if you are discharged with a hundred percent from the military, you only get care at—this is how it was explained to me—that you can only get care at the VA. So they discharged me with 90 percent and the VA found me a hundred percent disabled. And that way, with TRICARE, I can go to outside the VA.

And when I got my ID, they gave me a hundred, the military, or I do not know who it was, gave me a hundred percent and so it canceled it. But it took several, I do not know how long, month, 2 months or longer to reestablish it.

Mr. WALZ. What happened during that time, I mean, as far as your care and bills and things like that?

Corporal OWENS. I was going to the VA, so I was not billed anything, but it was just one more hassle, setting up appointments, calling people, and having to deal with it.

Mr. WALZ. You mentioned a couple of times, too, about this resource issue and people are telling you we are just overburdened, we just cannot do it.

Would it surprise you that members of the VA have sat in front of us and we have asked them if they needed more resources and they said no?

Corporal OWENS. That is a good point. You know, I hear all the time about reports that 100, 200 new people have been added to the system to Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) patients. It looks good on paper, but in reality, that is just an extra nurse or something to the hospital, you know, a new doctor, delegate of the hospital that can treat OIF patients, not to OIF patients, you know.

I mean, it is for us, but, you know, it is good for reports and good for Committees because it sounds like you are making progress. But the reality is, I do not see any results. I do not see any changes. You know, there are now OIF/OEF coordinators at all the VAs and whatnot, but the problem is, and this is a solution that I find, they need to have an OIF/OEF center.

You know, they have psychologists, this and that set aside for us, but they are in all different parts, different wings of the building. There is no correlation or communication among each other.

And, like I wrote in my testimony, a good example would be Johnny is not going to, say, his prosthetic appointments or other appointments and so he gets reprimanded, written up. They are like why are you not going, you are not doing anything to further your care. And the reality is he may be suffering from severe PTSD or his own emotional problems and so he just sits in his room.

And what they need is they need to come together like they do at Walter Reed and Brooke where all, social worker, prosthetist, orthopedic, vocational worker, they all meet every week and discuss their cases and the patients. And it helps give insight into some of the people's problems and the avenues of care they could give them.

Mr. WALZ. Thank you.

And then a final question as my time expires here. Ms. Wade, I think you have given a really powerful testimony and a really strong insight into an area that I think we are not addressing. And

it is the issue of respite care and what happens with the family and the caregivers, what happens to their career, what happens to their well-being. And there has been talk about that.

And this country means well and all of my constituents want to do whatever they can to help, but I know what happens to you as you see people and they will say, oh, it is good to see you, you are looking good. It looks like Ted is doing well and all that. And then they see you another 4 or 5 months later and they say, gee, how are you doing, are things going well. They do not realize every hour of every day of the intensity that goes into that and this is all part of the care. It is all part of taking care of that veteran.

So I appreciate your testimony. And I can tell you there are Members up here that definitely share this concern and believe this is the area, maybe the next big area where we should be focusing as quickly as possible to address that.

So I thank the Chairman and Ranking Member. I do thank you again for your kindness to let me speak.

And, of course, I am not sure what to say to you. Sorry is not good enough in this case. And everybody is going to stand in front of you and tell you that. You said you have heard it many a time.

The only thing we can say to you is that we are going to give every ounce of effort that we can to address this and make sure that you do not go through this. And I know we may never gain your trust back in that system, but we owe it to those that follow you to do that.

So thank you for being here.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. I will try this one again.

[Microphone technical difficulties.]

I guess I will not.

All three of you, your statements certainly were riveting and sad, very sad. I visit the various hospitals as many other Members do and I have to ask a basic question.

When you were going through this, did you ever contact your Member of Congress' office for help? Because I know that many Members of Congress take the care of the veteran to be very, very personal.

As a matter of fact, I have the VA hopping in giving me a report every 2 weeks on a veteran in my district that I know kind of slipped through the cracks. And I think it is very important that we know about it because I do not think there is a Member of Congress who, if he or she knew that this was going on would have not immediately jumped into action.

So did any of you contact your Member of Congress about the problems you were having with care?

Corporal OWENS. Well, for me, did I contact my Member of Congress, no. I do not know if other people on my behalf did. I know one incident, I had written the President and wrote a letter and gave it to Colin Powell to give to him, but it was returned the following week. But, no, I cannot say I did.

Ms. BROWN-WAITE. Sergeant or Ms. Wade.

Ms. WADE. I guess I have worked some with Senator Byrd's office, one of our Senators from North Carolina. He came to me and

offered to help. I had tried to contact Senator Dole's office and there was just too many hoops to jump through and too much red tape.

And honestly I think this is one of the problems with people with severe brain injuries or someone that requires a lot of intensive long-term care. I do not have time. There is a lot of people that I need to ask for help in a lot of different areas. And I just gave up.

I had contacted Senator Dole's office about a military-related issue since she is on the Armed Services Committee and I was sent a VA waiver. And I just did not have time to explain that it was not a VA issue.

And so I mean, honestly, the people that have helped me also, Senator Hagel, I had met by accident. It is an interesting story. I was quarantined with him during an anthrax scare, but, you know, there is a couple of Senators that I met that offered me help. And those are the people that I have gone to because there are just people that are trying mightily to get by every day and we do not have the time to get these things done.

Ms. BROWN-WAITE. The reason I ask that is because every Member of Congress has staff that work on these kinds of issues and get the elected Member involved to make sure that things happen.

I am sorry that you did not have a positive reaction and that you did not have action by the Congressional staff and the Members of Congress, the Senators that you mention.

You know, maybe the House Members are so much closer and our districts are so much smaller that maybe we have the luxury that the Senators do not. I honestly do not know. But I know that every Member of Congress, every Member in this House on both sides of the aisle deeply care about veterans and followup on veterans' care.

Absolutely. Mr. Bilbray, Representative Bilbray from California just said, "that is what we are here for."

Let me ask each of you if you had any outreach from either the Department of Defense or the Department of Veterans Affairs after your discharge from inpatient care and what kind of support or care was offered to you or your family.

Corporal, would you like to go first?

Corporal OWENS. Nothing really stands out. I cannot say that they did not. But nothing stands out because when I was discharged, you know, this all happened within a month. You know, with my leg tearing, the muscle failing again all happened within a month and 6 months it took to get this done.

So I cannot really think if they had, you know, I do not see what it would have taken this long. I went to them, to the VA, and told them, so they were aware of everything. It was obvious what was wrong with me. No, not that I can think of.

Ms. BROWN-WAITE. Sergeant or Ms. Wade.

Sergeant WADE. I do not——

Ms. WADE. Do you want me to start from the beginning since you were asleep? Okay.

For Ted, he had a social worker initially at Walter Reed and Ted was retired from the military before he regained consciousness. So he quickly was not their responsibility. We did have a social worker

at Walter Reed, who even though he was not her jurisdiction, she still kept in touch with me and tried to help me out.

I will say the person, the group that has been in touch with us from start until now is the amputee service at Walter Reed. That is the only group of people that have been with us through the whole ride. The amputee case manager there, I am convinced knows everything in the world. But Steve Springer, the amputee case manager, and the physician who ran the amputee program at Walter Reed who is now the Chief of Rehabilitation, Colonel Paul Paswena, they are the ones that have been with us throughout this whole ride.

Ted's care was very fragmented. We had a social worker when he was in Richmond where one of the level one polytrauma sites is now. But, you know, once we left there, there was not any contact with them anymore.

When we got home, there is an OEF/OIF case manager at our VA hospital. She is there when I go to her for issues, but she is not really there for any kind of really injury-specific case management. It is out of her realm of expertise. So she was there when we were at Durham the first time and she was there when we were at Durham the second time. We have been through seven facilities.

And really, I guess the last 3 years, our continuity has been the civilian place where Ted goes, the civilian practice he goes to. They have a brain injury case manager who from the first day we went there until just Monday was the last time I talked to her.

Even when Ted is at a different facility for treatment, like right now he is at Walter Reed getting a new prosthesis and doing prosthetic training and rehabbing from some surgery, she still talks to Ted for an hour once a week regardless of where he is in the United States.

So the amputee case manager at Walter Reed and the case manager at our civilian facility for TBI have been our most continuity.

And what we are very hopeful about is the Federal Recovery Coordinator Program. Ted was recently assigned someone in the Federal Recovery Coordinator Program. And that has been maybe 2, 2½ weeks. She has already passed her first couple of tests which is a big thing with me.

But we are hopeful that that will maybe create some better continuity. My concern, though, with that, is there are good reasons why they are starting off slowly with this program, because it is hard to get a hundred people out there, training them when you do not even know what you need to train them for yet and what kind of services people need.

But one of my concerns is in starting off slowly and where a lot of the case management focus has been after the Walter Reed articles in the *Washington Post*, a lot of the focus has been on the military treatment facilities and the polytrauma sites. Polytrauma network sites, only a small handful, a few hundred people have been through those. It is a relatively small number compared to the large group of people being wounded.

And needless to say, the military treatment facilities are short lived.

My concern with the changes in case management, I know that I hear patients at Walter Reed are currently complaining that they

have to check in with five different case managers in 1 day and doctors complaining that the case managers are getting underfoot and they do not have time.

Ms. BROWN-WAITE. Excuse me. Is that currently——

Ms. WADE. Yes, ma'am.

Ms. BROWN-WAITE [continuing]. They are complaining about that?

Ms. WADE. And so what I feel like is that it would be smart to have some sort of visibility of all the case managers that exist from all these different programs. I mean, Ted theoretically has five or six, because there are a lot of people who left the military treatment facilities like my husband who just dropped off a cliff.

I really think that if some of these groups of case managers could be restructured and reassigned that someone needs to have the job of reaching back and finding the people that have been lost for the last few years and finding out if they ever got the treatment they needed. And if they did not, make it happen now.

Ms. BROWN-WAITE. Thank you very much.

Did you get a copy of the case plan for your husband when he was leaving the hospital, a case management plan, what they were going to do?

Ms. WADE. No, ma'am. I do not think they were doing that.

Ms. BROWN-WAITE. So there was no case management plan with followup care?

Ms. WADE. I will say our Federal Recovery Coordinator, the first day I met with her, that was our first conversation was what were our immediate goals for the next 6 months and what were our goals for the next 5 years. And one of the big improvements, but it was about my goals too. It was the first time anyone has ever asked about me and, you know, what was going to happen to me in all of this.

Ms. BROWN-WAITE. Thank you very much.

I have exceeded my time and I thank the Chairman for being understanding. And I yield back.

Mr. MITCHELL. Thank you.

Congressman Space.

Mr. SPACE. Thank you, Mr. Chairman.

Corporal Owens, Sergeant Wade, Ms. Wade, I am really struck by your testimony. By the way, you did a wonderful job. I know this was not easy for you. I am struck by your sacrifice and your courage and your heroism.

I think that Tim Walz, what he said is right. There is really no more important place in America than right here, especially for a Member of Congress.

What you have done, what you have given up, and what you have gone through are quite remarkable. It is really important for you to be here. It is really important for me and my colleagues to hear your stories, again because it is important for us to know the kind of sacrifice that you are all making and you have made.

Certainly it is important for us to understand what we have to do better to live up to our obligation to you that tragically we have not been as good as we should have been on. And perhaps most importantly, it is important for us, for the Members of Congress, to see firsthand the price that is being paid for this war.

And I thank you for being here.

Corporal, I had one question I wanted to ask you about in response to your testimony. You had indicated that time and again, you differed in your own assessment of your own injuries and your own need for treatment from what VA hospital doctors were advising you on and that I think you had three or four different amputative procedures on the same leg and that as a result of what appear to be flawed procedures or diagnoses or opinions, you have endured a lot of pain and a lot of suffering that might not have otherwise occurred.

And my question is this: You know, was there an avenue? Did you feel that there was an appropriate avenue for you to obtain a second opinion? I mean, it is something that many of us who are not within the veterans' system take for granted.

Did you feel that you had that kind of recourse that you could have seen a doctor efficiently, quickly, just to get a different assessment or did you feel that your options were limited in that respect?

Corporal OWENS. It was kind of limited. And there is a team at an amputee clinic, you know, an orthopedic and kind of a primary doctor, so that is my point of reference or contact. And that is who did not approve of, you know, our—you know, who referred me back to Brooke who wanted to do the same procedure. And I said, well that is not what I want. So, I was really there and then come back to the VA and say, well, this is what they are going to do. It is not what I want.

And so from there, I was just kind of on my own, you know. I did not really know where else to turn to find someone to back me up and say this is the procedure, you know, that I found and want. And the way I feel, it is my right to choose what care and what procedure I want.

I mean, it is not like it was going to be something harmful or something that was just blatantly just going to be wrong. I mean, it is my preference and I researched it and read up on it. It is a medically proven procedure. It is not like some quack procedure or anything. It is done by qualified professionals.

So, no, I did not really feel I had a lot of places to turn for a second opinion.

Mr. SPACE. Okay. Thank you.

And I just want to close. Corporal, are you the one from Congressman Lampson's district? You know, I heard your testimony that you had not reached out to his office. I can tell you that you have one of the most compassionate and concerned Members in this body and I know that he would have been there for you had you reached out to him.

But I think the point is that you should not have to reach out to your Member of Congress to get adequate just satisfactory base-level care within the administration. And we want to make sure that we do everything we can to allow you to get that care without having to take those extraordinary steps.

Thank you. I yield back.

Mr. MITCHELL. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

I had my staff here, so I had to go to another hearing, but I am very glad to be back. And I had some notes that she took and particularly with Corporal Owens. In your testimony, you talked about dealing with the VA and it is a bit of a hassle. I think those are your words. You also said that sometimes you feel like you are on your own and almost there is no support system.

I notice in some of the notes here that the VA is trying to improve that and one of the things they have talked about is developing several Web-based applications, including a Federal Individual Recovery Plan and National Resource Directory.

They are going to team with military healthcare personnel to use the recovery plan to create in one set of documents on the Web a so-called map for recovery for wounded veterans ill or perhaps obviously ones that are injured and their families.

And I guess my question for you, I guess for both of you, Ms. Wade and Corporal Owens, would this Web portal that would provide all these benefits in one area be helpful for you?

I have a bill, H.R. 3646, where you could go to the VA and find every job in the country that is giving affirmative action for veterans. So if you are in my hometown of Ocala and you have a disability and you want to find work in the government or in the private sector that is giving special preference to veterans, this Web site, this bill was established so that you could go and find this work. And it might be in Colorado, it might be in New Hampshire, it might be in Florida, but you could go to one area and find it.

And so I think the Department of Veterans Affairs is trying to develop all this in one Web site and I guess it is sort of a clearinghouse.

And so my question to you is, this Web-based application for individual recovery plans and National Resource Directory, health records, and creating one set of documents, sort of a recovery map for you, perhaps each of you might talk a little bit about that if that would be helpful.

Corporal OWENS. It cannot hurt, but that is not where the effort and money and time needs to be spent. It is nice, but it is something to try to glitz and glamour, you know, just making a Web site. No one is going to go look at it. There are tons of Web sites out there. I can tell you that. I get papers all the time, go to this Web site, go to that.

With the VA and stuff, there are vocational rehab jobs and, you know, several other places. That is not a problem finding a job or places that will take you. The problem lies on the ground. They need more foot soldiers. They need more people that are experienced and know the system and know how to work it and advocate for you when you need something, not turning to a computer or calling a hotline.

You need someone. You call up and say here is my problem. You tell them that day and then you go carry on with your job and what you have else and leave it to them because with a Web site, that is just leaving stuff to you. And that is not our job to do this. Our job was to recover and move on with our life, which all of us wanted to do and put this behind us.

And the problem is not all these programs. The problem is the accessibility to the healthcare and the bureaucracy and red tape is

what needs to be fixed. And I see all the time they are setting up this program, they are setting up that. I think that is just a way to get more funding to make it look like attention has been going places.

And I think probably what you hear at all these hearings is, because I know at least from my experience and all my friends, they do not have problems finding a job or training or education. They have a problem getting their benefits, getting their ratings.

I know she is still dealing with it, you know, still trying to get his proper rating and what he is entitled to. And that was a problem for me. It took me a year and a half to finally, through the VA, to get my claims and everything processed.

You know, I went through several months to do my med board. It took 3 to 5 months of meetings, addendums, talk to the psychologist, rehashing everything, getting ready only——

Mr. STEARNS. So you are just saying it is a multitude of bureaucracy and you have to jump through all these hoops, families do, to eventually get service which at some point is a breaking point for families because they are so frustrated.

Ms. Wade.

Ms. WADE. I have some concerns with this. I do think it would have helped me narrow down where to look for things, but you also have to keep in mind that I am someone who loves to research things and there are other people that are not very good at that.

I think also a very important point to make and I think that the culture of the VA has to change. The culture of DoD has to change in expecting people to come to them. Someone like my husband is not capable of using a Web site like that. It is part of the impairment from his brain injury.

And so for him, it would not be useful. And, again, it means then that it is falling on somebody else to do it for him. And there are also a lot of people with TBI who just are not able to initiate things. And so that is one of the difficulties with something like that.

I do think it would be useful for someone like myself who likes to hunt down information.

But part of the problem with it also is that so often, I just had this happen a couple of weeks ago when I was talking to some VA people in the polytrauma system, that, you know, it is we have X, Y, and Z. And I will say, well, I was actually looking for A, B, and C.

I think that part of the problem with consolidating how to get to these programs is you have to know what program you need. You also have to have someone who knows the patient well enough to know when one of those programs is not available, you know, when there is something else they need that is not there.

There just has to be more. You need a case manager who really, really knows the individual. I do not think it should be up to the individual to identify what their needs are. They may not know better.

Mr. STEARNS. What happened if the VA provided a proactive person to help you with the portal, that that person would come over, go through the Web, show you everything, go through all the pro-

grams, and on a regular basis in one spot sit down with you and do it for you?

Ms. WADE. Three hours later, my husband would not remember how to do it. He has memory issues. So for him, that would not help.

Mr. STEARNS. But the family would benefit by seeing it and seeing the networking that they could go through.

Ms. WADE. If they do not have a full-time job and children to take care of and they have the time to. I mean, I do think that it is a useful resource. I am just concerned that it is going to become some sort of catch-all.

