TRANSITIONING HEROES: NEW ERA, SAME PROBLEMS?

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BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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January 21, 2010

TRANSITIONING HEROES: NEW ERA, SAME PROBLEMS?

THURSDAY, JANUARY 21, 2010

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

The Subcommittee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Walz, Adler, Hall, Roe, and Stearns.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning, and welcome to the Subcommittee on Oversight Investigations hearing on "Transitioning Heroes: New Era, Same Problems?" This meeting will come to order.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and submit statements for the record. Hearing no objection so ordered.

I would like to thank everyone for attending today's Oversight and Investigations Subcommittee hearing entitled, "Transitioning Heroes: New Era, Same Problems?" Thank you especially to our witnesses for testifying today.

We are here today to address what both the U.S. Department of Defense (DoD) and the U.S. Department of Veterans Affairs (VA) are doing to assist the men and women of our armed forces to seamlessly transition back to civilian life. Time and again we have heard from our returning servicemembers expecting a smooth transition back to the lives they once lived only to find themselves lost in a complex and frustrating bureaucracy.

Today we will hear from a severely injured veteran, Staff Sergeant Sean Johnson who was hit by a mortar round in Iraq and is now completely blind. Although he has received excellent treatment at the Blind Rehabilitation Center in Chicago, he was never assigned a Federal Care Coordinator after contacting the VA almost a year ago.

In addition, Staff Sergeant Johnson and his family are experiencing the hardships of navigating through both the DoD system and VA system at the same time.

This is just one example of many. Staff Sergeant Johnson joins those veterans and their families who share the same concerns that our veterans service organizations (VSOs) will voice here today.

Additionally, as I have said before, outreach to our Nation's veterans is an equally important task. Both the VA and DoD must ensure that veterans and their families are properly informed about the benefits and services they have earned when they return to civilian life.

We need to proactively bring the VA to our veterans, as opposed to waiting for veterans to find the VA. This is a critical part of delivering the care they have earned in exchange for their brave service.

The VA should be a place where veterans can easily, and with confidence, go for the help they seek, but the VA must also be willing to reach out to those veterans. Effective outreach will not only ensure better delivery of services for our veterans, but will also increase morale.

I am hopeful that today both the VA and DoD will shed light on what they are doing to make certain our veterans are receiving the best possible care available; they are being provided with the services and resources they have earned; and most importantly, that the two Departments are working together to ensure that these benefits earned are seamlessly delivered.

I believe that all my colleagues join me in being steadfast in our hopes that Secretary Shinseki, as he transforms the VA into a 21st century organization, will help eliminate the stigma that so many of our Nation's veterans have placed upon the VA. We must ensure that both the VA and DoD are working together and providing veterans the services that they rightfully deserve.

Again, thanks to all our witnesses for testifying today, and we look forward to hearing your testimony.

Before I recognize the Ranking Member for his remarks I would like to swear in our witnesses. I ask that all witnesses please stand and raise their right hand.

[Witnesses sworn.]

Thank you. I would like to now recognize Dr. Roe for opening remarks.

[The prepared statement of Chairman Mitchell appears on p. 39.]

OPENING STATEMENT OF HON. DAVID P. ROE

Mr. ROE. Thank you for yielding, Mr. Chairman.

I would first like to thank the Members of the first panel for their service to this country. Not only their military service, but their continued service by appearing here today to share their testimony and help us work toward a better transition for our Nation's veterans.

Prior to this hearing, my staff provided me with a list of the hearings held by the Committee on Veterans' Affairs over the past 10 years, totaling around 33 hearings. The topics have ranged from employment transition through the use of polytrauma centers, pre- and post-deployment heath assessments, sharing of electronic health records of our wounded servicemembers, transition assistance programs (TAPs) for Guard and Reserve forces, and the list goes on.

As you can tell, helping our servicemembers move from the military to civilian life is of great importance to this Committee.

Concern in Congress about helping our servicemembers transition to civilian life didn't start 10 years ago. During the 97th Congress, Congress codified this concept of DoD/VA sharing, now known as seamless transition in 1982 with passage of the Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act. This act created the VA Care Committee to supervise and manage opportunities to share medical resources.

Today's hearing will enable the Committee to review the various programs that have been instituted to assist our Nation's veterans and wounded warriors in their transition to civilian life. We will be looking forward not only at the medical record exchange between VA and DoD, but also at the various other transition services, the use of polytrauma centers across the country, and programs available to assist our veterans.

This is not the first hearing to look at these items, and I am certain it will not be our last. We here in Congress must do everything we can to make certain that the transition our military personnel undergo is smooth, easy, and the programs available are truly helping our Nation's veterans.

In the past it appears that any transition many servicemembers have encountered have not been exactly seamless, and certainly not easy or smooth.

Mr. Chairman, I appreciate you holding this hearing today, and I believe we have much to learn from the witnesses today.

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

[The prepared statement of Congressman Roe appears on p. 39.]

Mr. MITCHELL. Thank you. Mr. Walz.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well thank you, Mr. Chairman and Ranking Member, and I will submit a statement to the record, but I want to thank both of you for holding this hearing and for our witnesses for being here. There is nothing more important that we do than to care for our veterans, and many of you in this room, and I know my colleagues up here, have heard me talk about seamless transition until I am blue in the face. There might be a reason for this. I just heard Dr. Roe talking about when we first started talking about this here, that is before I started basic training and did a 25-year career, and took some time off, and came to Congress, and here we sit today still talking about it.

It is unacceptable, it is not getting the care for our veterans, it is costing this country money, and it is undermining the faith in what we do for them. We have the capability, we have the technology. I am absolutely convinced that this is the fundamental systemic issue on claims backlogs, on many other issues, and so I want to congratulate the Chairman and the Ranking Member once again for tackling this issue.

It is complex and all of you who will testify today know that, but when we hear from Staff Sergeant Johnson, and I think you are going to hear some of the issues he faced is, no one in this country thinks that is acceptable. No one thinks it is acceptable. And the problem with it is, is that I think Tom Zampieri is out there somewhere from the Blinded Veterans of America, they can predict this

every time what is going to happen, and they tell us exactly what the pitfalls are, exactly where the veteran is going to fall through the cracks, and then they give us suggestions on how to fix that.

And I hope now that this is the time. It feels like the momentum is there, and so I look forward to hearing from our witnesses on ways we can correct this. I yield back.

[No statement was submitted.]

Mr. MITCHELL. Thank you. At this time I would like to welcome Panel 1 to the witness table. Joining us on our first panel is Staff Sergeant Sean Johnson, an Operation Iraqi Freedom (OIF) veteran from South Dakota. Joseph Wilson, Deputy Director of Health Care, Veterans Affairs and Rehabilitation Commission, American Legion; Thomas Tarantino, Legislative Associate for Iraq and Afghanistan Veterans of America (IAVA); and Captain Jonathan Pruden, Area Outreach Coordinator for the Wounded Warrior Project (WWP). Each will have 5 minutes to make their presentation, but I also want them to know their complete statement will be entered into the record, but please keep it to 5 minutes. And I will ask in this order the speakers: Staff Sergeant Johnson, Mr. Wilson, Mr. Tarantino, and Captain Pruden.

Thank you again for being here, and first Staff Sergeant Johnson, would you please begin.

STATEMENTS OF STAFF SERGEANT SEAN D. JOHNSON, USA, ABERDEEN, SD (OIF VETERAN); JOSEPH L. WILSON, DEPUTY DIRECTOR, HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; TOM TARANTINO, LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND CAPTAIN JONATHAN PRUDEN, USA (RET.), AREA OUTREACH COORDINATOR, WOUNDED WARRIOR PROJECT

STATEMENT OF STAFF SERGEANT SEAN D. JOHNSON, USA

Sergeant JOHNSON. Chairman Mitchell, Ranking Member Roe, and the rest of the Committee. I thank you for giving me the invitation and the chance to give my testimony today. And I have to put in a disclaimer. I am not here in a military capacity, I am here as a veteran and a private citizen.

My name is Sean Johnson and I am 38 years old. I am a three-time deployed vet, Persian Gulf, Bosnia, and Iraq. And I was deployed to Iraq on October 19th, 2005. And between October 19th, 2005, and March 25th, 2006, I was exposed to four mortar blasts within 30 feet and a rocket blast, also within 30 feet. On March 25th, 2006, I was exposed to a mortar blast 10 feet away. I remember a bright light and a loud boom and that is it. It blew me 3 feet in the air and 7 feet back and I landed on my shoulders and my neck. I have received damage to my C-spine from C1 to C7. Before I got up, I was kind of paralyzed, I didn't know what was going on. As I looked through my feet another mortar hit 25 feet away. The other blast I was able to shake it off, this blast I couldn't. I didn't hear for almost a day. I was dizzy, confused, I couldn't see in the distance, I couldn't see at night, I had headaches and abdominal pain.

And then I went into the hospital in May of 2006, and I was there for 7 days. A trauma surgeon was in charge of my case, and they concentrated on the abdominal pain. Sent me back and forth to Germany twice, and they couldn't figure it out. And they said it has got to be a gastrointestinal problem.

Well, in between these trips to Germany they gave me antibiotics and stopped antibiotics, so I ended up with a serious infection. And I was sent back to the States to Fort Riley, Kansas. I was placed in the med hold there.

There were all kinds of problems there. I had to launch seven Congressional complaints, and I was told at one time that if I stopped talking to my Congressmen, they would actually treat me.

Fort Riley, the doctors there want to take care of their patients. They don't want to make referrals, they don't want Walter Reed or Brooke Army Medical Center (BAMC) to evaluate their patients, they want to treat them themselves. It is a type of an ego problem I believe.

After the Congressional complaints, I did receive treatment at Walter Reed for pain, and at that time I got back to Fort Riley and they said we can't help you anymore. And at that time they sent me home, because the program, the Community Based Health Care Organization (CBHCO) that you guys created, they said my case was too complex and they couldn't help me anymore. And the Reserves, had hands tied.

I have had an Medical Evaluation Board (MEB) waiting for 2 years, and I just started it now. And they told me would take another 2 years to get through it. They are making me drill, and basically I go to drill and they pay me to sit in a small room to do nothing.

I did not receive the transition of care. I wasn't contacted by a Federal Recovery Coordinator, I wasn't contacted by anybody. I had to copy my medical records on paper, take them to the VA, and at that point they entered them into their system, then they started all over again. Checking the abdominal pain. And then somebody referred me to the polytrauma doctors because of the blast injury. And they said, well you have a head injury, you have severe post-traumatic stress disorder (PTSD), and at that point I was treated, and then my vision loss came about a year later.

I was seen by one optometrist and a couple of ophthalmologists. They said my eyes are fine. The VA spent thousands of dollars to send me to a neuro-ophthalmologist and she said my eyes are—my optic nerves are dead. When we came back the Compensation and Pension (C&P) panel said, no, that doesn't count. My question is, why did they spend thousands of dollars to get an expert opinion and they don't use it?

So you are going through comp and pension exams unnecessarily over and over again before you get your benefits, and that just adds to the backlog. Not only that, but if they keep going back to a lower level of care, they won't be able to correct the problem.

It really bothers me that it took 21 months to figure out a Traumatic Brain Injury (TBI). Twenty-one months. I went through all the Army treatment, I went through part of the VA treatment, and it took them 21 months to discern that it was a traumatic brain

injury, and that is really scary. Because you can't get the treatment that you need timely enough to benefit you.

