SEAMLESS TRANSITION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

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CONTENTS

May 19, 2005

Page

Seamless Transition 1

OPENING STATEMENTS

Hon. Michael Bilirakis, Chairman, Subcommittee on Oversight and Investigations 1
Hon. Silvestre Reyes, Acting Ranking Democratic Member 3
Prepared statement of Mr. Reyes 36

WITNESSES

Bascetta, Cynthia A., Director of Health Care, Veterans' Health and Benefits, Government Accountability Office 5
Prepared statement of Ms. Bascetta 38
Fass, Brenda, Veterans Health Administration Social Worker Walter Reed Medical Center 7
Prepared statement of Ms. Faas 52
Petty, Linda, Veterans' Benefits Administration Benefits Counselor, Walter Reed Medical Center 9
Prepared statement of Ms. Petty 55
Duckworth, L. Tammy, Operation Iraqi Freedom Veteran 11
Prepared statement of Major Duckworth 60
Fryer, Gwendolyn, Southern Regional Medical Command Military Liaison to James E. Haley Veterans' Affairs Medical Center, United States Army 23
Prepared statement of Col. Fryer 68
Frank, Timothy, Liaison Officer to the Secretary of Veterans Affairs, United States Marine Corps 25
Prepared statement of Col. Frank 77
Brown, John, Director, Office of Seamless Transition, Department of Veterans Affairs 27
Prepared statement of Mr. Brown 87
Boone, Linda, Executive Director, National Coalition for Homeless Veterans 28
Prepared statement of Ms. Boone 100

POST-HEARING QUESTIONS FOR THE RECORD

Response to Questions from Committee to Col. Fryer 107

SEAMLESS TRANSITION

THURSDAY, MAY 19, 2005

U.S. House of Representatives,
Subcommittee on Oversight and Investigations,
Committee on Veterans' Affairs,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael Bilirakis [chairman of the Subcommittee] presiding.

Present: Representatives Bilirakis, Reyes, and Bradley.

Mr. Bilirakis. Today's hearing will provide an opportunity to learn firsthand about the efforts by the Department of Defense and the Department of Veterans' Affairs in assisting military service personnel transitioning from active military service to veteran status.

One of my goals as chairman, and I might add it's probably the top goal of the Committee, particularly the Oversight Committee at this time, is to ensure that these efforts are transparent to the servicemember, a constant generally referred to as seamless transition. Over the past several years this Subcommittee has aggressively pursued implementation of seamless transition. Past efforts have been met with mixed results.

Let me be very clear, I intend to ensure that seamless transition becomes a reality. Time does fly up here and we have our causes, and the regular routine stuff sometimes keeps us from meeting the goal that we set for ourselves. But I hope that with the help of the great staff and the work of minority members, Mr. Strickland and Mr. Reyes, we will be able to do it. Our service personnel and their families deserve nothing less.

Separating from military service can be a very stressful event. It's often filled with apprehension, trepidation, and a great deal of uncertainty. It's something that I experienced many, many years ago. This is especially true for personnel that are injured or disabled in the performance of their duty. It's also true for the families of military personnel whose loved ones may have received severe injuries, like traumatic brain injuries, spinal cord, or other debilitating injuries.

We are all too familiar with stories in the national press about

wounded servicemembers falling through the cracks in the process of transitioning from DOD with regard to health care and compensation and disability benefits. It's heartbreaking to see these young men and women with serious injuries left destitute at the most trying time of their young lives.

So one of my first initiatives as chairman of the Subcommittee was to conduct field oversight activities, and recently we completed field visits at the James A. Haley VA Medical Center in Tampa, Florida and the Walter Reed Army Medical Center.

I was pleased by the initiatives by both the DOD and the VA and their efforts to achieve seamless transition. I look forward to hearing from the dedicated personnel that work hard every day behind the scenes to ensure that our nation's veterans receive the care that they deserve.

While I applaud the two agencies for their work, more can be done. Overall, the goal of a seamless transition is to educate servicemembers about VA benefits and to provide the servicemember a single emphasis, a single comprehensive medical examination that meets the requirements for DOD discharge physicals and VA's disability and compensation examination. You will be surprised at the difficulty we are having to get that simple thing done. That should also extend to other VA programs such as the GI Bill and vocational rehabilitation.

Ideally, servicemembers who elect to file for disability and compensation would have a VA decision under a disability claim at the time of discharge. In cases of severe injuries and disabilities, seamless transition should encompass the continuity of care and benefits when transferring from one health care system to another.

Today's hearing will focus on the timely transfer of servicemembers from military hospitals to VA Medical Centers, a review of the benefits and delivery of discharge programs and service specific initiatives. DOD and VA must get serious -- they must get serious about working together to make this a reality, and this Subcommittee stands ready to make that happen.

I would now like to recognize Mr. Reyes from Texas, who is Ranking Member today, and with whom it has really been a pleasure throughout the years to work with on this Committee. Mr. Reyes.

MR. REYES. Thank you, Mr. Chairman. Likewise, it has been my privilege to work alongside you and all the other members of this Committee, to try to address issues that are so important to our veterans and those coming out of the military, and they will be taking advantage of the work that we do here in this Committee.

I apologize for running a little bit late, but as you know, Mr. Chairman, we've got conflicting hearings this morning. Mr. Strickland sends his apology. But last week when we were evacuated, that bottled up and doubled up a lot of the hearings, and we are all affected by that. In fact, I came here from one of the rare open hearings that

we have in the intelligence community.

Last night, we worked on the Armed Services Authorization Bill until almost 1 o'clock. So those are the kinds of things that are going on here. So I know I will have to go back to my intelligence hearing. But I would ask, Mr. Chairman, if our counsel can ask questions since Mr. Strickland is not going to be able to attend.

MR. BILIRAKIS. Yes, that has been mentioned to me previously, and I understand that there is a lot of this in this Committee. By all means, that certainly will be the case.

MR. REYES. Thank you so much, Mr. Chairman. We appreciate that courtesy.

I would also ask, Mr. Chairman, that my complete statement be placed in the record, and I will make some brief comments.

MR. BILIRAKIS. Yes. Without objection, the statements of all members of the Subcommittee, whether they be here or not, can be made part of the record. Please proceed, sir.

MR. REYES. Thank you, Mr. Chairman. First of all, I would like to welcome all of those testifying. I would also like to specifically recognize those who have served in uniform for being here this morning. The issue of servicemen transitioning back to civilian life is a very important and sometimes a very complicated one. It is not a new issue. America has the duty to ensure that this transition is smooth and accessible to all who served, as well as a duty to make each and every soldier, sailor, airman, or Marine who was injured or otherwise harmed while serving their country whole again.

While ongoing combat activities in Iraq and Afghanistan provide us with a constant stream of wounded and disabled GIs, this reality is not different from any past war of this country's history. Having said that, the injuries received in theater are sometimes different than in previous battles due to the ever-changing technology that is available for the protection of our troops. Different protective equipment and different modes of transportation that we see each and every day in both theaters.

Not only must we adapt as necessary to treat those injuries in a timely manner, we must create a system that will embrace all of their needs. We justifiably proclaim our healthcare system is one of the best in the world. Its capacity to cure the sick and to restore the injured has very few rivals anywhere. But Mr. Chairman, we do not always assure that those in need who have served in uniform benefit from the excellent system of health care. We need to remain vigilant to this.

How well are we doing in terms of seamless transition? VA and DOD coordination on this effort is generally good. For the average transitioning servicemember that is a testament to their abilities. For the severely injured, the system is excellent, yet we are often reminded of instances where someone has fallen through the safety net.

The Government Accountability Office observes that VA can utilize no systemwide official source of data on the returning servicemembers, but achieves its results by targeting individual facilities. This information can be shared locally, why can't it be shared systemwide? It seems to me a simple enough system to be able to give us that kind of information. Each agency needs to accommodate the other in an environment free from any types of barriers.

We also must remain conscious that not all battle injuries are visible. These individuals must be identified, engaged in the seamless transition, and receive treatment from a caring and adequately funded Veterans Administration. We also must maintain a vigil for emerging problems. We must assure that when the transition to civilian life seems complete, the elements of that transition require monitoring and sometimes action to mitigate emerging service-related problems.

We should learn from our past experiences and help these individuals complete the transition successfully and early. If we don't, the costs in both human and monetary terms will be much, much higher.

With that, Mr. Chairman, thank you very much for yielding me the time, and I yield back the balance of my time.

[The statement of Mr. Reyes appears on p. 36]

MR. BILIRAKIS. Thank you, sir, and you certainly made many, many good points. There are no other members here, so I won't ask if any other members wish to speak. It's a small Subcommittee. We only have four or five members on it. We may have another one or two coming in at one time or another.

I would like to recognize at this time our first panel. Ms. Cynthia Bascetta is the Director of Health Care, Veterans' Health and Benefits Issues, with the General Accountability Office. Ms. Brenda Faas is the Veterans' Health Administration Social Worker currently assigned to Walter Reed, and we met the other day. Ms. Linda Petty is a Veterans' Benefits Administration Benefits Counselor currently assigned to Walter Reed, and we met the other day; and Maj. Ladda Tammy Duckworth, who is an Operation Iraqi Freedom veteran currently receiving care at Walter Reed. Again, we met the other day. It's really wonderful to see you all here today.

I'm going to ask you to limit your oral testimony to five minutea. Obviously, if you're on a roll on something significant, I'm not going to cut you off. But your complete written statement will be made part of the record. So hopefully, you will complement or supplement that.

With that being the case, we will start off with Ms. Bascetta.

STATEMENTS OF CYNTHIA A. BASCETTA, DIRECTOR OF HEALTH CARE, VETERANS' HEALTH AND BENEFITS ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE; BRENDA FAAS, VETERANS' HEALTH ADMINISTRATION SOCIAL WORKER, WALTER REED MEDICAL CENTER; LINDA PETTY, VETERANS' BENEFITS ADMINISTRATION BENEFITS COUNSELOR, WALTER REED MEDICAL CENTER; AND MAJ. L. TAMMY DUCKWORTH, OPERATION IRAQI FREEDOM VETERAN

STATEMENT OF CYNTHIA A. BASCETTA

MS. BASCETTA. Thank you, Mr. Chairman and Mr. Reyes. We appreciate being here today to discuss GAO's work on the seamless transition.

Today, I would like to focus on VA's efforts to expedite vocational rehabilitation services to those seriously injured in Afghanistan and Iraq, and the related issue of its progress in developing a data sharing agreement with DOD. As you know, more than 12,000 servicemembers have been injured in combat since 2001, and a top priority is the continuity of their medical care between DOD and VA, as well as their smooth access to other VA benefits if they should decide to separate from the military.

My comments today are based on a report that we issued this January on VA's efforts to expedite vocational rehabilitation services. To do our work, we reviewed the VA's formal and informal procedures and conducted interviews with officials at 12 of VA's regional offices. Five of these offices were located near the Military Treatment Facilities that provide medical care to the majority of seriously injured servicemembers. We are also reporting on our ongoing review of the VA and DOD efforts to develop a data sharing agreement that would comply with the Health Insurance Portability and Accountability Act's privacy rule which governs the sharing of individually identifiable health data. We discussed the information contained in this statement with DOD and VA officials who concurred with our findings.

In September 2003, VA asked if its regional offices could learn the identities, medical conditions and military status of seriously injured servicemembers in their areas by coordinating with staffs at the MTF. The regional offices were instructed to focus on servicemembers who were definitely or likely to separate from the military, and to assign case managers to them. VA underscored the importance of early intervention and the provision which allows VA to provide services even before discharge.

Lack of systematic data from DOD, however, proved challenging. So in the spring of 2004, VA requested that DOD provide personal

identifying data, medical data, and DOD's injury classification for servicemembers. We found that in the absence of systematic data from DOD, the completeness and reliability of VA's data was dependent upon the nature of their local relationships.

For example, one regional office received from the MTF only the names of new patients, but no data on the severity of their medical conditions. In contrast, another regional office reported receiving lists of MTF patients with information on the severity of their injuries, as well as lists of servicemembers for whom the Army had initiated a medical separation.

We noted that in the absence of a data sharing agreement, VA cannot reliably identify all seriously injured servicemembers, or know with certainty when they are medically stable, when they may be undergoing evaluation for medical discharge, or when they have been discharged. As a result, VA cannot reasonably assure that some of these servicemembers who may benefit from vocational rehabilitation have not been overlooked.

To remedy this, we recommended that VA and DOD collaborate to reach an agreement for VA to have access to information that both agencies agree is needed to promote the servicemember's recovery and return to work in whether they remain in the military or transition to the civilian sector. However, DOD and VA have not yet developed a data sharing agreement even though they have been discussing the issue for more than two years. We identified their different understandings of the HIPAA Privacy Rule as an impediment to their progress.

Two examples illustrate the nature of their disagreement. First, the privacy rule permits government agencies providing public benefits to disclose individually, identifiable health data to each other when the program serves the same or similar populations. VA officials told us that they believed DOD can share health data because the Departments do serve the same or similar populations, and both provide public benefits.

On the other hand, the DOD official responsible for implementing the privacy rule contends that serving the same or similar populations would apply only to servicemembers who were duly eligible for both DOD and VA services. He also said that the services provided by DOD are not public benefits because they are unlike the examples in the preamble to the privacy rule, which does not define public benefits. The second example involves the Departments' differing views regarding when in the separation process DOD could share health data with VA. DOD is reluctant to do so until it is certain that a servicemember will separate, while VA believes DOD could share the data sooner.

Mr. Chairman, VA and DOD are currently working on a memorandum of understanding that they tell us moves them closer to a data

sharing agreement. Unfortunately, we found that the draft MOU essentially restates many of the legal authorities already contained in the privacy rule. Consequently, VA and DOD will still have to resolve the details of what health data can be shared and when it can be shared. Until then we believe that the transition of servicemembers from DOD to VA for vocational rehabilitation and for other necessary services and benefits may not be as seamless as possible.

That concludes my remarks, and I will be happy to answer your questions.

[The statement of Ms. Bascetta appears on p. 38]

MR. BILIRAKIS. Well, you know, when I inquired about DOD, I think it would be a good idea to have the VA representative and the DOD representative sitting at the same table to try to explain to us why in the hell it takes two years to even get to the point where they're even close to an agreement. But that will come, possibly at the next hearing. You know the unexpected consequences of our acts sometimes, when we came up with HIPAA, I'm not sure that God was on our shoulder, I think somebody else was probably on our shoulder. But it's really caused an awful lot of problems, obviously, in health care.

Ms. Faas.

STATEMENT OF BRENDA FAAS

MS. FAAS. Yes. Mr. Chairman and members of the Committee, I am privileged to appear before you today to discuss my role as a VA/DOD Liaison for Health Care stationed at Walter Reed Army Medical Center. I am honored to serve the injured soldiers, sailors, airmen, and Marines who are returning from theaters of combat and who may benefit from VA services.

My role is one of two VA/DOD Liaisons at Walter Reed involves partnering with the MTF staff, active-duty servicemembers, veterans, family members and the VA Medical Center staff across the country to ensure a seamless transition of care and services.

Together with the Walter Reed social work staff and other interdisciplinary team members, we develop a treatment plan, which I help to expedite within the VA Health Care System. I am assigned full-time, on-site at Walter Reed Army and meet face-to-face with patients and staff. I provide consultation to staff regarding the availability of health care and I also educate servicemembers and their families regarding VA health care benefits.

When the MTF staff identifies a servicemember who will need a VA health-care, a referral is generated. Which also includes medical records and a treatment plan. Referrals may involve servicemembers who require medical care while on convalescent leave who are being separated or retired from the military and will need continuous medi-

cal care.

Transfers of care may involve patient services such as acute rehabilitation for dramatic brain injuries, spinal cord injuries, visual impairment, and loss of limbs or function, as well as acute inpatient psychiatry. Outpatient service may include primary care, orthopedics, physical occupational therapy, neurology, oncology, and mental health.

An important part of coordination of care involves meeting with the servicemember and the family to review this treatment and transfer plan. I pay particular attention to any special needs that the family member or servicemember may have.

Once I have received a referral, the servicemember is enrolled in the VA Health Care System and the transfer of care is coordinated with the OIF/OEF point of contact at the designated VA Medical Center. The point of contact arranges for outpatient appointments and/or inpatient admission. I then meet with the patient and the family member at Walter Reed to conform the appointments being made, to provide them with the point of contact information, and to continue to address any issues or concerns they may have about the transition process. I remain available to answer any questions while they remain at Walter Reed before they're transferred.

I also monitor the transfer through our computerized Patient Record System that the VA has, so is a patient is being transferred say from here to California, I can monitor that transfer and actually look in the computer system and see if they actually attend their appointment or were they admitted properly.

Due to the renowned Amputee Clinic at Walter Reed, we have a high volume of patients with amputations from all branches of the service. These patients will require long-term medical and prosthetic care. I work closely with Walter Reed in the Washington, DC VA Medical Center to provide prosthetic equipment, such as ultra-light wheelchairs, collapsible canes and crutches, and hand-cycles for cardiovascular exercise.

I collaborate with Walter Reed Department of Physical Medicine and Rehabilitation and the VA-Maryland Health Care System to schedule driving evaluations for patient with amputation, traumatic brain injuries and visual impairments. I also communicate with the VA Blind Rehab Specialist who visits the visually impaired patients at Walter Reed to provide education about VA's Blind Rehab Services.

I also work with the Veterans Benefits counselor and Vocational Rehab Educational counselor from the Veterans Benefits Administration who are located at Walter Reed. We communicate on a daily basis to review the needs of the patients and how we can coordinate our services to support an optimal level of functioning and independence.

Change provokes anxiety, and my goal as a VA/DOD liaison is to help the OIF/OEF veterans faced their new lives with enthusiasm, hope and optimism. Enhancement of coordinated services between DOD and VA promotes a positive transition from military to civilian life and ultimately has a lasting effect on our veterans' families and community. I am honored to serve those who have served our country.

Mr. Chairman, this concludes my statement. I look forward to answering any questions.

[The statement of Ms. Faas appears on p. 52]

MR. BILIRAKIS. Thank you very much, Ms. Faas.

Ms. Petty, please proceed.

STATEMENT OF LINDA S. PETTY

MS. PETTY. Mr. Chairman and members of the Subcommittee, it is a privilege to appear before you today to discuss my role as the supervisor of the Veterans Benefits Administration's Outreach Team at Walter Reed. I retired from the United States Army in 2003 after 28 years of both active and reserve service. I am honored that VBA gave me the opportunity to work at Walter Reed supporting these servicemen and women, our newest veterans.

VBA detailed a full-time benefits counselor from the Washington Regional Office to Walter Reed Army Medical Center in August of 2003. I joined the Walter Reade staff in March 2004 as a supervisor. My role was to coordinate support requirements, develop administrative procedures, and provide a single point of contact for both the military and VA issues. We currently have four full-time, permanent staff members at Walter Reed and one at Bethesda. We also have a contract for Vocational Rehabilitation and Employment counselor to provide early testing and evaluations.

We strive to meet every injured servicemember returning from the theater of operations with special emphasis on those designated by the military as very seriously injured, seriously injured or special category persons as soon as medically appropriate.

From the beginning, we tried to schedule visits within 72 hours of the patient's arrival. This was an unrealistic and inappropriate goal. We found that few patients were physically or emotionally ready to discuss veteran benefits that soon after arrival.

We now attempt to see every impatient as soon as medically possible. We receive referrals from the military social workers, from the case managers, and the VA social workers, and periodically we check with the ward nurses to see if there's anyone we need to visit.

At the first visit, we introduce ourselves and gather some basic contact and personal information. We try to follow up every few days

with a short visit to gauge when they are ready for more information or to start the claim. It's often weeks or even months before someone is ready to start a benefits claim. Our goal is to build a relationship based on the servicemember's needs.

One of our unique aspects is our full-time Vocational Rehabilitation and Education and Employment counselor. This counselor provides vocational evaluation and testing, r,sum, review, and employment referrals. We issue ergonomic computers and equipment is on his eligibility is established. The VR&E program at Walter Reed also arranges volunteer employment opportunities so servicemembers can get valuable civilian work experience prior to separation. The VR&E program gives both servicemembers and their families reassurance that they do have employment options after separation.

In July of 2004 the clinic physicians invited VBA counselors to participate in their weekly outpatient amputee clinic. These meetings allow us to see patients we might have otherwise have missed, to follow both those who have started a benefits claim, and to answer questions about the claims process. The VBA counselor at Bethesda attends similar interdisciplinary meetings.

We work very closely with the VHA social workers and health-care liaisons. Often the VBA counselors have worked with the patient long before they're ready for referral to the VHA. VHA contacts us when they find a patient with benefits questions and we do the same with health-care questions.

I periodically attend the Fisher House Family Support Group meetings to provide information on the VA benefits available in the claims process. We prepare claims for compensation, automobile grants, long guarantee and adapted housing, and voc rehab. We gather all available medical evidence needed to support the claims. Claims from both Bethesda and Walter Reed are processed from the Washington VA Regional office. They process as much of the claim as possible before separation, and finalize it upon receipt of proof of service. Our goal is to have the benefits waiting for the servicemember, not the servicemember waiting for benefits.

Each VBA regional office also has an OIF coordinator and an alternate. We notify the coordinator when a patient leaves Walter Reed or Bethesda, even if it's just for a few weeks of convalescent leave. We tell the regional office how to contact the servicemember, what we have done to date, and let them know of any special needs they might have.

The Under Secretary for benefits established very specific guidelines for outreach and claims processing for all of these special category casualties. These claims are case managed and receive priority processing at the regional offices.

The VBA regional services at Walter Reed and Bethesda are not limited to -- awaiting to those OIF/OEF servicemembers. We counsel

all other servicemembers awaiting medical boards, provide transition services to include Transition Assistance Program briefings and pre-retirement briefings. We also counsel retirees and surviving family members.

Mr. Chairman, this concludes my statement. I look forward to answering any questions that you or other Committee members might have.

[The statement of Ms. Petty appears on p. 55]

MR. BILIRAKIS. Thank you so much, Ms. Petty. As time goes on we're going to have questions for all three of you, certainly.

Before getting to Maj. Duckworth, first, Major, I would like to thank you for your extraordinary courage, your sense of duty, your desire to continue to serve your country, and it's just wonderful that you brought your Mom with you here today. Ma'am, would you please rise so that we can give you what you deserve, applause?

[Applause.]

MR. BILIRAKIS. Thank you, ma'am, for loaning Maj. Duckworth to her country.