Mr. STEARNS. Both of you seem to be advocating that the VA should have more personnel to come into the home, help the families in a way to go through the bureaucracy without them having to funnel the attack against the bureaucracy.

Ms. WADE. And to know the patient better. I mean, just recently, Ted had some issues with medication. Anybody who would have encountered him at the VA hospital would have just assumed that he was being agitated, getting easily agitated because that happens with TBI.

His amputee case manager at Walter Reed who has known him for years encountered my husband and knows what his individual baseline is and knew that that was not how he usually is and asked me. Well, he actually looked up that there were some medication changes and he called me about it.

But it is not just having anyone there to show me. Someone has to really know my husband.

Mr. STEARNS. Someone that knows the history. Yeah, knows your husband.

Ms. WADE. And really know him.

Mr. STEARNS. Yeah.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

First, I want to say to the panel, I want to thank you very much. And I do not think you realize what a service you are providing this Nation by being here today and by doing what you have been doing over the last how many months. It is a very measured, very effective message.

I also have got to say that as somebody who grew up in the Navy and still hear my mother to this day as an 88-year-old lady talking about having to sit in the emergency room from six in the morning until six at night waiting for somebody to see you that bureaucracies, especially Federal bureaucracies, and even the military can be very frustrating sometimes.

It is inherent that in a system where people neither get fired for doing the wrong thing nor get more pay for doing the right thing, the system inherently tends to be very insensitive to outcome and service.

But I think that, you know, Ms. Wade, you have given us some good insight into two things. First, the concept of having a clearinghouse is something that some people could use and could help to improve it.

But I think when it comes down to it is while we may have a triage team to talk about the multi facets, we need to have a designated caseworker who is delegated the responsibility of being basically an ombudsman of making sure that when there is a glitch, you have somebody that you can contact. When there is a frustration with a certain bureaucrat, there is always that person you can come back to as your team or your advocate to help you in the system.

And I guess the frustration always with working with government, any kind of bureaucracy is to have somebody to be your advocate who knows your case and your situation and knows the bureaucracy and how to navigate through it.

And when we get too many people playing the games where you have five or six or ten people, you do not know who to go to to specifically address those issues. So you need to have that go-to person. And I hope that we can talk about that.

And I have got to apologize to you, Ms. Wade, because you have really been very measured at the fact of starting this small process with a few trainees and working out. And the reason why they have to do that is that if we do train, we do have a big program and it does not work out, nobody wants to go back and correct those problems.

You know, the biggest problem in Washington is not that we try new things and it is not that we make mistakes. The problem is when we try new things and make mistakes, we never want to be brave enough to go back and correct it and say we have had a problem.

I really do not have any specific question except for the fact that, you know, am I right to assume that we really do need to give the returning heroes the ability to have one person and somebody that they can kind of rely on in this situation, because sadly, as the Congresswoman pointed out, we do not teach our kids in school which government agency to go to when you take care?

I know Richard very well. The Senator is a good friend of mine and we sat together for 6 years in the House. But it is your representative in the House of Representatives who has a small enough district to be more responsive than a Senator.

And sadly the people will call us about traffic lights and potholes in Congress and I say I do not do that anymore. I used to be a Mayor and now I am not.

But then do not call when it is a specific issue and do not understand that Congressman are not up here. They are here to serve and that is why we are here to be your ombudsman until we can get you one in the system.

So the question is, am I right to assume that the clearinghouse is a good thing, but what we really do need to do is simplify the oversight part and try to give a designee, one designee for you to go to?

Corporal OWENS. Yeah. What you have to understand is that our needs are newer needs than past veterans. You know, we are a whole new breed of patients. Our survival rate is a lot higher. The type of injuries are different. And so it is going to require a new game plan and different mode of thinking than what has been implemented in the past. And that is what, I think, a lot of people

do not understand because they are not opening themselves up to a newer—that we need newer programs, a newer way of doing things.

Mr. BILBRAY. Maybe our thing is we need to make sure their job reflects more on doing the right thing and less on worrying about making mistakes if they make mistakes. You know, that is the biggest problem we have is the bureaucracy tends to say the less I do, the less exposure I have of making a mistake and they only judge me by mistakes, not by successes.

Ms. WADE. My only——

Mr. MITCHELL. Go ahead. We have got to go. And I want Mr. Lampson very quickly. Go ahead.

Ms. WADE. My only comment with the one person is I do not want that to be misunderstood. I do need more than one person. I need a single point of contact. My husband's amputee case manager is a very important thing for him.

You know, like, for instance, the issue that Casey was having with his leg, an amputee case manager who has worked a lot with amputees that are recently injured would have known what to do in that situation.

For me, I need a TBI case manager for Ted's TBI rehabilitation plan. So what I have told many people is I need a case manager for my case managers.

Mr. MITCHELL. Thank you.

Ms. WADE. So I just do not need it to be one person.

Mr. BILBRAY. That is good.

Mr. MITCHELL. Thank you.

We have to go vote and we will be back. And I want those people here to stay here.

But, Mr. Lampson, before we go, would you like to make a comment?

Mr. LAMPSON. I would like to make a comment, actually two very short comments and one question. And it follows up really on what Congressman Bilbray was just talking about.

But, first, you know, it is as if the care they do receive has been by trial and error. And I think that is their point. It is something new. Corporal Owens just made the comment that it is a new set of problems. They are polytrauma patients today that we have not known how to take care of in the past.

I am very impressed by your concern about those who you are trying to be a representative for and coming here to Congress in the hopes that someone else will not have to come here later on.

My other point is the comment that both Congressmen Bilbray, Stearns, and Zach Space made about how we really do want to know about what is going on and try our best to be responsive to what is happening.

I carry a card in my pocket, and have for more than a year now, with the names of the 19 men who have died from my district. I walk the halls of the veterans' hospital in Houston, Texas, and at Walter Reed visiting with folks like this recovering from their injuries. Yet, it took being contacted by this Committee to find out that I had a person in my district who was having this kind of problem.

So there is something that is even further broken. How do we get information? Here is my question of you all. How do we get infor-

mation out to other members of the service to know that they should be able to turn to any level of this government, whether it is their Representative, their Senator, their President, or whoever else, to be able to say something is wrong and I need special attention? Do you have any further comment that you can make about that?

Corporal OWENS. It just never really crossed my mind because there is the hospital, the VA. That is what it is, for medical needs. So I do not think of my Senator or Congressman to turn to for medical needs, you know. And I have no doubt that you or any other person want to serve me. It is just I——

Mr. LAMPSON. My point is that we need to find a way that we can make sure that other folks in your situation know to contact us. We want to reach out to you.

Ms. WADE. I guess part of the difficulty with that is patient confidentiality and overcoming those barriers. But I do know that somehow or other, one of our Senators does—I do not know if they scour newspapers to find out who has been wounded or what, but, I mean, we got a letter offering assistance if we needed it in the mail.

Mr. LAMPSON. Well, we do both as well. And I have a retired Marine who returned from Iraq and went to work on my staff as the outreach person. And we even meet with on a bimonthly basis about 15 organizations of veterans, their leaders in my offices every other month. Still there are things that are falling through the cracks.

I have a physician at home who has actually volunteered to repair the face, he is a plastic surgeon, of anybody who needs that special attention. Getting that information out is something that I think that we need to pay attention to.

I think you are magnificent people for being willing to give your lives to our country. You should not have to be going through the difficulties that you are facing today. If there is ever anything that any Member of Congress can do, ask your friends to ask us to respond. I think we will do so.

Thank you, Mr. Chairman and Ranking Member, for allowing me to come today.

Mr. MITCHELL. Hopefully you will all be able to stay here. We are going to finish this up and we have got some other questions. And we will be back right after the vote. Thank you.

[Recess.]

Mr. MITCHELL. We are going to go ahead and get started. Others are on their way.

One of the things that I wanted to ask both the groups here are, first of all, Corporal Owens, you mentioned last night that you have been trying to get your medical records and you have never received your records; is that correct?

Corporal OWENS. Right. I have not. I have been trying to get my med board which is about four inches thick. I have not gotten it yet.

Mr. MITCHELL. And I would hope that those of you who are here that have some responsibility of that make sure that Corporal Owens gets his medical records. He has never had them. About four inches thick. He has asked for them and asked for them.

And when were you injured?

Corporal OWENS. September 2004.

Mr. MITCHELL. September of 2004 and he does not have them. That is one of the things we have been trying to deal with, to get some kind of a seamless transition with DoD records and the VA records. There is no way he can get the right and proper care without all the records and he does not have them.

The other thing that is interesting you told me last night is that you found in your records that you were not even awarded the Purple Heart; is that correct?

Corporal OWENS. When I got to the VA, this was about a year ago or so or I do not know how long ago, several months ago, I was looking through my case manager's computer and scrolled down. It said I did not have the Purple Heart. It said I did not have dental injuries. It did not have any of my claims. All it had was I lost both legs and that is it.

Mr. MITCHELL. That is amazing that they have on there you lost both legs, but not a Purple Heart. And they rebuilt your jaw and your mouth and it had nothing about your dental.

Corporal OWENS. No PTSD, no dental, no scars, nothing.

Mr. MITCHELL. And I will tell you it is the lack of records and the continuity of them that has caused—you can imagine what it does to people who have PTSD and traumatic brain injury. It does not help.

And, Ms. Wade, I think you suggested a similar situation with you.

Ms. WADE. And I think what is hard for us, too, is that I have had so much on my plate trying to manage all Ted's medical affairs that there are things that have just simply slipped my mind.

I am trying to get a hold of some records. I want to get his PEV, his physical evaluation word file as well. There are some records from Germany I have never been able to get a hold of. Particularly I wanted his MRIs of his brain after his brain surgery.

But, I mean one of the things that is difficult with this, I guess, lack of continuity in the records is I had a therapist recently comment that it seems like my husband was tracking strangely with his eyesight when they were working on a crossword puzzle. And it triggered a memory. And I went back and read an article that his speech therapist from the polytrauma center had written about him. And I had completely forgotten that my husband was having vision issues back in Richmond. Well, there was no followthrough. He had never been seen by an ophthalmologist.

And come to find out Walter Reed referred Ted to a neuro-ophthalmologist and he has visual impairment. He has a blind spot in his vision and he also has some other visual impairment.

But, you know, in this jumping from hospital to hospital and the lack of case management, the lack of records, you know, a nice, concise record and maybe a list of just his major injuries, it would have been nice.

But we are also dealing with having his VA rating fixed. He just had his new one updated. I guess it was a 3-year update. And it was simply done on his VA medical records. Well, really the only thing he goes to the VA for anymore is speech therapy. And so they

did not have access to any of his other records. So I am going to have to file an appeal to have other things added in.

And like Casey, there were new things that came up. There is not a complete record and there is not a complete diagnosis of all his issues.

Corporal OWENS. But the problem with that is, and in my case, and it has got to be for her, since they do not have those records, you have to then be reevaluated by the VA. So since they did not have anything other than my legs, I had to go to the dentist, you know, or to, you know, dental. I had to set up an appointment, wait like a month for it.

I had to have MRIs for different things. I had to see the dermatologist. I had to see all these different doctors, psychologists for my PTSD, another stranger I have never met, have to tell my story again, rehash old memories, and it just gets old time and time again doing it over and over when you have done it once for your med board by qualified, competent people. It is just like why can it not pass on to other people? And, you know, that is——

Ms. WADE. And Medicare included, I think, because we—I mean, I do not know if you had to do this, but we had to go through the whole welcome to Medicare exam also. There is a lot of repetition.

Mr. MITCHELL. Right. And, you know, this hearing is not only to hear your story here, but it is also to send a message to those that can do something about it. And they are sitting behind you and they will be testifying later. And I hope that they look at this, that both of you are unique and that you have worked through the system. In spite of the system, you have gotten things done. A lot of them, as you said, do not have the time. They do not have the resources. They just cannot do it.

And this is you serving as a model, that if this has happened to you and you are people who know how to work the system, think of how many others that it is happening to. And it should not.

Okay. If there is anything else that either one of you would like to say? Okay. Yes, Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

Ms. Wade, what disability rating did Ted receive?

Ms. WADE. He was given both a hundred percent by the military and the VA. I had a couple people look at his rating that actually told me, and I am going to have to have this fixed, but based on the way his rating is written, I had a couple former raters read it and a couple——

Mr. WALZ. It is all in the wording.

Ms. WADE. Yeah. It is all in the wording. They said that Ted actually may qualify for a next level of special monthly compensation if his injuries are worded differently.

But part of the problem is and one of the reasons I brought up about the special monthly compensation is that those things are written based on physical residuals, not cognitive residuals. They have not been updated for the current injuries.

I mean, again, even in some of the vocational rehab aspects, the Independent Living Program for vocational rehab is really designed for physical needs, not cognitive needs. And I think all of these things need to be updated to fit the current injuries.

And I think part of that with the special monthly compensation and needing more assistance is one of the important things to keep in mind is that not everyone has family to help them out and they might need to hire someone to lend them a hand.

Ms. BROWN-WAITE. Another question. Having served as basically a patient advocate for family members, I know it is all in the questions that you ask. Certainly when I was taking care of my mom and now my husband and I know you have to be specific and you have to press for the right answers.

Along the line, did you find anybody purposely gave you incorrect information, Corporal?

Corporal OWENS. No.

Ms. BROWN-WAITE. Sergeant or Ms. Wade.

Ms. WADE. I have been given incorrect information. Whether or not it was done on purpose, I do not know. I have been given incorrect information quite a few times, though, and I do not know if it is the people do not know the rules or if someone has interpreted them differently than I have when I have read them. But I have been given a lot of incorrect information.

Ms. BROWN-WAITE. And I would like to ask both of you, on a scale of one to five, five being the highest, how would you rate the orthotic and prosthetic department of the facilities that you were treated in?

Corporal OWENS. Well, I was treated at Walter Reed or Brooke. Five.

Sergeant WADE. Five as well.

Ms. WADE. We do not use the VA orthotics and prosthetics. I mean, like Casey's situation, it was just too much of a hassle. And part of that is because of the nature of Ted's injury, that the closest VA contractor to work on his arm is maybe about a 6-hour drive from us. It is easier for us to come to Walter Reed than to wait a few weeks to have someone work on his prosthesis.

And there also is not a therapist with the expertise that they need for his prosthetic training at our VA hospital. So we just do not even bother. It is just easier to go back to the military because there are no hassles and we can just walk right in the door.

Corporal OWENS. The problem for me is, and other people like us, is we are a different patient than what they usually deal with because they are usually dealing with diabetics, people that are older in age, that are retired. And so, you know, I want my stuff. I want to see them 4 or 5 days a week for an hour or two and get done, whereas some people are just, you know, they can come in, get fitted once, twice a week, and, you know, they are not as active and not as, I will not say motivated, but are not requiring them as much and needing them expedited, you know, not needing them as quick and as fast because I need it done so I can get back to school and go back to work. So it is accessibility, I guess.

Ms. BROWN-WAITE. One of my concerns about the orthotic and prosthetic service providers is in many States, they have to be licensed. I know Florida when I was in the State legislature, we were like the second State to license them, but we had no effect on licensing for the Federal Government.

And the Federal Government still does not require in States where a license is required that the VA providers or even the DoD

providers have to be licensed and meet all of the State qualifications. That is why I asked about how you would rank the level of service.

Thank you very much. I have no further questions, Mr. Chairman.

Mr. MITCHELL. Thank you.

Just one last thing. I think it is something you are going through, but also for some of our next panelists. And that is how do inaccurate records, your medical records affect the ability to get VA benefits?

Corporal OWENS. Well, you know, like I said, since they only had me under, you know, just missing my legs, I was a hundred percent, but if you do not have those other records and those claims, you can only go to a hundred percent, but having those claims, you get extra compensation. If you have all your claims, but you cannot get treatment for them unless it is claims because then it is not service connected.

Ms. WADE. I think it is also, like my husband, I was looking at his records because I need to appeal his final medical board and we are looking at about 3,500 pages, and so it seems like there needs to be a better way to really highlight the major issues.

But part of what is difficult with that, again, is the physicians have to know what exactly it is they need to document. They are not raters. And the raters have their set guidelines they are using and if the doctor does not know those guidelines, then they do not know how they are supposed to be documenting things.

I mean, one of the things with my husband is, yes, he got a hundred percent for the traumatic brain injury, but he also has, one of the things we were discussing last night, he has very bad muscle spasticity. And at times, he loses voluntary control of his limbs.

Well, his records say muscle spasticity. A friend of ours, it says loss of voluntary control of two limbs. His friend is rated as hemiplegic which gives him the next level of special monthly compensation. Ted just has muscle spasticity and, therefore, is not given anything for that residual.

It means that he cannot use his prosthesis when he is having trouble. It gives him loss of use of his limb he has already lost. It is harder for him to compensate for the loss of his arm because of this medical condition. But if the person documenting this does not know how they are supposed to be wording it to meet what a rater is looking for, then it becomes an issue.

Ms. BROWN-WAITE. Just one other thing. I would strongly suggest in getting your husband's records that you do engage your Member of Congress. As many of us have said, that is what we are here for. And the congressional staff and the Congressperson do get involved in this.

And I always apologize to my veterans that they have to come to me to get the records that they should be able to get. But getting records from DoD is not easy. And that is something that every Member of Congress on both sides of the aisle that their offices do regularly.

Now, you will have to fill out a privacy form that authorizes your Member of Congress to help you, but it sure will speed things up if you have had a problem. And please pass that word on to other

families that you are in touch with. Please use us. We are here and we are grateful to help those who sacrificed so much for our country while in the military and the families. And with all you have been through, I am surprised you do not have gray hair.

And I yield back.

Mr. MITCHELL. Thank you.

And I want to thank you not only for the sacrifice for the country, but what you are doing for other veterans. You are speaking for a lot of people, a lot of people. And I appreciate that.

And I also in my opening statement, I pointed out that, you know, you may be disappointed, but you are not bitter. You are very proud to have served your country and that is admirable. And I appreciate everything that you are doing.

And with that, we will conclude this panel. Thank you very much.

And the second panel, Meredith Beck and Todd Bowers. And, Meredith, would you care to go first?