The Federal Recovery Coordinators, we didn't even know about them. Nothing was ever said to us. And 4 years later I got a call from one the night before last. Two to 4 years later. There is no transition between case managers in the DoD side, and case managers in the VA side. None. There was no transition. If I wouldn't have brought my paperwork they wouldn't know what was going on. And there are a lot of younger soldiers that don't know that, don't know to copy their paperwork, or aren't given the opportunity to stay and get their disability. They are given a severance check and sent off. I know it has happened several times. I have talked to people in the med holds about it, and it is just shameful. You know, they put the burden on the VA instead of taking care of the soldier and then transferring him. There is no seamless transition, it is just not there.

And one of the suggestions that I have, the Vision Center of Excellence needs to be staffed and needs to be—the building needs to be created at Bethesda and they need to get that done. They were given $6 million in the last round of money that was handed out and nothing has been done. They need to get that building up, they need to get the staff, because they are the ones who are going to do the trauma research and the eye research, which is what the injuries are coming out of Iraq and Afghanistan. The number of eye injuries is staggering, and it is happening 2 years after the injury. So it is not something that happens right away.

And the scary part is, the benefits, Traumatic Servicemembers Group Life Insurance (TSGLI). If you are past 730 days they don't pay out the money, and that is a legislative thing, the DoD put that disclaimer in there. Well if you have eye injuries and you go blind 2½ years later there is no help for you, and that is the money that is supposed to help you get started on getting your house done, getting your bills paid.

The other thing that I would like to see, and I think it would help, is the Caregiver Bill, and I believe that was brought up and it is in the Senate and the House. My wife has given me tremendous care and looked out for me, and it is really a strain. A strain on my children, a strain on her work, and she may end up losing her job because she has to be gone all the time to take care of me. I can't go to doctor's appointments without her because I don't remember what goes on. And I suggest that that may be a fix.

And there needs to be red flag system. There needs to be. For TBI and seriously injured soldiers. They need to be in polytrauma care, and they need to be taken care of. And not a year down the road. The Federal Recovery Coordinators, they need to be there right away to make sure that the patients are getting the care they need. Because up until now there are hundreds, maybe a thousand soldiers like me who get left behind. It is unacceptable.

You have people that aren't getting the care they need, and they are getting left behind or slipped through the cracks, and you sit there for 4 years to get a med board that probably takes 3 days. Four years later. I was injured on the battlefield. Four years later. They still haven't given me a Purple Heart. You know, things like that, where soldiers are waiting, and there is no need for that. The

care is there, it just needs to get the soldiers to the care. And the doctors are strained. The doctors are strained, the nurses are strained because of the overloaded system. And I understand they added four or five Federal Recovery Coordinators just recently this past week and they are overloaded. You have 100,000 people that are potentially patients and you have 20 Federal Recovery Coordinators. How effective is that?

I guess the biggest thing I want you to know is that people are falling through the cracks and this needs to be addressed. And the Federal Recovery Coordinators, they need to have access to get this taken care of. The severely injured soldiers can't wait.

You know, if you are blind in the VA, if you are not permanent and total they won't give you the benefits of a vehicle payment, or a house grant. They give a certain amount of money for your house to be structured. They won't give it to you unless you are permanent and total. Well blind soldiers need to have that money so that they can make their houses safe and their lives better, not to wait endlessly through exams and exams and exams to finally get permanent and total. That needs to be done right away.

You know, there are five neuro-ophthalmologists in the country. If they say you are blind, you are not going to get better, then they need to accept that.

And I hope that by my testifying today that some of the problems are out there, and you can come up with ways to help. And I hope that my testimony has helped bring things to light.

And I speak not for myself today, but for all the soldiers that can't be here to speak, that are falling through the cracks and not getting the care they need, and not getting the care they need in a timely manner.

And I want to thank you for the opportunity to be here today, and I will answer any questions that I can. And I appreciate you giving me a little extra time to give my testimony, as it is a little difficult to summarize when you have a vision problem. So that is all I have and I will answer any questions that I can. Thank you.

[The prepared statement of Sergeant Johnson appears on p. 41.]

Mr. MITCHELL. Thank you very much. Mr. Wilson?

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Chairman Mitchell and Members of the Subcommittee, thank you for the opportunity to present the American Legion's views on seamless transition issues. Currently, there are approximately 23.4 million veterans in the United States; of that total, 7.8 million are enrolled in the VA health care system. VA treats 5.8 million veterans at more than 150 hospitals and 800 plus clinics.

As we examine the transition process, the American Legion, in its efforts to ensure transitioning servicemembers receive continuous/seamless care, has determined that veterans are facing various challenges, which may irrevocably deter any chance of a successful and smooth transition back into their local communities.

An example of challenges include incomplete Post Deployment Health Reassessment questionnaires or PDHRA, inability to fully share medical records among the Department of Defense and VA

health care facilities, lack of space at VA medical facilities, and shortage of staff, to include nurses and physicians.

VA and DoD both play important roles in the transition process. As women and men return from Iraq and Afghanistan facing uncertainty with injuries and illnesses, the American Legion contends that closer oversight must be placed on various programs, such as the PDHRA and Federal Recovery Coordination Program, or FRCP, that have been implemented to ensure no one falls through the cracks. We ask Congress to assess these roles to ascertain the appropriateness of functional tools required to accommodate the Nation's veterans, their families, and the complex issues they are met with.

DoD and VA have created and implemented various programs to support each servicemember and veterans as they transition from active duty to civilian life to include the PDHRA.

The PDHRA program was established to identify and address servicemembers health concerns that emerge over time following deployments. To be in compliance with DoD's policy, each military service must electronically submit PDHRA questionnaires to DoD's central depository. However, a recent audit disclosed that the central depository did not contain questionnaires for approximately 23 percent of the 319,000 OEF/OIF, Operation Enduring Freedom or Operation Iraqi Freedom, servicemembers who returned from theater. This means approximately 72,000 servicemembers were without questionnaires in the repository. The response to the absence of the questionnaires concluded that DoD does not have reasonable assurance that servicemembers, to whom the PDHRA requirement applies, were given the opportunity to fill out the questionnaire and identify as well as address health concerns that could emerge over time following deployment.

The American Legion believes the administration of the PDHRA is essential to the success of the servicemembers transition, because the results would disclose telltale signs of debilitating illnesses, such as the disorders that plague many veterans who have gone undiagnosed at separation from active duty.

Next the Federal Recovery Coordination program. The American Legion would also like to ensure that the FRCP is successfully assisting all recovering servicemembers and veterans suffering from severe wounds, illnesses, and injuries, as well as their families in accessing the care, services, and benefits provided through specifically, DoD and VA.

There are more challenges transitioning servicemembers and veterans face. There have been various reports of critical challenges involving veterans who have recently departed from active-duty service. These challenges, as reported by RAND, includes barriers to mental health care access in community settings. More to specify it was discovered that military servicemembers and veterans are often reluctant to seek mental health care. The mental health workforce has insufficient capacity.

The American Legion recently passed Resolution No. 29, Improvements to Implement a Seamless Transition, which recognized gaps in services, and has consistently advocated improvements be made to the process of servicemembers in their transition from active duty to civilian life. The American Legion continues to express

that servicemembers and their families are easily overwhelmed when dealing with the bureaucracy of multiple departments. However, a more expeditious process that explicitly focuses on moving servicemembers from point A to point B, i.e., DoD to VA, respectively, would ensure timely and accessible care.

The American Legion believes it is extremely vital that this Nation's servicemembers, before their departure, should be placed in a comparable or full duplex capable, fully compatible, DoD/VA database with appointment reminders to ensure their transition isn't stifled by the unknown; after all, active-duty servicemembers have been conditioned to be directed to all military appointments and events.

Upon separation from service these newly transitioned veterans may continue to have the expectation that everything will be set up for them. Both DoD and VA are working to ensure servicemembers and veterans successfully receive information and treatment respectively.

It is the American Legion's contention that the interaction between DoD and VA be heightened, most importantly, by complete shared access of medical records of servicemembers and veterans, as well as assessments of this relationship.

Let us remember that there is no pause button for veterans. Every moment is critical and must be treated as such. Although the World War II veterans' population is diminishing at approximately 1,000 daily; other veterans, to include those from the Vietnam era to current OEF/OIF are presenting to VA with old and new issues. Complacency and communication between DoD and VA and implementation of programs can never be relative.

The American Legion hereby reiterates its position and urge careful oversight of effective communication between DoD and VA to include verbal and written, as well as full implementation of programs to ensure no one is left behind during the transition process.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates this opportunity to submit testimony, and looks forward to working with you and your colleagues to ensure all servicemembers are met with the best of health care upon transitioning into the community. Thank you.

[The prepared statement of Mr. Wilson appears on p. 44.]

Mr. MITCHELL. Thank you. Mr. Tarantino.

STATEMENT OF TOM TARANTINO

Mr. TARANTINO. Mr. Chairman, Ranking Member, and Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America's 180,000 members and supporters, I would like to thank you for the opportunity to speak before you today.

As an OIF veteran with 10 years of service in the Army, I have seen firsthand the difficulties that many veterans face when transitioning from servicemember to veteran for both the wounded warrior who is torn from service due to their extraordinary sacrifice or the young veteran who spent most of their formative years in uniform, the transition can be difficult.

At a time when most of our civilian peers have begun to hit their professional stride, many of us now must start over, and this transition is felt by all, but none more acutely than the brave men and

women who have sacrificed blood and limb for the country and who now must enter a world that does not fully understand their needs.

Veterans of Iraq and Afghanistan may regularly receive excellent care in the ever-expanding polytrauma system. And while these centers can provide excellent care for servicemembers and veterans, there is a noticeable drop in the quality of care when transitioning to community-based institutions near the veterans home of record.

Additionally, the quality of services for disabled veterans near their home generally does not match the standards of care that a veteran receives at a polytrauma center, and no where is this more true for veterans who are in the National Guard and Reserve component.

Additionally, IAVA is concerned with the structure of some adaptive services benefits that many veterans use after leaving polytrauma care. Veterans are being forced into debt because of shortcomings in the benefits and the services that the VA provides.

Currently, benefits for adaptive housing and automobiles are stuck at 1970's funding levels, and most are just one-time deals. With about 80 percent of OIF and OEF veterans under the age of 30, a veteran living with permanent disabilities will more than likely require more than one automobile in his or her life. The current rate may have bought a van equipped with adaptive modifications back in 1972. Today, that same amount might get you a mid size Kia with no adaptive technology.

These veterans are left to pay the difference, and we cannot tolerate a benefits system that requires a veteran to incur debt just to perform everyday functions.

Also, many veterans wounded in Iraq and Afghanistan are not homeowners and must return to their family homes to recover. They are then faced with the choice during their critical time in their recovery to choose between adapting the home that they are recovering in, or save that benefit for the home that they will eventually settle.

The need for these services is obvious and the figures that require upgrading are absolutely known, so there is no excuse for leaving a veteran with substandard benefits.

VA social workers play an indispensible role in the treatment of veterans recovering from multiple traumatic injuries, and the VA must rapidly expand their numbers. As more and more OIF and OEF veterans enter the VA health system, their overall needs will continue to inundate the overworked and understaffed cadre of social work professionals within the VA system. Private sector social workers, on an average, work on a caseworker to client ratio of 1 to 10 to 1 to 15. In comparison, in-house VA social workers operate at a ratio near 1 to 35. The VA must address this issue before the ratios expand further, and these caseworkers cannot properly address the needs of our veterans and their families under these currently crushing workloads.