Major, your personal story of your tour of duty in OIF needs to be heard today. You can do so as briefly as you wish or whatever. The story of your medical care in the military medical system, from the MEDEVAC helicopters, to combat support hospitals, Landstuhl Regional Medical Center in Germany, and finally here at Walter Reed, also needs to be told from your eyes.

We also want to hear what you have seen and experienced in your rehabilitation at Walter Reed, specifically DOD's and VA's efforts to facilitate, educate, and aid you and your fellow heroes, the only true heroes, I might add, in our society. They and the law enforcement people and the fire people. In returning to duty, or transitioning to the VA medical system and civilian life.

Major, I realize that you are still in the service. I hope that you can share with us, you know all the positives as well -- also the negatives, and that your branch of service will allow you to do that, because our effort here is to not scold anybody or hit anybody over the head. Our effort is to try to get things fixed. So hopefully, you can help us in that regard. The microphone is yours, I'm not even going to turn on the light. So you just take your time. Please proceed.

STATEMENT OF MAJ. L. TAMMY DUCKWORTH

MAJ. DUCKWORTH. Thank you. Mr. Chairman, Acting Ranking Member Reyes.

MR. BILIRAKIS. Move the mike little closer, we want to make sure

everybody can hear your comments.

MAJ. DUCKWORTH. I'll try to sit forward.

Mr. Chairman, Acting Ranking Member Reyes, thank you for the opportunity to come before you today to discuss the care of wounded servicemembers injured in Operations Enduring Freedom and Iraqi Freedom and our efforts to facilitate the transition between the military and the Department of Veterans' Affairs health care facilities and between military and veteran status.

On November 12th, 2004 I was flying a mission in Baghdad on the way back to home base. At the end of the mission I was hit by an RPG, which amputated my legs in flight, came up through the floor of the aircraft, the window that is between the pilot's legs which we use in order to land the aircraft and do close hover work. My pilot in command, the other pilot in the aircraft, successfully landed the aircraft. Chop II, which is a second aircraft in our flight, took all of the injured on board, transferred us to Taji, at which point I entered the military health care system, which was quite remarkable.

The MEDEVAC aircraft, even though I had lost over 50 percent of the blood in my body, and had been what my crew members thought was dead -- they thought they were recovering a body -- the MEDEVAC aircraft, which is a flying hospital of sorts, a flying trauma room, was able to actually revive me in the five-minute flight from Taji to Baghdad to the CSH, and I was actually rolled into the Combat Support hospital (CSH) alert and talking. This is from being what people thought I was dead.

At the hospital in Baghdad they performed emergency amputations of the remainder of my right leg, and cleaned up my left leg, at which point the doctors determined that I was probably going to become a triple amputee and lose my right arm also. So they very quickly transferred me to Landstuhl. After getting to Landstuhl, I stayed there 16 hours, and from Landstuhl I was sent right on to Walter Reed because of the very same fear that I would lose my right arm. I arrived at Walter Reed within 60 hours of my initial injury. I arrived in the CSH in Baghdad within approximately 25 minutes from when I was hit.

So due to the rapidness of this health-care system and the forward placement of surgeons in Baghdad and Landstuhl, they were able to save my arm. I hope to have at least 75 percent recovery and use of my right arm, which is vital to me because I wish to stay in the military, serve in the National Guard and continue to fly helicopters. So having my right arm is a major development for me, and I'm grateful. Every day that I see my surgeon who works on my arm, I thank him and I tell him, thank you for my arm.

So that's my background. I feel that the core component of the seamless transition is our nation's investment in its finest citizens, the past and present members of the military. I believe we must con-

tinue to fund and support the military treatment facilities.

Military treatment facilities are a crucial part of integrated medical system, which has performed so well during this conflict. In any previous conflict I would not be alive. It is a testament to the superior protective equipment that I was wearing, and to the medical care pipeline from the frontline that I can be here today.

I would urge you to think of the efforts of the Army Medical Department and the VA as a force multiplier in two ways. First, these organizations can help us retain good soldiers, Marines, airmen and sailors who would have otherwise not been able to continue to physically accomplish their missions and remain in the service of the United States. These wounded have already been trained a great expense, as well as been tested and gained invaluable experience in the crucible of combat.

Second, our warriors must be able to focus completely and single-mindedly on the mission at hand, serving the people of the United States of America. When that mission is to close with and destroy our nation's enemies, I believe that we want our warriors to be secure in the knowledge that, when they are hurt we will take care of them.

As disabled soliders transition to veteran status, we will look to the VA to provide continued access to health care, health technology, assisted-living devices and social services. The VA will have to face the challenge of providing care at the high level set by the military health care facilities. This is a challenge that the VA can meet if it is given enough resources and if it listens to the disable servicemembers and puts forth the effort to meet our needs.

The first, most easily identified need that the VA will have to support is continued access to technology, such as in prosthetics research. Disabled veteran will require access to involving technology as they age, and as the available technology undergoes renovation and changes.

Second, as I look around at other wounded soldiers, it is clear that the majority of them are young with long lives ahead of them. Whether we will continue to have the honor of serving in uniform, or return to productive civilian lives, we will require continued access to technology as we age. The VA will need to support this need over the long-term as currently wounded soldiers will be making use of its services over a lifetime.

Third, disabled soldiers will need access to assisted-living devices.

Fourth, the VA will need to provide access to social services such as job counseling and psychological support. Those that sustained brain injury as well as those that developed psychological trauma will need long-term counseling and support.

Fifth, it does the disabled veteran no good if he or she is unable to access the various programs provided by the VA. For disabled veterans living in areas far from VA hospitals and facilities, travel itself is

a significant obstacle to their continued care.

I can only hope and implore that the VA's steps up to receive disabled veterans as we transition into its care from the military medical system. In order to do so, the VA will have to identify and develop specific programs and those programs will have to be funded into the future. I also asked that his system such as a checklist be created to give to injured soldiers or their next of kin, to give them a roadmap to follow as they move from the military medical system into the VA.

While I currently cannot comment from personal experience on the quality of care available in veterans' hospitals, I have been witness to the outreach efforts of the VA. These efforts have been highly personal, and as a result, my concept of the VA is not that of the faceless bureaucracy.

At this point the face of the VA as a veteran and amputee that befriended my husband and mother even as I lay unconscious in the Intensive Care Unit. The VA is a former Army ranger and his wife who came to visit me and all the other wounded in a hospital rooms. The VA is a vet who wheels in to check on the condition of my wheelchair and tells me from his personal experience the importance of a good seat cushion.

I applaud the VA and the Department of Defense partnership that assists military servicemembers who have served in combat and aims to provide them with a seamless transition to civilian life and veteran status.

Selecting individuals from amongst the American people who would willingly serve in the armed services are a limited resource. Our warriors are expensive and indispensable. I believe we must jealously guard this resource, retaining as many as possible in the service, and sparing little in the effort to return one of them to duty.

The investment in training dollars represented by even one junior non-commissioned officer could easily be several hundred thousand dollars over the course of five to six years. Such are the expense of assets that the military treatment facilities is in the business of fixing and maintaining, and I believe the American people's tax dollars are well spend there.

Additionally, once out of the military, our veterans make up a highly trained and disciplined pool of workers ready to add to the productivity of the civilian work force. Veterans supported by the VA and able to lead productive lives are valuable contributors to the economy. The cost of providing wheelchairs and prosthetics to veterans through the VA system is an investment recouped through taxes paid by those same veterans who can now work as a result of these devices.

Finally, on behalf of our injured, wounded, or ill servicemembers and their families, I thank members of this great institution for this opportunity to address their concerns for medical care of our nation's

veterans, soldiers, Marines, sailors and airmen.

Thank you for the opportunity to be here today, and I look forward to your questions.

[The statement of Maj. Duckworth appears on p. 60]

MR. BILIRAKIS. Thank you so much, Major. The chair recognizes himself and the light can go on now. Let me switch this on here.

Ms. Bascetta, do you believe that DOD's concern regarding the HIPAA Privacy Rule provisions have merit?

MS. BASCETTA. That's a very important question. I think that you mentioned in your opening statement that there might have been unintended consequences of HIPAA, and we understand why DOD takes this law very seriously.

Surely, there is nothing more important than the privacy rights of an individual's health information. But it is hard for us to understand how in more than two years DOD could not figure out a HIPAA-compliant way to share data with VA, which is ultimately for the benefit of the servicemember.

If they couldn't do this on their own, or they were fearful of being in violation of HIPAA, we believe that they could have and should have contacted HHS's Office of Civil Rights who could have helped them by interpreting the HIPAA privacy rule, which is in HHS's jurisdiction.

So I guess the bottom line is that HIPAA certainly requires strict attention, and it might have even been an obstacle early on, but we don't believe it was an insurmountable one.

MR. BILIRAKIS. Do you think that it should have taken as long as it has, a couple of years, to really not even reach -- as I understand that they were supposed to reach some sort of agreement by today. I don't know whether that's just a coincidence and that we are having a hearing today. But I'm not sure really, what took place as far as that is concerned. What do you think, is there something more that the Congress should do in this regard? I mean, you know we all realize that probably HIPAA is not perfect. Of course, it is the law and we do appreciate DOD's problem that they want to abide by the law. They don't want to bear any undue risks or whatever the case may be.

Should we be doing more in that regard, I mean, they have come up to us as far as I know. They may have gone to the Armed Services Committee, but as far as I know they have not come to the Veterans Committee and sat down with us and said, hey these are changes or maybe clarifications we need, or what was the intent of the legislation, so to speak, et cetera.

MS. BASCETTA. We don't think at this point that there is a legislative fix that is required in HIPAA. Certainly not without the Department's asking first for consultation from HHS on the matter. It would be premature to say that HIPAA is the problem or needs a legislative fix. I would add that it could be that you'll have to legislate to tell

the DOD, to direct DOD to develop a HIPAA-compliant agreement to share data. But we think they can do it.

MR. BILIRAKIS. We're you involved in the regional visits to help determine whether the, you know the single medical physical thing was taking place?

MS. BASCETTA. Actually another team did that work, but I'm familiar with it.

MR. BILIRAKIS. You're familiar with it.

MS. BASCETTA. Mm-hmm.

MR. BILIRAKIS. Now the statistics as I -- I don't recall the statistics. I guess there is some 100 and some bases out there and I think you told us, GAO told us 12 of them were in compliance, or eight of them were compliant or something like that. Then it was ultimately determined that, I think that only what, one was?

MS. BASCETTA. Four.

MR. BILIRAKIS. Four? Four were actually in compliance in other words. So they were sharing data, I guess, adequately so that the physical -- that there was one physical that both groups, that both Departments agreed with, is that right?

MS. BASCETTA. Yes.

MR. BILIRAKIS. Please explain that.

MS. BASCETTA. I know that you are interested --

MR. BILIRAKIS. Whatever it is that you know in that regard, because it kind of blows my mind.

MS. BASCETTA. Right. I know that you are interested in this topic because it was mentioned in your invitation to the hearing.

MR. BILIRAKIS. Yes.

MS. BASCETTA. So I brought the report with me. I don't have information on the accuracy of the number of BDD sites. There are either 139 or 140, or there may be even 144. But what we found in our report was that 20 military installations with BDD programs were supposed to have the single separation exam, which is a component of the BDD sites.

When we evaluated programs at eight of the 28 installations who had the single separation exam, we found that four of installations did not actually have the program in place. I can provide for you the --

MR. BILIRAKIS. They didn't even know what BDD stood for as I understand it.

MS. BASCETTA. Uhmm.

MR. BILIRAKIS. They not only didn't have it in place?

MS. BASCETTA. I'm not sure about that. That specific language isn't in this report. But for example, at one location officials told us that a single separation exam was in place prior to our visit, but when we got there we discovered that it wasn't being followed, and the single separation exam wasn't even in operation. So there is documenta-

tion about that at the four locations. We also identified another military installation that had a single separation program, even though it wasn't included in their list. So there were errors of omission as well as other errors.

MR. BILIRAKIS. Yeah.

MS. BASCETTA. So we're not confident in the numbers that we're getting from VA on that program.

MR. BILIRAKIS. Thank you very much, Ms. Bascetta.

MS. BASCETTA. Mm-hmm.

MR. BILIRAKIS. Mr. Reyes to inquire.

MR. REYES. Thank you, Mr. Chairman. I regret that I am going to have to leave after I asked this question. But I'm going to focus mostly on you, Maj. Duckworth. Just last night we marked up the Armed Services budget. Next week part of that bill, there is a provision there that we are trying to redefine the role of women in the military and in particular combat. It just strikes me that you're the perfect example. Your personal testimony and your personal courage and dedication to this country is exactly what I hope to talk about next week on the floor, because in my district, regrettably, I've attended two funerals for two women that had been killed in Iraq.

It strikes me that when we talk about, I think to use your words, the spectacular care that you received and the ability to have you back here 60 hours I believe you said after you were injured. I'm going to assume that you are a Black Hawk helicopter pilot?

MAJ. DUCKWORTH. Yes, sir.

MR. REYES. The question that I have is the care that you have been provided and by your statement the MTF's being spectacular, you also state that you do not believe it can be duplicated at a civilian hospital at any price.

I guess my first question, Major, is, is it fair to say that some of your concerns may be based on medical expertise and some of your concerns are based on cultural needs of servicemembers? In other words there is a relationship there given the kind of care that is required after being traumatically injured in combat, 60 hours later you are in the hands of military doctors that really know, understand and empathize with your situation. Is that fair to say?

MAJ. DUCKWORTH. Yes, sir, it is, exactly. First off, I'm a helicopter pilot because I chose the only combat arms branch that would allow women into combat, which is aviation. At the time that I was being commissioned, I requested aviation because I didn't want to face fewer risks than the male soldiers, so that's how I became a helicopter pilot.

My concerns with transitioning away from the military treatment facilities are two-fold. Just as you have mentioned, first and foremost, these facilities have the expertise to deal with the very peculiar wounds that come out of combat.

For example, I actually sat in on a training program for peer visitors just within the last couple of weeks where we talked with other amputees. We actually spoke with a gentleman who had been dealing in prosthetics for about 25 years. He makes prosthetic legs. He was unfamiliar with a condition called HO that many of the soldiers who are amputees have.

What it is, HO is when bone starts to grow into the tissue were a blast injury happened. Because this man had never dealt with anybody who had been an amputee as a result of a blast injury, he was not familiar with this condition, which is so pervasive amongst the population at Walter Reed that it is a matter of course that they understood what to do.

I also believe that my arm would probably had not been saved if it had not been for the surgeons at Walter Reed, because they were very familiar with the effects of blast injuries and the shrapnel that I incurred. It is very different from losing your limbs from diabetes or losing your limbs in a car accident. That's my completely nonprofessional, non-medical opinion.

The second issue is the cultural issue. The doctors at Walter Reed, where I am personally being treated, many of the doctors and nurses have been in Baghdad. They were at the very same CSH and they understood what it meant to have to wear the body armor. They understood what it means to have been the target of mortar and rocket attacks themselves, because that medical hospital is one of the main targets for the insurgents. So there is that cultural background that is a big help.

Also to be as part of a population, a concentration of other amputees who have gone through the same thing that you have gone through, who are just like yourself generally healthy prior to being -- undergoing this traumatic injury is a source of encouragement for one another. I can sit in that room, in the physical therapy room because I am learning to walk with the other soldiers, and we all know and understand what we have gone through.

So it is not just the health-care providers, it is also being with other soldiers, as well.

MR. REYES. Thank you, Major. Mr. Chairman, can I follow up with one question?

MR. BILIRAKIS. By all means.

MR. REYES. Major, when the transition is made and the servicemembers care comes under the VA, are those two same rationales that are of concern to you, are they still important in your opinion?

MAJ. DUCKWORTH. I think once I had transitioned to the VA system, sir, I had gone to the initial phases of recovery when those items are the most crucial, having the other soldiers, having the military doctors. Once I've transitioned into the health-care, the VA system, I believe that I will be much more able and more self-reliant than I am

within the initial first months.

For example, I received my first legs in January, just two months after I was injured, and I was able to see that is something that I can do, I can learn to walk again because the other soldiers were doing it. I doubt if I were by myself, one of -- maybe one or two amputees in a hospital someplace, that I would have actually been able to conceive of doing that. Whereas being at Walter Reed where I saw people doing it all the time, it was of course, you know two months after having my legs blown off I'm going to be walking again.

MR. REYES. Thank you very much, Major. Thank you for your testimony. Thank you for your service. You're an American hero. Thank you.

MAJ. DUCKWORTH. It's an honor to wear the uniform, sir.

MR. BILIRAKIS. You know, we all feel that way. Here they are, you know with a limb missing and other sets of problems and they just feel that way.

Major, do you have -- maybe sort of trying to hitchhike a little bit on Mr. Reyes' question. Do you have any concerns that the expertise that you have experienced in the military facilities will not be there with the VA? I mean, do you have a concern with that regard? Do you expect the same sort of expertise that you have experienced?

MAJ. DUCKWORTH. In the initial stages, sir, I do.

MR. BILIRAKIS. You do.

MAJ. DUCKWORTH. Just because of the volume of patients that come through initially. For example, there has been approximately over 250 amputees in this latest conflict and they had generally been divided between, I believe, Brook Army Medical Center and Walter Reed.

If you separate or distribute those amputees over all of the VA hospitals, you now have a population of two or three perhaps in each hospital across the 50 United States. So I would think that the expertise that are being gained by the physical therapists, for example my personal physical therapist she's seen 15 other blast injury and amputees prior to this.

MR. BILIRAKIS. Yes.

MAJ. DUCKWORTH. But if she was working at a VA hospital, in the initial months I think that it is a significant factor. But again --

MR. BILIRAKIS. It would be something new to her, to that physical therapists.

MAJ. DUCKWORTH. Yes, sir, and she would see -- not be able to pick up on some of the problems that I am having, because she would not have seen it and someone else, having seen just maybe two or three in her local VA hospital.

However, I think that once I graduated from the military treatment system and had moved on to the next stage in my life, moved on to the VA system, then I don't think it's an issue once you make

that transition. I just believe that in the beginning, this is my first six-month right now, I think that it's vital for me to be with other soldiers, and be with a large enough population, that the people providing the medical care have seen that many people going through and understand the injuries.

MR. BILIRAKIS. In the follow-ups, Ms. Faas and Ms. Petty, in the follow-ups that you have, and I understand that you have got that in effect at Walter Reed, I hope that's all over the system maybe we could find out about that as we go on. Have you run into this problem that we're talking about? In other words, that the resources in the VA may not be as adequate, mainly because of lack of experience, if you will, with you know certain conditions, et cetera?

MS. FAAS. Anytime in my experience of transferring any patients, you know, I do pass along those medical records to the facilities so that they are aware of what injuries the patient has. To my experience, I haven't had any VA staff say they could not manage the care.

As Maj. Duckworth mentioned with some of the amputees, the bulk of their care is at the MTF and then once they've recovered, then they're going on to the VA hospitals.

MR. BILIRAKIS. But no problems as far back you know?

MS. FAAS. From my experience they have all been very receptive.

MR. BILIRAKIS. Mm-hmm. Brenda, anything you want to add to that? I mean, Lynda. Lynda, did you want to add anything to that?

MS. PETTY. No.

MR. BILIRAKIS. Okay. All right, Mr. Bradley to inquire.

MR. BRADLEY. Thank you very much, Mr. Chairman. I apologize for not being here for the earlier part of your testimony, but I have two questions for Ms. Faas. To what extent do you facilitate the sharing of medical information between Walter Reed Army Medical Center and the VA Health Care Facilities where injured service personnel are being transferred?

MS. FAAS. I received medical records specific to the treatment that is being requested. In the referral packet, we have referral form and when I get the information from the MTF staff, particularly usually the social worker, I received the medical records at that time, and then I transfer them to the VA.

MR. BRADLEY. Secondly, in your written testimony you stated that the DOD participated at times on the VA's Seamless Transition Task Force. Could you please explain that in what you mean by ``at times" in what could be done to perhaps better facilitate that?

MS. FAAS. I'm sorry.

MR. BRADLEY. I'm sorry, that was a question for the GAO representative.

MS. FAAS. Okay.

MR. BRADLEY. I'm sorry.

MS. BASCETTA. I can respond to that. In our January report on

vocational rehabilitation we characterized DOD's participation as ad hoc. In other words, the Seamless Transition Task Force was a unilateral initiative of a VA, and it was actually formed in response to some negative media about certain veterans who were, in fact, falling through the cracks.

DOD had some participation in the task force but they weren't formal members. Of course, we are aware that there are other avenues for DOD and VA to talk about the seamless transition at the executive level through the Joint Executive Committee, the Health Executive Committee and the Benefits Executive Committee.

MR. BRADLEY. Thank you. That's all I have.

MR. BILIRAKIS. Before I yield to Mr. Sistek to ask Mr. Strickland's questions, I would advise Ms. Duckworth, Maj. Duckworth, that as I understand it, VA I guess also has the same concerns that you have. I failed to mention to you that as I understand that there are four -- VA has designated four, what they call Polytrauma Centers, and I know that Haley in Tampa is one of them, in my area.

So we're probably, hopefully we're talking about the 250 not going, not being spread that thin, in other words, probably four centers and hopefully they will be able to handle things.

MAJ. DUCKWORTH. Okay.

MR. BILIRAKIS. Just to make you feel a little better. It certainly makes me feel a little better. Mr. Sistek, please proceed.

MR. SISTEK. Thank you very much, Mr. Chairman. I would like to follow up on your very first question with GAO concerning HIPAA. Ms. Bascetta, you stated there is no systemwide sharing of information, but that information is shared due to the efforts of the regional offices in coordinating with the MTF's, to gather data specific for that MTF, to allow for an information exchange.

So we have an information exchange working locally, and seemingly producing some pretty good results. But there is nothing working systemwide. Does HIPAA distinguish between local informal agreements and the systemwide agreement, and can the informal agreements already in place serve as a precedent to perhaps help DOD find its way through the HIPAA maze?

MS. BASCETTA. Well, I think that's a good point. I don't have the specifics on the local arrangements that have been worked out with regard to HIPAA. But for example, some of them may have authorizations from servicemembers to release information. Others may be less formal than that. I point out that we've found the need for the systematic data sharing because the local arrangements were not always very successful. It did impede the ability of VA to provide early intervention, and to be able to follow up with servicemembers as they left the MTF's or the VA hospitals and went back to their homes.

But I think you pointed out, looking at some of those arrangements to see whether they could serve as models or as precedents is a good

one.

MR. SISTEK. Your testimony on page three mentions the Joint Executive Committee and the Joint Executive Committee has produced a Joint Strategic Plan in 2004. There is a series of initiatives under that Joint Strategic Plan that have milestones that have already passed, some of which includes the sharing of best practices between the DOD and VA; performance measures for communications plan; defining GME and training needs; developing operational procedures. Do you know if these particular milestones have been met?