Ms. BECK. Yes, sir.

STATEMENTS OF MEREDITH BECK, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT; AND TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

STATEMENT OF MEREDITH BECK

Ms. BECK. Mr. Chairman, distinguished Members of the Subcommittee, thank you for the opportunity to testify before you regarding post-acute care for seriously injured servicemembers.

My name is Meredith Beck and I am the National Policy Director for the Wounded Warrior Project (WWP), a nonprofit, nonpartisan organization dedicated to assisting the men and women of the United States Armed Forces who have been injured in the recent conflicts around the world.

During those conflicts in Iraq and Afghanistan, there have been approximately 30,000 soldiers, sailors, airmen, and Marines wounded in action. Fortunately, due to the advances in medical technology, the number of those killed in action are far fewer.

However, in many cases, the wounded have suffered devastating injuries and require long-term outpatient care and rehabilitation. As they have suffered these injuries, WWP is pleased that the Subcommittee has chosen to focus on this aspect.

As a result of our direct daily contact with these wounded warriors, we have a unique perspective on their needs and obstacles they face as they attempt to transition, reintegrate, and live in the communities where they have served.

I also want to note that my job as the Policy Director is to speak directly to these families across the board. What I then do is create policy themes and proposals based on the themes that they have demonstrated.

Unfortunately, my job is easy these days because the themes that the families are presenting are almost uniform in what they are presenting. The Wades, Casey, they are prime examples of that.

However, as Sarah noted, it is very important for you all to understand that these two, the Wades and Casey, are not typical of your daily average wounded veteran and their families.

Sarah is very well-spoken. Casey is incredible at what he does. And the families that we deal with, and they represent them well, but the families they deal with do not in many cases have the capacity to be able to navigate these systems as well as they have.

Because of our contact with these servicemembers, we have identified a number of areas, and you will probably hear some repetition from the two of them because they have come directly from people like them, and the following areas are common themes among these families.

The options for care specifically with respect to those with traumatic brain injury, those suffering from TBI require individualized comprehensive care. And while the VA has made progress in this area, the Agency is still in the process of establishing extensive, consistent, long-term continuum of care available throughout the Nation.

As such and due to the need for long ongoing therapy and rehabilitation, many seriously injured veterans and families have indicated that their number one request is increased access to options for care, including access to private facilities previously available to them while on active duty.

The next topic is discrepancies in benefits. Many veterans and families of the seriously injured have indicated confusion, frustration, and disappointment upon learning that they are not eligible for the same benefits and care as veterans as they were on active duty and vice versa.

For example, consider that an active-duty patient can be seen at a VA polytrauma center to treat his traumatic brain injury. However, while at the VA facility, the servicemember, due to his duty status, cannot enjoy VA benefits such as vocational rehabilitation or independent living services. They can be assessed for those benefits, but they cannot have them until they are actually retired.

Alternatively, as mentioned previously, and unbeknownst to most families, a medically retired servicemember cannot use his or her TRICARE benefits to access private care as TRICARE does not cover cognitive therapy once retired.

While there is an obvious need for and advantage to an active-duty service, those who are severely injured as a result of their service in an all-volunteer force deserve special consideration.

The recently passed NDAA contained a provision intended to address those discrepancies. Specifically section 1631 authorizes for a limited period of time the Secretary of Defense to provide any veteran with a serious injury or illness the same medical care and benefits as a member on active duty and entitles the severely injured still on active duty to receive those veterans' benefits, excluding compensation, to facilitate their long-term recovery and rehabilitation.

While the provision recognizes the strengths of each Agency, and they do both have strengths, and the necessity of basing an individual's care and benefits on his or her medical condition rather than on their status as active duty or retired, it is subject to significant regulation and will require oversight to ensure its success.

The next topic is respite care. I will say personally my brother is currently a Marine major serving in Fallujah. He has four children under the age of seven. If something happens to him, I want to know, and this is why I do this and why I talk to these families, I want to know that he is going to be taken care of and that his wife will have the ability to take care of their children and take care of him.

For those who have suffered and who are seriously injured, one cannot discuss their care without discussing their caregiver. While the VA currently offers some respite care, the available options are often not entirely appropriate given the average age and types of injuries of those serving in Iraq and Afghanistan.

For example, similar to the Wades, retired Army Sergeant Eric Edmondson from North Carolina suffered a severe brain injury in Iraq several years ago, but he is aware and responsive. In fact, he enjoys spending time with his family and recently went fishing with his 3-year-old daughter, Gracie.

Eric's family is unwilling to place him in a respite facility for fear it could cause a regression in his rehabilitation and cause Eric distress, which ultimately means his family does not get any form of respite.

However, WWP has noted that similar to others, Eric's family has used their personal funds to pay for an innovative type of individualized therapy that also provides a unique form of respite to the caregiver.

In Eric's case, rather than staying indoors all day, his family pays an individual out of their own funds to take him to the park and watch his daughter play. Eric thrives each time and his progress and enjoyment are noticeable.

As a result of Eric's success as well as others in similar situations, WWP proposes that the Department of Veterans Affairs initiate a pilot program partnering with local universities that the VA already has partnerships with to provide such a care and respite initiative for those with brain injury.

As part of the veteran's ongoing therapy, the program would draw graduate students from the appropriate fields, i.e., social work, nursing, psychology, train them to interact with the veterans and match them with the eligible veterans in their local area so that an individualized program can be developed.

In return for making the requisite reports to the veteran's physician on his or her status, the graduate student would receive course credit for doing such work.

The creation of a program would have several positive effects. In recognition of the individual nature of brain injury, the program would encourage an innovative means of providing age-appropriate maintenance therapy to those suffering from TBI, which for the long term is absolutely necessary. Their rehab is never finished.

While the veteran is benefiting from the therapy aspects of the program, the family caregiver would be offered much needed respite.

And, three, interaction with the graduate students would increase general community awareness of the sacrifices of our Nation's veterans and the needs of those suffering from TBI.

Mr. MITCHELL. Could you wrap it up?

Ms. BECK. Yes, sir.

Last, the oversight aspect of this. Finally, consistent with the recommendations of the Veterans' Disability Benefits Commission and to ensure the best care and benefits for those who have sacrificed for our Nation, it is imperative that a joint permanent structure be in place to evaluate the changes, monitor the systems, and make further recommendations for process improvement.

It should not require Casey and the Wades to be the ones who find the problems. They should be able to rely on the people who are providing their care to provide that oversight and the ability to give those recommendations for change.

With the passage of time, as veterans' issues fade from the national spotlight, it is necessary to have that structure so that we can all make sure that we are coordinating future intra- and interagency coordination.

Thank you, and I look forward to your questions.

[The prepared statement of Ms. Beck appears on p. 54.]

Mr. MITCHELL. Thank you.

Mr. Bowers, you have 5 minutes.

STATEMENT OF TODD BOWERS

Mr. BOWERS. Mr. Chairman, Ranking Member, and distinguished members of the Subcommittee, on behalf of the Iraq and Afghanistan Veterans of America (IAVA) and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding this important subject.

I would also like to point out that my testimony today is as Director of Government Affairs for the Iraq and Afghanistan Veterans of America and does not reflect the views and opinions of the United States Marine Corps of which I currently serve as a Sergeant in the Reserves.

The tremendous advancements in frontline medical care have made many combat injuries more survivable. In Vietnam, the mortality rate of combat injuries was one in four while the mortality rate in Iraq is one in ten. That means today's battlefield medicine has saved approximately 6,000 American lives that would have been lost if they were still using Vietnam era medical techniques. This is a tremendous success story for the DoD medical system.

But the corollary of improved survival rate is an increase in the number of severely wounded troops returning home. As the *Independent Budget* states, and I quote, "We are seeing extraordinarily disabled veterans coming home from Iraq and Afghanistan with levels of disability unheard of in past wars."

Many of these young wounded veterans will require long-term care, not just at Walter Reed and Bethesda, but in their communities across this country.

At the VA, these veterans with traumatic brain injury and blast injuries are confronting a system designed to treat diabetes and Alzheimer's.

The DoD and the VA have already taken some crucial steps to improve inpatient care for these young, severely wounded patients. There are four major polytrauma rehabilitation centers in Florida, Virginia, Minneapolis, Minnesota, and Palo Alto, California, which use teams of physicians and specialists that administer individ-

ually tailored rehabilitation plans, including full spectrum care, for traumatic brain injuries.

These centers are also part of the defense and veterans brain injury center network. These key centers offer cutting-edge treatment for severely wounded troops who are receiving inpatient care. But what is available to troops near their homes?

As of 2003, according to the U.S. Government Accountability Office, more than 25 percent of veterans enrolled in VA healthcare, over 1.7 million, live over 60 minutes driving from a VA hospital. This number is likely higher today because the mission in Iraq has relied heavily on recruits from rural areas and under-served by VA hospitals and clinics.

This places a tremendous burden on the families and also the veteran. With the current gasoline prices, for example, and many treatment centers hours away, treatment is often impossible to facilitate.

Imagine, if you will, that your loved one has returned from combat wounded and it is your responsibility to make sure they are receiving the proper treatment. This is too much to ask of our servicemembers and their veteran families.

In response, the VA has created regional network sites that work with major polytrauma centers to cater to patients closer to their homes. The VA is also planning to add new polytrauma support clinics to provide followup services for those who no longer require inpatient care but still need rehabilitation.

The 75 polytrauma support clinic teams help veterans get access to specialized rehabilitation services closer to their homes and communities and also are responsible for ensuring these patients do not fall through the cracks after leaving full-time care.

For hospitals without a polytrauma support clinic, a single person has been designated as the point of contact to coordinate care for local veterans with polytraumas. These are good first steps, but much more has to be done to get these wounded veterans the care they need. A single point of contact that can offer referrals to distant hospitals and clinics is simply not an adequate response to a wounded veteran's healthcare needs.

IAVA joins the other *Independent Budget* of veterans service organizations in calling for an increase in funding for home and community-based care and a detailed plan from the VA regarding their long-term response to the need of today's veterans.

I would be happy to answer any questions at this time.

[The prepared statement of Mr. Bowers appears on p. 55.]

Mr. MITCHELL. Thank you very much.

I have a question of both of you. Both of your organizations came about as a result of the wars in Afghanistan and Iraq. How many other organizations like that have spurred up as a result of this war?

Ms. BECK. Probably countless numbers of organizations. I am not sure that the number, though, who have—there are countless organizations that provide care support services benefits for servicemembers. Of the organizations that actually do policy work related to this area, I would say that we are probably the only two.

Mr. BOWERS. Uh-huh. And we are good friends.

Ms. BECK. And we are friends.

Mr. MITCHELL. The reason I ask that is that with this war, which is relying solely on volunteers and the growth in the number of organizations like yours to serve this war, it really seems that it is kind of market driven. The government is not doing its job and as a result, volunteers from the private sector are stepping forward. And that is really not a very good story.

And I listened to Corporal Casey Owens, many times saying that he has completely given up on the government services and has gone completely to the private services and all those services are organizations like you.

That is a sad commentary. And just a comment on that.

Ms. BECK. If I could, sir, one thing about that, and, yes, the government certainly needs to be providing a lot of these benefits in a more organized, better fashion, and quality of care obviously in the past two situations we have seen.

There is one aspect for the organizations, though, to make sure that the communities are aware. I know that Todd has a large campaign to make sure that the communities are aware of the needs of these servicemembers and to provide a means through which individuals can contribute and understand.

So there is hopefully a need for them. But at the same time, I certainly agree that the government should be providing a better, more structured form of quality benefits for the individuals.

Mr. MITCHELL. Well, and to comment along with that, most people are not personally affected——

Ms. BECK. No, sir.

Mr. MITCHELL [continuing]. By this war. And very few are. And we see how affected those that are involved in this area. And I applaud you for doing that because we need to make people aware. It is just not a typical war.

It has been said before by the first panel that it looks like they are dealing with a government organization or the VA that is not aware. Times have changed. It is a different war, different wounds, different conditions, and that we need to catch up.

And I applaud your organizations because at least I gather that you are trying to do that very thing, to really turn things around and come up to speed with today's war and today's needs.

Mr. BOWERS. Just to add on that, Meredith mentioned something that we are doing actually with IAVA is communication is key to let individuals know what resources are available not only through the VA or DoD but also what other veterans service organizations are there to help.

And we have partnered with the Ad Council on a 3-year campaign that is going to communicate to the American public to let them know what services are available and also to destigmatize, and I emphasize this, to destigmatize the stigma related to servicemembers seeking mental health treatment.

Mr. MITCHELL. Absolutely.

Mr. BOWERS. Until that is broken, we are really going to have a hard time getting people to step into the doors to receive the treatment they need. And we are hoping that this campaign will be a good way to do that.

Mr. MITCHELL. Absolutely. And you all are doing a very admirable job. And it is unfortunate. I have heard from hearing after

hearing where the veterans do not know what is available. Unless they know the right questions to ask, they do not know what is available.

And I understand that is what you all are doing is reminding people what is available and how to ask the questions and how to access what it is that they should have because the government is not doing that. They are not telling everyone what they should get.

Ms. BECK. The government tends to be in its own stovepipe essentially. So it is not only DoD and VA. DoD and VA, you know, for the most part recognize that there is a problem here and they are working on fixing it and they have got a ways to go, but they are working on it.

These guys, they do not just have to deal with the DoD and VA, especially as the most severely injured. You have Medicare, Social Security Disability Insurance, the Department of Labor, the Department of Education, all of those agencies right in a row, and any one of them is difficult to navigate much less seven or eight of them as a severely injured servicemember or a 19-year-old spouse.

Mr. MITCHELL. And I appreciate the fact that you are saying the VA recognizes they need to change. But, you know, that is in the long run. In the short run, you know, there are the Wades, the Owens. There are 19-year-old mothers. They have to live every day. And it is great that they see that they need to turn the ship around, but we have got people who are living right now. And that is who we need to take care of.

Ms. BECK. Which is why it is so important, sir, that when we are creating—there is a common misperception out there that people like the Wades and Casey who were injured a little while ago that all of their problems are fixed now because they were injured a while ago. But it is so important that as we put these new policies and programs into place that we are reaching back to those families who came before and making sure that they are taken care of because they are the reason those programs were created in the first place. So that is of the utmost importance to the Wounded Warrior Project is to find those families who came before.

Mr. MITCHELL. And just one last comment before I turn it over. Mr. Bowers talked about the need for bringing services out to the rural areas. It is a different kind of war. As you mentioned, it is not a draft. So most of the recruits are coming from rural areas and this is where the need is going to be.

So instead of maybe in past wars where you can locate in large urban areas, the recruits, the needs are coming from different areas. And I think that is something that the VA needs to recognize.

Mr. BOWERS. It is. And I would also add to that that it is very important to know that rural veterans do not necessarily have access to the Internet. So as we often hear that, well, we can put together a Web site and an outreach element, that is very effective for most, but only 8 percent of this country's rural areas have access to broadband.

You also have issues with individuals who have traumatic brain injury or post traumatic stress disorder. It is going to be extremely difficult for them to try and rely on a Web site to find answers. You

know, that is something that we have always said there needs to be that direct contact.

And specifically at my Reserve center last weekend, we actually had the VA there. They were there to register every single Marine there. We also met with folks from the Vet Centers. There were six individuals there and we also completed an electronic version of our post-deployment health reassessment form. It was textbook. It was exactly what we needed to start doing the second these conflicts began and when troops started returning home.

But there has been a long period of time since then and a lot of people have fallen through that gap. And the biggest takeaway was that it was not mandated. It was just my unit being proactive and saying we need to make sure our Marines get this. It is not a mandate by any way, shape, or form.

Ms. BECK. Sir, Sarah will come after me if I do not point out that, yes, the rural veterans are certainly in need of the aspects. But what Sarah would point out and I will speak for her is that they were from Chapel Hill, North Carolina. They were in the heart of the research triangle and because of the way benefits were configured, they did not have access to the places they need to be. So that is also a concern.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you. Thank you, Mr. Chairman.

Mr. Bowers, when I read your biography, it was one of those moments when you say "wow." Thank you so much for your service as a Marine and for your two voluntary tours in Iraq.

Mr. BOWERS. Another one coming up in January, too, so I will miss you guys.

Ms. BROWN-WAITE. Please stay in touch by the Internet. You heard me before say about the importance of staying in touch with your Member of Congress.

I congratulate you on your award for the Purple Heart. You know, it is amazing that the sniper round hit your rifle scope. You know, we can only hope that you, too, had him in the scope of your rifle.

You had indicated that your organization has about 80,000 active members.

Mr. BOWERS. Yes, ma'am.

Ms. BROWN-WAITE. Could you tell us how many of the approximately 80,000 active members would fall in the category of today's hearing, just a percentage, and can you give us any specific complaints, shortfalls, or perhaps unaddressed issues that we have not touched on today? In other words, people and issues that kind of fall through the cracks.

Mr. BOWERS. I would say that of our membership, we have relatively low numbers of individuals who deal with polytrauma centers and who have been injured. With that said, I spend a lot of time up at Walter Reed and Bethesda just hearing from the servicemembers and finding out what their difficulties are.

The biggest thing that I have come across is the lack of support for families. I would say that is the number one thing that we have heard from folks at a lot of different levels. Many times with families, and Ms. Wade was right on with this, you know, she is, you

know, bearing the brunt of a lot of the lack of support networks and things for these wounded servicemembers. And that is probably the biggest thing I have heard across the board there.

Ms. BROWN-WAITE. Have you heard of any of the other polytrauma units actually hiring the spouse to work in the VA hospital? I know that down in Tampa in Haley Hospital, they actually do that. Is that happening around the country in the other polytrauma units?

Mr. BOWERS. I have not heard of any cases. I have heard of one case where someone was offered a job, but the polytrauma center was 4 hours away, so they could not facilitate the move.

Ms. BROWN-WAITE. This actually was a family that moved to Tampa to be close to the servicemember while he was being treated there. And I thought that is wonderful. We should encourage that. You know, if they want to work or if they need to work, that is a great way to provide families support and have that person right there in the hospital.

Ms. BECK. Ma'am, if I could, one of the primary objectives of the Wounded Warrior Project, we do not have members, but that is our sole base is attempting to have caregivers compensated for the work that they are doing.