For spouses and dependents of veterans who gave the last full measure of devotion to this country, the VA provides educational benefits under Chapter 35, the Survivors' and Dependents' Education Assistance Act or DEA. In 2008, the VA reported that over 80,000 family members took advantage of this program, more than

the number of reservists using Chapter 1606, and unlike the generous Post-9/11 GI Bill or the recently increased Montgomery GI Bill, DEA provides a paltry sum of just over $900 a month, which will cover less than 60 percent of the cost of an education.

IAVA believes that DEA benefit rates should be aligned with those of the new GI Bill, and if we don't what will end up happening is a two-tiered benefits system. One tier our family members were able to attend college because they qualified for the Gunnery Sergeant Fry Scholarship under the Post-9/11 GI Bill. The second tier are those forced to use DEA who take out student loans just to pay for a community college.

Now since 2008, we have seen a noticeable shift in how the VA educates veterans about the benefits and services that we are talking about today. I have personally met with representatives from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the VA Business Office to discuss how they can better reach out to veterans of Iraq and Afghanistan. There has been a visible improvement with online and television advertisement, but there is a clear lack of coordination between VA departments. Within the VA, I firmly believe that there is talent, will, and desire to change the passive nature of VA communication; however, there are still substantial cultural and structural hurtles that must be overcome.

IAVA believes that in order for the VA to conduct effective outreach to let these veterans know what is available to them it must centralize its efforts and speak as one Department of Veterans Affairs.

See, the average veteran doesn't understand the difference between VHA and VBA. The average American certainly doesn't understand. When I wait an entire semester for my GI Bill check to come, I am not upset with the VBA, I am upset at the VA. When I wait 2 months to get a medical appointment, I am not upset at the VHA, I am upset at the VA. If the VA ever wants to effectively improve its communications, it must speak to the veteran population and the American people clearly and avoiding government jargon.

Thank you once again for the chance to communicate our opinions on several of the issues facing veterans of Iraq and Afghanistan, and we look forward to continuing to work with the Committee, and I appreciate your time and attention. Thank you.

[The prepared statement of Mr. Tarantino appears on p. 47.]

Mr. MITCHELL. Thank you. Mr. Pruden.

STATEMENT OF CAPTAIN JONATHAN PRUDEN

Captain PRUDEN. Mr. Chairman and Members of the Subcommittee, thank you for inviting Wounded Warrior Project to share its perspective on issues of seamless transition between the Departments of Defense and the VA.

I was an Army captain who in 2003, became one of the first improvised explosive device casualties of Operation Iraqi Freedom. I have made that transition myself. Now after 20 operations at seven different hospitals, including amputation of my right leg, I work as an Area Outreach Coordinator for the Wounded Warrior Project. I

work with hundreds of warriors around the southeast covering Florida, Georgia, Alabama, and South Carolina.

Over the past 6 years, I have witnessed DoD and VA making significant strides in care coordination and information sharing. This Subcommittee's steady focus on these issues has helped to achieve greater seamlessness for wounded warriors. But even the most well coordinated, seamless handoff from DoD to VA will not change the fact that for many wounded warriors this transition feels like they have been thrown off a cliff.

While the two departments can take pride in certain areas of real progress, wounded warriors leaving the service continue to face programmatic, cultural, and structural barriers at the VA. It is critical, in our view, that those barriers be toppled and that key VA programs and service-delivery mechanisms be re-engineered with the goal of having wounded warriors thrive physically, psychologically, and economically.

Currently the VA does not provide wounded warriors 21st century help that they need. As you know, many are not only combating co-occurring PTSD and substance-use issues, but co-occurring traumatic brain injuries, burns, amputations. Often, they are dealing with the constellation of issues which is pain, anger, depression, unemployment, lack of employment opportunity, and lack of permanent housing. In some cases these issues and behavioral health problems have resulted in run-ins with the law.

VA has an array of programs targeted at specific problems, but little in the way of a holistic coordinated approach to turn these lives around. It must move in the direction of providing wrap-around services that integrate the work of VA's Health and Benefits Administrations. Much work also needs to be done within those administrations to make existing programs more veteran centric.

Let me cite a few examples. Too many veterans under VA care for PTSD or other mental health conditions are still simply being given pills to manage their symptoms despite a policy that emphasizes a goal of recovery and rehabilitation rather than just symptom management. This needs to change.

OEF/OIF veterans who are struggling with PTSD need good clinical care, but they also need support and mentoring from peers who have made strides in battling the same demons. We urge the VA employ OEF/OIF veterans at every medical center to provide such peer support, as well as to do outreach to the many who have been reluctant to seek treatment.

To offer another example, our own work with wounded warriors has highlighted the difficulties facing those who have PTSD and need in-patient treatment. VA's in-patient programs don't have uniform admission criteria. Each facility seems to set its own criteria. Too often warrior's circumstances don't fit those inflexible criteria for specialized PTSD care and they are denied admission to these programs they so vitally need.

In short, rather than veteran-centered care this seems to be more like barrier-centered care. A veteran centric systems would not, as some facilities do, impose rigid requirements that a veteran must have had success in out-patient therapy for 3 to 6 months to qualify for admission, must have had no suicidal attempts or suicidal ideation even for the past 6 months, must first complete out-pa-

tient anger management before they can receive treatment, must first be substance abuse free for a certain amount of time, and must first be interviewed, and if accepted, may be admitted at a later date.

Tragically many OEF/OIF veterans who are suffering with severe PTSD are hanging on by a fingernail, and they don't have months to wait to receive the in-patient care.

Wounded Warrior Project field staff has considerable experience in helping OEF/OIF veterans get needed mental health care from VA facilities, but we have encountered great difficulty with placements when veteran's conditions pose a relatively urgent need for specialized in-patient treatment. The most pronounced of these cases have involved veterans who have been jailed because of behaviors linked to PTSD and substance abuse, and whose cases have come before a judge who is willing to having the veteran undergo treatment rather than incarceration.

In several cases, however, VA medical center personnel who have attempted to facilitate such placements have been stymied by long waiting lists at specialized in-patient facilities inside their VISN. On numerous occasions, our field staff have inquired on behalf of our warriors about in-patient PTSD placement options beyond the confines of a particular VISN, only to learn that VA staff have no central repository of information or clearinghouse to turn to, to find out about programs that exist outside of their Veterans Integrated Services Network (VISN) or their immediate area.

I am aware of one case where in Tuscaloosa, Alabama, there were 125 individual veterans on a waiting list for a dual diagnosis substance abuse PTSD program. One hundred eighty miles away in Jackson, Mississippi, was an analogous program with empty beds the next week. The two programs didn't know the other one exist because there was a VISN line between them, and this is unacceptable.

We have urged the Department of Veterans Affairs to establish a clearinghouse on these programs to provide relatively real-time patient and placement information. To date; however, this recommendation has elicited no response.

To cite another area, employment is certainly key to successful reintegration. Yet in programs targeted at helping veterans gain Federal employment, wounded warriors encounter troubling obstacles even at the VA, the one agency you would expect to go the extra mile in employing veterans.

As you know, Mr. Chairman, service-connected disabled veterans are entitled to a ten-point preference in Federal hiring, but those extra points seem to give our warriors little or no practical help. Instead, the complex hurdles of the KSAOs (Knowledge, Skills, Abilities and Other characteristics) in demonstrating ones qualifications for a particular Federal job often knock qualified warriors out of contention, even in the VA. Surely the Department could establish some mechanisms to help overcome these hurdles.

Mr. MITCHELL. Captain, could you wrap this up?

Captain PRUDEN. Yes, sir.

Mr. MITCHELL. Thank you.

Captain PRUDEN. In short, Mr. Chairman, to achieve its ultimate goals of seamless transition it will not only require work to bring

VA and DoD closer to fill the gaps, but a substantive transformation within the VA to insure that this is the most successful and well-adjusted generation of veterans ever.

Thank you. That concludes my testimony.

[The prepared statement of Captain Pruden appears on p. 48.]

Mr. MITCHELL. Thank you very much. There are a couple questions I want to ask, and first to Staff Sergeant Johnson. Did I understand you correctly that you are still going to Reserve meetings?

Sergeant JOHNSON. Yes. I was put in a transients, trainees, holdees and students (TTHS) holding cell, and they told me that until my MEB is over and they give me a disability rating that I have to go to monthly drills. And like I said, I go into a room, I sit there, that is it.

Mr. MITCHELL. How long after you returned home did you become blind?

Sergeant JOHNSON. About a year.

Mr. MITCHELL. About a year?

Sergeant JOHNSON. Year and a half.

Mr. MITCHELL. Could this have been prevented?

Sergeant JOHNSON. No. From the blast injury my optic nerves already started to die, and the TBI had affected—my brain so it can't comprehend what my eyes are seeing, so according to what they told me it couldn't have been prevented, but the eye services would have helped tremendously.

Mr. MITCHELL. In that time period there could have been some transition to knowing what was going to happen, instead nothing happened until after you actually became blind?

Sergeant JOHNSON. Yes.

Mr. MITCHELL. And did I hear you say that you have not even received your Purple Heart yet?

Sergeant JOHNSON. Correct.

Mr. MITCHELL. And how many years has that been?

Sergeant JOHNSON. Four years.

Mr. MITCHELL. Four years? Thank you.

Let me ask Mr. Wilson something. What are the top two concerns for veterans that you hear from in your organization transitioning from DoD?

Mr. WILSON. I actually heard those issues yesterday, during a site visit at one of the four Level 1 polytrauma centers in Tampa, transitioning, and screening.

Mr. MITCHELL. They what?

Mr. WILSON. Servicemembers/veterans have no knowledge of the program. We have heard that some weren't screened extensively. So screening and pretty much ignorance of VA programs or even the transition from DoD to VA itself.

Mr. MITCHELL. So even if the VA comes—and they will testify I am sure—that they have all these programs, the problem is the veterans don't know about them.

Mr. WILSON. The American Legion conducts site visits at VAMC's from January to June; we write that publication and we disseminate it to all 535 Congressional Members. If one evaluates the VA they are going to find very good programs. DoD, very good programs.

Again, the problem is the transition from DoD to VA and/or the communication between the two, which begins also with medical records. Yesterday there was a doctor speaking on really good new patient programs, I asked him about challenges. He stated, "The challenge is getting records from DoD." I asked, "Well how do you do it? Do you do it the conventional way?" He says, "Exactly, the conventional way, and that takes lots of time."

Being an old computer guy I know there is such technology as duplex capability. There has to be more oversight on this. I mean it is frustrating now even to computer users who don't use computers that often, they know that there is a program that will allow both DoD and VA to communicate with one another.

Mr. MITCHELL. Thank you. Mr. Tarantino. What complaints do you hear most from veterans who are in the process of transitioning?

Mr. TARANTINO. Well, I think what we are hearing is definitely that there is a lack of communication, and this is not just for servicemembers leaving active duty, this is particularly for servicemembers in the National Guard and the Reserve. I know myself, I would have never gone to see the VA if an old sergeant major who was going through the Army Alumni Program with me hadn't grabbed me and said, "You know, sir, right now you are young, you are macho, and you are stupid. When you get to be my age you are going to be old, you are going to be less macho, and you will probably still be stupid, but you are going to be in pain and you are going to need to know what is available to you." And the VA does not make itself known to active duty or to the Reserve component.

And what we are seeing especially in the National Guard and the Reserve component, is that soldiers get these invisible injuries, they get discharged 48 to 72 hours after they leave Baghdad, and now they are home, they are drilling, and they need care, and they have to go to the VA. But there is no mechanism to bring them back into the fold of the DoD and say, okay, you are injured, you need a medical retirement, or we need to take care of you.