MS. BASCETTA. No, I don't. We haven't been tracking this in a way that I am able to report on that today. We do have work that was mandated in the National Defense Authorization Act last year, for us to look at sharing that goes on between VA and DOD, not the data sharing agreement that we're talking about today, but the broader resource sharing. So we are following up and reviewing the communication at the executive levels.

MR. SISTEK. Thank you very much. I believe information sharing is a major part of the Joint Strategic Plan. Mr. Chairman, thank you very much.

MR. BILIRAKIS. Thank you, Mr. Sistek. Well, Major and ladies, thank you so very much. You have been awfully helpful.

We have a series of questions, which, you know, we felt just wouldn't be enough time to ask them orally. So we will be furnishing them to you as per the usual, and we would hope that you would respond in a timely fashion.

Again basically, you're dedicated folks. Otherwise, you wouldn't be doing what you're doing. So help us sort of help you do your job better, where you feel a lot better about your job, that the right things are being done.

So feel free to recommend to us, answer our questions. If you feel that there is any kind of a problem internally that prevents you from making a recommendation that you would like to make, we obviously would like to know about that. Not that I think anything like that would happen.

Thanks so very much.

MS. BASCETTA. Thank you.

MS. PETTY. Thank you.

MS. FAAS. Thank you.

MAJ. DUCKWORTH. Thank you.

MR. BILIRAKIS. Okay. We would ask the second panel to come forward. Col. Gwendolyn Fryer, United States Army's Southern Regional Medical Command Military Liaison to the James E. Haley Veterans' Affairs Medical Center in Tampa, Florida. I have already welcomed her to Tampa.

Col. Timothy Frank, United States Marine Corps' Liaison Officer to the Secretary of Veteran Affairs. Col. Frank, thanks for being here

and thanks for taking on that chore. We probably won't be spending a lot of time with you.

Mr. John Brown is the Director of the Office of Seamless Transition, Direct Department of Veteran Affairs. Certainly, sir, we will be spending a lot of time with you.

Ms. Linda Boone is the Executive Director of the National Correlation for Homeless Veterans.

Okay, again, your written statement as part of the record. We would turn the clock on for five minutes and we would hope that you would sort of complement or supplement your statement, your written statement. Then, I will call on you, Col. Fryer, to start us off.

STATEMENTS OF COL. GWENDOLYN FRYER, SOUTHERN REGIONAL MEDICAL COMMAND MILITARY LIAISON TO JAMES E. HALEY VETERANS' AFFAIRS MEDICAL CENTER, UNITED STATES ARMY; COL. TIMOTHY FRANK, LIAISON OFFICER TO THE SECRETARY OF VETERANS' AFFAIRS, UNITED STATES MARINE CORPS; JOHN BROWN, DIRECTOR, OFFICE OF SEAMLESS TRANSITION, DEPARTMENT OF VETERANS' AFFAIRS; AND LINDA BOONE, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS

STATEMENT OF COL. GWENDOLYN FRYER

COL. FRYER. Good morning, Mr. Chairman, Congressman Bradley, distinguished Committee members.

I am Col. Gwendolyn Fryer and I to as the others am very honored to appear before you today to discuss the new and evolving role of the Army Polytrauma Liaison. This role was established in March 2005 through the collaboration, partnership and collective wisdom of Lieutenant General Kevin Kiley, The Surgeon General of the Army; Dr. Jonathan D. Perlin, Under Secretary of Health for the VA; and the VA Office of Seamless Transition.

Today, I represent one of four Army Polytrauma Liaisons. We are strategically assigned to one of the four Department of Veterans' Affairs Polytrauma Centers. I am assigned, of course, to the James E. Haley Veterans Hospital in Tampa, Florida, and my counterparts are assigned at either the Richmond Virginia, Minneapolis, Minnesota, or Palo Alto, California Centers.

Although assigned to separate and distinct locations the four of us agree that this role is extremely valuable as it directly and positively impacts the successful seamless transition of our injured servicemembers and their families.

In the initial establishment of this role the partnership and collaboration efforts between the Department of Defense, represented by

the staff of the Office of the Surgeon General and the Department of Veterans' Affairs, represented by the staff of the VA Office Seamless Transition were very obvious to the four of us. These two organizations spoke with one voice as they provided the necessary training to the four liaisons, and ensured that we understood that we were to:

(1) manage and care for all active duty inpatient servicemembers regardless of branch of service or components, but those specifically assigned to the traumatic brain injury or spinal cord injury units of our specific facilities.

(2) to care for the whole family, not just the servicemembers.

In addition, OTSG and the Office of Seamless Transition ensured the development of a framework for success as I have termed it. This framework involves the designation and utilization of VA employees to serve as an internal VA mentor and external program manager, through which the Polytrauma Liaisons could themselves have a smooth transition into the VA system and between the DOD/VA leaderships.

Since arrival at the Tampa VA, I have been able to further develop and expand my role of Polytrauma Liaison Officer in the same atmosphere of collaboration in partnership with the VA leadership and subordinate staff, the servicemembers and their families, the interdisciplinary clinical staff, volunteer service organizations, regional and local agencies, and of course, the line leadership of the servicemembers' parent unit.

Each of these groups represent sources through which key administrative, clinical or care management issues of the servicemember or family member can be resolved; and likewise, they represent the multifaceted functions I am involved in on a daily, weekly or monthly basis as this role continues to evolve, develop and mature.

Over the past five weeks, I have been embraced as a key member of the Tampa VA's Leadership and Health Care Teams,allowing me to work closely with OEF, OIF Transition Teams and Committees, attend Haley House (equivalent to the Fisher House) committee meetings, gain access to patient database systems, attend selected nursing meetings; assist in facilitating Purple Heart award ceremonies and retirement ceremonies; and of course, facilitate resolutions for the military issues that impact the quality of life of the servicemember and family such as pay, travel, transportation, distribution of household goods, legal assistance and board actions.

Clearly, this role has made difference. As a green-suitor in the facility, I am the boots on the ground, real-time, real-life helper and voice for the servicemembers and their families. I am their advocate and serve to remind others involved in their care, that the servicemembers volunteered to serve their nation, but this transition is unplanned and represents a psychological transition, which is over and above the physical trauma.

In thirty years as a registered professional nurse, 24 years on active duty, this role has clearly been the most rewarding and fulfilling role of my career. It is my honor to serve those servicemembers and their families. So Mr. Chairman, this concludes my statement and I am happy to respond to any questions you or other Committee members may have.

[The statement of Col. Fryer appears on p. 68]

MR. BILIRAKIS. Thank you very much, Col. Fryer. Col. Frank.

STATEMENT OF COL. TIMOTHY E. FRANK

COL. FRANK. Thank you, Mr. Chairman.

MR. BILIRAKIS. You'll have to pull that closer, I guess.

COL. FRANK. Can you hear me now, Mr. Chairman.

MR. BILIRAKIS. Yes.

COL. FRANK. Thank you, Mr. Chairman, Congressman Bradley, and distinguished members of the Subcommittee. I appreciate this opportunity to present to you today my perspective on how we can best support or wounded warriors and their families as they transition from military hospitals to VA Medical Centers, and for many ultimately from active duty to a veteran status.

As I reflected on the issue of seamless transition, I drew from my 23 years of experience in both the active and reserve component, and my assignment as the Officer In-charge of Marine Casualty Services at the National Naval Medical Center, where our Marines and sailors are provided their acute casualty care.

The Marine Corps remains highly focused on caring for our injured Marines and sailors, and ensuring that their family members are provided for and comforted in the wake of their injury. Supporting injured Marines and their families is a complex task as their specific needs vary from case to case. We do our best to tailor our support to fit their individual needs and those of their families, showing flexibility whenever and wherever possible.

The Marine Corps continuously evaluates its processes and makes adjustments where necessary to ensure that the appropriate level of support is provided. While we have encountered problems, we are actively collecting lessons learned and incorporating needed changes.

I would like to make five key points. First, thanks to significantly advanced medical capabilities the survival rate for our seriously wounded Marines and sailors has seen a dramatic increase. They are, however, returning with severe debilitating injuries much more so than in past conflicts. The complexity of these injuries coupled with the individualized nature of recovery has required a more comprehensive, multidisciplinary program of casualty care. As we support and care for these Marines and their families, we've learned from

experience that we must remain flexible and be ready to adapt to an ever-changing situation. Secondly, Military Treatment Facilities are not resourced to provide the specialized care for our servicemembers who sustained spinal cord injuries, dramatic brain injuries, and loss of sight. The VA is known for its integrated system of health care for these conditions. Therefore, we rely on them to provide continued care and rehabilitation for our wounded Marines and sailors who have progressed from the acute care stage.

The magnitude of these injuries and the lengthy rehabilitation and recovery periods involved have not only taxed the Military Treatment Facility, but the VA Health Care System as well. Both military medicine and the VA will have to continue implementing new programs and initiatives as they strive to broaden coordination of care and family support.

My third point is that quality casualty care requires extensive planning and coordination, which begins upon arrival at the MTF, through transition to the VA Medical Center, and continues even after discharge. Over the course of time, a positive and very cooperative relationship has been forged between the Military Treatment Facility, the Marine Corps, and the VA, with significant progress made towards achieving a seamless continuum of care. We are all working together and remain committed to keeping the treatment, recovering and transition of our injured servicemembers as our highest priority.

My fourth point is that the Marine Corps realizes that the injuries our Marines and sailors receive would have a significant impact on them for the rest of their lives, and that they and their families will need support and assistance long after they left the Military Treatment Facility.

The Marine for Life Injured Support Program provides continuity of support for our wounded as they continue with their recovery, make their transition to the Department of Veterans' Affairs and reconnect to their communities. Together with DOD's Military Severely Injured Joint Support Operations Center, Marine for Life Injured Support will bridge any gaps and provide around-the-clock advocacy and assistance.

And finally, the recovery and successful transition of our wounded is not the responsibility of any single organization. It is a partnership between the Department of Defense and the Department of Veterans' Affairs. The assignment of two Marines at the VA Central Office was a collaborative decision between the Commandant of the Marine Corps and the Secretary of Veterans Affairs, and the Director of the Office of Seamless Transition.

As one of those officers, I bring experience in casualty care and support, in addition to a background in both personal and family readiness, and hope to be a valuable asset to the dynamic, dedicated

and professional seamless transition team under the direction of Mr. John Brown.

In conclusion, I consider it a precious, a very precious privilege to serve the many brave Marines and sailors who have given so much in the service of our great nation. I look forward to continuing this support from within the VA's Office of Seamless Transition.

Mr. Chairman, I look forward to answering any questions you or the other Committee members might have.

[The statement of Col. Frank appears on p. 77]

MR. BILIRAKIS. Thank you so very much, Col. Frank.

Mr. Brown, please proceed, sir. You have a big job.

STATEMENT OF JOHN BROWN

MR. BROWN. Mr. Chairman and the members of the Subcommittee, I appreciate the opportunity to appear before you to discuss the VA's efforts towards affecting a seamless transition for separating servicemembers from the DOD to the VA.

I retired from the U.S. Army in 2002 after 26 years of service. I am proud and honored to serve as the Director of the Seamless Transition Office. Mr. Chairman, the VA has no higher calling, no more important mission then to provide the best health care and benefits to our nation's combat veterans. We will honor these heroes and their families by providing them with the compassion and the dignity that they have earned.

In August of 2003, VA created the Task Force for the Seamless Transition of Returning Servicemembers. This task force focused on the internal coordination efforts to ensure that VA approached the seamless transition mission in a comprehensive manner. In January of this year, VA established a permanent Seamless Transition Office to assume the duties of the Task Force. The Seamless Transition Office report to Deputy Under Secretary for Health. It is composed of representatives from across the entire department. It is a 1-VA endeavor.

The Seamless Transition Task Force and the Seamless Transition Office have achieved many successes. These include outreach and communications, trimming workload, data collection and staff education. The VA has put into place a number of strategies, policies and programs to provide timely services to these returning servicemembers and veterans. And throughout the process, we have greatly improved dialogue and collaboration between VA and DOD.

Today, the VA is reaching out to all new combat veterans in unprecedented ways. Since fiscal year 2002, we have spoken to more than 700,000 active-duty and National Guard reserve members in discharge planning and orientation sessions.

Secretary Principi and Secretary Nicholson have sent more than 290,000 thank you letters with information brochures to OEF/OIF veteran identified by DOD as having left active duty. We have prepared to videos, wallet cards, and web sites to ensure that they are all aware of their eligibility for VA health care.

Each VA Health Center has identified a point of contact to coordinate activities locally, and to ensure that no person is left during or lost during transition. VA has also assigned full-time social workers and benefit counselors to seven Military Treatment Facilities to facilitate immediate, comprehensive and compassionate care, and family support. VA social workers have coordinated more 2000 transfers of OEF/OIF servicemembers and veterans to VA Medical Facilities and BDA benefit counselors have interviewed almost 5000 OEF servicemembers hospitalized at Medical Treatment Facilities.

To ensure that our commitment is understood and shared at every level of the Department, we have developed training materials and other tools for our frontline staff to assist them in identifying combat veterans so that they take the steps necessary to provide all veterans approach access to VA services and benefits.

Although the Seamless Transition Initiative was created to support servicemembers who served in OEF/OIF, it is intended to become an enduring process. Therefore, VA is working with DOD to obtain a list of servicemembers who enter the Physical Evaluation Board process. The list will enable VA to contact the servicemembers and initiate benefit applications and transfer of health care to VA prior to discharge from the military. VA is strengthening its support for the veterans and their families to accommodate them in Fisher houses and hotels as the veterans continue the rehabilitation process.

Finally, the Seamless Transition Office will guide the VA's activities in meeting the expectations of our newest veterans and their families.

Mr. Chairman, this concludes my statement. I will be happy to respond to any questions that you or other members of the Committee might have. Thank you.

[The statement of Mr. Brown appears on p. 87]

MR. BILIRAKIS. Thank you very much, Mr. Brown.

Ms. Boone.

STATEMENT OF LINDA BOONE

MS. BOONE. Thank you. The VA estimates approximately 250,000 veterans are homeless on any given night. More than 500,000 experience homelessness over the course of a year. Male veterans are twice as likely to become homeless as their non-veteran counterparts, and female veterans are four times as likely to become homeless as their

non-veteran counterparts. Like their non-veteran counterparts, veterans are at high risk of homelessness due to extremely low or no income, dismal living conditions and a lack of access to health care.

In addition to these shared factors, a large number of at risk veterans live with post-traumatic stress disorders and addictions acquired during or aggravated by their military service. In addition, their families and social networks are fractured due to lengthy periods away from their communities. These problems are directly traceable to their experience in the military service or to their return to civilian life without appropriate transitional supports.

Take Sgt. Vanessa Turner. She was deployed to Iraq and while serving in combat theater, she collapsed and fell into a coma and nearly died of heart failure. She was evacuated to Europe and then to Walter Reed and release with a pending medical discharge. That is the good part of Ms. Turner's story. Ms. Turner was released from Walter Reed with neither a place to live nor ongoing health care in place. Without a home she and her daughter bounced from place to place. When she went to the VA Medical Center she was told that she would have to wait three months to see a doctor.

When she asked the Army to ship her possessions from her unit based in Germany, where she had lived, they told her that she had to fly back at her own expense to get them for herself. When she sought help to secure a veteran's loan for a house in Boston, she was told that the only real option was to move to another part of the state. Ms. Turner's situation was partially resolved only by the persistent intervention of a member of Congress.

Regrettably, there are dozens of more Vanessa Turners returning from Iraq and Afghanistan without a place to call home.

Though community-based Homeless Veterans Service Providers that National Coalition for Homeless Veterans represents, are reporting servicemembers from OEF and OIF among their service users. Some of these newly homeless veterans are seriously injured. Others are fighting PTSD and other emotional and addictive impairments. Still others simply have been unable to find work. Regardless of the cause is a country as wealthy as the United States with the best military personnel and veterans support systems in the world, it is simply outrageous that any servicemember or former servicemember becomes homeless.

NCHV is generally supportive of the various Federal government wide joint service-specific initiatives underway to assist severely injured servicemembers and transitioning to civilian life. We are interested in knowing, however, what these various initiatives are doing to support seriously injured servicemembers and their families facing a housing crisis.

What housing counseling assistance does each initiative presently provide? How are seriously injured servicemembers and eminent

risk of homelessness assisted in securing permanent housing in the communities from which they will be returning? Have any of the services succeeded in involving the Department of Housing and Urban Development in their efforts?

What connections are these initiatives making with local public housing authorities or nonprofit housing providers? Is housing even on the radar of these various initiatives? As this Committee is well aware of information of resource sharing between DOD and VA, while improving in recent years, remains a challenge for the two Departments resulting in redundancy, inefficiency, higher costs and ultimately less than excellent health care for both our nation's servicemembers and veterans.

In 2001, President Bush established the President's Task Force to Improve Health Care for Our Nation's Veterans and charged it to identify ways to improve health care delivery to DOD and VA beneficiaries. The Task Force released its report in 2003. Regrettably, DOD and VA have made slow progress on several of the Task Force's recommendations, including some that are directly applicable to the seamless health care transition.

The servicemembers separating from the Armed Services have available to them to transition services programs. Pre-separation Counseling and the Transition Assistance Program. Former servicemembers with whom homeless veterans service providers are in daily contact report that pre-separation counseling and transition assistance programs are lacking any number of areas.

Among their concerns is the depth and the content of pre-separation counseling is quite variable cross the delivery sites. Pre-separation counseling may be limited to brief group level presentations rather than individualized transition planning. Servicemember participation in the Transition Assistance Program is at the will of the unit commander and often allowed only during off-duty time. Neither program includes content on homelessness awareness or housing counseling assistance and referral.

Weaknesses in both the content and delivery of the servicemember separation program results in many servicemembers failing to receive information necessary to ensure their stable health care and steady employment, and secure housing upon their return to civilian life. This places servicemembers at risk of homelessness.

In response to these concerns, Representative Andrews has introduced H.R. 2074, The Servicemembers Enhanced Transition Services Act, to improve transition assistance. We urge this Committee members to cosponsor H.R. 2074 and ensure its enactment this session. Thank you.

[The statement of Ms. Boone appears on p. 100]

MR. BILIRAKIS. Thank you, Ms. Boone. The chair yields time to himself. Col. Frank, Mr. Brown, Col. Fryer, if you wish, a response to Ms. Boone. She asked an awful lot of questions she wanted answers to and I don't blame her. So responses.

MR. BROWN. Certainly.

MR. BILIRAKIS. Maybe I'm catching you by surprise here.

MR. BROWN. Yes, sir, the testimony did, too.

MR. BILIRAKIS. Yes.

MR. BROWN. But this is a very serious area that I think America has to look at. I was unaware of all of the questions and concerns that are in your testimony. I know we do have a homeless problem in America today.

I would like to review your testimony, ma'am, and look at all of the questions that you have asked. Then reply for the record, sir.

MR. BILIRAKIS. Yes. In the process of your function as Director of Seamless Transition for the VA, homelessness is a part of that? I mean, you know the concern for homelessness? In other words, the follow-through thing that Colonel Frank explained so very well, and that I saw at Walter Reed which includes homelessness, not just health care and some of the other things.

MR. BROWN. The entire process includes homelessness.

MR. BILIRAKIS. Mm-hmm.

MR. BROWN. But what I have been charged to do within the first four months of my tenure is to build his office, to put people in them, and my first object was to not let anyone fall through the crack.

MR. BILIRAKIS. Yes, you've been there for four months?

MR. BROWN. Yes, sir.

MR. BILIRAKIS. Oh, boy.

MR. BROWN. In the position.

MR. BILIRAKIS. Yes.

MR. BROWN. From 3 January.

MR. BILIRAKIS. Well, I said you have a tough job, but it's even tougher if you've only been there for four months.

MR. BROWN. Yes, sir. So the primary objective was to make sure that as I transitioned from the Task Force Initiatives, I use resources from the Task Force as I built the office.

MR. BILIRAKIS. Yes.

MR. BROWN. And as I began -

MR. BILIRAKIS. Well, I'm glad that you're able to hear this testimony.

MR. BROWN. Yes, sir.

MR. BILIRAKIS. So I guess that will be a factor in your building.

MR. BROWN. I would like to look at your concerns, ma'am in detail.

MR. BILIRAKIS. Okay. I know that Colonel Frank was looking at you with great earnestness in your comments. Go ahead ma'am.

COL. FRANK. I would just like to comment on the Transition As-

sistance Program. I know that in the Marine Corps that's a mandatory program, and there is pre-separation counseling, and there is a transition assistance workshop, both of which are required for any servicemember who completes 180 days of continuous active duty.

It was at one time a requirement for reserves who were mobilized. However, that is now optional. Pre-separation counseling is still a requirement, and certainly a leadership responsibility to make sure that that happens. For our mobilized Marines Transitional Assistance Workshop is to be made available to them should they want to take it.

I used to do some personal and family readiness programs, and I think the Marine Corps -- I can speak for the Marine Corps only, has a very strong Transition Assistance Program. She was correct in some -- it is group. It's a group session. However, there is a transition assistance program manager with a staff who at any time a Marine or anybody, a sailor attached to the Marine unit, seeks out specific transition assistance guidance and perhaps help with direction on developing a personal plan for their transition, there is someone there to help them.

A lot of our Marines, unfortunately, think that the transition is going to be easier than it turned out to be. I don't think that they look ahead. But the resources and the support mechanism is in place for them to address those issues.

The Marine Corps also has the Marine for Life program, which the Marine for Life Injured Support program has kind of piggybacked off of, and that is a transition program. General Jones Institute of that program specifically to give our Marines a better transition, and to ensure that those Marines who honorably wore the eagle, globe and anchor were able to meld back into their communities with jobs, with a reconnect to their community resources. It covers almost, you know topic or subjects that you can imagine.

So I feel like Marines Corps-wise, anyway, that we have good transition assistance programs in place. Maybe a lot of it is -- there's more there than maybe the Marines are aware of, and again, that is something we can work to rectify.

MR. BILIRAKIS. Yes, what a great slogan, Marine for Life. I know that every Marine considers themselves a Marine regardless, and I found that to be true at the veterans post and what not.

COL. FRANK. Right.

MR. BILIRAKIS. But I believe that the Corps seriously takes that it is dedicated to the slogan. It's not just a slogan, it's something they live.

COL. FRANK. Absolutely. It becomes ingrained into your heart from the moment you put on that eagle, globe and anchor.