The VA actually already has this program for spinal cord injury patients. And they train, certify, and make eligible for compensation those family caregivers.

In many cases, I know that it may not be the most ideal situation for the family member to be providing that care, but they are doing it anyway.

So what we would ask is that through those programs, looking at that San Diego VA where they provide that service, looking at replicating that especially for the most severely injured, brain injured servicemembers where their families are often leaving their jobs and providing that care really and suffering from extreme financial distress from doing so.

Ms. BROWN-WAITE. Do you have an estimate of how much the proposed respite care pilot program would cost the VA?

Ms. BECK. I do not have an overall estimate. I would say that since it would be done with the universities and the students would be not paid, they would be getting course credit for doing that, it would really be a cost of organizing and coordinating, not necessarily the payment process for providing that service.

Ms. BROWN-WAITE. We are having the Blackberries going off and it is not to be rude, but we have to have them on so we know when once again we will be called to the floor.

Do you have any additional suggestions that you did not include in your testimony?

Ms. BECK. Gosh, I could go on forever, but I will not.

Really I think Todd hit the nail on the head with the family aspect of this, including the families in the care aspect of it, and also understanding that without the families, the VA would be in a lot of trouble, and that we rely on them tremendously. And for that aspect, the issue of coordination among the agencies which I know is something that we have talked about before, but it is of utmost importance.

I had someone from the Department of Defense, from TRICARE tell me, we were trying to resolve a very complex issue that faces these servicemembers about their eligibility for Medicare and TRICARE, and her response was what do you want me to do, hand walk these guys through the process. That was my answer. So, yes, yes, actually. Then we solved the problem.

Ms. BROWN-WAITE. That is that person's job?

Ms. BECK. The awareness factor here is tremendous and promoting that awareness of what these servicemembers do and how the families are suffering should not be borne by only those people who happen to be either interested in or happen to be suffering from it. So the increased awareness from Members of Congress, their staff, down to every citizen in the United States is absolutely imperative.

Mr. BOWERS. One portion that I did not include in my testimony, but I would point the Subcommittee toward, the *Independent Budget* makes a lot of comments in regards to nursing home care. A tremendous amount of veterans are coming home and having to rely on nursing home care because of the increased amount of traumatic brain injuries that we have seen in the wars in Iraq and Afghanistan.

What we have heard from our membership and from personal stories from individuals is that it is hard to be a 22- and 25-year-old in a nursing home, in a VA nursing home. There is not a lot going on for these younger veterans and they are still young, vibrant individuals who still have their entire lives to look forward to. And the resources are not necessarily made available to them to be able to continue to better themselves.

And whether it be educational resources, social activities, things along those lines, there is a gap for a lot of those folks that are at the nursing homes. And there has also been some discrepancies that the *Independent Budget* also identifies that there has been a shortage of beds within these nursing homes also.

Ms. BROWN-WAITE. I know that there is a program of assisted living where the person truly just needs some assistance. Do we need to focus more resources on that? And I happen to personally agree with you. I come from Florida. I know that the majority of people in nursing homes in Florida are elderly. And there is a great divide there and a lack of common interest even. And so is the answer more assisted living facilities and specific nursing homes for OIF/OEF returning warriors?

Ms. BECK. I think we need to be careful, however, because we do have an opportunity here because this is a smaller population. But if we build these large facilities just for OEF/OIF servicemembers, then their families will have to travel to those facilities because there just are not enough of them, of a need there.

So building a facility is maybe one option, but I think that looking at the options of, you know, thinking outside the box here. We have individuals with individual needs. We should take this as an opportunity that we have of such a small population and perhaps leverage community resources and leverage those things that are already there to be able to provide the best care and nursing home care near these people's homes.

Ms. BROWN-WAITE. Do you think that the veteran population would resist perhaps, especially in rural areas, a contract with a service provider of respite care, of physical therapy? I mean, we want to make sure the services come to the veteran who needs them.

Mr. BOWERS. I would definitely stand by that individuals when given the choice whether they need to stay at a nursing home or be at home with assisted living will much rather be at home with assisted living. It allows them to be out involved more with the community. So I would say yes to that.

If they do require a nursing home, if they do not have the family support and, therefore, they do have to live in a nursing home, those steps to make it easier for these individuals would be much more effective.

But I would agree with Meredith that by going out and developing centers specifically for OIF/OEF veterans may be a bit much. We need to think long term.

And, you know, just speaking with my Marines, we know the Global War on Terrorism is never going to end. So we have got a lot of work to do.

Ms. BROWN-WAITE. Please thank your Marines for us and thank you for again going back and thank you for your service.

And, Ms. Beck, thank you for all that you do.

I yield back.

Mr. MITCHELL. Thank you.

And thank you very much.

I would like at this time to welcome panel three and I am probably going to mess your name up. I am sorry. Dr. Madhulika.

Dr. AGARWAL. Madhulika Agarwal.

Mr. MITCHELL. Agarwal. Thank you. Is the Chief Patient Care Services Officer for the Veterans Health Administration (VHA). We look forward to hearing from her and her team.

Let me just say before you start, and I appreciate you being here and I know that you are also a messenger, and hopefully what you heard today, what we all heard today brings some results and some fruits because it is just frustrating when we hear these things and we write it down and it is just another report somewhere.

You have heard today real needs and real concerns. And I suspect that you are in a position to do something about it, at least we hope so. Thank you.

STATEMENT OF MAHDULIKA AGARWAL, M.D., MPH, CHIEF OFFICER, PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KRISTIN DAY, LCSW, CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK SERVICE, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION; AND LUCILLE BECK, PH.D., CHIEF CONSULTANT, REHABILITATION SERVICES AND, PROGRAM DIRECTOR FOR AUDIOLOGY AND SPEECH PATHOLOGY PROGRAM, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. AGARWAL. Thank you.

Good afternoon, Mr. Chairman and distinguished Members of the Subcommittee. Thank you for the opportunity to testify before you on the Department of Veterans Affairs care for seriously wounded veterans after they complete their inpatient care.

I am accompanied by Dr. Lucille Beck on my right, who is the Chief Consultant for Rehabilitation Services, and Ms. Kristen Day on my left, who is the Chief Consultant, Care Management and Social Work Services.

I would like to request that my written statement be submitted for the record.

Mr. MITCHELL. Yes, it will.

Dr. AGARWAL. Thank you.

With your permission, sir, before I begin my oral testimony, I would like to thank Corporal Owens, Sergeant Wade, and Ms. Wade. As you said earlier, they have tremendous courage and enormous resilience. I want to thank them for their sacrifice and for their service to our country.

We have heard your story and with your input and your support, we will continue to work every day to enhance and improve our healthcare system.

VA is committed to providing the scope of services that ensure a continuum of world-class care, which extends from acute rehabilitation to vocational and community reentry programs for all veterans at locations closer to their home and communities.

In May 2007, VA expanded the case management program for OEF/OIF veterans in response to the President's Commission on Care for America's Returning Wounded Warriors.

VHA and the Veterans Benefits Administration (VBA) established new procedures for the transition of care, coordination of services, and case management of the OEF/OIF veterans.

This program represents an integrated team approach located in VA medical centers. Now the OEF/OIF veterans are screened for case management needs and those with severe injuries are automatically provided a case manager. Additionally, any veteran who requests a case manager is also provided one.

VA provides clinical rehabilitative services in several specialized areas that employ the latest technology and procedures to provide our veterans with the best available care and access to rehabilitation for polytrauma and traumatic brain injury, spinal cord injury, visual impairment, mental health, and other areas.

In October 2007, as recommended by the Dole-Shalala Commission, we have partnered with DoD to establish the Joint VA/DoD Federal Recovery Coordination Program. The Federal Recovery Coordinator, or the FRC, is intended to serve all seriously injured servicemembers and veterans regardless of where they receive their care and has the unique authority to navigate within and between the VA, DoD, and the private sector.

These newly established FRCs will collaborate with VA medical centers, military treatment facilities, and private-sector treatment teams during recovery and rehabilitation phase to ensure that veterans receive the right services at the right time.

VA is committed to providing key services to assist caregivers with case management service coordination and support for the veteran, as well as education on how to obtain community re-

sources such as legal assistance, financial support, and housing assistance.

Eight caregiver assistance pilot programs were awarded grants in October 2007 to explore options, providing support services for caregivers in areas across the country, especially in areas where few such options are available.

In February 2008, VA's Under Secretary for Health approved funding to enhance programs that provide specialized support and care in home and communities that facilitate the transition and support of seriously injured veterans.

These programs include the Volunteer Respite Program which will create access to the needed home respite services for family caregivers, and the Medical Foster Home Program which provides an in-home alternative to nursing home care, merging personal care in a private home with medical and rehabilitation support from specialized VA home care programs.

These programs will aid seriously injured veterans living in their own homes and those who are no longer able to live independently, but prefer an in home alternative within their community.

Moreover, in compliance with the 2008 "National Defense Authorization Act," VA is collaborating with the Defense and Veterans Brain Injury Center to design and execute a 5-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans to enhance their rehabilitation, quality of life, and community reintegration.

VA is providing outreach both locally and nationally to veterans and servicemembers. This begins with a letter from the Secretary of Veterans Affairs providing information about healthcare and other benefits while thanking them for their services and welcoming them home.

VA works with the DoD in implementing the post-deployment health reassessment and among National Guard and Reserve component.

Additionally, VA established a national polytrauma Web site and a polytrauma call center. The call center is available 24 hours a day, 7 days a week for families and patients for questions about care as well a polytrauma system of care. This center is staffed by healthcare professionals.

We are honored to provide care and service to America's veterans. VA has the unique privilege of having a lifelong commitment to those who have borne the battle in service to our country.

For those who return from combat with serious injuries or illness, we work closely with DoD to ensure a continuum of care, but we also work with those who do not need immediate care to make it as accessible as possible.

Thank you again for the opportunity to testify before you and for your input. I will be happy to address your questions at this time.

[The prepared statement of Dr. Agarwal appears on p. 57.]

Mr. MITCHELL. Thank you very much.

There is a couple of things that I heard about the programs you had and I think you heard some response by the first panel about some of the programs.

And Web sites may be good, but what are we doing about individualizing, people who do not access the Web sites, people who

cannot access the Web sites, people who cannot because they do not know how, or they are not connected with the internet?

You know, one of the things that I think, and I want to say this in general, because as we listen to these individuals, and this is a different war with different injuries, you are going to have a much different clientele than the VA is used to having.

We heard even from the last panel about young veterans being in care centers, 24-year-olds, 25-year-olds. There is a difference. And I think that someone needs to recognize the difference and also the fact that it is great for the long term that we are changing the VA.

But, again, these people are living right now and these people need services now. They need respite care now. They need people to guide them through now. And it is great to have long-term vision and do this, but I am concerned about what is happening right now.

One of the things that I have been concerned about since the very beginning is the records and tracking the records. And I hope that you will be able to get the records that were asked for in the very first panel.

And I am going to ask you again to get those records and we are going to check back that all the complete records that these people deserve and should have, are received. And if you would afterward find out how to contact them so they can get their records.

Dr. AGARWAL. Yes, sir.

Mr. MITCHELL. The other thing that is important, and I think you recognize this by listening to these people, that total care is a family thing and that if families do not get the help, and we heard earlier and in the very first panel where a 19-year-old mother finally just gave up and left. This is what we are dealing with. It is not just the soldiers.

In fact, when I went to Iraq, we heard from the military people at that time that because this is an all-volunteer Army and all-volunteer service now, they are recruiting families. It is not just the soldier. So the families are a very important part of the total service and, therefore, the families should be treated in the same way that the individual servicemember is treated.

One of the things that is important, and I knew this from being a government teacher and involved with all levels of government, you know, it is important to have a trust in government. And sometimes the only government agency, wherever it is, whatever level, that a person goes to gives them an attitude about the whole government in general. And I am not talking local or State. All of them.

And it sounds to me from the very first panel that Corporal Owens just gave up. He did not trust the VA anymore. He went to private providers. This is horrible. And how do we get people to continue to volunteer not only for the military, but in government service in general if they lose trust because it is too much trouble, it is too big, they do not take care of their needs?

And you are an important part of helping build trust in government because I do not know of anyone, and you have heard this up here, who does not believe that these soldiers, deserve the very

best. They are giving up more than the general public because this is a volunteer Army.

The other thing I want to mention that there was an office, the Office of Seamless Transition that was created and it was supposed to be a point of contact between the veterans and the DoD. And this office was disbanded almost immediately after it was implemented.

And we continually talk about a seamless transition from the DoD to VA. I want to ask if you know why this office was disbanded and why we have not been working toward a seamless transition?

Dr. AGARWAL. I am sorry if I may answer the last question. We do have seamless transition processes currently in the Central Office. And, in fact, Kristen Day's office in the Office of Patient Care Services has assumed a large part of that responsibility of working with the DoD as well as working within our own system in the VA.

Mr. MITCHELL. So you are saying that the Office of Seamless Transition is in effect, it is there, or is it just individual departments within the VA that are trying to bring about a seamless transition?

Dr. AGARWAL. I——

Mr. MITCHELL. If you do not know, that is okay. But I would like if you would check into it and get back to us.

Dr. AGARWAL. I will check into it and get back to you.

Mr. MITCHELL. What happened to this office? What has happened to making sure——

Dr. AGARWAL. Sure. I will do that.

Mr. MITCHELL [continuing]. That there is a seamless transition?

Dr. AGARWAL. Yes.

[The following information from VA was subsequently received:]

Question: Why was the Office of Seamless Transition dissolved? Who has taken on their responsibilities?

Answer: The Office of Seamless Transition is not dissolved; rather, it is reorganized to best allow for the operation and management of the component parts. The component parts evolved as the mission expanded, and the logical placement of the work became evident. The Office of Seamless Transition has transitioned into the following three categories: clinical, outreach and policy.

Care Management and Social Work Services (Care Management) is responsible for the clinical component. Care Management works closely with Polytrauma, Rehabilitation, Social Work, and Mental Health Services. These program offices are all under the single VHA organizational structure of Patient Care Services. Military liaisons, VBA and our internal social work and nursing staff members are responsible for patient issues.

This new office's missions are to coordinate patients' health care and to partner with VBA in meeting their benefits needs. OEF/OIF coordinators at each VA medical center and benefits office coordinate with DoD discharge staff to facilitate a continuum of care and services at locations nearest the veteran's residence after their military discharge. This coordination allows enhanced identification of these veterans at their local VA facilities for processing of benefits claims and continuity of medical care.

VA/DoD Coordination is responsible for the VHA OEF/OIF outreach component. This component works with the Reserve and National Guard and closely with DoD. For example, starting in May 2008, VA/DoD Coordination began making phone calls to 17,000 veterans who may have a need for care management, and to 550,000 separating Guard/Reserve veterans who may not be aware of the VA health care system. VA/DoD Coordination also coordinates efforts with Reserve and National Guard Units on DoD's Post-Deployment Health Reassessment (PDHRA) Initiative. During the period No-

vember 2005 thru May 2008, Vet Centers staff have supported over 1,400 PDHRA On-Site and Call Center Unit level events along with DoD's 24/7 PDHRA Call Center. These Reserve and National Guard PDHRA activities have generated over 60,000 referrals to VA Medical Centers and Vet Centers.

The OEF/OIF Policy Coordination Office is responsible for the policy component. The Executive Director and staff serve the Under Secretary for Health in a special assistant role created to address the numerous Commission, Task Force and report recommendations that have come out in the past year. The Policy Coordination Office works with several offices, departments and agencies within and outside of VHA to facilitate changes. The office also serves as the Under Secretary for Health's daily contact point for Senior Oversight Committee (SOC) activities.

Mr. MITCHELL. And one last question before I turn it over. The Federal Recovery Coordinators, what kind of benefits will they provide? Are they going to be able to provide not only medical benefits and information but also the general benefits that every veteran is entitled to?

Dr. AGARWAL. Sir, they are the overarching coordinators and so, therefore, they will have the ability and the authority to oversee all benefits.

Mr. MITCHELL. Not only medical——

Dr. AGARWAL. Not just healthcare——

Mr. MITCHELL [continuing]. But all the benefits.

Dr. AGARWAL [continuing]. But all, yes, sir.

Mr. MITCHELL. We are talking about GI Bill, everything.

Dr. AGARWAL. Yes, sir.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you.

And as you can tell, we have votes that have started.

Doctor, why are the VHA and VBA just now jointly developing a comprehensive list of severely injured OEF/OIF veterans? Is this not something that should have been done all along, that the Department should have been tracking?

Dr. AGARWAL. Thank you for that question, ma'am.

Yes, they have been tracking. But I think they are working on the proper requirements and the definitions in that list. There is such a list that exists at this point in time between the two departments and we are further refining it.

Ms. BROWN-WAITE. When did the list start to be created?

Dr. AGARWAL. In fact, very soon, we have an initiative in place which is going to work toward outreaching for all those that were mentioned earlier who may not have come into our system, to have the telephone contact so that we can then connect them to our OEF/OIF case management programs as well as to the right kinds of individuals in our own healthcare system.

Ms. BROWN-WAITE. Let me make sure I understand what you said because I do not think you answered my question. How long ago did you start this list?

Dr. AGARWAL. Ma'am, I will have to take that for the record and get back to you. I do not know when we started this list.

[The following information from VA was subsequently received:]

Question: Why are VHA and VBA only now tracking seriously injured (SI) veterans? When did this process start?

Answer: The Department of Veterans Affairs (VA) began tracking seriously injured veterans in 2003 by placing VA Liaisons for Health Care and benefits counselors at those military treatment facilities serving as key medical centers for seriously wounded returning troops. VA experimented with organizing this data several different ways, but found earlier versions were not sufficiently responsive to clinical and care management needs. VA is now working with the Department of Defense to consolidate data into a single, comprehensive list.

VHA's Care Management and Social Work Service, in collaboration with VBA, is overseeing the development of a VA national list of severely injured patients from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) treated in VA's health care system. This national VA list integrates information across programs and includes patients receiving VA care management within the following programs: (1) Spinal Cord Injury, (2) Polytrauma, (3) Visual Impairment, and (4) Amputation. Each list also identifies Care Managers in these program areas, the VBA regional office of jurisdiction, and the OEF/OIF Coordinator responsible for case managing the servicemember or veteran's claims.