In many cases we are seeing members, Iraq and Afghanistan veterans that are 70 to 80 percent VA disabled that are getting called up out of the IRR back onto active duty because the DoD has absolutely no idea that these guys were injured. And that is the big nightmare scenario that we are seeing with our membership.

Mr. MITCHELL. Thank you. And one last question to Captain Pruden. Do you think that the Office of Wounded Warrior Care and Transition Policy is on the right track? What improvements could be made?

Captain PRUDEN. From what I know I think they are on the right track. I think they have made some very substantial improvements over the past several years here, and the addition of five more Federal Recovery Care Coordinators is certainly a step in the right direction.

I would like to see again a more seamless handoff to the VA. I would like to see case managers who are—as Secretary Shinseki created the Seamless Transition Patient Advocate (TPA) Program doing the handoffs from the VA to DoD, unfortunately a lot of those slots were filled by social workers with no DoD experience, but a lot of experience in finding employment in the VA. And so I would

like to see, again, TPAs be able to do their job and reach across and work directly with DoD to pull them into the new system.

Mr. MITCHELL. Thank you. Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman. Just a comment to Mr. Tarantino. In your testimony you had concerns raised over the seventies, and rightly so, funding level of the adaptive housing grants, and I want to make certain that you are aware that Congressman John Boozman who is on the Committee and Ranking Member of the Subcommittee on Economic Opportunity, introduced legislation that would increase funding, H.R. 1169, from the small housing grants of $12,000 to $36,000 and the larger housing grants from $60,000 to $180,000. The bill would also increase automobile grants up to $33,000.

So I understand that there are some PAYGO issues with this obviously that have to be worked through, but I think all the Members on this Committee will look favorably toward that. So I just wanted to pass that along.

You know, and the Chairman has been here one term, but you know you haven't been here a lot of terms when your group goes to Great Lakes, Illinois, in January, which is what we did. When other people are going to Hawaii, we went to Great Lakes.

And what I keep hearing. I have been in the infantry, I have been to Afghanistan and spent a week there, been to Walter Reed and now to Great Lakes, and we have a VA in my hometown, so I have a pretty good idea, but I am still having a problem getting my arms around this. And after 33 hearings we are still hearing the same thing. And I think it is time to sit down. And I agree with you all, I see a VA at home that is trying to do the right thing. I go to a Walter Reed and I see them doing great work with the veterans there and the rehab with the wounded warriors. No doubt about it, as a physician I am amazed at the recovery that a lot of these wounded warriors are achieving now. But it is not coordinated where the left hand and the right hand knows what is going on. It is not because people are not trying. I absolutely believe that.

But I am going to ask any one of you if you will take this pass and just tell us, is it beginning when the warrior—and I believe that what we need is, is when a soldier signs up that that soldier needs to have—be in the VA system that day, and I think they need to have one record. And I think, Mr. Wilson, you are absolutely right, you've got information here and information here and nobody can share the information. So I am beginning to get my arms around on what we need to do, but just to comment on my statement. Mr. Wilson you can start if you would like, or Mr. Tarantino.

Mr. WILSON. Okay. You know, I had mentioned and it was in the testimony that the role of DoD and VA must be that of "safety net catalyst." Titled terminology epitomizes a respective program. For example, we notice that the term "seamless transition" they pretty much shied away from; it's now called "continuum of care." Seamless transition, I think the terminology holds us to a standard, and I will give you an analogy. VA's nursing home care facilities are now called community living centers. The American Legion has visited many, over 50 in this Nation, and they are holding to that standard, I think it's even better, because they are trying to pretty

much help that veteran who is transitioning identify with their respective community by transforming the nursing home facility into a main street type community facility. So with VA, everything may be in a name. So seamless transition makes us aware of this process. Before it was called seamless transition as I said the name was changed to continuum of care, and I think we shied away from that level boost.

Mr. ROE. Let me interrupt for just a second because I don't have much time left. But I know when I got out of the Army basically I gave myself my own physical to get out, because I wanted out, like most of us do. And I think that is what happens when you said we are young and stupid. I think you are right about that.

Would it help when a veteran ETS's (Expiration of Term of Service) from the military if the VA were there at the time of separation and to prepare that veteran to move on? And I know I was given a physical, but is everybody given a physical on the way out the door? Do you have a record when you leave the military, are you examined by a physician or a physician assistant or whatever and get a complete physical exam before you leave so that you have that information when you leave? Because, see I think if you are injured, the best time to find out how bad your injury is, and it may change. As you pointed out, as you get older things change. But you at least at that point in time you would know exactly what was wrong with that soldier. And Captain Pruden or Mr. Tarantino. Either one. Captain?

Captain PRUDEN. I think that having a pre-release physical is vital as part of this. But I will tell you that servicemembers who are coming off active duty currently because of enhanced oversight and programs that have been implemented in the last 6 years, do have a whole array of briefings about benefits that are available to them as they leave the service. Oftentimes there is a bit of information overload. They don't remember most of what is told them. They have 100 forms they have to sign. And so they leave the service having heard one time this thing that goes in one ear, out the other. They don't recognize that they will need that in the future.

So I think again, it is critical the VA be there doing outreach as these guys are coming into the VA system. And you know, when the OEF/OIF folks are coming into the VA and enrolling in the VA, that they have the best primary care physicians around. As you guys know, the primary care managers at the VA are sort of the gatekeepers to all of their specialty care and will be the primary folks interacting with our wounded warriors and our veterans. And if nurse case managers—OEF/OIF nurse case managers could have override capabilities to put wounded warriors and veterans with appropriate primary care managers instead of sort of leftovers after—older veterans talk, and they know who the best doctors at the VA are.

Mr. ROE. Not only veterans talk.

Captain PRUDEN. Yeah. But they know who the best doctors are at the VA, and so there is a waiting list to get on with that primary care manager. The newest nurse case managers and the least experienced and perhaps maybe not the best physicians in the VA are the ones who have open slots typically, and oftentimes these warriors are assigned to folks who don't know about head or trophic

ossification, a lot of the conditions that these guys are coming back from Iraq and Afghanistan with. You need a primary care manager who is familiar with these things, who is competent to serve as the gatekeeper to push them out to the appropriate services.

Mr. ROE. Okay. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you. Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman and Ranking Member and other Members of the Committee for allowing me to go out of order. I have a meeting like most of us that I'm double booked on. But proud to say we have a member of the Wounded Warrior Project who has joined our staff in the 19th District in New York, and the meeting I am going to is for another veteran who we hope will join our staff here working on veterans' issues.

It is disappointing to know that as we enter 2010, more than 9 years after we first entered Afghanistan, transitioning our troops is still such a challenge, and that we have to do better for all of our men and women in uniform, and our heroes like Staff Sergeant Johnson deserve better.

I have visited the wounded warrior transition (WWT) unit at West Point, which is in my district, and commend the men and women who are working there. But even this success illustrates the shortcoming we have with only 35 WTUs in the whole country. We have servicemen and women from as far away as Vermont coming down to southern New York to Hudson Valley to come to the WTU in West Point to receive treatment.

There is also a limited VA presence at West Point, and these are among the reasons that I plan to introduce legislation to improve this seamless transition by mandating that the VA have a permanent presence on all active-duty military facilities and require one-on-one consultations with active troops as they begin the transition process. There should be no improperly filled out enrollment forms, you know, it should cut down on processing time, and reduce the ever growing backlog, which is going to grow even more, as a result of the addition of three new Agent Orange connected diseases. Leukemia, Ischemic Heart Disease, and Parkinson's Disease, but I am sure you can fill me in.

I wanted to ask you, Staff Sergeant Johnson, in your written testimony you said that you were told if you stopped contacting your Senators you would be given medical treatment. Can you tell us who told you that?

Sergeant JOHNSON. The Reserve case manager at Fort Riley, Kansas. Shortly after that I was transferred to another case manager, because I stood up to her and said that this is not right, it is ridiculous, and I am not going to stand for it. And then I was transferred to another care manager.

But like it was said before, the case managers are stretched thin. So instead of one-on-one or one-on-five it is one-on-ten or fifteen. So you get left behind.

Mr. HALL. Well good for you for standing up like that, and I am not surprised, but many veterans get their problems solved or at least help getting their problems solved in part by coming to Members of Congress or Senators, and it is just shameful that somebody should tell you to stop contacting your elected representatives as

if you gave up your rights as a citizen by being a soldier. That is very unfortunate.

But I wanted to ask Captain Pruden, you mentioned the difficulty of some OEF/OIF veterans to get PTSD treatment. Do you believe that presumptive service connection for a PTSD will help this problem, such as the rule change that we are expecting from VA?

Captain PRUDEN. Could you clarify the question as far as what a presumptive PTSD diagnosis would look like in your mind?

Mr. HALL. Well there was a rule change proposed by the Department, the Secretary has testified before the full VA Committee about it, and the public comment period closed before Christmas, I think it was in November, and they are evaluating thousands of pages of testimony now before making the final announcement of what the rule change will be, but it would presume any PTSD to be service connected if that man or woman in question had served in a combat zone or an area of hostilities with the enemy so as to remove the need for a particular incident being proven.

Captain PRUDEN. I think that is appropriate. I think that PTSD obviously is not necessarily caused by a certain focal instance where your own life is threatened, but it can be caused by the generalized fear of mortar attack or seeing dead bodies all around, seeing civilian casualties. So no, I think that is an appropriate step and would help facilitate more appropriate care for these guys as they are coming back. And unfortunately it is oftentimes when you have the burden of proof heaped on these guys, these warriors as they are returning it is a real challenge with the psychological issues they are dealing with to try to come up with the evidence they need. So I think a presumptive rating makes a lot of sense.

Mr. HALL. Thank you very much. Thank you, Mr. Chairman. I will submit my statement in writing.

[The prepared statement of Congressman Hall appears on p. 40.]

Mr. MITCHELL. Thank you. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman, and thank you very much for holding this hearing. Perhaps going along with what Mr. Hall said and the opening statement of Mr. Roe when he mentioned we had 33 hearings—I think Mr. Roe mentioned we had about 33 hearings on this topic the last 10 years. I asked staff to give me, going back to 2000 to the 106th Congress, the Subcommittee on Health had a VA hearing on health care sharing between DoD and the Veterans Administration. In 2002, there was a hearing in the Subcommittee on Benefits on the Transition Assistance Program and Disabled Transition Assistance Program. You can even go through this list and you can just see that in 2005 we had an oversight hearing on the Transition Assistance and Disabled Transition Assistance Program. So this issue has not been without hearings.

I think now, Mr. Chairman, what we need to do is, as a result of this hearing, come up with a bill, one perhaps that Mr. Hall mentioned and one that I think both Mr. Roe and I can work on to amend. I have several ideas, and Captain Pruden is in my Congressional district from Gainesville, Florida, and is working with the Wounded Warrior Project.

So I think, Mr. Chairman, you have a unique opportunity, based upon what we heard today, and what the record shows, that we should try and solve this problem. And I know the second panel is going to mention veterans or the Veterans Administration, some of their personnel are here, but it appears to me there are two problems.

One is when the veteran leaves, when he leaves the military active service, the coordination with the Veterans Administration has not been successful. Perhaps we should have some VA employees at the point of demobilization that are there when a veteran leaves the military, whether that is at the military base or at the country where he is just so that he gets it.