MR. BILIRAKIS. Col. Fryer, do you want to add anything?

COL. FRYER. Sir, I'm simply going to add that I did what Col. Frank

has said. In fact, programs like that are set up for our servicemembers in the Army.

MR. BILIRAKIS. Yes.

COL. FRYER. However, because the area of discussion is not in the area of my expertise, I will take it for the record.

MR. BILIRAKIS. Sure. I know that you've just recently arrived in Tampa and what not. There is a homeless problem down there. I mean, I'm aware of that.

Mr. Brown, do you care to comment? You know, my emphasis of course, is the seamless transition. But a major part of that, of course is this one physical, the one joint physical, if you will, that both DOD and VA agreed to. Four out of approximately 140 military installations, for those have BDD in effect apparently, or something to that effect. Would you care to comment.

MR. BROWN. Yes, sir.

MR. BILIRAKIS. You know, we're not here to throw, again stones at DOD as I said earlier. They have a tough job, particularly these days. There's no question about that. But your job, you seem to be dedicated to it, but you need cooperation. Are you getting adequate cooperation? Comment please.

MR. BROWN. Yes, sir. I am not the expert on benefits delivery at discharge. But I do believe it is a good program. We do have 140 sites that are able to process our physicals. We have 50 MOUs, 53 MOUs to date that have been signed between VA and DOD. We have another 80 MOUs that are in the process of being signed. They should be signed in the near future.

MR. BILIRAKIS. What does that mean, MOUs?

MR. BROWN. MOUs is between VA and DOD facilities on who's going to actually perform --

MR. BILIRAKIS. The physicals and what not?

MR. BROWN. -- the physicals at the facilities.

MR. BILIRAKIS. I see. You have those signed, but they're not in effect yet? In the real world, this is taking place in more than four facilities? Out of 140, GAO targeted 20, looked at eight of them, and discovered that four out of the eight did not even know what BDD stood for.

MR. BROWN. Yes, sir. As I said, Sir, at my opening comments I am not the resident expert on this.

MR. BILIRAKIS. Yes.

MR. BROWN. But generically I know exactly what has been done overall.

MR. BILIRAKIS. Yes, but see, you know that's very important of the seamless transition, is it not?

MR. BROWN. Yes, sir.

MR. BILIRAKIS. As far as getting or applying for their benefits and all of that stuff.

MR. BROWN. It supports the seamless transition process.

MR. BILIRAKIS. Yes. Well, all right, we need your help in terms of getting these things done. We'll be talking to the Armed Services Committee. I guess that is what we still call them? Isn't it still Armed Services? Yes, we will be talking to the Armed Services Committee about this, and maybe meet with them and possibly have a joint hearing. I don't know, but I have mentioned that to them before. I will yield to Mr. Sistek.

MR. SISTEK. Thank you again, Mr. Chairman. One very quick question for Ms. Boone.

Focusing on recently separated or discharged servicemembers, why do they become homeless? What are the root causes? You've had experience with your organization since, basically 1990, what emerges as ``root cause" of them becoming homeless recently after separating?

MS. BOONE. For this current war's veterans we think it's sort of (1) is that they don't have information when they are leaving. Their separation process is flawed. The pre-separation counseling process is flawed. The TAP programs are flawed and in fact, they're not really being done. Consistently across the board, TAP programs are not mandatory if several the Marines Corps. The pre-separation counseling people can opt out of it. The checkoff list that DOD uses lets people opt out of it, which was not the intent of the law.

The other thing, the veterans that we have interacted with, our servicemen are community-based providers are working with, the majority of them are looking for employment, and that ends up being you know a very basic necessity in order to have housing, and to have all of the other things is you need income. It's about economics and they need jobs. They are coming to them because they don't have those transferable skills.

Many of them also have issues around health, post-traumatic stress disorder, and we're starting to see substance abuse also as an issue.

MR. SISTEK. Thank you, Ms. Boone. No further questions.

MR. BILIRAKIS. All right, ladies and gentlemen, thank you so much. There's so much more here. We have an awful lot of questions and were going to submit them to you in writing.

But I would ask you, you know, Col. Frank, for instance, in your written testimony you have talked about encountering problems in addressing the needs the Marines have in an effort to achieve seamless transition and whatnot. So we're talking about experience that you are having with your Marines. We need that information from you.

I understand that you're collecting data and collecting lessons learned from them, and that sort of thing. This could be very helpful to us. Hopefully, of course, you are working with Mr. Brown as far as those areas are concerned. But that's really what we need.

You know, there are problems out there and no matter what we do. I mean, bigness usually connotates lack of perfection, so nothing is going to be perfect. But we ought to be a little better, doing a lot better than we are doing. The BDD concept of the one physical that's agreed upon between the two, so that a person in the military who's about to be discharged, it's basically all of the paperwork -- the physical and all of the paperwork has all been taking care of before almost they are even discharged to start their benefits thing rolling. The big back log that we now have would be cut down drastically and whatnot. It makes sense to concentrate on areas like that, and that's why we raise these points.

I know that bureaucracy and everything of that nature, heck, I've had 23 years of it. It's horrible. But, I guess what I am saying is that we can do better, and we should do better and you can help us.

MR. BROWN. Yes, sir.

MR. BILIRAKIS. So please respond to the questions we submit to you. But also don't hesitate to make any recommendations to us. Share with us some of things that you are running into and whatnot, so we can do a better job. If there isn't anything further, will excuse you and declare this hearing over, and hope that we can see better things resulting from it. Thank you very much.

COL. FRYER. Thank you, Mr. Chairman.

COL. FRANK. Thank you, Mr. Chairman.

MR. BROWN. Thank you, Mr. Chairman.

MS. BOONE. Thank you, Mr. Chairman.

[Whereupon at 11:35 a.m., the Subcommittee was adjourned.]

APPENDIX

Opening Statement of Congressman Sylvestre Reyes
Hearing on the Seamless Transition – May 19, 2005

Mr. Chairman

This issue of military servicemen and service women transitioning to civilian life is not a new issue. America has a duty to assure that this transition is as smooth as possible and to do our best to make the soldier, sailor, airman or marine who was injured or harmed while serving their country, whole again.

With war - comes causalities. Our ongoing combat activities in Iraq and Afghanistan provide us with numbers of wounded and disabled GIs. This reality is not different from any other war in our long history. America's duty to care for the disabled and injured service person transitioning to civilian life has not changed.

We proudly – justifiably proudly – proclaim our health care system as one of the best in the world. Its capacity to cure the sick and restore the injured has very few rivals on this planet.

But Mr. Chairman, we do not always assure that those in need who have served in uniform benefit from that excellent system of health care. The dots do not always connect. Until the dots all connect, we must remain vigilant.

How well are we doing now?

In a "Good – Better – Best" comparison we are doing "Better." VA and DoD coordination on this effort is generally good for the average transitioning service member. For the very severely injured, the system is excellent. We should strive to make the former outstanding and the latter just about perfect. We can achieve those goals with sound documentation and coordination between DoD and VA. Each agency needs to accommodate the other in an environment free from barriers.

The most seriously injured seem to be successfully engaging the seamless transition with few exceptions. Much attention is focused in this area. We see a higher percentage of amputation injuries than were seen in previous conflicts because of the Kevlar® protective vests. Where once a combat injury could cause death – it now may result in the loss of a limb. The rate of amputation is higher because lives were saved because of the protective vests. In the cold equations of war, this is a tangible improvement.

Prosthetics are essential for the treatment of the returning ampu-

tee. The DoD and VA are taking advantage of technological advances in prosthetics to treat these individuals, usually with results superior to the treatments available a generation ago.

When we consider the needs of the seriously injured in the seamless transition, we must be aware of the role of the family in the recovery and rehabilitation of the injured. Congress must assure that financial limitations or great distances do not deter the reunion of America's heroes with their families.

Amputations are just one consequence. We must also provide state of the art care for other injuries such as traumatic brain injury and the loss of eyesight. We must assure that all injured are cared for, this includes those with visible injury, and those without visible injury.

Those without visible injuries also need attention – this includes those with mental and emotional problems such as PTSD. These individuals must be identified, engage a seamless transition, and receive treatment from a caring and adequately funded VA. It is the latter – funding – issue that has been much debated in this hearing room over the years.

We must also maintain vigil for emerging problems. Our military participants in previous wars have sometimes discovered service related problems years after their service; the portfolio of Agent Orange-related disabilities is instructive here. We must assure that even when the transition to civilian life seems complete, that elements of that transition require monitoring and sometimes action to mitigate emerging service related problems.

Seamless transition is a broad umbrella that must consider the welfare of transitioning service members beyond the issue of health care. Cooperation between DoD and VA can help here too. Some individuals may fail to join society in the traditional sense – these people may end up homeless and indigent. The failure to assist these individuals at an early stage of the transition may result in greater problems years later. We should learn from our past experiences and help these individuals complete the transition successfully and early. If we don't, the costs in both human and monetary terms will be much, much higher.

The seamless transition must work across the entire spectrum.

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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DOD AND VA

Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-05-722T

May 19, 2005

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-05-722T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

DOD AND VA

Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services

Why GAO Did This Study

Since the onset of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), the Department of Defense (DOD) reported that more than 12,000 servicemembers have been injured in combat. While many return to active duty, others with more serious injuries are likely to be discharged from the military. To ensure the continuity of medical care and access to all other Department of Veterans Affairs' (VA) benefits, such as vocational rehabilitation, VA formed its Seamless Transition Task Force.

In January 2005, GAO reported that VA had given high priority to OEF/OIF servicemembers, but faced challenges in identifying, locating, and following up with seriously injured servicemembers. GAO recommended that VA and DOD reach an agreement for VA to obtain systematic data from DOD, and the departments concurred. However, DOD raised privacy concerns.

GAO was asked to review VA's efforts to expedite vocational rehabilitation services to seriously injured servicemembers and to determine the status of an agreement between DOD and VA to share health data. GAO relied on its prior work; interviewed VA and DOD officials; and reviewed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule, which govern the sharing of individually identifiable health data.

www.gao.gov/cgi-bin/getrpt?GAO-05-722T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

What GAO Found

While VA has taken steps to expedite services to seriously injured servicemembers, VA does not have systematic data from DOD on seriously injured servicemembers who may need VA vocational rehabilitation and other benefits. As a result, VA has had to rely on its regional offices to develop informal data sharing arrangements with local military treatment facility (MTF) staff to identify servicemembers who may need vocational rehabilitation services. However, VA staff have no official data source from DOD from which to confirm the completeness and reliability of the data they obtain. Furthermore, they cannot provide reasonable assurance that some seriously injured servicemembers who may have benefited from vocational rehabilitation services have not been overlooked. Although several VA headquarters officials and regional office staff GAO interviewed said that systematic data from DOD would provide them with a way to reliably identify and follow up with seriously injured servicemembers, DOD and VA have not developed a data sharing agreement. Additionally, VA officials said these data would help VA plan for projected increases in the need for services for newly returning OEF/OIF servicemembers. VA has requested that DOD provide systematic data on seriously injured servicemembers who may need vocational rehabilitation.

DOD and VA have been working on a data sharing agreement for over 2 years, but have not reached an agreement. DOD and VA differ in their understanding of HIPAA Privacy Rule provisions that govern the sharing of individually identifiable health data for servicemembers currently receiving treatment at MTFs, and the extent to which the Privacy Rule would permit that exchange. DOD's and VA's inability to resolve these differences has impeded coming to an agreement on exchanging seriously injured servicemembers' individually identifiable health data. Despite being unable to agree on an exchange of individually identifiable health data, DOD and VA are reviewing a draft memorandum of understanding, which the departments believe will move them closer to a data sharing agreement. However, GAO found that the draft memorandum restates many of the legal authorities contained in the Privacy Rule for the use and disclosure of individually identifiable health data. As a result, even if the memorandum of understanding is finalized, DOD and VA will still have to agree on what types of individually identifiable health data can be exchanged and when the data can be shared. DOD and VA generally agreed with GAO's findings.

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to share our perspectives on seriously injured servicemembers who could benefit from services offered by the Department of Veterans Affairs (VA), such as vocational rehabilitation, disability compensation, and health care, as they transition from servicemember to veteran status. Since the onset of Operation Enduring Freedom (OEF) in October 2001 and Operation Iraqi Freedom (OIF) in March 2003, the Department of Defense (DOD) has reported that more than 12,000 servicemembers have been injured in combat. While many return to active duty after they are treated, others who are more seriously injured are likely to be discharged from their military obligations and return to civilian life with disabilities. To ensure the continuity of medical care as a first priority as well as to coordinate efforts to ensure access to all other VA benefits, such as vocational rehabilitation, VA formed its Seamless Transition Task Force in August 2003.

In January 2005, we reported that while VA has given high priority to providing services to OEF/OIF servicemembers, it was challenged in its efforts to identify, locate, and follow up with seriously injured servicemembers.[1] One key problem has been the lack of systematic data from DOD about who is seriously injured, the nature of their injuries, and where the servicemembers received treatment. As DOD and VA have worked toward a seamless transition, DOD raised concerns about privacy issues and the sharing of individually identifiable health data. We recommended that VA and DOD collaborate to reach an agreement for VA to have access to DOD data for seriously injured servicemembers that both departments agree are needed to promote recovery and return to work and both departments concurred.

You asked us to testify on VA's and DOD's efforts to provide a seamless transition for seriously injured OEF/OIF servicemembers. Specifically, we (1) reviewed VA's efforts to expedite vocational rehabilitation services to seriously injured servicemembers and (2) determined the status of an agreement between DOD and VA to share health data. My comments today highlight the findings of our earlier work on VA's vocational rehabilitation

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

services for seriously injured servicemembers returning from OEF/OIF and our ongoing work on DOD's and VA's data sharing agreement.[2]

Our January 2005 report on VA's efforts to expedite vocational rehabilitation services to OEF/OIF servicemembers was based on interviews with officials at VA headquarters and at 12 of VA's 57 regional offices. Five of the 12 regional offices are located near the five major Army military treatment facilities (MTF) treating the majority of seriously injured OEF/OIF servicemembers during our review. We visited Walter Reed Army Medical Center where most seriously injured Army servicemembers are initially treated. To do our work on the status of DOD's and VA's data sharing agreement, we reviewed a draft memorandum of understanding for the sharing of data between DOD and VA, pertinent provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule, which govern the sharing of individually identifiable health data.[3] We also spoke with officials responsible for the implementation of the Privacy Rule at DOD and VA. We discussed the information contained in this statement with DOD and VA officials who agreed with our findings. We did our work from March through May 2005 in accordance with generally accepted government auditing standards.

In summary, while VA has taken steps to expedite services to seriously injured OEF/OIF servicemembers, VA does not have systematic data from DOD on those servicemembers who may need vocational rehabilitation and other benefits from VA. As a result, VA has had to rely on its regional offices to develop informal data sharing arrangements with local MTF staff to identify servicemembers who may need vocational rehabilitation services. However, VA staff have no official data source from DOD from which to confirm the completeness and reliability of the data obtained through these informal, local arrangements. Furthermore, VA staff cannot provide reasonable assurance that some seriously injured servicemembers who may have benefited from early intervention by a vocational rehabilitation counselor have not been overlooked. Unresolved issues between DOD and VA continue to delay the systematic sharing of data. To obtain systematic data from DOD on seriously injured OEF/OIF servicemembers who may need VA services, DOD and VA have been working on an agreement to exchange servicemembers' health data for

[2]See related GAO products listed at the end of this testimony.

[3]Pub. L. No. 104-191, § 264, 110 Stat. 1936, 2033-34; 45 C.F.R. § 164.500, *et seq.* (2004).

over 2 years. DOD and VA differ in their understanding of HIPAA Privacy Rule provisions that govern the sharing of individually identifiable health data for seriously injured servicemembers receiving treatment in MTFs, and the extent to which the Privacy Rule would permit that exchange. DOD's and VA's inability to resolve these differences has impeded coming to an agreement on exchanging seriously injured servicemembers' individually identifiable health data. We continue to believe that an agreement between DOD and VA to share health data would expedite the delivery of VA services to OEF/OIF servicemembers, as well as help ensure a seamless transition.

Background

Servicemembers deployed to Afghanistan and Iraq are surviving injuries that would have been fatal in past conflicts due, in part, to advances in battlefield medicine and protective equipment. However, the severity of their injuries can result in a lengthy transition from injured servicemember to veteran. Initially, most seriously injured servicemembers are brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to major MTFs in the United States. According to DOD officials, once stabilized and discharged from MTFs, servicemembers usually relocate closer to their homes or military bases and are treated as outpatients. At this point, the military generally begins to assess whether the servicemember will be able to remain in the military, a process that could take months to complete.

Faced with the need to provide benefits and services to a new generation of veterans with disabilities, VA formed an internal task force—the Seamless Transition Task Force—in August 2003 to develop and implement policies to improve the transition of injured servicemembers back to civilian life. Although the task force's initial priority was to ensure the continuity of medical care for injured servicemembers as they transitioned from military to VA health care, it also coordinated efforts to ensure access to all other VA benefits, including vocational rehabilitation.

DOD has also supported transition assistance in various ways. For example, the VA/DOD Joint Executive Committee was established in February 2002 to promote collaboration between the two departments, including resolving obstacles to information sharing. The committee is chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. In addition, the Army—in cooperation with VA—established the Disabled Soldier Support System in April 2004 as an advocacy group and information clearinghouse to clarify the services available to disabled soldiers as they transition to

civilian life. In addition, DOD participated at times on VA's Seamless Transition Task Force.

Separation from the military and return to civilian life often entail the exchange of individually identifiable health data between DOD and VA. The exchange of these data must comply with the HIPAA Privacy Rule, which became effective April 14, 2001.[4] The Privacy Rule permits VA and DOD to share servicemembers' health data under certain circumstances.

VA Has Taken Steps to Expedite Vocational Rehabilitation Services, but Lack of Systematic Data from DOD Poses a Challenge

VA has given priority consideration and assistance to seriously injured servicemembers returning from Afghanistan and Iraq. In a September 2003 letter, VA asked its regional offices to coordinate with staff at MTFs in their areas to ascertain the identities, medical conditions, and military status of the seriously injured OEF/OIF servicemembers. VA specifically instructed regional offices to focus on servicemembers whose disabilities were definitely or likely to result in military separation. Minimally, this included servicemembers with injuries that had been classified as "very serious," "serious," or in a "special category."[5] In this letter, VA instructed its regional offices to assign a case manager to each seriously injured servicemember who applied for disability compensation. In addition, VA noted the particular importance of early intervention for those who were seriously injured and emphasized that seriously injured servicemembers applying for vocational rehabilitation should receive the fastest possible service. Moreover, VA reminded vocational rehabilitation staff that they

[4]The Privacy Rule applies to covered entities and specifies how individually identifiable health data may be used and disclosed by covered entities. See 45 C.F.R. §§ 164.500(a), 164.502 (2004). Covered entities are defined in the Privacy Rule as health plans, clearinghouses, and certain health care providers. Both the DOD health care system and the VA health care system are covered entities. See 45 C.F.R. § 160.103 (2004). All covered entities had to comply with the Privacy Rule by April 14, 2003, with the exception of small health plans.

[5]Army regulations classify illnesses and injuries as "very serious" when life is imminently endangered; as "serious" when there is a cause for immediate concern but there is no imminent danger to life; and as "special category" when the patient has a particular condition, such as loss of limb or sight, a psychiatric condition, paralysis, or a permanent disfigurement.

can initiate evaluation and counseling and, in some cases, authorize training before a servicemember was discharged.[6]

Since most seriously injured servicemembers are initially treated at major MTFs, VA has detailed staff to these facilities to identify and educate these servicemembers about VA services.[7] These staff include VA social workers and disability compensation benefits counselors. At Walter Reed Army Medical Center, where the largest number of seriously injured servicemembers has been treated, VA's Washington, D.C. regional office has since 2001 also provided a vocational rehabilitation counselor to work with hospitalized patients, specifically to offer and provide vocational counseling and evaluation. The counselor reported attempting to contact all patients within 48 hours of their arrival and visited them routinely thereafter to establish rapport. Her primary mission is to work with servicemembers who will need to prepare for civilian employment, although she told us that her early intervention efforts could also help servicemembers who are able to remain in the military.

Staff at another regional office noted that they also advocate early intervention. These staff said that they try to contact servicemembers as soon as possible to establish rapport and provide vocational rehabilitation program information even before the servicemembers are physically ready to begin vocational rehabilitation. We previously reported on the importance of early intervention to maximize the work potential of individuals with disabilities. We reported, for example, that rehabilitation offered as close as possible to the onset of disabling impairments has the greatest likelihood of success.[8]

[6]Servicemembers can receive vocational rehabilitation services prior to separation from the military under certain circumstances. For example, hospitalized servicemembers pending discharge may receive all VA vocational rehabilitation benefits—such as counseling, evaluation, and training—except for the monthly subsistence allowance. 38 U.S.C. §§ 3102, 3104, and 3113.

[7]In our January 2005 report, we focused on five MTFs, which treated the majority of seriously injured OEF/OIF servicemembers: Brooke Army Medical Center in Texas; Walter Reed Army Medical Center in Washington, D.C.; Madigan Army Medical Center in Washington; Eisenhower Army Medical Center in Georgia; and Darnall Army Community Hospital in Texas. VA also has placed staff at Evans Army Community Hospital in Colorado and Bethesda Naval Medical Center in Maryland.

[8]GAO, *Vocational Rehabilitation: VA Has Opportunities to Improve Services, but Faces Significant Challenges*, GAO-05-572T (Washington, D.C.: Apr. 20, 2005), and *SSA Disability: Program Redesign Necessary to Encourage Return to Work*, GAO/HEHS-96-62 (Washington, D.C.: Apr. 24, 1996).

Despite efforts by VA's regional offices to identify and obtain medical information on seriously injured OEF/OIF servicemembers, lack of systematic data from DOD poses a challenge. Although VA requested in the spring of 2004 that DOD provide on a systematic basis personal identifying data, medical data, and DOD's injury classification for seriously injured servicemembers, DOD and VA have not developed a data sharing agreement. In the absence of a data sharing agreement with DOD, VA cannot reliably identify all seriously injured servicemembers or know with certainty when they are medically stabilized, when they may be undergoing evaluation for a medical discharge, or when they are discharged from the military. As a result, VA cannot provide reasonable assurance that some seriously injured servicemembers who may benefit from vocational rehabilitation services have not been overlooked.