VA also developed a Web-based system that will identify care managers, by name, across the VA system for patients whose care falls into the four categories mentioned above. Additional features were built into this online system to identify care management follow-up timeframes and issues identified in the care management process. VA implemented the application on April 29, 2008.

VA staff gathers critical information about servicemembers medically evacuated from the war zones in and around Iraq and Afghanistan shortly after their arrival at military treatment facilities in the United States. Additionally, VA medical centers and Regional Offices established local teams to provide benefits, services, and track care management locally throughout their program areas. In April 2007, VA implemented the Veterans Tracking Application (VTA), a modified version of the DoD Joint Patient Tracking Application (JPTA) that tracks the movement of medically evacuated servicemembers, and their medical information, from the theater of operations to MTFs. VTA merged information from existing spreadsheets and other programs to form one Web-based system that allows users from different locations to access real-time information about the servicemembers and veterans we serve.

Not all servicemembers or veterans transition from an MTF to a VA medical center. The newly created Federal Recovery Coordination Program identifies these individuals and assists in coordinating their care as required.

Ms. BROWN-WAITE. A ballpark. Last year, last 2 years, last——

Dr. AGARWAL. I am going to ask Kristen Day.

Ms. DAY. The original Office of Seamless Transition began consolidating information and the list, I believe, in approximately 2005. The clinical care of those individuals are consolidated in the new Office of Care Management and Social Work.

And the coordination, we have VBA representatives in our office. We have DoD representatives in our office. And we are refining and building a list that is more comprehensive and has more data elements attached to it. So the list has been in existence for several years, but we are implementing a strategy that will go beyond a list and identify the single point of contact case manager, the current needs, and the current status.

Ms. BROWN-WAITE. Okay. So it is a refined list is what I think I am hearing you say?

Ms. DAY. Yes, ma'am.

Ms. BROWN-WAITE. Okay. Doctor, in your testimony, you mentioned medical foster homes and volunteer respite services. We unfortunately have found that many times when you have volunteers that their intentions are not always what we would hope that they would be.

What kind of screening procedure do you have or plan on having? What kind of background checks are you going to be doing for these volunteers to protect the obvious wounded military person?

Dr. AGARWAL. Yes, ma'am. Thank you for that question.

May I just address the issue of the medical foster homes? This program has been in effect for several years at this point in time. It actually started in Arkansas and has been scaled to some other areas and has also been used in a pilot program setting with the spinal cord injury and disease programs. It has proven to be remarkably successful with seemingly high satisfaction rates much to the surprise of our own staff as well as, of course, the families and the veterans.

So there is fairly intense screening that goes on before the veterans are placed in these settings, which includes home inspections, which includes regular visits, which includes all kinds of background checks, as well as constant vigilance. This is a medical foster home, so the individuals who are placed in these settings are also followed by our home-based primary care teams or the spinal cord injury and home care teams.

And that is what is envisioned for the traumatic brain injury program at this moment.

Ms. BROWN-WAITE. So I want to make sure that I fully understand what your plans are. You are going to have extensive background checks done on the volunteer respite program?

Dr. AGARWAL. Ma'am, let me confirm the extensive piece of it, but I know that for——

Ms. BROWN-WAITE. Doctor, I am sorry. I did not mean to be disrespectful. If you do not do criminal checks, that is criminal.

Dr. AGARWAL. I agree with you.

[The following information from VA was subsequently received:]

Question: Please describe the background checks VA performs on volunteers in the Medical Foster Home and Volunteer Respite programs, as well as any other programs where volunteers provide in-home assistance to veterans.

Answer: Volunteers who have home respite assignments require a Special Agreement Check (SAC) for fingerprints, which serves as a criminal background check. Volunteers are also checked against the List of Excluded Individuals & Entities (LEIE) database and the Healthcare Integrity and Protection Data Bank (HIPDB), both of which are administered by the Department of Health and Human Services (HHS).

VA's Medical Foster Home Program follows Federal Regulations for Community Residential Care (38 CFR 17.61 to 17.72). The home caregivers or sponsors are not volunteers, as they are paid by the veteran. VA is revising Community Residential Care regulations to clarify that Federal or State criminal background checks are required to participate in VA's Community Residential Care programs. Currently, VA follows State regulations regarding mandated background checks.

All VISNs and VA facilities accept and process volunteers according to the same standardized procedures outlined in the VHA Handbook 1620.01, "Voluntary Service Procedures," and the memorandum titled "Acceptance Requirements for VA Volunteers" from the Deputy Under Secretary for Operations and Management (10N), dated February 22, 2007. This handbook and the memorandum are attached.

[The VHA Handbook 1620.01, "Voluntary Service Procedures" will be retained in the Committee files.]

[The Memorandum entitled, "Acceptance Requirements for VA Volunteers" from the Deputy Under Secretary for Operations and Management (10N), dated February 22, 2007, appears on p. 63.]

Ms. BROWN-WAITE. Mr. Chairman, I yield back.

Mr. MITCHELL. Thank you.

Again, we are going to wrap up because we have had all the panels, but I just want to emphasize that I hope that you get the records for Corporal Owens and for Sergeant Wade, the medical records that they have been asking for since their injuries and get them to them.

[The following information from VA was subsequently received:]

> The FRC provided hard copies of the results to Mr. and Mrs. Wade during their face-to-face meeting on March 6, 2008. Corporal Owens confirmed the receipt of his records on April 25. Additional information was provided to the Subcommittee, which will be retained in the Committee files.

Mr. MITCHELL. Thank you very much——

Dr. AGARWAL. Thank you.

Mr. MITCHELL [continuing]. For being here. And I want to thank all our witnesses and thank you all again for something that is very important to all of us.

Thank you. This Committee is adjourned.

[Whereupon, at 1:00 p.m., the Subcommittee was adjourned.]

APPENDIX

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

We are here today to hear from veterans, their families, and the Department of Veterans Affairs about the long-term care of our most severely wounded Afghanistan and Iraq veterans. We know that DoD and VA provide the excellent inpatient healthcare for these warriors. But many of the most seriously injured require extensive outpatient care, some of them for life. Their families need care and assistance as well. Unfortunately, once these veterans leave the hospital, the care they receive does not seem to be on par with what they received directly following their injury. I think we can do better.

Planning for veterans' healthcare was not planned very well at the outset of this war. The need to provide care and assistance to wounded servicemembers, and their families, in significant number and for the long term has been largely ignored. We will hear today what it has been like for some of them. Their stories are inspiring but also discouraging. They are inspiring because—even after they have suffered terrible injuries—they carry no bitterness, only pride from their service. Discouraging because they have been left to fend for themselves for too long.

The Department of Defense and the VA are large organizations with an overwhelming bureaucracy. Their care and services often overlap in messy and unpredictable ways. At a time of enormous stress, this bureaucracy only hurts the injured warrior and his family

When our troops return from theater with serious injuries, they are met with a dozen seemingly unrelated people with different services. We addressed much of these problems last year with the passage of the Dignity for Wounded Warriors bill. But there is obviously still more to be done.

We need to realize that families are an integral part of treatment and recovery, and have their own needs. Unfortunately, the VA is restricted from providing the many services families need and deserve when their sons, daughters, siblings, and parents return with service-connected injuries.

We have been playing catch-up since the beginning of this war. It is irresponsible that the only support structure available to the 19 year old wife of an injured soldier is the wife of a similarly injured soldier.

We are going to hear from people that have been dealing with the difficulties of the system for a long time. On February 14, 2004 Army Sergeant Ted Wade lost his right arm and suffered severed traumatic brain injury, along with many other injuries, in an IED explosion in Iraq. Sgt. Wade is here today with his wife, Sarah.

Marine Corporal Casey Owens of Houston, Texas lost both his legs when his unarmored Humveee struck a landmine in Iraq on September 20, 2004. Corporal Owens and Mrs. Wade will tell us about the frustrations and difficulties they have faced, and we look forward to their testimony.

Sarah and Ted Wade have devoted themselves to helping hundreds of other injured servicemembers and their families. And just 2 weeks after he was injured, Casey Owens told his family that he wanted a camcorder so he could document his progress from start to finish. He could only communicate by writing at the time of his request. He wanted to show his future children how far he had come and how good he'd had it.

Today, you can find Casey gliding down the slopes at Aspen. We owe Corporal Owens and Sergeant Wade a great debt. We cannot repay that debt, but we can make sure that Corporal Owens and Sergeant Wade, their families, and everyone like them, get long-term care and services that are also world class.

Prepared Statement of Hon. Nick Lampson
a Representative in Congress from the State of Texas

Thank you, Chairman Mitchell and Ranking Member Brown-Waite for inviting me to today's hearing. I am honored to join you on this distinguished Subcommittee and am proud to introduce Corporal Casey Owens of Missouri City, Texas. Casey is an exemplary young man, and I commend him for his willingness to continue to serve his country and his fellow veterans.

I was impressed when we met yesterday for the first time by all of his accomplishments. A graduate of Mayde Creek High School, he went on to the University of Texas. But following the attacks on September 11, he decided to join the Marines. He was deployed twice—the first time from February 2003 to October 2003 and the second time from August 2004 until September 20, 2004 when he sustained his injuries. During his time in the Marine Corps he received several medals in recognition of his distinguished service.

Less than a year after sustaining his injuries, Casey successfully completed the Marine Corps Marathon in 2005 using a hand-cranked wheel chair with a time of approximately 2½ hours—probably better than any of us here. He is currently training as a member of a competitive ski team in Colorado that has been recognized by the Paralympics and the VA as an official training center.

Even more impressive than these accomplishments, in my opinion, is Casey's advocacy for veterans' care. He has worked with Mayor Bill White's Veterans Task Force, which was established last year to address the needs of Houston's veterans, both young and old, when it comes to housing, health and mental care, job training, and other issues. And he has come here today, to testify before Congress about the challenges new veterans in this country continue to face as they transition from DoD to the VA system and try to navigate it.

Most impressive, though is the concern for his fellow veterans and those that will come after him. He is here today to ensure that our Nation's future wounded warriors will not go through the same frustrations and feelings of neglect that he and his friends have experienced as the DoD and VA have struggled to adapt to a new breed of patients. They deserve much more in return for their service, and I commend Casey for his advocacy on their behalf.

Thank you again, Chairman Mitchell and Ranking Member Brown-Waite for allowing me to join the Subcommittee today for this hearing. As a Representative from a State with of one of the Nation's largest veterans' populations, I sincerely appreciate your invitation, and would like to commend your leadership and the entire Committee for your commitment to all of our Nation's veterans. I am especially pleased to be here to listen to the testimony of my constituent, Casey Owens, as well as the other witnesses.

Care for veterans such as Edward Wade and Casey Owens was by trial and error, as there was no system of care in place for these new types of injuries—both external and internal. Casey expressed to me his worry that there are still issues with care for polytrauma patients today. And I was most impressed with his concern for those who will come after them and his hope that they will not come to Congress with the same exact issues, complications, and frustrations as we are hearing today. I am proud that this Congress has taken steps to address the issues—through record funding levels and new initiatives to address the injuries of these conflicts—multiple amputations, TBI, PTSD. The DoD and VA have initiated new, and innovative ways to help OEF and OIF veterans, but the system is still daunting and adapting to a new model for care has proven difficult. Casey pointed out however, that as he has traveled across the country, meeting and competing with fellow veterans, he has realized and encountered the disparity in care at VA centers across the country. He also brought up an important point to me—what are the new caseworkers and nurses doing? How is the new funding being put to use exactly? What are the results? As we are knee-deep in the budget season and approach the appropriations process, I believe these are critical questions that MUST be answered—so that veterans 2 to 3 years down the line do not come to us with the same problems. These wounded warriors deserve no less—they truly have made the ultimate sacrifice for our country and they do not deserve to be feel that they must jump through hoops—or worse, that they have been neglected, when they need our help the most.

Over the past couple of years I have heard about the same issues from veterans across my district—as well as from the testimony we will hear today: increase options for care, increase coordination between DoD and VA regarding records and evaluations, increase coordination between departments of the VA, and the need for

more help for families and caregivers. Last year this Congress approved record funding levels and other legislation to address these issues—and I am eager to hear about the progress. As we are continuing to hear about these issues, I fear we still have a long way to go. The hurdles our soldiers and their families face should not be so difficult.

Prepared Statement of Corporal Casey A. Owens, USMC (Ret.), Houston, TX (U.S. Marine Corps Combat Veteran)

I was seriously injured on September 20, 2004 while serving under 1st Battalion 7th Regiment. I was assisting in a medivac (medical evacuation) to rescue Sgt. Foster Harrington when I ran over two anti-tank mines, which resulted in the loss of both legs. Consequently, I also suffered two collapsed lungs, numerous shrapnel wounds, pulmonary embolism, broken clavicle and jaw, perforated eardrums, trauma to my head. I was flown to Landstuhl, Germany from a field hospital in Iraq, and awoke from a coma 3 weeks later in Bethesda Maryland Naval Hospital. After numerous surgeries to stabilize me, I was transferred to Walter Reed Army Medical Center and Brooke Medical Center for my recovery phase. Over the next year and a half, I received more than sufficient care from these centers.

I was retired February 26, 2006. Shortly thereafter, I had to return to Brooke Army Medical Center to have my right myodesis repaired for a second time. I enrolled into the VA on April 1, 2006. I had transitioned to care under the VA system and was no longer in the Department of Defense's system. By this time, my right myodesis failed for a third time. After bringing it to the attention of the VA doctors, I was instructed to return to Brooke Army Medical Center for treatment. The doctor had suggested that I undergo the same procedure that I had the first two times again. I did not approve of their recommendation, and my objections had fallen on his deaf ear. I returned to the Houston VA letting them know I was not satisfied.

It was not until 6 months later that the procedure I had requested and wanted was performed. The two previous surgeries took less than 72 hours to be approved. I decided to call on non-profit organizations for assistance. Organizations such as Semper Fi Fund, Marine for Life, Wounded Warriors and other non-government personnel helped me and their help was colossal. In my opinion, this reflects poorly upon the culture and decisions of the VA system currently in place. While some of the problems I have encountered have been resolved, many have not. The learning curve of VA's system is steep and its bureaucratic maze is hard to understand. It has been 30 years since the last major war and what lessons has the VA learned since then? Did no one expect another war or learn anything from Viet Nam? What have the educated and highly paid personnel who have been appointed to correct the system been focusing their attention on? While the system continues to be broken, where is all the government funding going that is supposed to be fixing the system and what are they doing with it?

A tremendous problem that I have encountered is the double standard of the VA and the Department of Defense's claims and rating for veterans. It took me 3 to 5 months of agonizing appointments and addendums to finalize my medical board, which were performed by competent and qualified military and civilian personnel. After I had completed my medical boards, I thought I was finished with that process, only to find out I was not. When I enrolled in the VA, it took almost another year and a half to finalize those claims. It is actions like this that make veterans avoid the VA. My qualms are not that the VA does not have enough programs in place to benefit veterans or the adequacy of it rather, it is the bureaucracy and red tape that are the problems. While many problems have been addressed, it is time for SOLUTIONS.

A key solution to solving many problems is establishing an OIF/OEF Center. Though this idea has been explored by setting up OIF/OEF coordinators at every VA, it is not enough. There needs to be a centralized building or group of personnel specifically for them. A great example for the VA to emulate is something I experienced at Walter Reed and Brooke Army Medical Centers. There, key staff met weekly to discuss all aspects of patient care and kept an open line of communication between departments. For example, Joe Marine does not show up for physical therapy or his prosthetic appointments. With all of the departments communicating with one another, a psychologist may intervene and have some insight as to why he may be avoiding these appointments. It may be because he is suffering from severe PTSD and does not want to leave his room. From there, the department heads can agree on the best course of treatment and can initiate it in a holistic approach. Another matter I take great issue with, and have experienced it and continue to do so, is

the sharing of medial records between the Department of Defense and the VA. One solution may be the implementation of an ID card, similar to that which is in place for Active duty personnel. Each ID card has a microchip, which could contain all of their military and medical records accessible by a computer.

The impression that I get from the VA is that some within the organization think it is the duty of the veteran to endure and resolve these problems on their own. Those, like me, who were paid as a Marine Corp Grunt to do their job to the best of their ability never questioned whether if we got injured my government would be there for me. We all knew it would. It is now time for those who are responsible for the VA to care for those who did their duty.

This is my sworn testimony and I stand by it just as I stand by my Marine Corp and the job we did in Iraq.

Semper Fi

Cpl. Casey Owens, 1–7 US

Prepared Statement of Sarah Wade, Chapel Hill, NC
on behalf of Sergeant Edward Wade, USA (Ret.)
(U.S. Army Combat Veteran)

Chairman Mitchell, Members of the Subcommittee, thank you for the opportunity to speak to you today regarding our experiences following my husband's injuries in Iraq. My name is Sarah Wade. I am the wife of SGT Edward Wade, or Ted as he prefers to be called.

My husband joined the Army's 82nd Airborne Division during the summer of 2000, and following the attacks of September 11, he was called on to serve first in Afghanistan and later Iraq. On February 14, 2004, his humvee was hit by an Improvised Explosive Device on a mission in Mahmudiyah. He sustained a very severe traumatic brain injury, or TBI, his right arm was completely severed above the elbow, suffered a fractured leg, broken right foot, shrapnel injuries, visual impairment, complications due to acute anemia, hyperglycemia, infections, and would later be diagnosed with Post Traumatic Stress Disorder. He remained in a coma for over 2½ months, and withdrawal of life support was considered, but thankfully he pulled through.

As an above elbow amputee with a severe TBI, Ted was one of the first major explosive blast "polytrauma" cases from Operation Iraqi Freedom, Walter Reed Army Medical Center or the Department of Veterans Affairs (VA) had to rehabilitate. Much of his treatment was by trial and error, as there was no model system of care for a patient like Ted, and there still is no long-term model today. His situation was an enormous challenge, as Walter Reed was only able to rehabilitate an amputee, not a TBI, the VA was able to nominally treat a TBI, but not an above elbow amputee, and neither were staffed to provide appropriate behavioral health care for a patient with a severe TBI. Because Ted could not access the necessary services, where and when he needed them, he suffered a significant setback in 2005, that put him in the hospital for 2 weeks, and would take a year to rebound from.