The second thing is, I think we have to have enforced by the Veterans Administration the medical checks. Staff Sergeant Johnson, when you left the military did you actually have a medical screening, including an eye exam? I wasn't clear on that.

Sergeant JOHNSON. Yes, when I was demobilized because the hospital could no longer do anything for me I was given an exit physical.

Mr. STEARNS. Including an eye exam?

Sergeant JOHNSON. Yes.

Mr. STEARNS. Okay.

Sergeant JOHNSON. Before I went back home to my unit.

Mr. STEARNS. Yes.

Sergeant JOHNSON. The problem is the reservists have been deployed for a year. They come back and instead of debriefing them and keeping them for a little bit to see if they have the PTSD issues, they are in and out in 3 days.

Mr. STEARNS. I understand.

Sergeant JOHNSON. Nobody wants to stay at the site, they want to go home and see their families.

Mr. STEARNS. Yes, I understand.

Sergeant JOHNSON. So they are going to say whatever they want to hear——

Mr. STEARNS. To get out of there.

Sergeant JOHNSON [continuing]. Or whatever they need to say so they can go home.

Mr. STEARNS. Did you have a mental health screening?

Sergeant JOHNSON. Yes.

Mr. STEARNS. And you had a dental examination?

Sergeant JOHNSON. Yes.

Mr. STEARNS. Captain Pruden, I think with all your injuries and everything, you obviously had a medical screening. Did you also have a mental health screening? Do you recollect when you left?

Captain PRUDEN. There was a screening form that I filled out and a PTSD screening criteria form that I filled out, but did not have psychological evaluation.

Mr. STEARNS. Yes. So you were asked to sign something, but were you briefed on what you were signing and the meaning of it and so forth?

Captain PRUDEN. I believe that I was. And again, I think the issue really is you are doing so much so fast, going through the NEBPB process——

Mr. STEARNS. You don't understand the significance of what you are doing.

Captain PRUDEN. Exactly.

Mr. STEARNS. Yes. Based upon the conversations you and I have had in my office and based upon your testimony, what kind of changes, if you could wave a wand today, based upon your experience, would you like to see? Communication between the VA central office and the caseworkers working in the different VISNs? What would you do today at the Veterans Administration to help those that are suffering from traumatic brain injuries, PTSD, or other serious mental health issues and what we as members could follow up and do based upon your recommendation?

Captain PRUDEN. You know, as I mentioned in the testimony, sir, I would recommend that there be a central clearinghouse of information that pulls in information about specialized PTSD, substance abuse, TBI programs across VISNs, and that that also would be pushed back out to the caseworkers who could use the information. Most caseworkers are overloaded, as the other witnesses have testified to, and they have a window of about this big, and when they get a warrior in front of them, a veteran in front of them that needs help they are going to send them to the place down the street, because it is the place down the street, it is the place they know. Not because it has available beds, not because it is necessarily the best facility for them, they send them to that facility because they don't know any better, and there is no information coming in, and the VISNs have become small feed centers. And so having a central clearinghouse for information would I think be a tangible way to make a difference with the case managers of these warriors.

Mr. STEARNS. Mr. Chairman, I think based upon his testimony, what we should do is write a letter to the Secretary of Veterans Affairs asking them if they have a central point of communication. I think they will say they do. What we would ask is for them to put in writing if it is systemwide. They might have it in different geographical locations, but what I think the captain is saying, is we need something that is systemwide so that everybody can go to that one person, not to separate geographic locations.

Captain PRUDEN. Yes, sir. I talked to over two dozen OEF/OIF caseworkers across the Nation about these programs, not a single one of them could tell me about programs outside of their VISN except occasional anecdotal things. So if the information exists it is not getting to the folks who need it.

Mr. STEARNS. So I think that would be appropriate. And then as a result of what he says we can follow up if necessary with legislation.

The other big problem that I have heard over the years serving on the Veterans Affairs Committee is the effectiveness of peer-to-peer support and peer-to-peer mentoring amongst veterans. Captain Pruden, is that, in your opinion, being effectively done by the Veterans Administration?

Captain PRUDEN. It is not at this point. I mean, that is something that the Wounded Warrior Project and other VSOs are working on laterally, but I think that the best shot the VA has taken was creating the transition patient advocate physicians, were sup-

posed to be filled by OEF/OIF personnel, and unfortunately when that has been the case, I know of six personally who have filled those positions, OEF/OIF personnel, four of them are no longer working for the VA because they were so frustrated and a variety of issues that arose with that job. They thought they would have carte blanche to go out and do good and make sure the guys were taken care of as they came from DoD to the VA, and unfortunately that wasn't the way it worked out oftentimes.

Mr. STEARNS. Well let me just conclude, Mr. Chairman, by saying I think we have some very constructive ideas that have come from this panel. I think in addition to what Mr. Hall mentioned about having the VA representative there at the day they are discharged, that somehow we should have this mentoring, this peer-to-peer support and peer-to-peer mentoring, available for them in a consistent way so veterans before they sign up on these sheets can see these peer-to-peer mentor who can tell them what they are signing off and what it means. So if a fellow Marine, a fellow Army, a Navy, an Air Force personnel said to me, "Cliff, before you sign off let me tell you what the situation is. I have had post-traumatic stress disorder and I signed off and I shouldn't have. This is serious." So this idea of being young, macho, and stupid would be balanced by having fellow soldiers who have been through it, who have lost their eyesight, lost their limbs—sitting here with shrapnel in their body—could say listen, let us not be stupid here. I want to tell you what my life story is, and then they would get their attention rather than just saying I want to get to Dayton, Ohio, I want to get back to West Virginia. This is really serious, and you are looking in the eyes of guys that are veterans who are wounded and have suffered and they can tell them about the experience that their spouses have also suffered. So that would make them more informed.

So I appreciate all of your testimony and thank you for your time.

Mr. MITCHELL. Mr. Walz.

Mr. WALZ. Well thank you, Mr. Chairman, and thank each of you for your service. And Mr. Tarantino, I am that old sergeant major you talked to and I have sat through far too many of these. I think I am at a breaking point on this, along with many of you.

Mr. Johnson and especially Mrs. Johnson, who I will be talking to most of the time, because that is a key here that we have missed and it hurts this Nation and it is the wrong thing to do. But to you, Mr. Johnson, on behalf of the people of southern Minnesota, and I think it is fair to say the people of this country apologize to you for what you have been through, but I also realize that and a yellow ribbon magnet don't even get you a cup of coffee. And I have had it with that type of rhetoric, I have had it with that type of support, if you would call it.

And you want to hear a real sad story? In that very chair you are sitting in last year a young man named Travis Fugate sat in that same chair and went through the same thing. And we were warned about it, we were told about it, we lamented about it, we rang our hands, we gave—and you are going to hear Mr. Koch is going to come up, we will rail at DoD for not talking to VA, when

those people are absolutely committed to our veterans and we are simply still not finding a fix.

I find it absolutely appalling a caregiver bill—and Mrs. Johnson you will attest this when we hear what you have gone through and how your life has changed—passed this House, passed the Senate and sits there now. It took a week to pass the TARP bill, money sure moved quick to Wall Street. It took 3 days to pass the money to re-build the bridge in Minneapolis after it fell. Well your bridge is falling every day. And the euphemism of that or the vision, I am just appalled that we can't see this.

And I have to tell you, I have talked to Secretary Gates, I have talked to Secretary Shinseki, talked to Admiral Mullins, they are all committed. But you know if I was you, if I was asking today is, ask Members up here if they know their counterparts on the House Armed Services Committee. Why aren't they in here? Why can't we as a Congress talk together to figure it out? We keep talking about that. Oh no, we got our silo we got to protect. Go over and talk with who is on Representative Davis' Committee. If we can't name them shame on us. And you got them, and it is we that are handling that. We got it. It is our silo. It is our area of expertise. You know, I am the chairman there and all this.

So I have to tell you, the time for the rest of the talk is done. We can scream and yell at DoD and at VA and all that. We are not setting the model here. We are not pushing the thing forward.

And I want to just watch a few things. I think it is great. And Mr. Tarantino, a year or so ago we had VA in here and asked them about their outreach. We had to direct them, letter and spirit of the law to tell them that they could advertise. For every ad trying to get you in to be one of the few and the proud there ought to be one that say when you come home you are still few, you are still proud, and this country cares about you. But we had to tell them to do that. So then all of a sudden I saw a sign on the side of a bus. And then I go to the Web site and I can't even read it. My 9-year-old's club penguin site is more functional. And those are the things that how can we miss that? How can we get it wrong?

So I ask Mrs. Johnson, as all of us talk about this if all those things happen or whatever and we debate the little things on this, could you just tell us on the Committee how has your life changed since your husband and our staff sergeant was wounded? How have things changed for you?

Mrs. JOHNSON. Well we have three teenage children. We have been married for 15 years. And he came back to Fort Riley, and from the very beginning I knew things weren't right, but I didn't have the ability to be there with him. I had to be at work, I had a family to take care of, he was 12 hours away. Most of our conversations were by phone where, you know, my proud soldier would deceive me the best he could with oh, I am fine, it is great, I am feeling good today, I took my pills, it is all good. And so I had to do a lot of calling and complaining. And I used a lot of my time at work, asking a lot of favors from different people to, you know, can you cover my class for just a little bit while I go make this call? While I go call Senator Johnson's office back. I mean he would call and say, well maybe you shouldn't do that anymore because today

they brought me in and said I need to quit making these phone calls, or I need to quit asking for this. And I knew he wasn't right.

It took 9 months to get him home. He came home, was not able to be on the CBHCO Seal program. Was told that he was too severely injured, it is not a long-term program, we don't have the availability in your area, you need to just go home and go back to your regular job as a firefighter, as a lieutenant, in a position where he—first of all his physical stamina wasn't good, his confusion, he has memory loss, he can't make decisions. And to be able to say that he was going to come back and fill that capacity, I mean that was not good.

It took about 6 months. They had him on a mostly paper shuffling job at the fire department. They worked very well with him. But within a year he had to take a medical retirement. He could not meet the demands of that job and the quick thinking and decision-making things that he needed to do.

So we started with the VA when he got home. We did all of the legwork for that. He copied every one of his medical records from the military. At times we had to beg to get records of things. We had to search for things that didn't happen or didn't exist. We had to do all of the legwork on the VA end. And then throughout that process, while we have been very fortunate to have a great doctor in our polytrauma unit, prior to that there were no questions about blast injuries, about falls, about head injuries. They were focusing on the wrong problem. And I would say, "Look, you know what, he doesn't remember conversations we had yesterday." And the kids and myself were saying dad's not right, this is wrong, there is something missing here.

And so he returned home in May of 2007, and in December of 2007 someone finally asked, "Were you ever near a blast injury? Were you ever near an explosive device?" That is what finally tipped them off that well maybe we better examine him for a brain injury.

When we finally got that information—again, I really liked the doctor that we work with at the Sioux Falls VA, I think he does a great job—but the VA doesn't have any information on PTSD or TBI that they are handing out. They would sit us down, we would have our hour or half an hour appointment and then drive the 3 hours home and go home and Google everything. Everything that we know about every disability and injury and infection he has had is because we looked it up ourselves. And that is time consuming, it is difficult, it is hard to focus on your own position, focus on your children. We have to be at this or whatever appointment or activity, and fit in his appointments.

I am very fortunate with my principal at my school that he does let me be gone as often as I need to be. I can go in and say, this is what is going to happen and I need a sub. But I know that there are so many more that aren't that fortunate to be able to go in and say hey, I have to be gone for 3 days and just have that be okay, have that be provided, and to be able to have that support system.