In our review of 12 VA regional offices, we found that the nature of the local relationship between VA staff and MTF staff was a key factor in the completeness and reliability of the information that the MTF provided on seriously injured servicemembers. For example, at one location, the MTF staff provided VA regional office staff with the names of new patients but no indication of the severity of their conditions or the combat theater from which they were returning. Another regional office reported receiving lists of servicemembers for whom the Army had initiated a medical separation in addition to lists of patients with information on the severity of their injuries. Some regional offices were able to capitalize on long-standing informal relationships. For example, the VA coordinator responsible for identifying and monitoring the seriously injured servicemembers at one regional office had served as an Army nurse at the local MTF and was provided all pertinent information.

VA staff at the 12 regional offices generally expressed confidence that the data sources they developed enabled them to identify most seriously injured servicemembers. However, we noted that informal data sharing relationships could break down with changes in personnel at either the MTF or the VA regional office. Several VA headquarters' officials and regional office staff we interviewed said that systematic data from DOD would provide them with a way to reliably identify and follow up with seriously injured servicemembers. Additionally, VA officials said these data would help them plan for projected increases in services for newly returning OEF/OIF servicemembers.

Unresolved Issues Continue to Delay a Data Sharing Agreement

After more than 2 years of discussion, DOD and VA have not developed a data sharing agreement. Although DOD and VA officials agree that the HIPAA Privacy Rule permits the exchange of individually identifiable health data if the individual signs a proper authorization, the departments have not pursued this as an alternative to a data sharing agreement. DOD and VA officials said the departments want to pursue options under other provisions of the Privacy Rule that may permit them to exchange data without individual authorizations. However, DOD and VA differ in their understanding of HIPAA Privacy Rule provisions that govern the sharing of individually identifiable health data for servicemembers currently receiving treatment in MTFs without an authorization, and the extent to which the Privacy Rule would permit that exchange. DOD's and VA's inability to resolve these differences has impeded coming to an agreement on exchanging servicemembers' individually identifiable health data.

Two examples help illustrate the different views of DOD and VA regarding the HIPAA Privacy Rule. First, the Privacy Rule permits covered entities that are also government agencies providing public benefits to disclose individually identifiable health data to each other when the programs serve the same or similar populations, and the disclosure is necessary to coordinate the covered functions of such programs or to improve administration and management related to the covered functions of the programs.[9][10] VA officials have said they believe that this provision allows DOD to share servicemembers' health data with VA because the departments serve the same or similar populations—active duty servicemembers who transition to veteran status. VA officials also said they believe that DOD and VA provide public benefits. In contrast, a DOD official who is responsible for implementation of the Privacy Rule does not agree that DOD and VA serve the same or similar populations or that DOD provides public benefits. This official said he believes that serving the same or similar populations means that servicemembers have a dual eligibility for both DOD and VA services. Although the official said that while some former servicemembers are dually eligible for DOD and VA services, not all qualify for both services simultaneously. This official also said that the services that DOD provides are not public benefits because they are unlike the examples of public benefits programs provided in the

[9]See 45 C.F.R § 164.512(k)(6) (2004).

[10]Covered functions in general are a health plan's or health care provider's activities of providing or arranging for health care services. See 45 C.F.R. § 164.103 (2004).

preamble to the Privacy Rule.[11] The Privacy Rule does not define public benefits.

In the second example, the Privacy Rule explicitly permits the disclosure of individually identifiable health data by DOD to VA upon the separation or discharge of a servicemember in order to determine eligibility for VA benefits.[12] DOD views "upon the separation or discharge" as referring to the separation process that varies by servicemember, but which begins with the decision by DOD that the servicemember will separate. According to VA officials, the HIPAA Privacy Rule would allow DOD to share data sooner than the decision by DOD that the servicemember will separate. However, DOD is reluctant to provide individually identifiable health data to VA until DOD is certain that a servicemember will separate from the military. DOD is concerned that VA's outreach to servicemembers who are still on active duty could work at cross-purposes to the military's retention goals. According to DOD officials, it would be premature for VA to begin working with servicemembers who may eventually return to active duty. VA contends that DOD could define the specific point of separation or discharge earlier in the process. In commenting on our January 2005 report, VA said that a memorandum of understanding was then being negotiated that would allow VA to obtain from DOD the servicemember's medical information prior to discharge from military service. VA added that its Office of General Counsel was confident that there are exceptions in the Privacy Rule that would permit military service medical information to be disclosed for VA benefits purposes and that it had pressed the case with DOD's General Counsel. As of May 17, 2005, the memorandum of understanding between DOD and VA has not been finalized.

Despite being unable to agree on an exchange of individually identifiable health data, DOD and VA are currently reviewing a draft memorandum of understanding. DOD and VA officials told us they believe that the memorandum of understanding will move the two departments closer to a data sharing agreement. However, we found that the draft memorandum of understanding restates many of the legal authorities contained in the Privacy Rule for the use and disclosure of individually identifiable health data. For example, the draft memorandum of understanding does not specify that individually identifiable health data of OEF/OIF servicemembers shall be disclosed and restates that data will be shared

[11]See 65 Fed. Reg. 82462, 82541-42 (2000).

[12]See 45 C.F.R. § 164.512(k)(1)(ii) (2004).

upon separation or discharge without further defining the specific point during the separation or discharge process when data can be shared. As a result, even if the memorandum of understanding is finalized, DOD and VA will still not have a data sharing agreement that specifies what types of individually identifiable health data can be exchanged and when the data can be shared.

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

Contact and Acknowledgments

For further information, please contact Cynthia A. Bascetta at (202) 512-7101. Also contributing to this statement were Mary Ann Curran, Marcia Mann, Kevin Milne, and Janet Overton.

Related GAO Products

Vocational Rehabilitation: VA Has Opportunities to Improve Services, but Faces Significant Challenges. GAO-05-572T. Washington, D.C.: April 20, 2005.

VA Disability Benefits and Health Care: Providing Certain Services to the Seriously Injured Poses Challenges. GAO-05-444T. Washington, D.C.: March 17, 2005.

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

Health Information: First-Year Experiences under the Federal Privacy Rule. GAO-04-965. Washington, D.C.: September 3, 2004.

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Statement of
Brenda R. Faas, MSW
VA/DoD Liaison for Health Care
Washington DC Veterans Affairs Medical Center
Department of Veterans Affairs
Before the
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs

May 19, 2005

Mr. Chairman and members of the committee: I am privileged to appear before you today to discuss my role as a Department of Veterans Affairs (VA)/Department of Defense (DoD) Liaison for Health Care stationed at Walter Reed Army Medical Center (WRAMC) in Washington, DC. I am honored to serve the injured soldiers, sailors, airmen, and marines who are returning from theaters of combat and who may benefit from VA services

VA's Seamless Transition Program strives to ensure the continuity of health care and benefits for eligible veterans and their families, especially those who have been seriously injured or very seriously injured during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). We work in conjunction with the Military Treatment Facilities (MTF) across the country to identify active duty service members who will soon transition to veteran status and who may be eligible for VA benefits.

My role as one of two VA/DoD Liaisons at WRAMC involves partnering with MTF staff, active duty service members, veterans, family members and VA medical center staff (VAMC) across the country to ensure a seamless transition of care and services. My educational and professional background in the field of social work assists me in developing close working relationships with the social work staff and other interdisciplinary team members at WRAMC. Together, we develop a treatment plan, which I help to expedite within the VA Health Care System. I am assigned full time on-site at WRAMC and meet face-to-face with WRAMC patients and staff. I am available to provide consultation to staff regarding the availability of VA health care programs and education to service members and their families regarding VA health care benefits.

Once the MTF staff identifies a service member who will need VA health care, they generate a referral to me that includes appropriate medical documentation, demographic information, and a treatment plan. Referrals may involve service members who require medical follow-up while on thirty-day convalescent leave or service members who are being separated/retired from the military and who need continuous medical care. Transfers of care may involve inpatient services such as acute rehabilitation for traumatic brain injuries, spinal cord injuries, visual impairment, and loss of limbs or function, as well as acute inpatient psychiatric care. Outpatient service may include primary care, orthopedics, physical or occupational therapy, neurology, oncology, and mental health care. An important part of the coordination of care involves meeting with a service member and/or family to review the treatment and transfer plan, paying particular attention to any special needs of the service member or family.

Once I have received the referral, I enroll the service member in the VA Health Care System and coordinate the transfer of care with the OIF/OEF Point of Contact (POC) at the designated VAMC. The POC arranges for outpatient appointments and inpatient admissions. I meet with the service members, veterans, and their family members at WRAMC to confirm appointments, provide contact information at the receiving VAMC, and address any issues or concerns related to the transition process. I remain available to answer questions and maintain contact with service members and/or their families until they leave WRAMC. I also monitor the transfer through our remote data access in VA's Computerized Patient Record System.

Due to the renowned Amputee Clinic at WRAMC, we have a high volume of patients with amputations from all branches of the military who will require long-term medical and prosthetic care through the VA Health Care System. I work closely with WRAMC and the Washington, D.C. VAMC to provide prosthetic equipment, such as ultra-light wheelchairs, collapsible canes and crutches, and hand-cycles for cardiovascular exercise, to the service members and veterans while they are recovering at WRAMC. Young, active service members and veterans are eager to maintain a high level of physical functioning, which

includes participation in various athletic events. VA supports their desires and if certain athletic interests are known, we will educate the service members on what services VA can offer to promote their athletic interests and will forward that information to their local VAMCs.

I collaborate with the WRAMC Department of Physical Medicine and Rehabilitation (PM&R) and the VA Maryland Health Care System to schedule driving evaluations for patients with amputations, traumatic brain injuries and visual impairments. The driving evaluations ensure that the patients can safely operate a vehicle, which promotes a return to independent living. I also communicate with the Blind Rehabilitation Specialist from the VA Maryland Health Care System, who visits with visually-impaired patients at WRAMC to provide education about VA blind rehabilitation services.

I work in conjunction with the Veterans Benefits Administration's Veteran Service Representatives and Vocational Rehabilitation and Education Counselor located at WRAMC to promote maximum support from VA. We communicate on a daily basis to review the needs of patients and how we can coordinate our services to support an optimum level of functioning and independence. I also participate in a weekly support group for WRAMC patients held at the Fisher House to provide a forum for education and discussion about VA health care benefits.

Change itself provokes anxiety, and my goal as a VA/DoD Liaison is to help the OIF/OEF veterans face their new lives with enthusiasm, hope, and optimism. The enhancement of coordinated services between DoD and VA promotes a positive transition from military to civilian life and ultimately has a lasting effect on a veteran's family and community. I am honored to serve those who have served our country.

Mr. Chairman, this concludes my statement. I look forward to answering any questions that you or other member of the Committee might have.

Statement of
Lynda S. Petty
Veterans Benefits Administration
Officer-In-Charge for Veterans Benefits,
Walter Reed Army Medical Center

before the
House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

May 19, 2005

Chairman Bilirakis and members of the subcommittee, it is a privilege to appear before you today to discuss my role as the supervisor of the Veterans Benefits Administration's outreach team. I retired from the military service in 2003 after serving a total of 28 years, both active and reserve, in the United States Army. I was honored when VBA gave me the opportunity to come to the Walter Reed Army Medical Center and continue to support these service men and women, our newest veterans.

VBA detailed a full-time benefits counselor from the Washington Regional Office to Walter Reed Army Medical Center in August 2003. This counselor was to meet with Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) patients and provide them with timely, accurate information. The regional office detailed a second counselor in October 2003 to meet the growing demand for services from those OEF/OIF patients that were not as severely wounded, many of whom went directly into outpatient status. Additional benefits counselors from VA regional offices across the country volunteered to work at Walter Reed on 60 to 90 day details from August 2003 to January 2005, when two permanent staff members were hired. I joined the Walter Reed staff in March 2004 as the supervisor of the VBA staff. My role was to coordinate

support requirements, develop administrative procedures, and provide a single point of contact for both military and VA issues. In November 2004, we added a full-time counselor to the National Naval Medical Center in Bethesda. We currently have four full-time, permanent staff members at Walter Reed and one at Bethesda. In addition to the civil service employees, we also have a contract Vocational Rehabilitation and Employment (VR&E) counselor to provide early testing, and evaluations. The VR&E counselor began working at Walter Reed in December 2001.

We strive to meet every injured service member returning from the theater of operations with special emphasis on those designated by the military services as Very Seriously Injured (VSI), Seriously Injured (SI) or Special Category Person (SCP) (defined as maimed, blinded, burned, or amputee) as soon as medically appropriate.

In the beginning, we received a daily list of OEF/OIF inpatients at Walter Reed. We used the list to schedule visits within 72 hours of the patient's arrival. This was an unrealistic and inappropriate goal. We found that few patients were physically or emotionally ready to discuss veterans' benefits or face the implication that their military career may be over that soon after arrival.

We receive referrals from military social workers and case managers, VA social workers, and periodically check with ward nurses to see if there is anyone new we need to visit. At the first visit, we introduce ourselves, gather some basic contact and personal information, and leave a large, brightly colored card with our locations, office

hours, and phone numbers. We try to follow up every few days with a short visit to gauge when they are ready for more information or to start a claim. It is often weeks or even months before they are ready to start a benefits claim. We stress those benefits they can use on active duty and we emphasize that we are not trying to make decisions for them. Our goal is to build a relationship based on the individual service member's needs.

One of the unique aspects at Walter Reed and Bethesda is our full-time VR&E counselor. The counselor provides full VR&E evaluation and testing, resumé review, and employment referrals. We issue voice-activated computers and ergonomic equipment as soon as eligibility is established. The VR&E program at Walter Reed arranges volunteer employment opportunities to suit service members' civilian work experience prior to separation. If a patient plans to leave the Washington, D.C. area upon separation, our counselor forwards the complete assessments to a counselor at the new location. The VR&E program reassures both service members and family members that they do have employment options.

In the early stages, we may meet with family members instead of the patient. I periodically attend the Fisher House Family Support Group meetings to provide information on the VA benefits available and the claims process. I arrange for vocational rehabilitation and specially adapted housing presentations on a regular basis. When the patient or family members indicate they are ready for more information or to start the claim process, we assist them in completing and filing the necessary forms.

We prepare claims for compensation, automobile grants, specially adapted housing grants, and vocational rehabilitation and employment. We gather all available medical evidence needed to support the claims. The Washington Regional Office processes the applications from both Bethesda and Walter Reed. The Regional Office processes as much of the claim as possible before separation. They finalize it upon receipt of proof of separation (DD-form 214). Upon completion of the award, the claim is transferred to the service member's home of record. Our goal is to have benefits waiting for the service member rather than the service member waiting for benefits.

The command and staff at both Walter Reed and Bethesda fully support VBA and the Seamless Transition Initiative. They are very responsive to our requests for support. The medical staff considers VBA staff to be full members of the team providing care to OEF/OIF patients. VBA counselors started participating in Walter Reed's weekly outpatient amputee clinic at the invitation of clinic physicians in July 2004. These meetings allow us to see patients we might otherwise have missed, to follow up with those who have started a benefit claim, or answer questions about the claim process. These meetings also allow us to track a patient's progress with therapy and the medical boards. The VBA counselor at Bethesda attends similar interdisciplinary meetings.

We work very closely with the VHA social workers and health care liaisons. We make informal referrals to them when we learn that a patient has special needs or concerns about follow-on health care after they leave this area. Often the VBA counselors have worked with a patient long before they are ready for a referral from DOD to VHA. VHA

contacts us when they find a patient with benefits questions and we do the same with health care questions.

Each VBA regional office also has an OEF/OIF coordinator and alternate. We notify the coordinator when a patient leaves Walter Reed or Bethesda, even if it is just for a few weeks convalescent leave. We tell the regional office how to contact the service member, what we have done to date, and let them know of any special needs. The Under Secretary for Benefits established very specific guidelines for outreach and claims processing for all VSI/SI/SCP casualties. These claims are case managed and receive priority processing.

The VBA staffs at Walter Reed and Bethesda are not limited to OEF/OIF service members. We also counsel other service members awaiting medical boards, provide transition services, including Transition Assistance Program (TAP) and pre-retirement briefings, and survivors benefits counseling. The military social workers, nurse case managers, and ward managers often ask us to come to the ward and brief a non-OIF patient or family member about veterans' benefits

Mr. Chairman, this concludes my statement. I look forward to answering any questions that you or other committee members might have.

RECORD VERSION

STATEMENT BY

MAJOR L. TAMMY DUCKWORTH
UNITED STATES ARMY

COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 109TH CONGRESS

SEAMLESS TRANSITION FROM ACTIVE DUTY TO VETERANS' STATUS HEARING

19 MAY 2005

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON VETERANS AFFAIRS

Mr. Chairman and distinguished members of the Committee, thank you for the opportunity to come before you today to discuss the care of wounded service members injured in Operations Enduring Freedom(OEF) and Iraqi Freedom (OIF) and our efforts to facilitate the transition between the Military and Department of Veteran Affairs (VA) Health Care Facilities and between military and veteran status.

I feel that a core component of Seamless Transition is our nation's investment in its finest citizens, the past and present members of the military. I believe we must continue to fund and support Walter Reed Army Medical Center, Brooke Army Medical Center, National Naval Medical Center at Bethesda and other major Military Treatment Facilities. We must also ensure that the VA receives adequate funding to enable that organization to continue to enhance the care it provides for our veterans. It would be difficult for either agency in the Seamless Transition to participate as a full partner if it is unable to meet the current superior level of care due to lack of resources.

The medical efforts of Walter Reed Army Medical Center, as well as the medical team at Landstuhl Regional Medical Center, the Combat Support Hospitals and the in-theater MEDEVAC helicopter crews have been extraordinary. In any previous conflict I would not be alive. It is a testament to the superior protective equipment that I was wearing and to the medical care pipeline from the front lines that I can be here today.

Military Treatment Facilities (MTFs) are a crucial part of the integrated medical system, which has performed so well during this conflict. The medical personnel who we have pushed so far forward in the effort to save our warriors' lives during the 'Golden Hour' are trained at stateside MTFs. If in a 'cost saving' effort we were to dismember this integrated system, and outsource both the care and training provided by the MTFs,

we would cripple the training of medical personnel in blast injuries, gunshot wounds, theater specific bacterial infections and other injuries peculiar to the war wounded. I owe my life to Doctors and Nurses at the Combat Support Hospital who are highly trained in caring for, and operating on, those types of injuries. I know that this same training gave my surgeons at Walter Reed the expertise to save my arm when many feared that it would need to be amputated. The care provided to our wounded once they reach stateside MTFs is spectacular, and I do not believe that it can be duplicated at a civilian hospital at any price.

The presence of the peer group of wounded at Walter Reed, and especially amputees, is a huge factor in my recovery. Because we are concentrated in large MTFs and recovering together, it is a very positive environment. The patients and most of the medical staff are military and share a mission focused mind set. I am not isolated at Walter Reed, as I would be in a civilian hospital where the staff is unlikely to have experience with as large a concentration of amputees from blast injuries as at Walter Reed or Brooke Army Medical Centers.

I would urge you to think of the efforts of Army Medical Department and the VA as a force multiplier for two reasons. First, these organizations can help us retain good Soldiers, Marines, Airmen and Sailors who would have otherwise not been able to continue to physically accomplish their missions and remain in the service of the United States. These wounded have already been trained at great expense, as well as been tested and gained invaluable experience in the crucible of combat.

Secondly, our warriors must able to focus completely and single-mindedly on the mission at hand, serving the people of the United States of America. When that mission

is to close with and destroy our nation's enemies I believe that we want our warriors to be secure in the knowledge that, when they are hurt we will take care of them. The frontline Soldier should not expend a moment of time to worry about a fallen comrade. We must ensure that he knows, 'my buddy made to Walter Reed, he will be ok, they have the best doctors, and cutting edge technology there'. We will maintain the optimal morale and performance from our Soldiers through ensuring that these medical facilities are adequately funded.

I have experienced first hand the excellence of the Army's medical system for the combat wounded. Because of the type of injuries, and the geographical location of my home, I have been treated at Walter Reed. Had I been burned badly, or if my home been in the western part of our nation, I would have been sent to a different facility, and I believe it is just as important to fund all of those facilities, also.

As disabled soldiers transition to veteran status, we will look to the VA to provide continued access to healthcare, health technology, assisted living devices and social services. The VA will have to face the challenge of providing care at the high level set by the military healthcare facilities. This is a challenge that the VA can meet if it is given enough resources and if it listens to the disabled service member and puts forth the effort to meet our needs.

The first, most easily identified need that the VA will have to support is continued access to technology. Disabled veterans will require access to evolving technology as they age and as the available technology undergoes innovation and changes. The VA will need to track ongoing changes in medical technology such as in prosthetics research and inform the veteran of the availability of this new technology.

I am certain that while the American people are focused on injured Soldiers from the Global War on Terrorism, the funds to aid those Soldiers will continue to be forthcoming. I am concerned that during peacetime, funds for research such as in the field of prosthetics will be reduced. The VA needs to continue to support the cutting edge research that is underway as a result of the current conflict's wounded. In order to do so, the VA itself will need continued funding earmarked for this purpose.

Second, as I look around at the other wounded Soldiers, it is clear that the majority of them are young with long lives ahead of them. Whether we will continue to have the honor of serving in uniform, or return to productive civilian lives, we will require continued access to technology as we age. The VA will need to support this need over the long term as currently wounded Soldiers will be making use of its services over a lifetime.

Third, disabled soldiers will need access to assisted living devices such as:

1- High tech prosthetic care.

2- Orthopedic care.

3- Home modifications i.e. ramps, thresholds, lifts and wide doors.

4- Vehicle modifications/hand controls.

5- Specialty equipment such as wheelchairs (racing), bathroom equipment, hand cycle, adaptive sports equipment.

6- Specialty equipment for blinded soldiers such as talking appliances or computers.

7- Smart home technology.

Fourth, the VA will need to provide access to social services such as job counseling and psychological support. Many of the young wounded Soldiers today need advice on which jobs or educational programs will be most suited to them. Such career counseling will allow the Soldier to maximize the educational and job training benefits provided by the VA. Additionally, those that sustained brain injury as well as those that develop psychological trauma will need long term counseling and support.

Fifth, it does the disabled veteran no good if he or she is unable to access the various programs provided by the VA. While still assigned to Walter Reed I have immediate access to the prosthetics care that is part of my recovery process. This access will continue for me through the new amputee center. However, for disabled veterans living in areas far from VA Hospitals and facilities, travel itself is a significant obstacle to their continued care. These disabled veterans will need regular, easy transportation support from the VA.

I can only hope and implore that the VA steps up to receive disabled veterans as we transition into its care from the military medical system. In order to do so, the VA will have to identify and develop specific programs and those programs will have to be funded into the future. I also ask that a system such as a checklist be created to give to injured soldiers or their next of kin to give them a road map to follow as they move from the military medical system into the VA.