Ted has made a remarkable recovery by any standard, because we have strayed from standardized treatment, and developed a patient-centered path. I had to educate myself about, and coordinate, additional outside care. Often, access to the necessary services required intervention from the highest levels of government, or for us to personally finance them ourselves. But despite our best efforts, Ted is still unable to easily receive comprehensive care for all of his major health issues, due to shortcomings in the current system, and because of the time his needs demand of me, I have been unable to return to regular work or school. We have been blessed to have family, with the means to see us through these difficult times, and help with the expenses. I was fortunate to have the education, of growing up in Washington, D.C. and learning about the workings of the various Federal agencies. Our situation is not typical though.

We have a few ideas, to provide better long-term care, we respectfully wish to share:

Special Monthly Compensation for Integration, Quality of Life, Dependents' Educational Assistance, and Respite Care

Individuals like SGT Wade, who require someone to be available for assistance at all times, are not compensated appropriately. These Veterans would require residential care otherwise, but are not granted the higher level of Aid and Attendance, because they do not require daily healthcare services provided in the home by a person licensed to perform these services, or someone under regular supervision of a

licensed healthcare professional. We feel the criteria should be clearly outlined, so appropriate compensation may be granted in the case of an individual who needs assistance managing care, personal affairs, or requires support outside of the home, to rehabilitate and integrate into their community, or to achieve a better quality of life.

Both in the past and at present, we have paid someone to assist Ted outside of the home. This allows him the flexibility to hire a peer of his choice, to provide community support, and accompany him on sightseeing outings he has researched and planned with his therapist as part of his community integration, to provide transportation to the store to purchase books for homework assignments, go to the community center to swim laps, or help him balance his checkbook at the end of the day. Not only has this enabled Ted to come closer to achieving independence, but it has greatly improved symptoms of depression by restoring hope and self confidence, allowed him to attain fitness goals and control his blood sugar without insulin injections, all while providing much needed respite care for me. Unfortunately, the current VA respite programs are not appropriate for a veteran like Ted. With better resources, I might be able to access the Dependents' Educational Assistance for which I qualify, but our circumstances do not allow me to take advantage of, before the benefits expire. This would not only help me get back to having a life of my own, but raise Ted's standard of living as well, by increasing my earning capacity.

Compensated Work Therapy (CWT) for TBI

Largely due to the success of the program we have created for Ted, the next phase of his recovery will probably include some sort of vocational rehabilitation. He has already had the opportunity to participate in volunteer work, through counseling and job coaching provided by a private practice near our home, where he attends a day treatment program for behavioral health and TBI. Now he is ready for the next stepping stone to employment. The current Department of Veterans Affairs Vocational Rehabilitation and Employment Service is more of a challenge than is healthy for someone with the significant cognitive deficits and the emotional needs Ted has. VA work therapy programs, while developing work tolerances and promoting effective social skills for the more seriously impaired, are set in an insulated environment. A work therapy program, expanded to other community settings, to accommodate patients like Ted, who are better served outside of a sheltered atmosphere, would be more effective. Volunteer or internship positions, or later, a part-time job that sparks his interest, would be more therapeutic. Not only would this help him acquire the confidence and independence he needs to someday become gainfully employed, but aid in his integration, by providing constructive, meaningful activities for him to participate in outside of the home.

Counseling, Life Skills and Patient-Specific Case Management

Although many basic therapies are offered, rarely do they include teaching socially appropriate behaviors, which are commonly an issue after a TBI. This task often falls on the veteran's family member or spouse, increasing the responsibility of the caregiver, and causing conflict with the veteran, who feels he is being treated like a child. Ted has had the advantage of community peer support, but also a counselor at the private practice I have previously mentioned, to help him redevelop age appropriate social skills, allow me to be his spouse, and him to maintain his dignity. She has also worked with Ted to develop healthy coping skills, to manage cognitive deficits, improve mental health, and develop patient-centered treatment plans, which focus specifically on his unique challenges. Again, our situation is not typical though. This is something difficult to provide in an institutional care environment, like the Veterans Health Administration, without greater flexibility, and more resources to provide increased face time with the patient, and better injury-specific expertise.

Conclusion

The challenges we have faced are the same as countless other veterans, many of whom have not had the resources Ted has had available to him, or an advocate capable of negotiating the system. A veteran I often think about, who had a young wife with a newborn baby, and nothing more than a high school education, should have received the same world-class care as my husband, but sadly will not. Despite my best efforts to be a support to his spouse, who was overwhelmed by motherhood, while trying to negotiate a seemingly impossible system, she eventually left him, because it was more than she could handle. A veteran's care should not depend on what family they were born into, who they married, or whether or not family obligations allow for their loved one to advocate for them, but sadly it does. Though we will never be able to fully compensate seriously wounded veterans for the sacrifice

they have made on our behalf, we can certainly do a better job of managing their care, rehabilitating them to their fullest potential in a timely manner, and providing the necessary resources to maximize their quality of life. I am pleased to see the Subcommittee is taking a look back to explore ways to learn from the past, and address the needs of the veteran injured yesterday. This will ultimately improve the care of the servicemember injured today, as well. Mr. Chairman, thank you again for the opportunity to share our story with you today. I look forward to answering any questions you may have for us.

Prepared Statement of Meredith Beck
National Policy Director, Wounded Warrior Project

Mr. Chairman, Ranking Member Brown-Waite, distinguished Members of the Subcommittee, thank you for the opportunity to testify before you regarding post-acute care for the seriously injured. My name is Meredith Beck, and I am the National Policy Director for the Wounded Warrior Project (WWP), a non-profit, non-partisan organization dedicated to assisting the men and women of the United States Armed Forces who have been injured during the current conflicts around the world.

During the recent conflicts in Iraq and Afghanistan, there have been approximately 30,000 soldiers, sailors, airmen, and Marines wounded in action. Fortunately, due to advances in medical technology, the number of those killed in action is far lower. However, in many cases, as the wounded have suffered devastating injuries and require long-term outpatient care and rehabilitation, WWP is pleased that the Subcommittee has chosen to focus on this aspect.

As a result of our direct, daily contact with these wounded warriors, we have a unique perspective on their needs and the obstacles they face as they attempt to transition, reintegrate, and live in their communities. As such, WWP has identified the following areas of concern:

Options for Care: Specifically with respect to Traumatic Brain Injury, those suffering from TBI require individualized, comprehensive care, and while the VA has made progress in this area, the agency is still in the process of establishing an extensive, consistent, long-term continuum of care available throughout the Nation. As such, and due to the need for ongoing therapy and rehabilitation, many seriously injured veterans and families have indicated that their number one request is increased access to options for care, including access to private facilities previously available to them while on active duty.

Discrepancies in Benefits: On a related topic, many veterans and families of the seriously injured have indicated confusion, frustration, and disappointment upon learning that they are not eligible for the same benefits and care as veterans as they were on active duty and vice versa. For example, consider that an active duty patient can be seen at a VA Polytrauma Center to treat his Traumatic Brain Injury. However, while at the VA facility, the servicemember, due to his duty status, cannot enjoy VA benefits such as Vocational Rehabilitation or Independent Living Services that can be helpful in his recovery. Alternately, as mentioned previously and unbeknownst to most families, a medically retired servicemember cannot use his/her TRICARE benefits to access private care as TRICARE does not cover cognitive therapy once retired. While there is an obvious need for an advantage to active duty service, those who are severely injured as a result of their service in an all-volunteer force deserve special consideration.

The recently passed *National Defense Authorization Act for FY2008* contained a provision intended to address these discrepancies. Specifically, section 1631 authorizes for a limited period of time the Secretary of Defense to provide any veteran with a serious injury or illness the same medical care and benefits as a member on active duty and entitles the severely injured still on active duty to receive veterans' benefits, excluding compensation, to facilitate their long-term recovery and rehabilitation. While this provision recognizes the strengths of each agency and the necessity of basing an individual's care and benefits on his/her medical condition rather than on military status, it is subject to regulation and will require significant oversight to ensure its success.

Respite Care: For those who are seriously injured, one cannot discuss their care without discussing their caregiver. While the VA currently offers some respite care, the available options are often not entirely appropriate given the average age and types of injuries of those serving in Iraq and Afghanistan. For example, retired Army Sergeant Eric Edmundson suffered a severe brain injury in Iraq several years ago, but he is aware and responsive. In fact, he enjoys spending time with his fam-

ily and recently went fishing with his 3-year-old daughter Gracie. Eric's family is unwilling to place him in a respite facility for fear that it could cause a regression in his rehabilitation and cause Eric distress.

However, WWP has noted that similar to others, Eric's family has used their personal funds to pay for an innovative type of individualized therapy that also provides a unique form of respite for the caregiver. In Eric's case, rather than staying indoors all day, his family pays an individual to take him to the park to watch his daughter play. Eric thrives each time, and his progress and enjoyment are noticeable.

As a result of Eric's success as well as others in similar situations, WWP proposes that the Department of Veterans Affairs (VA) initiate a pilot program partnering with local universities to provide such a care/respite initiative for those with brain injury. As part of the veteran's ongoing therapy, the program would draw graduate students from appropriate fields (i.e. social work, nursing, psychology, etc.), train them to interact with the veterans, and match them with eligible veterans in their local area so that an individualized program can be developed. In return for making the requisite reports to the veteran's physician on his/her status, the graduate student would receive course credit.

The creation of such a program would have several positive effects including:

1. In recognition of the individual nature of Traumatic Brain Injury (TBI), the program would encourage an innovative means of providing age-appropriate maintenance therapy to those suffering from TBI.
2. While the veteran is benefiting from the therapy aspects of the program, the family caregiver would be offered much needed respite.
3. Interaction with the graduate students would increase general community awareness of the sacrifices of our Nation's veterans and the needs of those suffering from TBI.

Caregiver Compensation: Traumatic Brain Injury (TBI) has been widely identified as the "signature wound" of the Global War on Terror. While many organizations appropriately focus on the needs of the affected servicemember, the Wounded Warrior Project (WWP) has also identified the family caregiver as an individual in need of assistance. For example, in many circumstances, the spouse or parent is forced to leave his/her job to provide the necessary care for their loved one, leaving the entire family to suffer from an adverse economic situation. In these cases, the VA relies on the family member to assist in the servicemember's care, but has been denied financial compensation for such labor.

In recognition of this reality, WWP developed and endorsed legislation introduced by Representatives Salazar and Pascrell requiring the VA to train, certify, and make eligible for compensation the personal care attendants of severely injured TBI patients. This program would expand on one already in existence at the San Diego VA Medical Center for Spinal Cord Injury patients and would help alleviate some of the financial burden incurred by these families. WWP encourages the Subcommittee to review the program and help to ensure its implementation.

Oversight: Finally, consistent with the recommendation of the Veterans Disability Benefits Commission and to ensure the best care and benefits for those who have sacrificed so much for our Nation, it is imperative that a joint, permanent structure be in place to evaluate changes, monitor systems, and make further recommendations for process improvement. This office must be structured to minimize bureaucracy and must have a clearly defined mission with the appropriate authority to make necessary changes or recommendations as warranted. With the passage of time, as veterans issues fade from the national spotlight, it will be necessary to have such a joint structure in place to ensure future inter- and intra-agency coordination.

Mr. Chairman, thank you again for the opportunity to testify today, and I look forward to answering any questions you may have.

Prepared Statement of Todd Bowers
Director of Government Affairs, Iraq and Afghanistan Veterans of America

Mr. Chairman, Ranking Member and distinguished Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America, and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding this important subject. I would also like to point out that my testimony today is as the Director of Government Affairs for the Iraq and Afghanistan Veterans of America and does not reflect the views and opinions of the United States Marine Corps.

The tremendous advancements in frontline medical care have made many combat injuries more survivable. In Vietnam, the mortality rate for combat injuries was 1 in 4, while the mortality rate in Iraq is 1 in 10. That means today's battlefield medicine has saved approximately 6,000 American lives that would have been lost if we were still using Vietnam-era medical techniques. This is a tremendous success story for the DoD medical system.

But the corollary of the improved survival rate is an increase in the number of severely wounded troops returning home. As the *Independent Budget* states, "We are seeing extraordinarily disabled veterans coming home from Iraq and Afghanistan with levels of disability unheard of in past wars." Many of these young, wounded veterans will require long-term care, not just at Walter Reed and Bethesda, but in their communities across this country. At the VA, these veterans with Traumatic Brain Injury and blast injuries are confronting a system designed to treat diabetes and Alzheimer's.

The DoD and the VA have already taken some crucial steps to improve inpatient care for these young, severely wounded patients. There are four major Polytrauma Rehabilitation Centers, in Tampa, FL, Richmond, VA, Minneapolis, MN, and Palo Alto, CA, which use teams of physicians and specialists that administer individually tailored rehabilitation plans, including full-spectrum care for Traumatic Brain Injuries. These centers are also part of the Defense and Veterans Brain Injury Center network.

These key centers offer cutting-edge treatment for the severely wounded troops who are receiving inpatient care. But what is available to troops near their homes? As of 2003, according to the GAO, "more than 25 percent of veterans enrolled in VA health care—over 1.7 million—live over 60 minutes driving time from a VA hospital." This number is likely higher today, because the mission in Iraq has relied heavily on recruits from rural areas often underserved by VA hospitals and clinics. This places a tremendous burden on the families and also the veteran. With the current gasoline prices and many treatment centers hours away, treatment is often impossible to facilitate. Imagine if you will that your loved one has returned from combat wounded and it is your responsibility to make sure they are receiving the proper treatment. This is too much to ask of our servicemembers and veterans' families.

In response, the VA has created regional network sites that work with the major polytrauma centers to cater to patients closer to their homes. The VA is also planning to add new Polytrauma Support Clinics to provide followup services for those who no longer require inpatient care but still need rehabilitation. The 75 Polytrauma Support Clinic Teams help veterans get access to specialized rehabilitation services closer to their home communities, and also are responsible for ensuring that these patients don't "fall through the cracks" after leaving full-time care. For hospitals without a Polytrauma Support Clinic, a single person has been designated as the "point of contact" to coordinate care for local veterans with polytraumas.

These are good first steps, but much more must be done to get these wounded veterans the care they need. A "point of contact" that can offer referrals to distant

hospitals and clinics is simply not an adequate response to a wounded veteran's health care needs. IAVA joins the other IB–VSOs in calling for increased funding for home and community-based care, and a detailed plan from the VA regarding their long-term response to the needs of today's veterans.

Respectfully submitted.

Prepared Statement of Mahdulika Agarwal, M.D., MPH
Chief Officer, Patient Care Services, Veterans Health Administration
U.S. Department of Veterans Affairs

Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) care for seriously wounded veterans after they complete their inpatient care. I am accompanied by Dr. Lucille Beck, Chief Consultant for Rehabilitation Services and Ms. Kristin Day, Chief Consultant Care Management & Social Work Service, Veterans Health Administration (VHA).

VHA has long emphasized the importance of a personalized continuum of care for servicemembers. Our commitment extends beyond the initial transition across systems of care to ensure services continue to be provided to these individuals as veterans, and to their family members, who are essential to the recovery and rehabilitation of these injured warriors.

It is important to emphasize, however, that neither the transfer between health care systems, nor the transfer to veterans' status is a linear path. To ensure every veteran or servicemember receives the care and benefits they deserve, VA has created a Case Management Program for Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. The VA/DoD Federal Recovery Coordination Program (FRCP) further provides needed assistance and support for veterans and servicemembers with serious injuries or illnesses. VA's provision of both inpatient and outpatient rehabilitation services in locations across the country is designed to meet the short- and long-term needs of veterans with serious injuries, including Polytrauma, Traumatic Brain Injury (TBI), Spinal Cord Injury (SCI), and mental health needs. These overlapping strategies of case management and coordination of rehabilitative care allow me to state with confidence that VA is adapting to the needs of our returning veterans and operating a system capable of providing lifelong care to them. These programs provide little net value if veterans are unaware of the services available to them; consequently, VA has pursued outreach on multiple levels to see that our veterans, particularly those with severe injuries or illnesses, can access our system and receive the care they have so bravely earned.

OEF/OIF Case Management Program and Federal Recovery Coordination Program

We deeply appreciate the recommendations of The President's Commission on Care for America's Returning Wounded Warriors, chaired by Senator Dole and Former Secretary Shalala. Specifically, we echo their description of the importance of integrated care management, which they describe as providing, "... patients with the right care and benefits at the right time in the right place by leveraging all resources appropriate to their needs. For injured servicemembers—particularly the severely injured—integrated care management would build bridges across health care services in a single facility and across health care services and benefits provided by DoD and VA."[1]

VHA and VBA published a joint handbook (VHA Handbook 1010.01) in May 2007 establishing procedures for the transition of care, coordination of services and case management of OEF/OIF veterans. This joint Case Management Program represents a fully integrated team approach, and includes a Program Manager, Clinical Case Managers, a VBA Veterans Service Representative, and a Transition Patient Advocate. These teams are active at every VA Medical Center (VAMC). The Program Manager, who is either a nurse or social worker, has overall administrative and clinical responsibility for the team, and must ensure all OEF/OIF veterans are screened for case management needs. OEF/OIF veterans with severe injuries are automatically provided a case manager; all other OEF/OIF veterans are assigned a case manager upon request. Clinical Case managers, who are either nurses or social workers, coordinate patient care activities and ensure all VHA clinicians are pro-

[1] President's Commission on Care for America's Returning Wounded Warriors. "Serve, Support, and Simplify: Subcommittee Reports and Findings." p. 20–21. Available online: http://www.pccww.gov/docs/TOC%20Subcommittee%20Reports.pdf.

viding care to the patient in a cohesive, integrated manner. VBA team members assist veterans by educating them on VA benefits and assisting them with the benefit application process.