I mean not a lot of your younger family members, especially if you are busy, you have young children, you don't know who to ask, you don't know where to go. And I think a lot of those younger soldiers don't know that it is okay to yell and scream and call and

complain and keep looking for things. And I think the sad part is a lot of them believe what they are told. If you are told well if you do this, this will happen, or if you do this, you know, there is nothing more we can do, then that is what they accept.

And that was part of our goal from the very beginning, was let us see what we can do to make it a little easier for someone else so that when you come home after serving your country, you don't have to fight and you don't have to search on your own and try and find your own answers.

Mr. WALZ. Well thank you, and I think we all need to be very, very clear, this chain of events for this family was put in place because someone raised their hands and choose to defend this Nation and do what they were asked. That is the only thing that put them in this position. And these people are not victims. And the idea that this mother, this wife, this American has to come back and spend that time fighting is just appalling.

But I will tell you, everyone of us here better soul search a little bit. That seat will be occupied by another Travis Fugate, another Mr. Johnson, another down the road unless we determine at some point to stop it.

So I appreciate all the advice that is getting here. You are all exactly right on. But I am convinced it is far more than just logistical fixes on this, it is systemic cultural change on how we view this. And if it doesn't happen that is the result.

Mr. STEARNS. Will the gentleman yield before you close?

Mr. WALZ. Yes.

Mr. STEARNS. I think it was very important that you asked Mrs. Johnson that I appreciate you taking the time, Mr. Chairman, I ask unanimous consent if there is anything she wanted to add.

The question I have for her is, do you think that wives of veterans that are wounded like your husband should have an opportunity for counseling or some kind of support group for yourself?

Mrs. JOHNSON. Yes.

Mr. STEARNS. Because in effect you are becoming not only his regular wife and the mother to the children and working, but the stress on you must be unbelievable too, and there must be a breaking point where you can't go on unless you have some kind of support.

Mrs. JOHNSON. Yeah, I think that would be very beneficial. I mean, in our area we had the great family support with our unit when they were deployed, but everyone else's spouse came back, they went back to their normal lives with all their own little problems, but they didn't have injuries in our area. We don't have a lot of support for that. They don't have the family programs or the family counseling available.

Most recently Sean came back from a PTSD program through the VA in St. Cloud and during that time I was not contacted by any member of that staff from that VA to ask about any input from the family or the home regarding his PTSD, regarding his behaviors at home. I was not contacted while he was there. I wasn't contacted when he came home. They sent home his medical record, which is over 300 pages, and said if your wife has any questions she can call us.

Mr. WALZ. Unbelievable.

Mrs. JOHNSON. They did tell him that there are groups that are available for the wives and families if you live in that area. It is 4½ hours for us. The likelihood of me being able to take time off to go and go to these groups and get this support is not there.

And at one point the VA had a V-tel capability where Sean could get some OEF/OIF group peer support. That is no longer available. So now if he is going to have that peer-on-peer support it will be if he can make the appointments 3 hours away.

So yeah, I think there is a huge need to provide those things.

Mr. WALZ. The gentleman from Florida, that is a great point on that. And again, this is one of the issues, that portion is in the House version of the Caregivers Bill, but where is it at? It is setting. And he is exactly right.

So I appreciate the comments and for us to keep focus on this. It is our responsibility to get it done. So I yield back.

Mr. MITCHELL. Thank you very much. And I want to before you all leave and I hope you stay around for the next panel, want to express my gratitude, and I think everyone's up here for the service and the sacrifices that you have all made. You know, we sit through a lot of these hearings, and I just wish other people could get the same feeling out of this that we do. And I just want to say thank you so much for everything you have done.

Sergeant JOHNSON. I appreciate that. It was an honor.

Mr. MITCHELL. Thank you. And this panel is excused.

I want to welcome panel number 2 to the witness table. And for our second panel we will hear from the Honorable Noel Koch, Deputy Under Secretary of Defense for the Office of Wounded Warrior Care and Transition Policy, U.S. Department of Defense, Dr. Madhulika Agarwal, Chief Officer of Patient Care Services, Veterans Health Administration. Dr. Agarwal is accompanied by Dr. Karen Guice, Executive Director of the Federal Recovery Coordination Program, and Paul Hutter, Chief Officer of Legislative, Regulatory, and Intergovernmental Affairs, Veterans Health Administration.

And I would like to ask all of those who are making a presentation, Mr. Koch and Dr. Agarwal, if you would please keep your comments to 5 minutes, and your complete testimony will be put in the record. Mr. Koch.

STATEMENTS OF HON. NOEL KOCH, DEPUTY UNDER SECRETARY OF DEFENSE, WOUNDED WARRIOR CARE AND TRANSITION POLICY, U.S. DEPARTMENT OF DEFENSE; AND MADHULIKA AGARWAL, M.D., MPH, CHIEF OFFICER, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KAREN GUICE, M.D., MPP, EXECUTIVE DIRECTOR, FEDERAL RECOVERY COORDINATION PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND PAUL HUTTER, CHIEF OFFICER OF LEGISLATIVE, REGULATORY, AND INTERGOVERNMENTAL AFFAIRS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. NOEL KOCH

Mr. KOCH. Thank you, Mr. Chairman, and thank all of the distinguished Members of this panel for the opportunity and the privilege to come before you this morning. You have already agreed that our written testimony would be submitted for the record, and so let me just make a few oral observations.

The Members, the speakers in the last panel obviously leave all of us somewhat shaken. This panel didn't call us up here to listen to a litany of excuses for where we are and why we are where we are.

But let me say before I proceed too far into this, that what we are attempting to do is novel. We have never done it before in our history. And if we go back 15 years we were reducing the size of our armed forces, that we were cutting all the talent, anybody that wanted to leave got to leave, and suddenly we find ourselves in a war—in two wars in which we are being presented with the kind of problems that we are being presented with today. Some of these problems are as old as history. Post-traumatic stress goes back to the Greeks. We still haven't figured it out, and it is the biggest problem that we have. When people look at our wounded veterans they look at traumatic amputations and their heart goes out to that, and all of ours do, but these people deal with these things very easily. The people who have difficulties are those who suffer from post-traumatic stress, and so that is one of the things we are wrestling with.

Now it has been noted that we have a lot of effort behind this and we have a lot of programs, and that our biggest problem is a lack of ability to put this before the people who need it. We don't communicate well.

I spend most of the time out of my office. I spend time at places like Fort Riley and Fort Drum and Fort Benning and Fort Bragg and Balboa and BAMC and the polytrauma centers and all these places that you are familiar with, and I spend hundreds of hours with these wounded warriors and ill and injured warriors, so I have a pretty good sense of what it is that we are trying to do for them, what they feel that we need.

One of the things I want to say to you is that we are, you are, we all are dealing with something of a moving train here, and so while we take into account and take on board both emotionally and intellectually what we have heard here, a lot of these problems are

legacy issues, and we are moving ahead, and I think we are doing a better job at addressing the kinds of problems that were brought up here today.

Now having said that to the question of outreach, my office, The Wounded Warrior Care and Transition Policy Office has a number of programs to try to deal with this. One that I think most of the members are familiar with is the Transition Assistance Program. This was started back during the Gulf War, it is 20 years old, has never been updated, never been addressed, never been reformed. And in that period from the time that was back when we fought a war with most of our active components, now we are fighting two wars and chewing up our Reserve components, none of those changes in the realities that we were confronting were not addressed in the Transition Assistance Program. So in November we spend a week tearing this thing a part, putting it back together, and in the process of correcting that.

And one of the things that Congressman Roe said resonates here, and that is that we need to start at the beginning. We need to start not when a youngster becomes a veteran, but when they become a soldier or a Marine or an airman or a sailor to deal with this. So we need to start the counseling process at reveille, and it ought to run all the way through to TAPs. It ought to begin from the time we recruit them until the time we intern them. And so we are looking at that. We are looking at that.

And there are some very prosaic issues that come into this thing when you look at it. It is not the things that attract us emotionally such as a wounded soldier and his family. It is simpler things. It is like financial management. And when you are young, you know, you think the money just continues to flow. If you don't understand how to handle it by the time you get to be my age and you haven't learned to handle it you are going to be in an awful lot of trouble.

And so we have these youngsters coming back from down range, they have no place for them to spend money down there, they've got their base pay, they got trigger time, hazardous duty pay, all these things. They come home with $100,000, $150,000, $200,000. And what do they do with it? Well they are home, they are happy, they want to buy mom something.

One of my favorite stories is the young Marine that came home and bought himself a Porsche, which might have been reasonable enough, except that this young man is blind and the car is sitting in his living room.

So we need to teach them how to handle their money. It is just one of the things that we need to deal with. But I agree with Congressman Roe, we need to start at the beginning, and that is part of the TAP program. And part of that program since the VA has brought to task for not doing their share of this thing, part of this involves pre-separation counseling, which is mandatory for all these people, but the VA provides an extensive briefing, at least 4 hours on what is going to be when they get out.

Now the point is, at what point does that occur? And is it useful? And you have heard previous witnesses talk about what happens when people come home. They don't want to come home and listen to a lot of lectures. They want to come home and go home.

And it becomes even more difficult with our Reserve components when these people are not coming back to a base where we sort of have our hands on them. Because they are going to disperse to all the places that we have brought them in from. The Reserves and the National Guards tend to be not centered around our major bases where our active components are. So these are some of the problems that we confront.

And another one that was raised by one of the witnesses was a question of the effect of PTSD and people getting in trouble with the law. We are looking at veterans courts. We would like to nationalize this effort. We would like to have your help doing it. It is obvious these courts are not Federal courts that deal with these problems, but if there was a message that came out from this Congress, from this Committee saying that we need to treat people, or we at least need to take into account the fact that when they come back with difficulties, these difficulties may manifest themselves in going down the 405 at 127 miles an hour on a motorcycle. And when they lose a leg people say, well that is not a combat wound. Oh yes, it is. It probably it is. And so we need to look at how these effects occur and we need to look at how the courts handle these issues.

I think I am approaching the end of my 5 minutes, so I will defer the rest of my comments for questions and answers. But again, I want to thank you all for giving me the privilege of coming before you.

[The prepared statement of Hon. Koch appears on p. 51.]

Mr. MITCHELL. Thank you. Dr. Agarwal.

STATEMENT OF MADHULIKA AGARWAL, M.D.

Dr. AGARWAL. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for giving me the opportunity to be here today and to update you on various ways in which VA is improving the transition for returning servicemembers and veterans.

I would like to begin by thanking Staff Sergeant Johnson and his family for their service to our country and apologize for the difficulties he has had to face.

Together VA and DoD, as we just heard, are building a state-of-the-art post-combat care service for our returning servicemembers and veterans. We are continuing to refine these services, identify additional areas of need, and conduct wider research to improve outcomes.

VA has made significant advances in several ways in very important areas, and I will list a few. First VA has increased its outreach efforts for the returning servicemembers, including Guard and Reserve component and veterans. We are collaborating with DoD in expanding the TAP and the Disabled Transition Assistance Program (DTAP) briefings, the yellow ribbon reintegration program events, PDHRA, and the Combat Call Center Initiative.

VA is also aggressively pursuing the social media like *Twitter, Facebook, YouTube*, blogs. Also VA, DoD, and the Department of Labor support the National Resource Directory which has undergone significant revisions and is going to be relaunched in mid-February.