While I currently cannot comment from personal experience on the quality of care available in veterans" hospitals, I have been witness to the outreach efforts of the VA. These efforts have been highly personal, and as a result, my concept of the VA is not that of a faceless bureaucracy. At this point the face of the VA is a veteran and

amputee that befriended my husband and mother even as I lay unconscious in the Intensive Care Unit. The VA is a former Army Ranger and his wife who came to visit me and all the other wounded in our hospital rooms. The VA is a vet who wheels in to check on the condition of my wheelchair and tells me from his personal experience the importance of a good seat cushion.

I applaud the VA and Department of Defense (DOD) partnership that assists military service members who have served in combat and aims to provide them with a seamless transition to civilian life and veteran status.

Those select individuals from amongst the American people who would willingly serve in the armed services are a limited resource. Our warriors are expensive, and indispensable. I believe we must jealously guard this resource; retaining as many as possible in the service, and sparing little in the effort to return one of them to service. The investment in training dollars represented by even one junior Non-Commisioned Officer could easily be several hundred thousand dollars over the course of 5-6 years. Such are the expensive assets that Walter Reed is in the business of fixing and maintaining and I believe the American people's tax dollars are well spent there.

Additionally, once out of the military, our veterans make up a highly trained and disciplined pool of workers ready to add to the productivity of the civilian workforce. Veterans supported by the VA and able to lead productive lives are valuable contributors to the economy. The cost of providing wheelchairs or prosthetics to veterans through the VA system is an investment recouped through taxes paid by those same veterans who can now work as a result of these devices.

Finally, on behalf of our injured, wounded or ill Service members and their

families, I thank members of this great institution for this opportunity to address their concerns for medical care of our nation's Veterans, Soldiers, Marines, Sailors and Airmen.

RECORD VERSION

STATEMENT BY

GWENDOLYN FRYER, RN, BSN, MSN
COLONEL, UNITED STATES ARMY
ARMY POLYTRAUMA LIAISON OFFICER, JAMES A. HALEY VETERANS' HOSPITAL
TAMPA, FLORIDA

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 109TH CONGRESS

SEAMLESS TRANSITION FROM ACTIVE DUTY TO VETERANS' STATUS HEARING

19 MAY 2005

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON VETERANS' AFFAIRS

Mr. Chairman and Members of the Committee, I am honored to have the opportunity to appear before you today to discuss my current role and assignment as the Army Polytrauma Liaison Officer at the James A. Haley Veterans' Hospital in Tampa, Florida, and its direct relationship and impact on seamless transition and Department of Defense/Department of Veterans' Affairs partnership and collaboration.

I am Colonel Gwendolyn Fryer, a registered professional nurse for thirty years; twenty four of which have been served as an active duty Army Nurse Corps Officer and two and a half as a Reserve Army Nurse Corps Officer. During my thirty years of nursing, I have had a variety of assignments and challenging positions. However all of them pale in comparison to the fulfilling and professionally rewarding experience that this current assignment which began April 11, 2005 has been.

Currently, I am one of four Army Liaisons who are assigned to the four Department of Veterans' Affairs (VA) Polytrauma Centers located at Richmond, Virginia, Minneapolis, Minnesota, Palo Alto, California, and Tampa, Florida. Two of the liaison staff are Commissioned Officers and two are Non-Commissioned Officers (NCOs). Each of us brings personal and professional military knowledge, history and experience to our unique and evolving roles.

The assignment of "Green-Suiters" at these Polytrauma Centers was a collaborative decision between Lieutenant General Kevin Kiley, The Surgeon General of the Army; Dr. Jonathan B. Perlin, Under Secretary of Health for the VA; and staff of the VA Office of Seamless Transition. Although only in the position for a short period of time, I see enormous value in my role. After the initial assignment of six months is complete, Lieutenant General Kiley will evaluate the merits of the program.

Prior to reporting to this assignment, the four liaison staff members received a thorough and detailed orientation by the staff of the Office of The Surgeon General of the US Army (OTSG) in collaboration with the staff of the VA Office of Seamless Transition. During the orientation, several key imperatives were outlined and served as the foundational guidance for implementing this role. These imperatives were to manage and care for all active duty service members regardless of branch of service or component; to remember we are caring for the whole family not just the service member; and to remember the rehabilitation needs of the younger service member are uniquely different from the needs of the older veteran.

Since my arrival at the Tampa VA Medical Center, implementation of this role has been extremely successful due to several important factors. The first factor can be attributed to the pre-planning and development activities on the part of OTSG in collaboration with the VA Office of Seamless Transition. This plan ensured the identification of an internal VA mentor who serves as the point of contact for the Liaison Officer/NCO, assisting in all matters pertaining to the full implementation and integration of this program within the specific VA Medical Center. In addition, an external Program Manager was identified and serves to bring key leaders from US Army Medical Command, OTSG, and the VA Office of Seamless Transition to weekly conference calls with the four Army Liaisons and Marine Corps Liaison Officer. A well-defined job description and performance metrics were developed during this planning phase and also serve as the basis for program success.

The second factor impacting the successful implementation of this role is the established infrastructure and programs that currently exist within the Tampa VA

Medical Center, to specifically track injured service members from the time of initial notification, arrival, in-hospital care, and transfer to the next level of care or transition to retirement status. Staff members who are involved throughout this continuum of care are very knowledgeable about their responsibilities, and demonstrate dedication and commitment in anticipating transition needs of the service members before they are actually retired from the military.

The third factor is attributed to the Tampa VA Medical Center's Leadership and subordinate staff's receptiveness and willingness to integrate the role of the Polytrauma Liaison into the clinical, administrative, and care management activities currently in place for the active duty service members and their families. This integration includes, but is not limited to, my ability to actively participate in bi-weekly interdisciplinary rounds, weekly Operation Enduring Freedom / Operation Iraqi Freedom Director Reviews, weekly video teleconferences between the Tampa VA Medical Center and referring DOD facilities, weekly family support group meetings, monthly seamless transition team meetings, monthly volunteer service events that offer family recognition and appreciation events, and monthly Haley House meetings which ensure the family member has a place to reside for the remainder of the service member's assignment at the Tampa VA Medical Center. The leadership also ensured my inclusion in and access to database systems that provide timely patient information about current admissions and pending arrivals. The continued efforts displayed by the staff of Tampa VA Medical Center serve to promote team-building and collaboration resulting in a positive and therapeutic environment for the service members and their families. I have been embraced as a valued member of both the healthcare and leadership teams.

The fourth factor is attributed to the overwhelming positive responses to my presence from the active duty service members and their families--the most important members of the healthcare team. The types of injuries these service members sustain render them physically, mentally, psycho-socially and spiritually changed in a variety of ways depending on the severity of their injuries. The family members are integral to the rehabilitation efforts of the service members, as some cannot speak for themselves. In addition, the family members are also undergoing the shock and grief of this catastrophic event, but must continue to be strong in order to carry out their role in the rehabilitation of the service member. The Polytrauma Liaison is in a unique position to develop and sustain a relationship and bond with both the service members and family members that will instill trust and confidence in the VA system and the healthcare providers. This supports seamless transition, in that the service member and the family learn to trust the system they will be interacting with for many years to come. I perceive that the relationship and bond between the service and family members is built on their ability to trust me in this role, and instill confidence that they have an additional advocate in the facility. Family members and service members know that I am available to them twenty-four hours, seven days a week by phone, pager, and individualized patient rounds on all shifts.

In addition, I have insured collaborative working relationships with the assigned Social Workers who are intimately involved and aware of the service member's case. They are trusted members of the team as well. We work together to solve administrative issues that include: invitational travel orders for family members; transfer, attachment or travel orders for the service member; reimbursement and pay issues;

transportation and/or shipment of household or personal goods; lodging accommodations while at the Tampa VA; line of duty investigations and medical evaluation boards. I am an important military link for the social worker staff.

Clinical interventions are also necessary when the service members decide they do not want to comply with or do not participate in the required rehabilitation regime. This information is routinely obtained through my daily interactions and observations or by physician or staff requests for me to assist the VA social workers in encouraging the service member to cooperate and comply with their therapy. The service members seem to respond to a gentle, therapeutic reminder that "they can do it because they are a Soldier, Sailor, Airman, Marine, or Coast Guard" which is often a factor needed to get them motivated and energized to begin their long road to recovery. I have now seen service members who were withdrawing, or too weak to walk, begin to wheel themselves distances of 1-2 miles and eventually begin to walk with their therapies. I have also experienced service members who can not communicate in the traditional manner, use their eyes to communicate to me as instructed. And, I have been extremely touched when a specific sailor who has a diagnosis of both traumatic brain injury and spinal cord injury responded appropriately with his eyes when asked if he wanted to render a salute. When told to close one eye if he wanted to salute, he followed the command. Then when told to close both eyes to execute his salute, he followed that command. Of course it was my honor to render a salute to him.

My presence seems to bring a ray of hope for the family members and the service members. It signals to the service member that the military still cares about their transition to retirement status or return to active duty. It offers an opportunity for

service members who are aware of their current situation, to recall and demonstrate their military training, and perhaps draw strength from that training, making progress towards their next level of rehabilitation.

The fifth factor is attributed to the creation of the Army Polytrauma Liaison role itself and ultimately the way the Liaison operationalizes the role at the VA Medical Center. The overall inclusive mission of this role is to provide transition assistance and advocacy services to all active duty service members and their families. In a spirit of open communication, mutual respect, and a deep appreciation for the efforts of a superb healthcare team, I assured the leadership of the Tampa VA Medical Center that I am a team player. To this end, I have operationalized these duties by serving as the healthcare team's military subject matter expert on military matters; serving as the advocate for the service member and family on clinical issues, and when necessary; working with the healthcare team and the family; to bring resolution to clinical concerns and enhance staff; patient communication; attending selected nursing staff meetings and introducing the role and functions of this position; serving in a collaborative and support role to the Chief Nurse; attending leadership meetings held for the Chief of Staff and Hospital Director to review clinical issues and other concerns of the service member and family; working collaboratively with the facility's Public Affairs Officer to plan and execute a Purple Heart Ceremony, facilitating and executing VIP visits to the service members, and planning future retirement services for applicable service members; partnering with the Social Worker to attend selected family support group meetings which are held every Saturday; collaborating with Veterans' Services Organizations and where applicable, attending morale enhancement and recognition

activities for family members, such as the Military Officer's Association of America; serving as a member on selected committees or teams that focus on quality of life issues for the service members and their families such as the Haley House Committee, which insures lodging and financial support free of charge when necessary; and establishing professional working relationships with the line leadership team of the service member's assigned military unit, to enhance communication about and support to the service member. I have made initial contact with organizations (such as the Military Severely Injured Joint Support Operations Center, Marine for Life Program, the Army's Disabled Soldier Support System and the Polytrauma Center's Veterans' Services Organizations Office) in order to identify myself as a member of the team through which support to the service members and families can be coordinated; and ensuring a constant and abiding presence in the facility during every tour of duty.

As the Polytrauma Liaison I am a facilitator for military issues impacting the quality of life of the service member and his/her family.. As the role continues to evolve, it should become like the "military one source" for the service members and their families receiving care in Polytrauma Centers. Today, however, the Polytrauma Liaison role sends a clear statement to the service members and families that we are their real time and real life helpers, representing their "boots on the ground," and working as an integrated member of their healthcare team, to expeditiously manage, anticipate and move all pre-transition requirements along in a coordinated manner. In like manner, the Polytrauma Liaison is the voice for service members and their families, reminding those involved in their care that the service members volunteered to serve the nation, but this

transition is unplanned, and represents a psychological transition which is over and above the physical trauma.

As the program and the Polytrauma Liaisons' duties are reviewed and mature, the full impact of the Liaison role should be realized. The ability to respond more quickly to family issues and needs through a coordinated system of organizations and processes will enable the Polytrauma Liaisons to execute their key responsibilities in a more efficient manner and generate a wider range of options and support systems from which to choose. As we approach the future, I recommend DoD and VA expedite their development of interoperable data repositories that will support bidirectional exchange of computable data between the agencies. The highly successful Federal Health Information Exchange (FHIE) supports the one-way transfer of electronic military health data to the VA Computerized Patient Record System for review by VA clinicians. As I close this discussion, I would like to echo the comments made by a field commander while working with him to review the future disposition of his service member. I paraphrase, "COL Fryer, it is good to have a liaison in a role like yours assigned to a civilian facility where my service member is receiving care. Your role brings energy and clarity to complex issues that are more easily resolved because you understand the military system."

Mr. Chairman, again I want to thank you for providing me the opportunity to share information about the Army Polytrauma Liaison role, and its impact on supporting seamless transition and DOD/VA collaboration, as we join efforts to support our wounded American heroes.

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COMMITTEE ON VETERANS AFFAIRS

Statement of

Colonel Timothy E. Frank

United States Marine Corps

Marine Casualty Services

Marine Corps Liaison to the Office of Seamless Transition

Department of Veterans Affairs

Before the

Subcommittee on Oversight and Investigations

House Committee on Veterans Affairs

Concerning

The Efforts Being Made to Assist Military Personnel

In Making a "Seamless Transition" from

Active Duty to Veterans' Status

May 19, 2005

NOT FOR PUBLICATION UNTIL
RELEASED BY THE HOUSE
COMMITTEE ON VETERANS AFFAIRS

Mr. Chairman, Congressman Strickland, and distinguished members of the Subcommittee, I am grateful for this opportunity to appear before you today to discuss my experience as the Officer in Charge of Marine Casualty Services at the National Naval Medical Center (NNMC), and to present my perspective on how we can best support our wounded Warriors and their families as they transition from military hospitals to VA Medical Centers, and, in most cases, ultimately from active duty to veterans status.

The U.S. Marine Corps continues to be highly focused on caring for our injured Marines and sailors and ensuring that their family members are provided for and comforted in the wake of their injury. Supporting injured Marines and their families is a complex task, as their specific needs vary from case to case. We do our best to tailor our support to fit their individual needs and those of their families, showing flexibility wherever and whenever possible. From notification of an injury, to bringing families to bedside, to providing amenities in hospital rooms, and assisting with their transition back to full duty or to veteran's status, the Marine Corps continuously evaluates its processes and makes adjustments where necessary to see that the appropriate level of support is provided. While we have encountered problems, we are actively collecting lessons learned and incorporating needed changes.

I thank the committee for this opportunity to participate in this effort to create a seamless support system for wounded service members and their families as they transition to civilian life.

Establishment of Marine Casualty Services

As Marines, we take pride in taking care of our own. Based on lessons learned from

the treatment and processing of Marines and Sailors injured during Operation Enduring Freedom and the initial military action in Iraq, the decision was made to establish a Marine Casualty Services Branch at NNMC, under the leadership of a Senior Marine Officer. It became apparent early on that there were many pieces to the casualty care puzzle, and in order to maintain and guarantee visibility of our Marines and Sailors, we needed to improve our internal and external cross-functional coordination. To meet these emerging requirements, we established additional teams at Andrews Air Force Base to meet all incoming medevac flights, a team at Walter Reed to provide on site support for Marines receiving amputee rehabilitation, and personnel augmentation to the Joint Personnel Effects Division at Aberdeen. It was clear that we were going to have to remain actively involved with both day to day care, and time and staff permitting, do our best to continue to support and advocate for our Marines and families once they were transferred to a VA Medical Center in order to ensure that they received the high level of care and attention they did while hospitalized at NNMC.

Facing New Challenges

Outlined below are some of the reasons why the returning casualties were presenting a challenge to both the Military and VA treatment facilities. These factors not only lead to the expansion of Marine Casualty Services' role, but also to the implementation of new programs and initiatives by the Naval Hospital Commander intended to broaden coordination of care and family support.

- Multiple severe and complex injuries.
- Lengthy and intensive recovery and rehabilitation period.

- Comprehensive discharge planning requiring coordination and collaboration between numerous agencies.
- Need for extensive case management.
- High level of attention and support required by the family members.
- High profile patients (anxious families, media and National interest, VIP visitors, every patient with direct line to the Commander).

Marine and Family Support

Casualty care requires extensive planning and coordination. The Marines at Bethesda took pride in providing what I refer to as the "Lexus" level of assistance and support in keeping with our long standing tradition of taking care of own. Upon arrival, we immediately embraced the families, and recognized that their participation was essential to the morale and recovery of our injured Marines and Sailors. Our injured and their families knew that we were there for them 24 hours a day, and would do whatever it took to address any concerns, and reduce the emotional strain and uncertainty associated with the medical treatment process and unexpected traumatic injury.

In one particularly difficult case, a father who was so inspired by the efforts of the Marine Casualty Services Branch on his son's behalf, asked if it was possible for a parent to become an honorary Marine. The important lesson that we learned from these experiences was that it was not a matter of being perfect and having the solution to every problem—it was simply a matter of being there. By maintaining a professional, yet caring and compassionate relationship with our injured and their families, we were able to uphold the special trust and confidence afforded us during a very confusing and vulnerable time, earning their admiration and elevating their expectations.

Preparing our Injured Marines and Sailors for Transfer to the VA

In an attempt to better prepare our injured Marines and their families for the next phase of their treatment and rehabilitation within the VA, and in order to gain a greater appreciation for some of the challenges they might face, we conducted a mutually beneficial site visit to the McGuire VA Medical Center in Richmond. The visit gave us insight into how we could better prepare them for a successful transition to the VA, by managing their expectations and helping them adapt to this new environment. Areas of discussion included VA procedures for receiving Marines to the medical center, management of psychosocial needs of the Marine and families, and the rehabilitation process. This meeting helped us to understand that the acute care provided at the MTF and the programmatic rehabilitation provided at the VA Medical Centers require different approaches. This meeting also helped the VA staff better understand the family expectations, as well as what the Marine Corps expected in the way of continued care and support for both our injured Marines and their families.

The injured are transferred to VA facilities because they require rehabilitation in a variety of areas. The Marine's cognitive and motor skills must first be evaluated before a rehabilitation plan can be put in place. In order for the medical team to get a fair assessment of the Marine's true condition, they typically reduce the level of narcotics to a tolerable point. Along with narcotics reduction, the staff was very clear about defining treatment and rehab expectations with the express purpose of getting that Marine to a level of functionality which would allow him or her to reintegrate into the community while remaining as independent as possible. It was disconcerting to the families to see

their injured Marine in pain. Simple explanations from the doctors or therapists have helped to calm the families' fears.

The staff understood the importance of having the family present, but because the goals for treatment are different, the VA Medical Center must strictly adhere to the visitation policy. Additionally, after the first week of therapy, and keeping in line with their goal to make the Marine independent, family members are discouraged from visiting the Marine during therapy. This was upsetting to many family members because at NNMC they had round the clock access to their injured Marine, but VA is working to ensure that families understand the importance of protocols during this stage of recovery.

VA Addresses Family Needs

As a result of this meeting and previous experiences, the McGuire staff acknowledged that by addressing some of the many psychosocial needs of the family they could begin to establish a rapport that would prove beneficial to the Marine's recovery. VA Medical Centers are continually making adjustments to better serve the families which include establishing support groups, initiating plans for Fisher Houses, and having doctors and staff more available to speak with the Marine and family. We have all found that increased communication, education, and comprehensive discharge planning between Marine Casualty Services, the MTF and VA staffs can ensure that our injured and their families experience a smoother transition into this next phase of their care.

Marine for Life – Injured Support

The Marine Corps has a long history of caring for its fallen and injured Marines. The many Marines and Sailors who have suffered extremely serious combat injuries would not have survived in previous wars. Due to magnificent medical care, they are

fortunately still with us. Nevertheless, their trauma still has a potentially devastating impact on them, their families and their future.

Marine for Life – Injured Support is a formal program instituted by our Commandant to assist injured Marines, Sailors who served with Marines, and their families. The concept of Injured Support gives renewed meaning to "Once a Marine, Always a Marine" and assures all Marines that they never truly leave the Corps. The goal of this program is to bridge the difficult gap between military medical care and handoff to the Department of Veterans Affairs. The key is to ensure continuity of support through transition, provide assistance for however long it might take, and in combination with OSD's Military Severely Injured Joint Support Operations Center, provide case management tracking for several years afterwards. As our injured Marines continue with their recovery, potential transfer from active to veteran status, and assimilation back into their communities, Injured Support will be their greatest supporter and advocate.

This program has been in operation since January of this year with features that include advocacy within both the Department of Defense and external agencies, assistance with military disability processing and physical evaluation boards, assistance with employment, and improved Department of Veterans Affairs handling of Marine/Sailor cases. Injured Support representatives interact with Marine Casualty Services on a weekly basis to provide program information and contact numbers to hospitalized Marines and family members. Marine for Life – Injured Support is living proof of our motto -- "Semper Fidelis."

Importance of Case Management

Intensive case management is a key component for post discharge and follow-up care. Continued communication and coordination between the MTF Case Manager, VHA /DoD Liaison, VA Medical Center OEF/OIF Case Manager, and the Military Service Representative (in the Marine Corps this would be Marine for Life – Injured Support), is absolutely crucial as our injured proceed through their recovery. Without it, there is a greater chance they will somehow get lost in the system.

DoD-VA Partnership

Both DoD and the VA have placed the highest priority on the care and services being provided to injured service members. At NNMC, the onsite VA social worker and benefits counselor are integral members of the multidisciplinary team. They collaborate with the hospital staff, Marine Casualty Services personnel, family members, and VA Medical Center staff on a daily basis in order to ensure a seamless transition of care and services. The VA has recognized that our wounded Marines and Sailors differ from their traditional rehabilitation patient in age and extent or complexity of injury. To enhance continuity, clinical outcomes, and improve family support, the trauma team doctors at NNMC conduct weekly teleconferences with primary VA transfer sites, such as the VA Medical Centers in Richmond and Tampa. Additionally both NNMC and VA have conducted site visits within the last six months.

VA Poly-Trauma Conference

In February 2005, the VA Employee Education System in collaboration with the Office of the Deputy Under Secretary for Health hosted a program "VHA Poly-Trauma Lead Centers Conference" in Washington, DC. Over 30 senior health executives

from the four VA Poly-Trauma Centers participated in this conference, along with medical and non-medical personnel from Walter Reed Army Medical Center, National Naval Medical Center, and Marine Casualty Services. The purpose of this conference was to give VA personnel a better understanding of how the two major MTFs in the National Capital Region take care of the injured and their families, so that they could build and institute a better treatment and support plan for the numerous service men and women admitted to their facilities. Most of the concerns centered on communication, coordination of care, and family support. This conference proved very beneficial to all participants in providing a way ahead to better facilitate the transition from the MTF to the VA.