The Transition Patient Advocates (TPAs) serve as liaisons between the VAMC, the Veterans Integrated Service Network (VISN), VBA, and the patient. The TPA acts as a communicator, facilitator and problem solver. The team documents their activities in the Veterans Tracking Application (VTA), a Web-based tool designed to track injured and ill servicemembers and veterans as they transition to VA. VHA is also using the Primary Care Management Module (PCMM), an application within VHA's VistA Health Information system, to track patients assigned to an OEF/OIF Case Management team.

VA has developed a rigorous training schedule for this new program to ensure it is operating fully and effectively for all veterans requesting assistance. TPAs and VISN Points of Contact attended a training conference in Washington, D.C. in June 2007, and Program Managers received training in September 2007. VA held a week-long training conference in San Diego in January 2008 for Case Managers, and two regional training conferences for the entire OEF/OIF Case Management Team are planned for May and June 2008.

As a part of this effort, VHA and VBA are jointly developing a comprehensive list of severely injured OEF/OIF veterans. The two administrations are defining the requirements and definitions for this list, and will establish a single record to track VHA or VBA contact each month with severely injured veterans and servicemembers.

VA and DoD are working on jointly developing and implementing a comprehensive policy on improvements to the care, management, and transition of recovering servicemembers, pursuant to the National Defense Authorization Act of 2008.

In October 2007, VA partnered with DoD to establish the Joint VA/DoD Federal Recovery Coordination Program (FRCP). The FRCP will identify and integrate care and services for the seriously wounded, ill, and injured servicemember, veteran, and their families through recovery, rehabilitation, and community reintegration. VA hired an FRCP Director, an FRCP Supervisor, and eight Federal Recovery Coordinators (FRCs) in December 2007. The FRCs are currently deployed to Walter Reed and Brooke Army Medical Centers, as well as National Naval Medical Center at Bethesda. Two additional FRCs are currently being recruited and will be stationed at Brooke Army Medical Center and Balboa Naval Medical Center in San Diego. The FRCP is intended to serve all seriously injured servicemembers and veterans, regardless of where they receive their care. The central tenet of this program is close coordination of clinical and non-clinical care management for severely injured servicemembers, veterans, and their families across the lifetime continuum of care.

Caregiver Assistance

The Caregiver Pilot Task Force was formed in response to a provision of the "Veterans Benefits, Health Care, and Information Technology Act of 2006". Eight Caregiver Assistance Pilot Programs were awarded grants beginning in October 2007, at a total cost of approximately $5 million. The goal is to explore options for providing support services for caregivers in areas across the country where such services are needed for families of disabled or aging veterans, and where there are few other options available. These programs will also increase the caregiver support services available to OEF/OIF veterans in the immediate future and the long term. Examples of these pilots include:

- Home Based Primary Care programs, in Memphis and Palo Alto, are implementing interventions from the evidence-based REACH II National Institutes of Health Initiative to train and support caregivers in managing patient behaviors and their own stress.
- Caregivers in Gainesville, Florida will participate in a Transition Assistance Program using videophone technology to provide skills training, education and supportive problem solving.
- In Ohio, Caregiver Advocates will be available via telephone 24 hours a day to coordinate between VA and community services.
- VA will work with a community coalition to provide education, skills, training, and support for caregivers of veterans with TBI in California, using telehealth technology.
- The VA Pacific Islands Healthcare System will develop a Medical Foster Home program to provide overnight respite care for veterans.
- In Miami and Tampa, funding will be used to expand respite care, train home companions, and develop an emergency response system.
- Atlanta will use a model telehealth program to provide instrumental help and emotions support to caregivers who live in remote areas.

VA is committed to providing key services to assist caregivers with case management, service coordination, and support for the veteran, as well as education on how to obtain community resources such as legal assistance, financial support, housing assistance, and spiritual support.

Medical Foster Homes and Volunteer Respite Services

In February 2008, VA's Under Secretary for Health approved funding for programs to facilitate the transition and support of seriously injured veterans with Polytrauma, TBI, and/or SCI by providing specialized support and care in their homes and communities. This program will aid both veterans living in their homes and those who are no longer able to live independently but prefer an in-home alternative within their community. The Volunteer Respite program will create access to needed home respite services for family caregivers, while giving members of the community an opportunity to volunteer with VA closer to home, regardless of distance from a VA facility. VA Voluntary Service would recruit, train, and coordinate community volunteers to provide respite care in the homes of OEF/OIF veterans. The Medical Foster Home component provides an in-home alternative to nursing home care, merging personal care in a private home with medical and rehabilitation support from specialized VA home care programs.

Through these programs and others, VA will expand the availability of Medical Foster Homes (MFH) to seriously injured OEF/OIF veterans near specialized facilities within the communities in which they live. We will also expand the number of MFH sites and modify them to meet the needs of younger, seriously injured veterans with Polytrauma, TBI, and/or SCI, and strengthen the rehabilitation expertise of the VA home care teams who will serve them. Veterans with disabling injuries or conditions may need the support of a non-familial caregiver as they work toward independent living in the community, or may have long term care needs that initially, or eventually, exceed the capabilities their family can sustain. MFH may be a favorable alternative to nursing homes for these veterans as we facilitate their return to homes and communities.

Rehabilitative Services

VA provides clinical rehabilitative services in several specialized areas that employ the latest technology and procedures to provide our veterans with the best available care and access to rehabilitation for polytrauma and traumatic brain injury, spinal cord injury, visual impairment, and other areas. VA's Under Secretary for Health directed our facilities to seek a second opinion from civilian physicians upon request. Whenever an OEF/OIF veteran requires specialized rehabilitative services, the assigned OEF/OIF case manager engages with the clinical case manager that is appropriate for that area of rehabilitation; e.g., polytrauma, spinal cord injury, blindness. Throughout the rehabilitative process, the OEF/OIF case manager coordinates with the appropriate clinical case manager regarding the veteran's progress and rehabilitation.

Polytrauma System of Care

Over the past 2 years, VA has implemented an integrated system of specialized care for veterans sustaining traumatic brain injury (TBI) and other polytraumatic injuries. The Polytrauma System of Care consists of four regional TBI/Polytrauma Rehabilitation Centers (PRC) located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA. A fifth PRC is currently under design for construction in San Antonio, TX, and is expected to open in 2011. The four regional PRCs provide the most intensive specialized care and comprehensive rehabilitation for combat injured patients transferred from military treatment facilities. As veterans recover and transition closer to their homes, the Polytrauma System of Care provides a continuum of integrated care through 21 Polytrauma Network Sites, 76 Polytrauma Support Clinic Teams and 54 Polytrauma Points of Contact, located at VAMCs across the country. Throughout the Polytrauma System of Care, we have established a comprehensive process for coordinating support efforts and providing information for each patient and family member. On February 27, 2006, VA established a national Polytrauma Call Center available 24 hours a day, 7 days a week, for families and patients with questions. This Center is staffed by health care professionals trained specifically in Polytrauma care and case management issues and can be reached by calling 1–888–827–4824.

The care coordination process between the referring DoD military treatment facility and the PRC begins weeks before the active duty servicemember is transferred to VA for health care. The PRC physician monitors the medical course of recovery and is in contact with the MTF treating physician to ensure a smooth transition of clinical care. The admissions nurse case manager maintains close communication

with the referring facility, obtaining current and updated medical records. A social work case manager is in contact with the family to address their needs for psychosocial and logistical support. Prior to transfer, the PRC interdisciplinary team meets with the DoD treatment team and family by teleconference as another measure to ensure a smooth transition. The PRCs provide a continuum of rehabilitative care including a program for emerging consciousness, comprehensive acute rehabilitation, and transitional rehabilitation. Each of the PRCs is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Intensive case management is provided by the PRCs at a ratio of 1 case manager per 6 patients, and families have access to assistance 24 hours a day, 7 days a week. The interdisciplinary rehabilitation treatment plan of care reflects the goals and objectives of the patient and/or family.

From March 2003 through December 2007, the PRCs provided inpatient rehabilitation to 507 military servicemembers injured in combat theaters. The transition plan from the PRCs to the next care setting evolves as the active duty servicemember progresses in the rehabilitation program. Families are integral to the team and are active participants in therapies, learning about any residual impairments and ongoing care needs. The team collaborates with the family to identify the next care setting, and determine what will be needed to accommodate the transition of rehabilitative care. The consultation process includes a teleconference between the PRC team, the consulting team, the family, and the patient. These conferences allow for a coordinated transfer of the plan of care, and an opportunity to address specific questions.

Prior to discharge, each family and patient is trained in medical and nursing care appropriate for the patient. Once a discharge plan is coordinated with the family, VA initiates contact with necessary resources near the veteran's home community. Based upon location, an agreement is reached with one of the 21 VA Polytrauma Network Sites or an appropriate local provider within the patient's community. As veterans and servicemembers transition to their home communities, ongoing clinical and psychosocial case management is provided by a rehabilitation nurse and social worker from one of 76 Polytrauma Support Clinic Teams. VA social work case managers follow each patient within the Polytrauma System of Care at prescribed intervals contingent upon need. For example, there are four levels of case management: intensive case management, where contact is made daily or weekly; progressive case management, where VA contacts the patient monthly; supportive case management, quarterly; and lifetime case management, annually. For the many patients who are still active duty servicemembers, the military case managers are responsible for obtaining authorizations from DoD regarding orders and followup care based upon VA medical team recommendations.

VA is committed to ongoing review and improvement of our provision of care for these wounded or injured warriors. In this spirit, VA assembled a national research task force last summer to review and evaluate the long term care needs of our most seriously wounded or injured returning OEF/OIF veterans. This taskforce recently completed its work and identified several recommendations, which are being submitted to the Secretary for his review. Moreover, in compliance with the 2008 National Defense Authorization Act, VA is collaborating with the Defense and Veterans Brain Injury Center to design and execute a 5-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans to enhance their rehabilitation, quality of life, and community integration.

Spinal Cord Injury and Disorders

For Spinal Cord Injury and Disorders (SCI/D), VA has the largest single network of care in the Nation. VA facilities nationwide provided a full range of services to 26,191 veterans with SCI/D in 2007; 12,789 of these veterans received specialized care within the Spinal Cord Injury Centers and Spinal Cord Injury Support Clinics. For veterans with SCI/D, VA provides health care, maintains their medical equipment, and provides supplies, education and preventive health services. Since 2003, 364 active duty servicemembers have been treated in VA SCI units; of these, 116 acquired spinal cord injury in an OEF/OIF theater of operations. Each of these patients received care from a VA facility accredited by CARF. A national, multi-site vocational improvement research project identifies evidence-based vocational rehabilitation programs for veterans with SCI/D.

VA is improving and expanding our SCI/D nationally, with plans for a ribbon-cutting ceremony for a new facility in Minneapolis in February 2009. Our Denver, CO facility's design was funded in 2004 and land was acquired in 2006, while our Jackson, MS facility's funding is still being determined. Tampa's LTC facility (30 beds) is under construction and planning is underway for the VISN 3 SCI LTC facility. Each VA Spinal Cord Injury Center will be provided with state-of-the-art technology

and equipment to better support home-based therapies, provide closer management and monitoring of function and complications in the home, and offer closer attention to health promotion and prevention.

Blind Rehabilitation

For veterans and active duty personnel with visual impairment, VA provides comprehensive Blind Rehabilitation services that have demonstrated significantly greater success in increasing independent functioning than any other blind rehabilitation program. Currently, 164 Visual Impairment Service Team (VIST) Coordinators provide lifetime case management for all legally blind veterans, and all OEF/OIF patients with visual impairments. Additionally, 38 Blind Rehabilitation Outpatient Specialists (BROS) provide blind rehabilitation training to patients who are unable to travel to a blind center.

The VA Blind Rehabilitation Continuum of Care, announced January 2007, further extends a comprehensive, national rehabilitation system for all veterans and active duty personnel with visual impairments. Program expansion during 2008 will add 55 outpatient vision rehabilitation clinics, 35 additional BROS at VAMCs currently lacking those services, and 11 new VIST positions. The continuum of care will provide the full scope of vision services—from basic, low vision services to blind rehabilitation training—across all Veteran Integrated Service Networks (VISNs).

Outreach

VA has always been committed to outreach, and all the more so during periods of armed conflict. Given the importance of outreach to servicemembers and veterans of OEF/OIF, VA promotes and conducts activities at both national and local levels. VA has developed an array of training materials, directives, publications, and established points of contact at each VA facility. VA also partners with Federal agencies, Veterans Service Organization (VSOs), and State, county, and local agencies and governments. Our outreach to OEF/OIF participants begins when the servicemember returns home and continues through the transition period from servicemember to veteran and beyond.

Outreach to active duty personnel is a major part of VA's Outreach program and is generally accomplished through the Transition Assistance Program (TAP) sponsored in cooperation with the Departments of Defense and Labor. All VA benefits and services are included in TAP briefings. All returning OEF/OIF servicemembers are given a copy of VA Pamphlet 80–06–01, Federal Benefits for Veterans and Dependents.

Special outreach to Reserve/Guard members is an integral part of VA's outreach efforts. VA provides briefings on benefits and health care services at townhall meetings, family readiness groups, and during unit drills near the homes of returning Reserve/Guard members.

Since 2003, VA's outreach to those severely injured in OEF/OIF includes placing VA/DoD Social Work and Registered Nurse Liaisons and Benefits Counselors at Walter Reed Army Medical Center, the National Naval Medical Center and nine other military treatment facilities across the country.

In November 2005, VA began partnering with DoD in implementing the Post-Deployment Health Reassessment (PDHRA) among National Guard and Reserve Component (RC). The PDHRA is a DoD global health-screening tool that includes specific questions covering PTSD, alcohol misuse and Traumatic Brain Injury (TBI). VA's role in this partnership is fourfold: provide information on VA benefits among Reserve and Guard personnel; enroll eligible veteran in VA health care; provide assistance in scheduling followup appointments at VAMCs and Vet Centers; and develop ongoing referral and training relationships with Reserve and Guard Commanders. As of January 31, 2008, VA has supported PDHRA referrals from DoD's 24/7 Call Center, 283 Unit Call Center PDHRA events and 888 Unit On-Site PDHRA events. The RC PDHRA initiative has generated over 75,000 referrals, including 36,199 referrals to VAMCs and 17,214 referrals to Vet Centers representing 71% of total referrals.

Vet Center staff regularly participates in DoD-sponsored PDHRA events. Vet Centers provide information on VA benefits and care to servicemembers as they transition from military to civilian life at National Guard and Reserve demobilization sites, active duty transition briefings, and community events involving returning combat veterans such as homecoming events. Outreach is also performed with local VSOs and community agencies. Vet Center outreach is designed to provide information, minimize stigma, and help veterans obtain needed services as early as possible. More than 200,000 servicemembers have been provided outreach services, primarily at military demobilization sites, including National Guard and Reserve units. Vet

Centers initiate outreach efforts to area military installations and closely coordinate their efforts with military family support services at various military bases.

In October 2005, DoD Health Affairs began providing VA with a list of servicemembers entering the Physical Evaluation Board (PEB) process. These servicemembers sustained an injury or developed an illness that may preclude them from continuing on active duty and result in medical separation or retirement. This list will enable VHA to send outreach letters encouraging them to contact the nearest VA medical facility for future assistance in enrolling in VA health care and addressing their health care needs as they transition from active duty to veteran status. As of January 31, 2008, the VA has mailed 16,905 PEB outreach letters to servicemembers.

The Veterans Assistance at Discharge System process mails a "Welcome Home Package," including a letter from the Secretary, "A Summary of VA Benefits" (VA Pamphlet 21–00–1), and "Veterans Benefits Timetable" (VA Form 21–0501), to veterans recently separated or retired from active duty (including Guard/Reserve members). We re-send this information 6 months later to these veterans.

The Secretary of Veterans Affairs sends a letter to newly separated OEF/OIF veterans. The letters thank veterans for their service, welcome them home, and provide basic information about health care and other benefits provided by VA. To date, VA has mailed over 766,000 initial letters and 150,000 followup letters to veterans.

VA Regional Offices assist and support seriously injured OEF/OlF servicemembers and veterans by conducting case management activities, including outreach, coordinating services, and streamlining claims processing procedures.

In collaboration with DoD, VA published and distributed one million copies of a new brochure called, "A Summary of VA Benefits for National Guard and Reservists Personnel." The new brochure summarizes health care and other benefits available to this special population of combat veterans upon their return to civilian life.

As part of VA's "Coming Home to Work" program, participants work with a Vocational Rehabilitation and Employment Counselor (VRC) to obtain unpaid work experiences at government facilities. This represents an early outreach effort with special emphasis on OEF/OlF servicemembers pending medical separation from active duty at military treatment facilities.

VA also continues its Benefits Delivery at Discharge program, where servicemembers can apply for service-connected compensation, vocational rehabilitation, and employment services before discharge. Normally, prior to discharge, required physical examinations are conducted, service medical records are reviewed, and rating decisions are made.

Access to Care

VA has identified access to outpatient care as a priority in our effort to provide care for seriously wounded veterans after inpatient care is complete. VHA's strategic direction is to enhance non-institutional care with less dependence on large institutions. Our comprehensive care management plans offer guidance for providing care to veterans in their homes and communities. For those veterans who prefer to visit in person, VA issued a directive last June instructing our medical centers to explore offering extended hours for veterans unable to schedule appointments during the day. Similarly, our Vet Centers are available to veterans on nights and weekends for readjustment counseling needs.

Community Based Outpatient Clinics (CBOCs) have been the anchor for VA's efforts to expand access for veterans. CBOCs are complemented through partnerships, such as contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area. In addition, we provide rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans.

Telehealth provides veterans with access to care in their homes and local communities where possible and appropriate. It is a new modality of care requiring robust clinical practices, technology infrastructure and business processes to maintain and sustain the modality. Telehealth capabilities in VA have expanded in all clinical areas since FY 2004. There are telehealth programs within all VISNs and many programs have grown from point-to-point connections to inter-hospital and VISN-based networks. VA continues to evaluate the effectiveness of telehealth and to work with clinical leadership in the VISNs and VA facilities to introduce new clinical processes based on information technologies to assist clinicians in meeting the health care needs of older veterans. This reduces the barriers of distance and time that may restrict the availability of care. Currently, VA is piloting applications to create national tele-consultation networks to expand the provision of specialty care to rural and remote areas.