Second, we have expanded the Federal Recovery Coordination Program. This is a joint VA/DoD program which helps coordinate and access Federal, State and local programs benefits and services for the seriously wounded ill and injured servicemembers and veterans through recovery rehabilitation and reintegration into the community.

Third, our care management system begins at the military treatment facility where VA liaisons work in concert with the DoD case managers to facilitate a smooth transition of care from DoD to VA. Our OEF/OIF care management system is veteran and family centered. The case managers are actively involved in assisting our ill or injured veterans with reintegration into their home communities.

Fourth, our polytrauma system of care provides coordinated inpatient transitional and out-patient rehab services. Each of our four polytrauma centers and the 21 network sites offer unique and highly specialized rehab services which help servicemembers and veterans achieve optimal function and independence in their communities.

Fifth, VA has greatly enhanced its mental health services. We have hired more than 4,000 new mental health professionals in the last 3 years.

Sixth, we continue to emphasize interdisciplinary care, which is veterans centered and requires the treating disciplines to coordinate and integrate care. And we are achieving this through new education initiatives and TBI, PTSD sleep disorders, and in pain management.

Now a recent example is the joint VA/DoD clinical practice guideline on mild TBI that addresses the core conditions such a PTSD pain and sleep disorders.

Another example of integrated care is the post-deployment integrated care clinic. These are primary case based clinics where specialists are integrated into interdisciplinary teams who address the special needs of combat veterans.

We are also supporting more research for new treatments, and increasing the use of telehealth to reach those who live at great distances from our facilities and in rural areas.

Finally VA does recognize and deeply appreciates the critical role of caregivers and families in supporting veterans. VA offers a variety of respite and home services to supplement the care that is provided by family members to improve the quality of life of veterans and their caregivers; however, much needs to be done in this arena, and we are grateful to Congress for its support.

Secretary Shinseki is committed to transforming VA into a 21st century organization. A 21st century VA will focus on results and make sure our services are timely, consistent, and of the highest quality, and adapt to the changing needs of veterans. We will leverage technology and educate our workforce to achieve results. It is our privilege to care for those who have borne the battle in Iraq and Afghanistan and our previous Nation's conflicts, and it is our solemn responsibility to do all we can to restore them to their highest and best level of functioning and support them in their journey home every step of the way.

I thank the Subcommittee and you, Mr. Chairman. My colleagues and I are ready to answer your questions.

[The prepared statement of Dr. Agarwal appears on p. 53.]

Mr. MITCHELL. Thank you. Let me just say that—and I know, Mr. Koch you have a specialty in the Wounded Warrior Care and Transition Policy of the Defense Department, but you are in the Defense Department. Can't you do something about getting the sergeant his Purple Heart? Four years. I think that is unacceptable. And I was just asking around here—he is required to go to Reserve meetings. If he didn't go to a Reserve meeting would he be classified as AWOL? I just don't understand.

You know, Dr. Roe mentioned 33 hearings. We can have a hearing every week on this same issue, and we would hear the same things. And I know Dr. Agarwal and Dr. Guice and Mr. Hutter have all been here before, you hear these things. I don't leave these meetings very uplifted. It is a downer for a long time, and we have these continually. Because I know the people who spoke on the first panel, they are just the tip of the iceberg. They represent a lot of other people. And I just feel horrible that we have to have all this, and we hear the same thing over and over, different kinds of cases.

But I think particularly since Staff Sergeant Johnson is still on the roles or in the Reserve, I don't know who takes care of him. I can see the problem here. He tries to get some VA benefits; he tries to get some DoD benefits. You know, we could have one, we probably could have a hearing like this every day, and we would hear the same response from DoD, the same response from VA.

The point I think we are all trying to make is why can't we get it done?

When I heard Mr. Tarantino talk about the reimbursement rates for automobiles, or to refit or retrofit a home because of disabilities, and we are using 1970 figures. And then I heard Dr. Roe say that Mr. Boozman has a bill in. I don't know if Mr. Wilson found this out on his own, but I would think that DoD or the VA would come and say, hey guys, we need to change this. I can't imagine why it would take somebody to introduce a piece of legislation unless that is what is required. And I would think that this piece of legislation should put in an inflation factor.

Now and I also heard Dr. Roe said we are talking about PAYGO and so on. Let me tell you, we ought to pay for this the same way we paid for the war, the same way we got these people over there ought to be the same way we pay for it.

And I am really kind of appalled also that no one has come forward to say to any of these Committees, we need to upgrade the amount of money we are giving to people to retrofit cars, houses, or any other kind—caregivers, the family givers.

I used to teach government in high school, and I know that we used to teach them how important the legislative branch was and that the most important job is to legislate. But the longer I have been here I think the most important job we have is oversight. It is too bad that we have to continually hear over and over the same thing and we get the same responses back. You guys ought to feel bad. And somewhere you are in a better position than we are. If we need legislation, we will do it, just tell us what needs to be done.

And I don't have any other questions, because I get the same answers over and over anyway. So, Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman and the rest of the Committee Members. I think we all share frustration. And I know that I have spent a career, when I see a problem, I fix it and work on fixing it, and if it takes more people than one, we try to get it together and fix it.

And this is a huge problem when you are dealing with hundreds of thousands and millions of veterans as Mr. Wilson pointed out.

Here is a bit of frustration. When we send a soldier to Afghanistan to war, it takes $1 million a year of support to keep that one soldier in theater. So this 30,000 troops that we are going to send to Afghanistan in the next several months is going to cost $30 billion. And yet we have a system here that when we bring soldiers back, that we nickel and dime on what we are doing to take care of them. And I think I share that frustration with everybody here. We spend $1 million per year to keep you in combat, to keep you in harms way, we get you home, we don't have that same commitment to you. And I believe being a Vietnam era veteran that we owe you a lifetimes worth of service. And I know Mr. Koch is a Vietnam veteran.

And you know, we had a group of veterans that were left off the charts for about 20 years. We dropped the ball big time. And I think and I agree with Chairman Mitchell, I talked to him before the meeting and I am meeting with General Shinseki this afternoon, and I am going to share what we have said in this particular hearing today.

And I think we just need to sit down now with a group at the table, not in a formal setting, and get this problem fixed. I mean, we will have 33 more hearings. I mean a year ago exactly, when Travis was here—and sergeant major you are absolutely right, I mean exactly sitting right over there where Sergeant Johnson was.

We are having a meeting in Johnson City, Tennessee, for rural health. There is a sizeable sum of money, $250 million in rural health, and that is where I live, in a rural area, that is where Sergeant Johnson lives, in a rural area. And I am going to talk to the Secretary this afternoon, and hopefully he will visit Mountain Home VA in Johnson City, Tennessee, and I hopefully he will be there for this meeting, but it is a way how we provide support for these veterans who are a long way away.

And I think developing these out-patient clinics is vital. And right now what happens in an out-patient clinic, a particular VA like ours at home gets a certain amount of money, but it comes out of their budget to put an out-patient center near where the veteran is. I think that is essential. And the more I think about this the more essential I believe it is—is to get the care that the veteran needs out to the veteran, instead of having to travel not 3 hours, 6 hours. You have to go and get back home once you start.

And I also agree with Mrs. Johnson. I really appreciated your comments, I think to support the veterans. I remember very well that my scout master was killed in 1965 in Vietnam. He was a first sergeant in 101st airborne division. His family of four had a $10,000 insurance policy, and that was it. That is what we left him with, nothing.

We not only can do better, we are going to do better. And if I seem a bit frustrated I am. I don't have any questions either, Mr. Chairman, I just want to now not sit here next year with our same group here. And I can assure you that one of the things that I have been most impressed with in this Committee is that this Committee is not Republican or Democrat, it is about veterans and about doing the right thing.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman, and thank each of you for your service. Your commitment to our veterans is never in question. We understand that. And Mr. Koch, your service to this Nation and as a veteran and CO I very much appreciate that.

I just had a question for each of you to just take up as, how does a situation like Staff Sergeant Johnson's happen still? How does that happen with a chain of command? There is a first sergeant there somewhere, there is a sergeant major, and I am just at wits end to figure out how this still happens. I mean our hope is that it is the anomaly, but as I said, I see too many of these.

Does anybody have like an insight into how we are losing? I understand this when you transition back home. When I came back from a deployment, it was 48 hours. If you said you had an injury, you had to stay over till the next Monday, and there was no way in heck with a 3-year-old at home I was going to do that, so they showed me the horse whisperer and told me to be nice to my wife and sent us home, and that was it. And I understand we are all learning, but how does this still happen today? How did the Johnsons end up in this situation, if you could? I know I am asking you a generality here, but I am trying to grasp it.

Mr. KOCH. Let me try to take a shot at this, sir. I have to say in the first place we have the benefit of coming here and listening to the frustrations of other panels, and we have the benefit of listening to your frustrations, but there is a separation of powers and there are certain political issues that make it difficult for us to share our frustrations with you, but I can assure you they will probably balance out, and I understand how great yours are. And I won't go on too much in that vain, but you can hear it from General Chiavelli and others who I am sure you can talk to behind closed doors.

I would say I think first of all that Sergeant Johnson's situation is an anomaly. It is a tragic anomaly, but I think nevertheless that it is an anomaly. You don't generally bring folks up here to throw roses at you and bring Valentine's with you, I mean you are looking for the problems and not for all the things that are done right so that you can correct the problems and make sure that more things are done right. I don't know why he doesn't have his Purple Heart. I know a number of other people who have suffered wounds many years ago who don't have Purple Hearts, and they are usually administrative reasons or other reasons that the paper shufflers come up with. I will take this back and see what I can find out and see if I can get an answer to that and get back to you with it and see if we can expedite his receiving what he is entitled to receive.

In the area of sharing what little frustration I can, I mean, I can give you an example, things take time, and sometimes you don't discover problems unless you actually go out and look for them. So I happened to be at one military treatment facility and it was a naval facility, but I was talking to all these people, and I was talking to them in a group, and a number of them were soldiers. And I said, "How is the DES pilot going for you?" And they said, "We are not in it." And I said, "Why not?" "Well, we can't. They want us to go up to Fort Irwin."

So we came back, we wrote new policy to universalize the MEB process, and that was probably 2 or 3 months ago, and it is slowly—we tried to do it procedurally because it has such a, you know, seemed to be congruent with common sense that maybe we can get this done and we tried to push it up, but no it got pushed back down, and so we have had to write a policy and we are walking that through the system, and ultimately we will have more people going through the desk pilot and they won't be disadvantaged because they are in a different service than the MTF.

Mr. WALZ. My question, I guess what I would ask, Mr. Koch, is in 2007, I was in Iraq and I witnessed as they had seven databases open on medical records, not even including VistA and the transition to that, and I made a comment in a hearing here now going on 3 years ago that wouldn't it make sense to record serial concussive blasts, because we were starting to see data at that point that those were going to add to long-term issues. Because mark my word on this, just like Agent Orange or whatever it will be, in 10 years we will have people here trying to come to us and say I was exposed to a blast, there was no record, I asked why we didn't have blast meters that are cheap and carried. You know, we put them on packages of milk so if it is shaken and the thing breaks, we know. How difficult would it be to attach it to a soldier and we would know that they have been in these, record them, and have that data. One, for the care. Two to make sure they don't come back and fight. That was 3 years ago.

This virtual lifetime record we are talking about all of us agree with, is it going to happen? Is this an IT issue? I don't know how many platforms we operate. I heard somebody say people are frustrated with Windows 7, but you guys are using Windows 1 or whatever. How do we get beyond that?