The Commandant Reaffirms Corps' Commitment to Injured Marines

Severe injury has a traumatic impact on our Marines and their families, in that not only are life and death at stake, but there are also significant disruptions to family systems for months and years to come. They will find themselves navigating new territory and facing possibly some of the greatest challenges of their lives. Without a doubt, taking care of our wounded Marines, Sailors and their families is one of the Commandant's top priorities. He wants to make sure that our Marines can access their VA health care and benefits without complication and unnecessary delay. Additionally, his hope for our Marines is that they get the information, link to services and resources, and assistance they need to be self-sufficient, contributing members of their communities. His level of dedication to these Marines is evidenced by the placement of a Senior Marine Officer as Marine Liaison in the Department of Veterans Affairs' Office of Seamless Transition.

Conclusion

On behalf of all the selfless, dedicated men and women who serve in our Armed Forces, I thank this Committee for your continued support during these demanding times. The Department of Defense, Department of Veterans Affairs, and all of the individual services are committed to keeping the treatment, recovery and transition of our injured as their highest priority. As challenges arise, they will be addressed and resolved, and best practices will be instituted as they are developed. We must continue to partner and communicate to ensure the transition process is a positive one, helping our veterans to face this next phase of their lives with optimism and confidence.

Again, I thank the committee for your unwavering support.

Statement of
John Brown, Director
Seamless Transition Office
Department of Veterans Affairs
before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
United States House of Representatives

May 19, 2005

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss efforts of the Department of Veterans Affairs (VA) toward effecting a seamless transition for separating service members from the Department of Defense (DoD) to VA.

First, let me assure you that interest in this issue comes from the highest levels of the Department. Though only recently taking office, Secretary Jim Nicholson has reaffirmed VA's determination to assure that maximum efforts to serve the needs of newly returning service members are undertaken by the Department.

Deputy Secretary Gordon Mansfield is also deeply engaged in this endeavor as he co-chairs VA/DoD Joint Executive Council (JEC) with the Under Secretary for Defense for Personnel and Readiness, Dr. David Chu. In March of this year, Deputy Secretary Mansfield addressed the Joint DoD/VA Conference on Post Deployment Mental Health as they reviewed the potential impact of returning personnel.

Today, my statement will focus primarily on the efforts of VA's Seamless Transition Office (STO) to achieve a seamless transition for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans and their families. The STO is one part of the Department's network of services used to meet these needs.

Before I begin, however, I would like to share with you brief discussions of three issues that play a large role in helping to ensure a seamless transition for returning OIF and OEF service members, the availability of VA health care services, the oversight and guidance of the JEC, and VA/DoD electronic health information exchange. Later in my statement, I will include information about health care utilization of OIF and OEF veterans.

Health Care Services

VA is well positioned to provide health care to returning OIF and OEF veterans. As the largest integrated health care organization in the United States, we can meet their needs through nearly 1,300 health care facilities throughout the country, including 696 community-based outpatient clinics that provide health care access closer to veterans' homes. We also have 207 Vet Centers, which are often the first contact points for returning veterans seeking health care and benefits near their homes.

VA offers comprehensive primary and specialty health care to our enrollees. The quality of our care is second to none. We are an acknowledged leader in providing specialty care in the treatment of such illnesses as post-traumatic stress disorder (PTSD), spinal cord injury, and traumatic brain injury (TBI). We are now leveraging and enhancing the expertise already found in our four TBI centers to create Polytrauma centers to meet the complex needs of certain seriously injured veterans from all parts of the country. I will have more to say about the Polytrauma Centers later in my statement.

VA/DoD Joint Executive Council

The JEC provides overall support and guidance for the joint VA/DoD initiatives detailed throughout my statement. As stated earlier, the JEC is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary for Defense for Personnel and Readiness and ensures high level attention from both Departments to maximize opportunities to improve service to our mutual beneficiaries. Through this forum, VA and DoD have achieved significant success in improving interagency cooperation in areas such as deployment health, pharmacy, medical-surgical supplies, procurement, patient safety, clinical guidelines, geriatric care, contingency planning, medical education, information management/information technology, financial management and benefits coordination.

VA/DoD Electronic Exchange of Health Information

Our ability to provide care to returning OIF and OEF service members is enhanced to the extent that we can obtain accurate health care information from DoD in the shortest time frame possible. In 2002, VA and DoD gained approval of their Joint Electronic Health Records Interoperability Plan – HealthePeople (Federal). VA began implementation of Phase I of the plan, the Federal Health Information Exchange (FHIE) that same year. The FHIE supports the one-way transfer of electronic military health data on separated service members to the VA Computerized Patient Record System for viewing by VA clinicians treating veterans. Since FHIE implementation in 2002, DoD has transferred records for over 2.9 million unique patients to the FHIE repository, where more than 1 million records have been viewed by VA clinicians. VA and DoD are now developing interoperable data repositories that will support the bidirectional exchange of computable data between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR), known as Clinical Data Repository/Health Data Repository (CHDR).

Seamless Transition

Now let me explain the history, operations, and responsibilities of the STO. In August 2003, VA's Under Secretary for Benefits and Under Secretary for Health created a new VA Taskforce for the Seamless Transition of Returning Service Members. This taskforce was composed of VA senior leadership from key program offices and the VA/DoD Executive Council and focused initially on internal coordination efforts to ensure that VA approached the mission in a comprehensive manner as well as education of VA staff on the needs of returning veterans.

Although the responsibilities and operations of the Taskforce were limited to this comparatively narrow scope, their importance should not be underestimated. By ensuring the success of our initial encounters with returning OIF and OEF service members and veterans, we are establishing a sound basis for an ongoing and long-term positive relationship with our veteran patients and their families. This is especially important for those veterans who have the greatest need for our help, the most seriously disabled combat veterans who transition directly from Military Treatment

Facilities (MTFs) to VA medical centers (VAMCs) to continue their care and rehabilitation.

In January of this year, VA established a permanent Seamless Transition Office to assume the duties of the Taskforce. Although the STO administratively reports to the Deputy Under Secretary for Health, it may truly be described as a "One-VA" endeavor. Composed of representatives from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA), the STO now coordinates all Departmental activities related to the provision of benefits and health care for those service members transitioning directly from MTFs to VA facilities. The STO also provides coordination within VA for all other initiatives of DoD and the States to provide outreach services to OIF and OEF veterans. The office relies on the expertise of other VA program offices and VA field facilities to support its mission.

Seamless Transition Office Successes

Over the last 2 years, the Seamless Transition Task Force and the STO have achieved many successes in the areas of outreach and communication, trending workload, data collection, and staff education. We have worked hard with other offices in VBA, VHA, and DoD, to identify OIF and OEF veterans and to provide them with the best possible information and access to both health care and benefits. VA has put into place a number of strategies, policies, and programs to provide timely, appropriate services to these returning service members and veterans – especially those transitioning directly from DoD MTFs to VAMCs. The ability to enroll for VA health care and file for benefits prior to separation from active duty is the result of the seamless transition process. Throughout the process, we have greatly improved dialogue and collaboration between VA and DoD to better serve OEF/OIF veterans.

Liaisons and Benefits Counselors at DoD and VA

VA has assigned full-time social workers and benefits counselors to seven major MTFs, including Walter Reed Army Medical Center, the National Naval Medical Center in Bethesda, Brooke Army Medical Center, Eisenhower Army Medical Center, and the

Madigan, Ft. Carson, and Ft. Hood MTFs. These VA social workers work closely with MTF treatment teams to ensure that returning service members receive information and counseling about VA benefits and services. They also coordinate the transfer of active duty service members and recently discharged veterans to appropriate VA health care facilities and enroll them into the VA health care system. Through this collaboration, we have improved our ability to identify and serve returning service members who have sustained serious injuries or illnesses while serving our country. VHA staff has coordinated more than 2,000 transfers of OIF/OEF service members and veterans from an MTF to a VA medical facility. VBA benefits counselors are also stationed at MTF's to provide benefits information and assistance in applying for these benefits. These counselors are generally the first VA representatives to meet with the veteran and family members. From October 2003 through mid-March 2005, VBA benefits counselors interviewed almost 5,000 OIF/OEF service members hospitalized at MTFs.

Points of Contact at Regional Offices and Medical Centers

Each VAMC and VA Regional Office (VARO) has identified a point of contact (POC) to coordinate activities locally and to assure that the health care and benefits needs of returning service members and veterans are met. VA has distributed guidance on the role and functions of case management services to field staff to ensure that the roles and functions of the POCs and case managers are fully understood, and that proper coordination of benefits and services takes place.

Benefits Delivery at Discharge

Many of the OIF/OEF service members who are not seriously injured and therefore do not separate through one the MTFs, participate in VA's Benefits Delivery at Discharge Program (BDD). This program allows service members to begin the VA disability compensation application process 180 days prior to separation. In most cases, disabled service members participating in the BDD Program begin receiving VA disability compensation benefits within 60 days of their separation from active duty, which serves to ease the transition from active duty to civilian status. To expedite claims processing for these service members, VA and DoD have agreed upon a single

examination process, using VA's examination protocols, if an examination is also required by the military prior to separation. A memorandum of agreement to establish single examination procedures was signed by VA and DoD in November 2004. The BDD Program is currently offered at 140 military installations. In FY 2004, the BDD Program received approximately 40,000 claims from transitioning service members.

Outreach

For veterans whom we do not encounter in the MTF's or the mobilization stations during VA benefits briefings, the STO has worked with VA's Veterans Integrated Service Networks (VISNs) and VAROs to coordinate other outreach strategies. These individuals may not have the same serious combat-related injuries we have seen in the MTFs; however, they may have other health care, readjustment issues, or benefits needs that require assistance.

VA has developed and distributed pamphlets, brochures, and educational videos ("Our Turn to Serve"), designed for VA employees and others involved in this critical outreach efforts. A second video was developed, entitled "We Are By Your Side," for returning Guard/Reserve members and family to help them through the readjustment period upon returning home. Working with DoD, we developed a brochure entitled "A Summary of VA Benefits for National Guard and Reserve Personnel." The brochure summarizes the benefits available to this group of veterans upon their return to civilian life. We have distributed over a million copies of the brochure to all mobilization stations to ensure the widest possible dissemination through VA and DoD channels. It is also available online at:

http://www.va.gov/environagents/docs/SVABENEFITS.pdf and
http://www.defenselink.mil/r2/mobile/pdf/va_benefits_rs.pdf.

I have brought with me copies of several of these products and ask that they be made part of the record.

VA also actively participates in discharge planning and orientation sessions for returning service members. With the activation and deployment of large numbers of Reserve/National Guard members for the onset of military actions in Afghanistan and Iraq, VA, in collaboration with DoD, has greatly expanded outreach to returning

Reserve/National Guard members and their family members. National and local contacts have been made with Reserve/National Guard officials to schedule pre- and post-mobilization briefings for their members at the unit level. Returning Reserve/National Guard members can also elect to attend the formal 3-day Transition Assistance Program (TAP) workshops provided by VA personnel at mobilization stations. Knowing that this is an optional program for the Reserve/National Guard, VA has developed strategies to brief family members while the service member is still deployed and has arranged time on the unit training schedule and during reunions and family day activities.

From FY 2002 through the 1ST quarter of the FY 2005, VBA military services coordinators have conducted more than 19,000 briefings, reaching a total of more than 700,000 active duty service members. These briefings include 1,795 pre- and post-deployment briefings attended by over 88,000 activated Reserve and National Guard service members. During FY 2004 alone, VBA military services coordinators provided more than 7,200 benefits briefings to over 261,000 separating and retiring military personnel, including briefings aboard some Navy ships returning to the United States. Almost 1,400 of these briefings were conducted for Reserve and National Guard members. As of January of this year, we had already provided 2,260 briefings to 79,000 returning service members in FY 2005.

Other outreach activities include the distribution of flyers, posters, and information brochures to VAMCs, VAROs, and Vet Centers. VA has, in fact distributed more than 1.5 million brochures to DoD demobilization sites and USO's. VA has produced and distributed one million copies of a VA health care and benefits wallet/pocket card. The card lists a wide range of VA programs, and provides relevant phone numbers and email addresses.

VA has produced media aimed specifically at OIF and OEF veterans. Examples of these include:

- Newsletter: Three issues of the "OIF & OEF Review." This newsletter provides a wide range of information about health and other benefits issues to VA personnel, and veterans and their families. The newsletter has been

widely distributed to VAMCs, VAROs, and Vet Centers, and mailed out to all returning OIF/OEF veterans identified by DoD as leaving active military duty.

- Information Sheets: Two information sheets have been published, one each on OIF and OEF service, summarizing health issues for those two deployments. These were distributed to all VAMCs, VAROs, and Vet Centers.
- Video Production: A video targeted at returning OIF/OEF veterans and their families, entitled "*We Are by Your Side.*" The video thanks service members for their service and introduces both VA and DoD services that are available to returning vets as they transition to civilian life. This video was mentioned earlier in my statement. Another video was developed for VA and DoD employees to assist them in understanding the seamless transition process. This video can be used in a variety of settings such as waiting rooms, new employee orientations, and at off-site functions such as health fairs. Again, I ask that copies be made a part of the record.

As service members separate from the military, VA contacts them to welcome them home and explain what local VA benefits and services are available. Furthermore, we have made a wide selection of general information available to OIF and OEF veterans online through a direct "Iraqi Freedom" link from VA's Internet page (www.vba.va.gov/EFIF). This website provides information on VA benefits, including health care services, DoD benefits, and community resources available to regular active duty service members, activated members of the Reserves and National Guard, veterans, and veterans' family members.

Last year, VA began sending "thank-you" letters together with information brochures to each OIF and OEF veteran identified by DoD as having separated from active duty. These letters provide information on health care and other VA benefits, toll-free information numbers, and appropriate VA web sites for accessing additional information. The first letters and information brochures were mailed in April 2004, and thus far, VA has mailed letters to more than 290,000 returning OIF/OEF veterans. In 2005, letters and educational "toolkit" were sent to each of the National Guard Adjutants

General and the Reserve Chiefs explaining VA services and benefits. I am asking that a copy of this letter also be made part of the record.

A critical concern for veterans and their families is the potential for adverse health effects related to military deployments. VA has produced a brochure that addresses the main health concerns for military service in Afghanistan, another brochure for the current conflict in Iraq, and one that addresses health care for women veterans returning from the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad. These are widely distributed to military contacts and veterans service representatives; they can also be found on VA's website.

Another concern is the potential health impact of environmental exposures during deployment. Veterans may have questions about their symptoms and illnesses following deployment. VA addresses these concerns through such media as newsletters and fact-sheets, regular briefings to veterans' service organizations, national meetings on health and research issues, media interviews, educational materials, and websites, like www.va.gov/environagents. One major initiative to educate VA and DoD healthcare providers is the Veterans Health Initiative (VHI). Through the VHI, VA has developed training programs for such topics as care of war wounded, TBI, PTSD, and military sexual trauma, among others. This CD-ROM training has been distributed to VA and DoD Healthcare providers. Additionally, we have created a web page for VA employees on the activities of VA's seamless transition initiative. Included are the points of contact for all VA health care facilities and VAROs, copies of all applicable directives and policies, press releases, brochures, posters, and resource information.

VA Health Care Utilization

Veterans who have served or are now serving in Afghanistan and Iraq may, following separation from active duty, enroll in the VA health care system and, for a two-year period following the date of their separation, receive VA health care without co-

payment requirements for conditions that are or may be related to their combat service. Following this initial two-year period, they may continue their enrollment in the VA health care system but may become subject to any applicable co-payment requirements.

As of February 2005, VA had data on 360,674 OIF and OEF veterans who had separated from active duty. Approximately 24 percent of these veterans (85,857) have sought health care from VA. Most of these veterans have received outpatient care, while only a comparatively small number (1,980) have had an episode of hospitalization. Reservists and National Guard members make up the majority of those who have sought VA health care (44,178, or 52 percent). Those who separated from regular active duty have accounted for 48 percent (41,679). However, among separated OIF/OEF veterans eligible for VA health care, a greater percentage of veterans of regular active duty (29 percent) has sought VA health care than have Reservists/National Guards personnel (20 percent).

OIF and OEF veterans have sought VA health care for a wide-variety of physical and psychological problems. The most common health problems have been musculoskeletal ailments (principally joint and back disorders) and diseases of the digestive system, with teeth and gum problems being the predominant complaints. In total, OIF/OEF veterans have accounted for only slightly more than one percent of our total veteran patients (4.9 million in FY 2004).

Mr. Chairman, VA is aware that there has been particular interest about mental health issues among OIF and OEF veterans and VA's current and future capacity to treat these problems, in particular PTSD. First, I have been asked to assure the Subcommittee that VA has the programs and resources to meet the mental health needs of returning OIF and OEF veterans. Second, in regard to PTSD among OIF and OEF veterans, I have been asked to provide the further assurance that the PTSD workload that we have seen in these veterans has been only a small percentage of our overall PTSD workload. In FY 2004, we saw approximately 279,000 patients at VA health care facilities for PTSD and 63,000 in Vet Centers. Our latest data on OIF and OEF veterans indicate that as of February 2005, 9,688 of these veterans seen as patients at VAMCs carried an ICD-9 code corresponding to PTSD. Additionally, 2,332 veterans received services for PTSD through our Vet Centers. Allowing for those who

have received services at both VAMCs and Vet Centers, a total of 11,224 individual OIF/OEF veterans had been seen with actual or potential PTSD at VA facilities following their return from Iraq or Afghanistan. This figure represents only about three percent of the PTSD patients VA saw in FY 2004. It should be noted, however, that some of the 11,224 OIF/OEF veterans may include those with a provisional ("rule-out") diagnosis of PTSD who were being assessed for this disorder or other, unrelated disorders.

Meeting the comprehensive health care needs of returning OIF and OEF veterans who choose to come to VA is one of the Department's highest priorities. VA is confident that its FY 2005 budget and the Presidents' FY 2006 budget request contain sufficient funding to allow us to provide for all the health care needs of OIF and OEF veterans. Of course, we will continue to monitor the health care workload associated with OIF and OEF veterans to ensure that VA aligns its health care resources to meet their needs.

Polytrauma Centers

One of the harshest realities of combat in Iraq and Afghanistan is the number of service members returning from Iraq and Afghanistan with loss of limbs and other severe and lasting injuries. VA recognizes that it must provide specialized care for military service members and veterans who have sustained severe and multiple catastrophic injuries. Since the start of OIF/OEF, VA's four regional Traumatic Brain Injury (TBI) Lead Rehabilitation Centers (located in Minneapolis, Palo Alto, Richmond, and Tampa) have served as regional referral centers for individuals who have sustained serious disabling conditions due to combat. These programs are specially accredited to provide comprehensive rehabilitation services and TBI services. Patients treated at these facilities may have a serious TBI alone or in combination with amputation, blindness, or other visual impairment, complex orthopedic injuries, auditory and vestibular disorders, and mental health concerns. Because TBI influences all other areas of rehabilitation, it is critical that individuals receive care for their TBI prior to, or in conjunction with, rehabilitation for their additional injuries.

In accordance with section 302 of Public Law 108-422, VA has developed a plan to expand the scope of care at these four centers and create Polytrauma Centers. This

plan builds on the capabilities of the regional referral centers but adds additional clinical expertise to address the special problems that the multi-trauma combat injured patient may face. Such additional services include intensive psychological support treatment for both patient and family, intensive case management, improvements in the treatment of visual disturbance, improvements in the prescription and rehabilitation using the latest high tech specialty prostheses, development of a clinical database to track efficacy and outcomes of interventions provided, and provision of an infrastructure for important research initiatives. Additionally, the plan addresses services for patients in the outpatient setting for ongoing follow-up care not requiring hospitalization. The plan provides for enhancements to existing rehabilitation outpatient clinical services to ensure that necessary services can be provided within easier access to the patient's home.

On April 7, 2005, VA published a directive that requires the four Polytrauma Centers to assign social worker case managers at a ratio of one case manager for every six patients. These case managers will initiate contact with service members and veterans and their families before they are transferred to the polytrauma centers and will follow them throughout their rehabilitation and treatment. Additionally, VA Voluntary Service (VAVS) Managers at the four polytrauma centers are working with local community organizations and businesses to provide necessary information and services to family members who are staying with their family members. National Veteran Service Organizations (VSOs) have pledged their support to provide phone cards, discount lodging coupons, and local support for transportation of the family members. Each family member will receive a welcome package with information of the local area, coupons for lodging, and area attractions and coupons for the Veterans Canteen Service. In Palo Alto, for example, the Chief VAVS meets with the family members upon arrival and seeks support from area businesses and VSOs based on family needs.

Future Initiatives

- Although the Seamless Transition initiative was initially created to support service members who served in OIF/OEF, it is intended to become an enduring process

that will support all service members who, as a result of injury or illness, enter the disability process leading to medical separation or retirement.

- VA is working with DoD to obtain a list of service members who enter the Physical Evaluation Board (PEB) process. The PEB list will identify those veterans who sustained an injury or developed an illness that precluded them from continuing on active duty and resulted in medical separation or retirement. The list will enable VA to contact these service members to initiate benefit applications and transfer of health care to a VAMC prior to discharge from the military.
- VA is strengthening its support system for the veterans' and their families to accommodate them in Fisher Houses and hotels as the veterans continue the rehabilitation process. VA's goal is to honor each new veteran and their family with compassion, dignity, and coordination of every service and support that can help to restore function. VA has made great strides in ensuring our veterans experience a smooth transition to civilian life. VA is committed to institutionalizing the seamless transition process as we continue to further increase collaboration with DoD.
- Finally, the STO will lead the Department in continuing to orient VA culture to meet the expectations of our newest veterans and their families.

Conclusion

VA's most important mission is to "care for him who has borne the battle." I am honored to lead an office dedicated to fulfilling this mission. Mr. Chairman, this concludes my statement. I will be happy to respond to any questions that you or other members of the Subcommittee might have.

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Statement for the Record

Before the
Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs
U.S. House of Representatives
on
May 19, 2005

Linda Boone
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Executive Summary

Part I—Timely Transfer of Injured Servicemembers from DOD to VA & Service-Specific Initiatives

- Continue the Military Severely Injured Joint Support Operations Center and service-specific initiatives to support severely injured servicemembers.
- Require the Secretary of Defense to determine the best practices being used by the services to assist wounded servicemembers and to develop consistent standards and guidelines for such programs to ensure all members, regardless of service, are treated consistently.
- Formally authorize the Benefits Delivery at Discharge Program.