Conclusion

We are honored to provide care and service to America's veterans. For those who return from combat with serious injuries or illness, we work closely with DoD to ensure a swift and seamless transition to VA, but we also work with those who do not need immediate care to make it as accessible as possible. Thank you again for you the opportunity to meet with you today. I would be happy to address any questions that you have at this time.

Memorandum

Department of Veterans Affairs

Date: February 22, 2007
From: Deputy USH for Operations and Management (10N)
Subj: Acceptance Requirements for VA Volunteers
To: All VISN Directors (10N1–23)
All Medical Center Directors (00)

1. Effective immediately, all VISNs and VA facilities will accept and process volunteers according to the standardized process outlined in this memorandum and attachment.
2. This process is necessary to reduce barriers to volunteering at VA facilities, while complying with current laws and VA regulations. It enables VA to establish reasonable expectations for managing our ability to accept new volunteers while enhancing our volunteer recruitment activities.
3. For the purpose of accepting new volunteers, and determining the level of cyber security and privacy training they will require, four specific groups of volunteers have been established. Each group has specific requirements that correlate with the level of cyber security risk involved in their volunteer assignment. Every volunteer assignment will be categorized in one or more of the groups listed below.

Group A

VA employees who have volunteer assignments will require:

- A completed and signed application
- A general orientation
- An assignment-specific orientation
- A physical examination if driving is their volunteer assignment

Type of 10 Badge Required: Standard employee 10 badge

Group B

Volunteers with recreation, cemetery, book cart, or similar assignments will require:

- A completed and signed application
- A general orientation
- An assignment-specific orientation
- Privacy Policy Training
- A PPD Inoculation
- A photo 10 badge
- A physical examination if driving is their volunteer assignment
- A List of Excluded Individuals & Entities (LEIE) Health and Human Services (HHS) database check. The LEIE database check is performed automatically between databases.
- A Healthcare Integrity and Protection Data Bank (HIPDB) HHS database check. The HIPDB database check is completed by facility personnel.

Type of 10 Badge Required: FLASH

Group C

Volunteers who have assignments in any of the seven categories outlined in VHA Directives 0710 and VHA Handbook 1620.1 will require:

- All Group B requirements plus:
- A Special Agreement Check (SAC) for Fingerprint Only

Type of 10 Badge Required: NON–PIV

The *seven categories* for Group C are volunteers who have:

- Assignments associated with home health care;
- Assignments involving the provision of patient care or working alone with patients;
- Assignments involving contact with pharmaceuticals or other biological agents;
- Assignments that provide access to patient records;
- Assignments involving clinical research;
- Assignments that provide access to any VA computer system; or
- Access to any sensitive information not identified above (e.g., Privacy Act Protected Information)

Group D

Volunteers who have computer access or access to the LAN will require:

- All Group B & C requirements plus:
- A National Agreement Check Inquiry (NACl) Investigation
- Cyber Security Training
- A signature that the volunteer has read the VA's Rules of Behavior

Type of 10 Badge Required: PIV

4. These volunteer categories will standardize the acceptance process for all VA volunteers, regardless of the facility where they volunteer their time. This process will enable members of the community to serve those who have served, while safeguarding veteran private information.
5. The process outlined in this memorandum will be included as policy in VHA Handbook 1620.1, 'Voluntary Service Procedures". All VISN Directors and Medical Center Directors will ensure the implementation of this standardized process for acceptance of volunteers.

William F. Feeley, MSW, FACHE

Attachment: Volunteer Acceptance Requirements

VA Employees as Volunteers (already have necessary training and checks)	**Volunteers with No Access to Veterans Records or VA IT Systems**	**Volunteers with Access to Veterans**	**Volunteers with Access to VA IT Systems**

• Completed and signed application
• General Orientation
• Assignment–specific orientation
• Physical exmination (if driving is their volunteer assignment)
	• Completed and signed application
	• General orientation
	• Assignment–specific orientation
	• Privacy Policy Training
	• PPD Inoculation
	• Photo ID
	• Physical exmination (for volunteer drivers)
	• LEIE database check (List of Excluded Individual/Entities, Health and Human Services database, not completed by the volunteer)
	• Health Integrity and Protection Data Bank Check
		All Group B requirements plus:
		• Special Agreement Checks (SAC) for Fingerprint Only
			All Group B & C requirements plus:
			• NACI Investigation
			  • Completed
			  • Returned
			• Cyber Security Training
			• Sign VA's Rules of Behavior

Ongoing Requirement—Annual Supervisor Evaluation.

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
April 17, 2008

Hon. James B. Peake
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

On Thursday, March 13, 2008, the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs held a hearing on *Care of Seriously Wounded After Inpatient Care*.

During the hearing, the Subcommittee heard testimony from Dr. Madhulika Agarwal, Chief Patient Care Services Officer for the Veterans Health Administration. Dr. Agarwal was accompanied by Dr. Lucille Beck, Chief Consultant for Rehabilitation Services in the Veterans Health Administration; and Kristin Day, Chief Consultant for Care Management and Social Work. As a followup to that hearing, the Subcommittee is requesting that the following questions be answered for the record:

1. Please provide the Committee with a timeline for full implementation of the Federal Individual Recovery Plan (FIRP), and include in the timeline dates for each stage of implementation.
2. When will VA go back through the medical records and other sources of information for those seriously wounded veterans who have already been discharged into the civilian community (like Corporal Owens and Sergeant Wade) and bring these veterans into the FIRP with their own assigned Federal Recovery Coordinator (FRC), or otherwise provide those veterans with effective case management services?
3. Does the VA currently have sufficient staffing to handle the number of servicemembers and veterans who will need to rely on a Federal Recovery Coordinator (FRC) to assist them with their FIRP?
4. Are the FRCs in the current pilot assigned to newly injured servicemembers, to previously injured servicemembers (*i.e.*, servicemembers who were injured prior to the creation of the FRC pilot), or a combination thereof? If a combination, please provide the relative percentages of the two groups. If the pilot FRCs are being assigned primarily to newly injured servicemembers, please explain why this scare resource—FRCs—is being assigned to newly injured inpatients who have multiple case managers instead of previously injured servicemembers who may not have adequate case management?
5. Many of the most seriously injured OEF and OIF vets are treated in the VA's four Polytrauma Rehabilitation Centers (PRC). Has the VA tracked PRC patients after they leave the PRCs? If not, why not? How is VA ensuring that they receive everything they need?
6. Apart from PRC patients, what steps has VA taken to identify severely injured separated servicemembers who need ongoing care coordination?
7. What are VA's criteria to decide when a servicemember who has been treated at a PRC is no longer the responsibility of PRC case managers? In other words, what are the criteria for deciding to transition a servicemember from PRC case management to OIF/OEF care coordinator case management or something else?
8. What is the average caseload of a OIF/OEF care coordinator? Is this considered manageable? Is there a health care standard for this issue?
9. Have the special needs of severely injured rural vets been identified?
10. Please explain how VETSNET is being used to support the FRC pilot and the OIF/OEF care coordination program.
11. The testimony of Dr. Agarwal on page 3 states:

> As a part of this effort, VHA and VBA are jointly developing a comprehensive list of severely injured OEF/OIF veterans. The two administrations are defining the requirements and definitions for this list, and will establish a single record to track VHA or VBA contact each month with severely injured veterans and servicemembers.

Describe in detail how this list is being constructed and what the timeline is for completion of a comprehensive list.

We request you provide responses to the Subcommittee no later than close of business on June 11, 2008. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Staff Director, Geoffrey Bestor, Esq., at (202) 225–3569 or the Subcommittee Republican Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

HARRY E. MITCHELL
Chairman

GINNY BROWN–WAITE
Ranking Republican Member

Questions for the Record
The Honorable Harry E. Mitchell, Chairman
The Honorable Ginny Brown-Waite, Ranking Republican Member
Oversight and Investigations Subcommittee
House Veterans' Affairs Committee
March 13, 2008
Care of Seriously Wounded After Inpatient Care

Question 1: Please provide the Committee with a timeline for full implementation of the Federal Individual Recovery Plan (FIRP), and include in the timeline dates for each stage of implementation.

Response: A memorandum of understanding (MOU) between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) was signed on October 30, 2007, for the joint oversight of the Federal recovery coordination program (FRCP). In December 2007, VA hired the program's director and supervisor. In January 2008, VA hired Federal recovery coordinators (FRCs) who were placed at the following military treatment facilities (MTF):

Number of FRCs	Location	Status of Recruitment
3	Walter Reed Army Medical Center, Washington DC	• All on site and serving patients
2	National Naval Medical Center, Bethesda, MD	(1) On site and serving patients (1) Starts 5/19/08
3	Brooke Army Medical Center, San Antonio, TX	(2) On site and serving patients (1) In boarding process
2	Naval Medical Center, San Diego, CA	(1) In final selection stage (1) In boarding process

The FRCs started working with patients January 28, 2008. FRCs developed Federal individualized recovery plans (FIRP) for severely wounded, ill and injured servicemembers or veterans who meet the FRCP criteria. Phase One of the FRC program targeted those catastrophically wounded, ill or injured arriving from theatre to the MTF and is scheduled to be completed in May 2008. Phase Two, which will begin immediately after Phase One is complete, will expand the program's scope to include those servicemembers and veterans who were discharged from an MTF prior to January 2008.

Question 2: When will VA go back through the medical records and other sources of information for those seriously wounded veterans who have already been discharged into the civilian community (like Corporal Owens and Sergeant Wade) and bring these veterans into the FRCP with their own assigned Federal Recovery Coordinator (FRC), or otherwise provide those veterans with effective case management services?

Response: At this time, FRCs are accepting servicemembers/veterans injured prior to January 2008 into the FRCP on a referral basis. As mentioned above, Phase Two will start in June 2008, and will expand the program's scope to include those servicemembers and veterans who were discharged from a MTF prior to January

2008. Identification of this population will be conducted through a review of VA rehabilitation databases, to include spinal cord and blind rehabilitation, along with the polytrauma centers. In tandem, DoD will work through TRICARE in an effort to identify the same population for potential inclusion into the FRCP. Recruitment of staff to support this expansion effort has begun. An additional registered nurse is being recruited to champion this effort along with additional FRCs whose geographic placement will be based on identified patient needs.

Question 3: Does the VA currently have sufficient staffing to handle the number of servicemembers and veterans who will need to rely on the Federal Recovery Coordination Program to assist them with their FIRP?

Response: VA and DoD continue to closely monitor workload and geographic distribution of cases as the program matures. As of now the number of FRCs is adequate, but we expect that number to increase as we continue to identify servicemembers in need of their services.

Question 4: Are the FRCs in the current pilot assigned to newly injured servicemembers, to previously injured servicemembers, (i.e. servicemembers who were injured prior to the creation of the FRCP), or a combination thereof? If a combination, please provide the relative percentages of the two groups. If the pilot FRCs are being assigned primarily to newly injured servicemembers, please explain why this scarce resource—FRCs—is being assigned to newly inured inpatients who have multiple case managers instead of previously injured servicemembers who may not have adequate case management?

Response: Almost 25 percent of the patients in the FRCP were admitted to a MTF prior to the implementation of the program January 21, 2008. Phase One of the program is targeting catastrophically wounded, ill or injured arriving from theatre to a MTF. Phase Two will expand the program's scope to include those servicemembers and veterans who were discharged from a MTF prior to January 2008. The rationale behind this decision was that it allowed the FRCs to establish working relationships with the multidisciplinary teams, the MTF leadership, and those programs that support the severely ill/injured servicemembers.

Question 5: Many of the most seriously injured OEF and OIF vets are treated in the VA's four Polytrauma Rehabilitation Centers (PRC). Has the VA tracked PRC patients after they leave the PRCs? If not, why not? How is VA ensuring that they receive everything they need?

Response: Follow-up case management is provided by the PRCs in accordance with Veterans Health Administration (VHA) Handbook 1172.1. The assigned case manager is involved in developing the discharge plan of care with the treatment team, patient and family. This includes, arranging and coordinating ongoing services, and communicating with DoD and/or the local VA case manager.

While a patient is on active duty, DoD has authority over the servicemember's medical care. The PRC case manager partners with the military case manager, and documents post-discharge recommendations in the medical record to provide to DoD for active duty patients.

For patients who are veterans when they leave the PRC, the PRC case manager provides regular contact and followup with the patient, family, VA and any other service providers. The PRC case manager also tracks and monitors implementation of the care plan by the local VA by reviewing the electronic medical record. Video teleconferencing is often used to facilitate a smooth transition of care to the receiving VA care team and the polytrauma network site (PNS) responsible for monitoring the care plan and consulting with the local VA team.

Question 6: Apart from PRC patients, what steps has VA taken to identify severely injured separated servicemembers who need ongoing care coordination?

Response: VHA liaisons for health care and Veterans Benefit Administration (VBA) benefits counselors are stationed at 11 of the major MTFs receiving casualties from Afghanistan and Iraq. VHA liaisons, are either social workers or nurses. They facilitate the transfer of servicemembers and veterans from the MTF to a VA PRC or medical center closest to their home or most appropriate for the specialized services their medical condition requires. The benefits counselors brief servicemembers about VA benefits and assist them in applying for VA benefits and services.

These teams ensure that a VA facility has a process in place for the care of all Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans and servicemembers. The care is coordinated. Each VA medical center has an OEF/OIF

team which includes a nurse or social worker program manager, and nurse or social worker case manager. Transition patient advocates also support severely injured or ill OEF/OIF veterans by acting as an advocate for the patient and family as they move through the VA system of care. Additionally, each VA medical center has a process in place to ensure that the care of all OEF/OIF veterans and servicemembers is well-coordinated and that those who are severely ill or injured receive case management services from a nurse or social worker case manager.

The polytrauma system of care integrates services at regional centers, network sites, and at local VA medical centers to optimize resources and create points of access along a continuum of care. Specialized polytrauma care is provided at the VA facility closest to the veteran's home with the expertise necessary to manage rehabilitation, medical or mental health needs, and facilitate the veteran's re-integration into the home community.

The polytrauma system of care is designed to provide smooth transition from one level of care to the next. The PRC case manager maintains contact and/or monitors the care of patients discharged from the PRC for the patient's lifetime. The level of oversight, monitoring, or direct involvement of the PRC depends on the patient's access to care and services that are being provided at the local level.

Question 7: What are VA's criteria to decide when a servicemember who has been treated at a PRC is no longer the responsibility of PRC case managers? In other words, what are the criteria for deciding to transition a servicemember from PRC case management to OIF/OEF care coordinator case management or something else?

Response: The transition process may range from weekly or monthly contact for some, while monitoring on a quarterly or annual basis for others is appropriate. When direct PRC case management is no longer required, the PRC case manager will monitor the patient through the polytrauma case manager at a PNS, polytrauma support clinic team, or the OEF/OIF case manager. The PRC case manager continues to have ongoing responsibility to review the medical record and continue to followup with the primary case manager. The local VA continually has access to its PNS or PRC for consultation if new problems arise, or if the patient needs to be referred to a higher level for evaluation and treatment.

Question 8: What is the average caseload of an OEF/OIF care coordinator? Is this considered manageable? Is there a health care standard for this issue?

Response: Each OEF/OIF care manager follows approximately 24 patients as a national average. VHA Handbook 1010.01 states the caseload for nurse and social worker case managers will typically be no more than 25 to 30 patients per care manager. This ratio is consistent with DoD caseload as published in its medical management guide, DoD/TRICARE management activity, dated January 2006, which suggests a caseload of 25–35 acute and chronic cases per care manager.

Recognizing the crucial role nurses and social workers provide in case management and the need for a more consistent approach to determining caseloads, two national organizations are currently studying caseload calculations for nurses and social workers. The Case Management Society of America and the National Association of Social Workers are developing a caseload matrix.

Question 9: Have the special needs of severely injured rural vets been identified?

Response: Severely injured veterans living in rural areas are provided the case management services and oversight available to each veteran seen throughout the VA polytrauma system of care as well as the OEF/OIF care management program located at each VA medical facility (e.g., a nurse or social worker clinical case manager, transition patient advocates, OEF/OIF case manager, VBA counselors). An interdisciplinary team of rehabilitation specialists assesses the needs of seriously injured patients to match the treatment plan and coordinate support services needed. If local VA care is not available to a patient due to their geographic location, fee-based rehabilitation services are provided through the local community. The Office of Rural Health is working closely with the veterans integrated service networks to address access for all rural veterans, and has recently implemented initiatives to increase access to care to primary care.

Question 10: Please explain how VETSNET is being used to support the FRC pilot and the OEF/OIF care coordination program.

Response: Veterans services network (VETSNET) provides benefits counselors, OEF/OIF managers and coordinators with improved access to veteran and claims

data, on-time updates, and immediate status on pay. VETSNET is not directly available to the FRCs or the OEF/OIF team at the VA medical centers.

VETSNET is primarily used at this time by benefits counselors at MTFs. The benefits counselors meet with servicemembers and their families to provide benefits information and assistance to servicemembers applying for VBA benefits and services. Counselors assist servicemembers in completing claims and in gathering supporting evidence. While servicemembers are hospitalized, they are routinely informed of the status of their pending claims and given their counselor's name and contact information should they have followon questions or concerns.

The OEF/OIF team at the VA medical centers collaborates with the benefits counselors at the closest VA regional office.

Question 11: Dr. Agarwal's testimony on page 3 states that VHA and VBA are jointly developing a comprehensive list of severely injured OEF/OIF veterans. Describe in detail how this list is being constructed and what the timeline is for completion of a comprehensive list.

Response: VHA recently developed a new tool to track the care management of severely ill and injured OEF/OIF veterans. The new application is known as the care management tracking and reporting application (CMTRA). This robust tracking system allows OEF/OIF care managers to specify a care management schedule for each individual veteran and to identify specialty care managers such as polytrauma case managers and spinal cord injury case managers. The new application was implemented at VA medical centers on April 29, 2008. VHA mandated that all severely ill and injured OEF/OIF patients being case-managed need to be added to CMTRA. VBA is identifying a similar list of severely ill/injured patients. VA information technology staff will consolidate VHA and VBA information into a single, comprehensive database.