Part II—Matthew Boisvert HEROES Act

- Enact the Matthew Boisvert Help Extend Respect Owed to Every Soldier (HEROES) Act to provide improved benefits and procedures for the transition of members of the Armed Forces from combat zones to noncombat zones and for the transition of veterans from service in the Armed Forces to civilian life.

PART III—Servicemembers' Enhanced Transition Services Act

- Enact the Servicemembers' Enhanced Transition Services Act to improve transition assistance provided for members of the Armed Forces being discharged, released from active duty, or retired.

PART IV—VA Outreach Programs

- Incorporate homelessness prevention content into VA outreach efforts.
- Include separating servicemembers as a target of VA outreach program.

Introduction

The National Coalition for Homeless Veterans appreciates the opportunity to testimony on the efforts of the Department of Veterans Affairs and Department of Defense to assist military personnel in making a "seamless transition" from active duty to veterans' status.

The **National Coalition for Homeless Veterans** (NCHV), established in 1990, is a **nonprofit organization** with the **mission of ending homelessness among veterans** by shaping public policy, promoting collaboration, and building the capacity of service providers. NCHV's nearly 250 member organizations in 46 states and the District of Columbia provide housing and supportive services to homeless veterans and their families, such as street outreach, drop-in centers, emergency shelter, transitional housing, permanent housing, recuperative care, hospice care, food and clothing, primary health care, addiction and mental health services, employment supports, educational assistance, legal aid and benefit advocacy.

The VA estimates that approximately 250,000 veterans are homeless on any given night; more than 500,000 experience homelessness over the course of a year. *Conservatively, one of every three homeless adult males sleeping in a doorway, alley, box, car, barn or other location not fit for human habitation in our urban, suburban, and rural communities has served our nation in the Armed Forces.* Homeless veterans are mostly males (2 percent are females). 54 percent are people of color. The vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance. 45 percent have a mental illness. 50 percent have an addiction.

America's homeless veterans have served in World War II, Korea, the Cold War, Vietnam, Grenada, Panama, Lebanon, anti-drug cultivation efforts in South America, Afghanistan, and Iraq. 47 percent of homeless veterans served during the Vietnam Era. More than 67 percent served our nation for at least three years and 33 percent were stationed in a war zone.

Male veterans are twice as likely to become homeless as their non-veteran counterparts, and female veterans are about four times as likely to become homeless as their non-veteran counterparts. *Like their non-veteran counterparts, veterans are at high risk of homelessness due to extremely low or no income, dismal living conditions in cheap hotels or in overcrowded or substandard housing, and lack of access to health care.* **In addition to these shared factors, a large number of at-risk veterans live with post traumatic stress disorders and addictions acquired during or exacerbated by their military service. In addition, their family and social networks are fractured due to lengthy periods away from their communities of origin. These problems are directly traceable to their experience in military service or to their return to civilian society without appropriate transitional supports.**

Contrary to the perceptions that our nation's veterans are well-supported, in fact many go without the services they require and are eligible to receive. One and a half million veterans have incomes that fall below the federal poverty level. **Neither the VA, state or county departments of veteran affairs, nor community-based and faith-based service providers are adequately resourced to respond to these veterans' health, housing, and supportive services needs.** For example, the VA reports that its homeless treatment and community-based assistance network serves 100,000 veterans annually. *With an estimated 500,000 veterans experiencing homelessness at some time during a year and the VA reaching only 20 percent of those in need, 400,000 veterans remain without services from the department responsible for supporting them.* **Likewise, other federal, state, and local public agencies—notably housing and health departments—are not adequately responding to the housing, health care and supportive services needs of veterans.** Indeed, it appears that veterans fail to register as a target group for these agencies.

Our statement is organized in four parts. The first part focuses on the timely transfer of servicemembers from military hospitals to Veterans Affairs medical centers and service specific initiatives. The second part focuses on the health care and information sharing provisions of the Matthew Boisvert Help Extend Respect Owed to Every Soldiers Act (HEROES) Act. The third part focuses on the Servicemembers' Enhanced Transition Services Act. The fourth part presents our recommendations for strengthening the outreach programs of the Department of Veterans Affairs.

Part I—Timely Transfer of Injured Servicemembers from DOD to VA & Service-Specific Initiatives

NCHV shares the Committee's interest in ensuring that those of our nation's servicemembers who have sustained severe or debilitating injuries in the line of duty are provided the transition assistance necessary for physical stabilization, emotional recovery, physical and mental rehabilitation, and establishment of independent living, or fully-supported living when complete independence is no longer possible.

Like our fellow Americans, we have watched our servicemembers, through weekly news coverage, in awe and gratitude as one after the other amazing story of survival, courage, and hope is reported to us. We have watched as some of our seriously injured servicemembers heal their wounds, re-learn basic skills, and leave DOD or VA medical facilities on their own means or with extensive family supports in place. We are also heartened in the knowledge that the Department of Defense, Department of Veterans Affairs and other federal, state, local, and private agencies and their dedicated professionals have organized their resources and talents– some more successfully than others – to support these servicemembers in their return to civilian life.

Yet, we know that for each such successful transition, there is an equal or greater share of heartache – injured servicemembers for whom the return from battle is anything but seamless. *These are the servicemembers whose injuries, while serious, are not so grossly severe that military commanders have flagged them for priority attention. These are the servicemembers whose family members – if they even have strong family supports – are unsure how "the system" works and how to become patient advocates or public relations operatives. These are the servicemembers being caught between multiple federal, state, and county military and veterans agencies still struggling to share information with each other.* **And naturally, these are the servicemembers *so poorly supported* by our presumed "Grade A" military personnel and veterans affairs' systems that they become homeless.**

Take Vanessa Turner. Ms. Turner joined the U.S. Army in April 1997 and advanced to the rank of sergeant. She was deployed to Camp Balad, 20 miles west of Baghdad, in Operation Iraqi Freedom. While serving in the combat theater, she collapsed in 130-degree heat, fell into a coma, and nearly died of heart failure. She was evacuated to Europe, then to Walter Reed Army Medical Center in Washington, D.C., and released with a pending medical discharge in July 2003. And that is the good part of Ms. Turner's story.

Ms. Turner was released from Walter Reed – and discharged from the military – with neither a place to live nor ongoing health care in place. Without a home, she and her daughter bounced from place to place -- from the couch in her mother's cramped one-bedroom apartment, to a friend's couch, to her sister's friend's friend's couch. When she went to the Veterans Affairs Medical Center in West Roxbury, she was told she had to wait three months to see a doctor. When she asked the Army to ship her possessions from her unit's base in Germany, where she had lived with her daughter for more than a year, they told her she had to fly back at her own expense to get them herself. And when she sought help to secure a veterans' loan for a house in Boston, she said mortgage brokers told her the only real option was to move to Springfield or Worcester. Ms. Turner's tragic situation was partially resolved only with the persistent intervention of a Member of Congress.

Regrettably, there are dozens more Vanessa Turners – returning from Iraq and Afghanistan without a place to call home. Not all of them know to call their Member of Congress for relief – nor should they

have to! **The community-based homeless veteran service providers that NCHV represents are reporting servicemembers from Operation Enduring Freedom and Operation Iraqi Freedom among their service users.** Some of these newly homeless veterans are seriously injured. Others are fighting PTSD and other emotional and addictive impairments. Still others simply have been unable to find work. *Regardless of the cause, in a country as wealthy as the United States, with the best military personnel and veteran support systems in the world, it is simply outrageous that any servicemember or former servicemember becomes homeless.*

NCHV is generally supportive of the various federal government-wide, joint service, and service-specific initiatives underway to assist severely injured servicemembers in transitioning to civilian life. This includes the Military Severely Injured Joint Support Operations Center, Marine for Life, Army DS3, Air Force Palace HART, and Navy Support for the Severely Injured. These service coordination and transition assistance initiatives are a vast improvement over the poor treatment that servicemembers in previous campaigns received upon their return home. *These focused initiatives provide opportunities for servicemembers, family members, public officials, and veterans' service organizations to detect multi-service needs and plug system gaps.* NCHV supports a provision in the House Armed Services Committee version of the FY 2006 National Defense Authorization Act (HR 1815) that requires the Secretary of Defense to determine the best practices being used by the services in their service-specific initiatives to assist wounded servicemembers and to develop consistent standards and guidelines for such initiatives in order to ensure that all members, regardless of service, are treated consistently.

We are interested in knowing more about what these various initiatives are doing to support seriously injured servicemembers and their families facing a housing crisis. What housing counseling and assistance does each initiative presently provide? How are seriously injured servicemembers at imminent risk of homelessness assisted in securing permanent housing in the communities to which they will be returning prior to their discharge from military service? Have any of the services succeeded in involving the Department of Housing and Urban Development in their efforts? What connections are these initiatives making with local public housing authorities or nonprofit housing providers? Is housing even on the radar of these various initiatives?

We are particularly pleased with the Benefits Delivery at Discharge Program. This program establishes an expedited process for servicemembers to file an application for service-connected compensation before they separate from the military. *Veterans' compensation is potentially the determining factor in determining whether a veteran with disabilities will obtain housing or become homeless.* Any effort to expedite payment of veteran compensation and pension benefits is welcomed and should be fully supported. **We encourage Congress to authorize the Benefits Delivery at Discharge Program as a permanent program.**

Part II—Matthew Boisvert HEROES Act

As this Committee is well aware, **information and resource sharing between DOD and VA, while improving in recent years, remains a challenge for the two Departments, resulting in redundancy, inefficiency, higher costs, and ultimately less than excellent health care for both our nation's servicemembers and veterans, including separating servicemembers with serious injuries.** In 2001 President Bush established the President's Task Force to Improve Health Care for Our Nation's Veterans and charged it to identify ways to improve health care delivery to DOD and VA beneficiaries through better coordination and improved business practices. The Task Force released its report in 2003. *Regrettably, DOD and VA have made slow progress on several of the Task Force Recommendations, including some that are directly applicable to seamless health care transition.*

In response to these concerns, Representative Marty Meehan (D-MA) has included in his forthcoming *Matthew Boisvert Help Extend Respect to Every Soldier (HEROES) Act* a number of health care provisions that, if enacted, would greatly improve servicemembers' health care transition. **NCHV supports the HEROES Act and urges its enactment this session.** The bill is likely to receive a referral to the Veterans' Affairs Committee. *We urge Committee leadership to quickly schedule a hearing on and mark-up of the HEROES Act following its introduction. Further, we urge Committee members to co-sponsor the legislation.*

The HEROES Act is organized in four sections: health care, transition assistance, homeownership, and education. In light of the health care transition focus of this hearing, we draw the Committee's attention to the bill's health care provisions.

Minimum Standards for Post Deployment Medical Examinations (Section 101)

In 1997, Congress required DOD to establish a quality assurance program to ensure uniform standards for post-deployment health assessments of servicemembers deployed outside the United States. Unfortunately, the Department has not fulfilled this mandate, allowing standards to drop and some

servicemembers to go without proper examinations. The HEROES Act requires all returning servicemembers to undergo a thorough physical and mental health examination. The examination would take place prior to the administration of preseparation counseling, so that servicemembers with allegations of service-connected disability may be counseled on veterans' disability benefits.

Early Identification and Treatment of Mental Health and Substance Abuse Disorders (Section 102)

A July of 2004 study by the New England Journal of Medicine found that 17 percent of servicemembers returning from Iraq and Afghanistan suffer from major depression, anxiety or Post-Traumatic Stress Disorder (PTSD). Unfortunately, many servicemembers do not seek out assistance because of the stigma associated with mental health disorders.

The HEROES Act requires DOD to create a mass-media campaign about mental health and substance abuse disorders, including PTSD, to reduce the stigma surrounding these diseases. It also creates peer-support programs at military bases to educate servicemembers, their families, and their colleagues about the warning signs of PTSD and substance abuse.

Expansion of Post-Traumatic Stress Disorder Treatment Programs (Section 103)

The HEROES Act requires each VA clinic to have at least one mental health team trained in diagnosing and treating PTSD. It also creates a veteran outreach program to raise awareness about mental health services offered at VA clinics, including case management, group therapy, and education.

Contracts for Psychiatric Services Not Offered in VA Clinics (Section 104)

The HEROES Act requires the VA to cover the cost of psychiatric and mental health services provided to veterans by non-VA providers when the veteran lives far from a VA outpatient clinic offering services.

Transmittal to VA of Medical Records of All Members Separating from Active Duty (Section 105)

The HEROES Act requires the Secretary of Defense to transfer to the Secretary of Veterans Affairs the copies of service medical records of each member of the service separating from active duty (with limited exceptions). Current law requires the transfer of service medical records only for those members being medically separated or being retired. Furthermore, the Act requires the transfer of copies of service medical records to occur within seven days of separation, rather than the current 60 days.

Health Registry for Veterans of Operations Iraqi and Enduring Freedom (Section 106)

The HEROES Act improves the ability of VA to monitor the health status of veterans of Operations Iraqi and Enduring Freedom by transferring data on deployed servicemembers to the VA. This allows the VA to track demographic breakdowns of these individuals and their mental and physical health history.

Coordination between the Departments of Defense and Veterans Affairs (Section 205)

The HEROES Act directs DOD and VA to develop protocols for information sharing about servicemembers' assignments and risks and exposures in order to aid VA in providing appropriate medical care and other benefits to former servicemembers once part of the VA system.

PART III—Servicemembers' Enhanced Transition Services Act

Servicemembers separating from the Armed Forces, including servicemembers separating due to serious injuries, have available to them two transition services programs – preseparation counseling and Transition Assistance.

Current law (10 U.S.C. 1142) requires the Departments of Defense and Homeland Security to provide individual preseparation counseling to each member of the armed forces whose discharge or release from active duty is anticipated. Matters covered during the counseling include: a discussion of educational assistance, compensation, and rehabilitation benefits to which servicemembers are entitled; information concerning job search and job placement assistance; information concerning relocation assistance; information concerning medical and dental coverage; financial planning assistance; and the creation of a transition plan for the servicemember. Preseparation counseling takes many forms, but tends to be brief group presentations to servicemembers immediately prior to their separation.

Generally, in the case of an anticipated retirement, preseparation counseling shall commence as soon as possible during the 24-month period preceding the anticipated retirement date. In the case of a separation other than retirement, counseling shall commence as soon as possible during the 12-month period preceding the anticipated date. Counseling shall be made available no later than 90 days prior to separation. Servicemembers being discharged or released before the completion of that member's first

180 days of active duty are not eligible for preseparation counseling, unless the separation is due to disability.

Current law (10 U.S.C. 1144) authorizes the Department of Labor to furnish counseling, assistance in identifying employment and training opportunities, help in obtaining such employment and training, and other related information and services to members of the armed forces who are being separated from active duty. Elements of this program, known as the Transition Assistance Program (TAP), include information concerning employment and training assistance; information concerning Federal, state, and local programs and programs of military and veterans' service organizations; information about small business loan programs for veterans; information about the geographic locations to which members are returning; and other matters. Participation in the program is encouraged, not required. TAP is a three-day group-level workshop.

Former servicemembers with whom homeless veteran service providers are in daily contact report that the preseparation counseling and transition assistance programs are lacking in a number of areas. Among their concerns: the depth and content of preseparation counseling is quite variable across delivery sites. Preseparation counseling may be limited to brief group-level presentations rather than individualized transition planning (as is contemplated in the statute). **Servicemember participation in the Transition Assistance Program is at the will of the unit commander, and often allowed only during off-duty time. Neither program includes content on homelessness awareness or housing counseling assistance and referral.**

Weaknesses in the both the content and delivery of servicemember separation programs result in some servicemembers failing to receive information necessary to ensure their stable health care, steady employment, and secure housing upon their return to civilian life. **This places servicemembers at increased risk of homelessness.**

In response to these concerns, Representative Robert Andrews (D-NJ) has introduced the **Servicemembers' Enhanced Transition Services Act of 2005** (H.R. 2074) to improve transition assistance provided for members of the Armed Forces being discharged, released from active duty, or retired. **NCHV supports the Servicemembers' Enhanced Transition Services Act.**

The Servicemembers' Enhanced Transition Services Act strengthens the existing programs of the Department of Defense, the military branches, and the Department of Labor that support our nation's separating servicemembers as they return to civilian life. *The legislation would ensure equity in access to preseparation counseling and transition assistance regardless of the servicemembers' type of service, military branch, duty station, rank, or discharge condition. The bill would improve the quality of preseparation counseling currently available by making as much as eight hours of individualized transitional assistance available to servicemembers in addition to group workshops. Further, the legislation would expand the scope of content to be covered in preseparation counseling and transition assistance to ensure the dissemination of full information on the health care, compensation, employment and housing benefits to which servicemembers and veterans are eligible.*

We are pleased that the House Armed Services Committee is considering amendments to incorporate provisions of HR 2074 into its version of the National Defense Authorization Act. **We urge Veterans' Affairs Committee members to co-sponsor HR 2074 and ensure its enactment this session**, whether that is through the NDAA, another omnibus vehicle, or as a stand-alone measure.

PART IV—VA Outreach Programs

Servicemembers separating from the Armed Forces, including servicemembers separating due to serious injuries, receive opportunities to learn about benefits for which they may be eligible, both prior to separation (through preseparation counseling and the Transition Assistance Program) and post-discharge via Department of Veterans Affairs outreach. *VA outreach provides an opportunity, as yet untapped, to alert recently separated servicemembers to the increased risk of homelessness they face and the preventative services available to them if they find themselves at imminent risk of losing their living arrangement.*

Current law (38 U.S.C. 7722) requires VA to conduct a range of outreach efforts to alert veterans to the programs and services available through the Department. Also, current law (38 U.S.C. 2022) requires VA to develop a coordinated plan by the Mental Health Service and the Readjustment Counseling Service for joint outreach to veterans at risk of homelessness and an outreach program to provide information to homeless veterans and veterans at risk of homelessness. Individuals leaving the military are at high risk of homelessness due to a lack of job skills transferable to the civilian sector, disrupted or dissolved family and social support networks, and other risk factors that preceded their military service. Separating servicemembers must be made aware of the factors that contribute to homelessness and receive information about sources of preventive assistance *before* they exit the military.

A robust outreach program not only informs veterans of services available to them should they become homeless, but also to guides them on steps they may take to avert homelessness. **Congress should require VA outreach plans and outreach efforts to add homelessness prevention matter as expected outreach content, including information on risk factors for homelessness, a self-assessment of risk factors, and contact information for preventative assistance associated with homelessness.**

Current law (38 U.S.C. 2022) requires VA, in its outreach program, to target veterans being discharged or released from institutions after inpatient care. *Congress should add as an additional target population individuals separating from the armed forces.*

Conclusion

The National Coalition for Homeless Veterans looks forward to continuing to work with the Committee on Veterans' Affairs in ensuring that our nation does everything within its grasp to ensure a seamless transition for our nation's separating servicemembers. These soldiers have served our nation well. It is beyond time for us to repay the debt.

Curriculum Vitae

Linda Boone, Executive Director, assumed management of the National Coalition for Homeless Veterans in April 1996. Since then the organization has grown from a handful of members to nearly 250 community-based organizations, government agencies and businesses providing supportive services to more than 150,000 homeless veterans and their families every year.

Boone spent the first 20 years of her career in the high technology manufacturing environment before developing her own consulting and training business, working with multi-million dollar corporations to develop competitive management practices.

Boone's involvement with veteran issues began in 1969 as a volunteer in her local community. Her advocacy for homeless veterans began in 1990 after meeting veterans living under a boardwalk near her home. She went on to serve as the National President of the one million-member American Legion Auxiliary. During her administration, the organization contributed 10 million volunteer hours and $20 million to more than 11,000 communities worldwide.

Boone is recognized as one of the nation's foremost authorities on homeless veteran issues, and has had a significant impact on the development of and increased funding for many of the federal homeless veteran programs in existence today.

Federal Funding

The National Coalition for Homeless Veterans has received the following Federal grants:

FY03
HUD Grant to provide technical assistance to community-based organizations, $138, 502.

FY04
Department of Veterans Affairs Grant to provide technical assistance to community based organizations with experience in assisting homeless veterans, $517,422.

Department of Labor Grant to provide technical assistance to community based organizations with experience in assisting homeless veterans, $86,313.

FY05-06
Department of Veterans Affairs Grant to provide technical assistance to community based organizations with experience in assisting homeless veterans, two year total award is $1,112,500.

Hearing Date: 19 May 2005
Committee: HVAC
Subcommittee: Oversight & Investigation
Witness: COL Fryer
Question #5

ARMY POLYTRAUMA LIAISON

Question: In written testimony Colonel Fryer recommended DOD And VA expedite development of interoperable data repositories that will support bi-directional exchange of information between the two departments. As a clinician, you are most likely aware of the one way transfer of electronic medical information using Federal Health Information Exchange. How functional is this one way data exchange of medical information to VA practitioners?

Answer: The Polytrauma Liaisons do not directly access medical information using the Federal Health Information Exchange (FHIE). FHIE is strictly used to transfer information for Soldiers who are separating from the military and this information consists of records that must be transferred to the VA to support future healthcare and to support determination of VA disability ratings. FHIE is not used or designed to support real time transfer of clinical information between DOD and VA facilities. Generally speaking, full medical records are transferred to the VA when the Soldier is transferred.

Real time sharing of clinical information between DOD and VA is being facilitated by the Bidirectional Health Information Exchange (BHIE), which allows allergy, outpatient prescription and demographic data, and laboratory and radiology results to be shared for patients treated in both DOD and VA. All VA sites have access to this data from DOD sites that have implemented BHIE. BHIE is operational in Seattle, WA area and El Paso, TX. BHIE is scheduled to be installed at the Eisenhower Army Medical Center in Ft. Gordon, GA, the Naval Hospital Great Lakes, IL, and the Naval Medical Center in San Diego, CA in September 2005. Deployment to additional sites in FY05 is being coordinated with the Services, and local DOD/VA sites. Site selection was based on support to returning members of Operation Enduring Freedom and Operation Iraqi Freedom, number of visits for VA beneficiaries treated in DOD facilities, current FHIE usage, number and types of DOD medical treatment facilities, local sharing agreements, retiree population, and local site interest. BHIE is anticipated to be implemented at the following sites in early FY06: Bassett Army Community Hospital, Fairbanks, AK; Brooke Army medical Center, San Antonio, TX; National Capital Area to include Walter Reed, Bethesda, Dewitt and others; Landstuhl Regional Medical Center; David Grant Medical Center, CA; Elmendorf AFB Medical Facility, Anchorage, AK; Mike O'Callaghan Federal Hospital (Nellis AFB), NV; and Wilford Hall Medical Center, San Antonio, TX.

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