Mr. KOCH. Can I respond to that, sir?

Mr. WALZ. Sure.

Mr. KOCH. First of all with regard to registering blast effects that may produce traumatic brain injury, there is an awful lot of work going on, and we are working with the National Football League (NFL), I think probably some of you had talked to the NFL, because they have the same problems, and however well we are pushing toward that the Marines, you know, God love them, they had to keep it simple because they don't have as much to work with. And so while the rest of us are looking at helmets with sensors in them and things like this, which sound wonderful, but you are always looking for a technological solution, and the Marines, that is not the Marine way. So what they do is if you are in a blast situation and they bring you back and they ask you some simple questions. You get your bell rung? Yes. Okay. How long, you know,

what do you think 30 seconds, 40 seconds? Okay. So you go through that three times, three strikes you are out of theater and there is a record of it. And that is simple, and it works, and it is smart.

With regard to what comes under the broader umbrella of information technology, if I go too far down that road I am going to embarrass myself, but I know that the President himself is behind the virtual lifetime electronic record. When we started out with it, it was to look at medical records, and people who don't understand, including myself, who don't understand much about information technology, it is a kind of magical thing. So if we are going to do the medical records, as long as we are going to do that why don't we throw in personnel records and why don't we throw in the benefits records? And so we have done that. And the idea is that increases the complication arithmetically. Well it doesn't increase it arithmetically.

Mr. MITCHELL. Excuse me, Mr. Koch, we are about to be called for votes.

Mr. WALZ. Yes, I will yield back, but I thank you, and we will look into this more.

Mr. MITCHELL. And I would like Mr. Stearns to say something before we get called.

Mr. STEARNS. Thank you, Mr. Chairman. Dr. Agarwal, let me ask you a question. How long have you been an employee of Veterans Affairs?

Dr. AGARWAL. Sir, over——

Mr. STEARNS. How many years?

Dr. AGARWAL. Twenty plus years.

Mr. STEARNS. Twenty plus years?

Dr. AGARWAL. Yes, sir.

Mr. STEARNS. And how long have you been in your present position?

Dr. AGARWAL. Five years.

Mr. STEARNS. Five years. How many times have you had to testify before this Committee? Either the Subcommittee, full Committee, or any one of the Subcommittees?

Dr. AGARWAL. Sir, I would say at least three times.

Mr. STEARNS. My staff thinks it is between five and ten.

Dr. AGARWAL. Your staff is likely correct.

Mr. STEARNS. Also it appears to us that you have had to apologize in this area multiple times. Do you recollect that?

Dr. AGARWAL. Yes, sir.

Mr. STEARNS. Does it occur to you that your apology over these number of years—you have been in this position for 5 years—is at the point where there should be action rather than apologies?

Dr. AGARWAL. Sir, if I may respond to that.

Mr. STEARNS. Oh, sure. Sure.

Dr. AGARWAL. Indeed. You know, we continually strive to improve our system, but when we make mistakes we do apologize for it. And in this instance, sir, and in the past also.

Mr. STEARNS. So you are saying in the future you will have to apologize again? I mean, do you have any confidence you can come up here and testify and not have to apologize?

Dr. AGARWAL. Sir, I would love to be here and never have to apologize.

Mr. STEARNS. And you are saying the reason you have to apologize is because you don't have the resources or you don't have the manpower or you don't have the—the job is too much for you? I mean, at what point can we get the assurance that you will come up here and you won't have to apologize? What do we have to do to help you?

Dr. AGARWAL. Sir, as I said previously, you know, we are a system that continually looks to improve the quality of care that we deliver across the board. We are a large system. And by and large we do very well. We have created a great network in this instance of how to take care of servicemembers who are returning to us.

Mr. STEARNS. Okay.

Dr. AGARWAL. And the instance when we do not step up and do what we think we should be achieving I feel that it is my responsibility to make sure that we take it back and then we of course correct.

Mr. STEARNS. Well if I were in your position, I would come to this Committee in a proactive way and say I don't want to come up here and apologize anymore. Here is what I want to do to solve the problem. You are on the clinical side, right?

Dr. AGARWAL. Yes, sir.

Mr. STEARNS. So I mean, I would just outline it in a letter to the Chairman here, Mr. Filner and Mr. Buyer, and say this is what I need to get the job done so I don't have to apologize anymore.

Mr. Koch, let me ask you a question. The American Legion has testified that the Department—DoD has implemented a seamless transition to servicemembers, which includes medical screening, eye exam, dental examination, mental health screening. But we are under the understanding that these examinations for the Army and the Air Force are not being implemented. Is that true?

Mr. KOCH. I am not sure that that is true.

Mr. STEARNS. Well we have a fact here that the Army and the Air Force are not implementing separation physicals. It is done on a volunteer basis by them. And if they are doing it on a voluntary basis isn't that in violation of the law?

Mr. KOCH. The individual does have to agree to the examination. The individual as I understand it that is voluntary. Now let me refer to my notes here, because this is an area of some complication. There is a requirement that we do the things that are anticipated. Evaluate the health of the member at the time of separation and so on. If that person has been examined in the last 12 months then that may be waived. And that is one of the things that may be occurring here that gives the American Legion concern. And that is done with the consent of the member.

Mr. STEARNS. But let us say the person is injured and he doesn't want to do it? I think you have to have some kind of——

Mr. KOCH. I think, sir——

Mr. STEARNS. Or let us say he is injured and the injury doesn't appear until later. It seems to me that it should be sort of—I mean the law is saying that everyone should have a separation physical, but our understanding is the Army and the Air Force are not doing

it, and that is in violation of the law. Does that sound right? Am I all wrong or not?

Mr. KOCH. If I take your example if he is injured, and I mean, you have offered two cases here.

Mr. STEARNS. Okay, sure. Okay.

Mr. KOCH. If he is injured then the probability is he is going to be in care and this issue is not going to arise because it is going to be a constant——

Mr. STEARNS. Well, it is an injury they don't detect though. Maybe it is an injury they don't detect.

Mr. KOCH. Well that is the second case you present.

Mr. STEARNS. Yeah, okay.

Mr. KOCH. And if he has been examined previously within the last 12 months, if that injury—if he is in an incident which is likely to produce an injury then he is going to be examined for it. So I don't know that we can give you a categorical case or you can give us a categorical case that right across the board these examination are not being performed.

Mr. STEARNS. Okay. Mr. Chairman, I just want to conclude by saying you had mentioned this, the purpose is oversight. I had a bill in Congress in which no more legislation would be proposed for 2 years, and all we did was implement oversight of the legislation that we have passed in previous years. Now this bill didn't go anywhere. But at some point you are exactly right, this Committee, any Committee, Energy and Commerce, Ways and Means, they pass—we vote 1,000 times a year, and there is no oversight on any of these bills, and we sit here and wonder why some of them don't work. Well you need oversight and you need support. So I think you are right about oversight being a big, big important part of our job.

Mr. MITCHELL. I just want to before we conclude thank all of you for your service and what you are doing and recognize that Mr. Adler is here, and any other question that he has we will submit them and it will be a part of the record.

One last thing. I know, Mr. Koch, you said it takes time, and I understand that. But in the meantime people have house payments, they have bills. And it may be in the long run, but you have heard that phrase before, in the long run we are all dead. It is today that we live.

There is one other thing that we may end up having another hearing on, which I think may be under your control or somebody, and that is the Vision Center of Excellence. Where is it? What is the status of it? You know, that is something I just don't understand. We have already had hearings on that, and as I understand right now it is really in disarray again.

Mr. KOCH. My understanding is that it is in limbo, Mr. Chairman. I can't give you a——

Mr. MITCHELL. I don't want an answer. I just want you to know that we will probably have to have another one.

Mr. KOCH. Right.

Mr. MITCHELL. And you will all come back and say, you know, we are trying, we are trying to hire people, you know, all those other things. If I understand there is about the only employee right

now in that is part-time employee. That is not going to help. That is not going to do anything.

We have to go. And I just would say that this hearing is adjourned, and if anybody has any questions please submit them for the record.

[Whereupon, at 12:04 p.m., the Subcommittee was adjourned.]

A P P E N D I X

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

I would like to thank everyone for attending today's Oversight and Investigations Subcommittee hearing entitled, *Transitioning Heroes: New Era, Same Problems?* Thank you especially to our witnesses for testifying today.

We are here today to address what both the Department of Defense and the Department of Veterans Affairs are doing to assist the men and women of our armed forces to seamlessly transition back to civilian life. Time and again, we have heard from our returning servicemembers, expecting a smooth transition back to the lives they once lived, only to find themselves lost in a complex and frustrating bureaucracy.

Today, we will hear from a severely injured veteran, Sergeant Sean Johnson, who was hit by a mortar round in Iraq and is now completely blind. Although he has received excellent treatment at the Blind Rehabilitation Center in Chicago, he was never assigned a Federal Care Coordinator, after contacting the VA almost a year ago. In addition, Sergeant Johnson has also found himself experiencing the hardships of navigating through both the DoD system and VA system at the same time.

This is just one example of many. Sergeant Johnson joins those veterans and their families who share the same concerns that our Veterans Service Organizations will voice here today.

Additionally, as I have said before, outreach to our Nation's veterans is an equally important task. Both the VA and DoD must ensure that veterans and their families are properly informed about the benefits and services they have earned when they return to civilian life.

Proactively bringing the VA to our veterans, as opposed to waiting for veterans to find the VA, is a critical part of delivering the care they have earned in exchange for their brave service.

The VA should be a place where veterans can easily, and with confidence, go for the help they seek, but the VA must also be willing to reach out to these veterans. Effective outreach will not only ensure better delivery of services for our veterans, but will also increase morale.

I am hopeful that today, both the VA and DoD will shed light on what they are doing to make certain our veterans are receiving the best possible care available; they are being provided with the services and resources they have earned; and most importantly, that the two Departments are working together to ensure that these earned benefits are seamlessly delivered.

I believe that all my colleagues join me in being steadfast in our hopes that Secretary Shinseki, as he transforms the VA into a 21st century organization, will help eliminate the stigma that so many of our Nation's veterans have placed upon the VA. We must ensure that both the VA and DoD are working together and providing veterans the services that they rightfully deserve.

Again, thank you to all our witnesses for testifying today, and we look forward to hearing your testimony.

Prepared Statement of Hon. David P. Roe, Ranking Republican Member, Subcommittee on Oversight and Investigations

Thank you for yielding, Mr. Chairman.

I would first like to thank the members of the first panel for their service to this country, not only for their military service, but their continued service by appearing here today to share their testimony and help us work toward a better transition for our Nation's veterans.

Prior to this hearing, my staff provided me with a list of the hearings held by the Committee on Veterans' Affairs over the past 10 years. Totaling around 33 hear-

ings, the topics have ranged from employment transition, through the use of the polytrauma centers, pre- and post-deployment health assessments, sharing of the electronic health record of our wounded servicemembers, transition assistance programs for guard and reserve forces, and the list goes on. As you can tell, helping our servicemembers move from military to civilian life is of great importance to this Committee.

Concern in Congress about helping our servicemembers transition to civilian life didn't start 10 years ago. During the 97th Congress, Congress codified the concept of "DoD/VA Sharing", now known as "Seamless Transition" in 1982, with passage of the Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act (P.L. 97–174). This Act created the VA-Care Committee to supervise and manage opportunities to share medical resources.

Today's hearing will enable the Committee to review the various programs that have been instituted to assist our Nation's veterans, and wounded warriors in their transition to civilian life. We will be looking not only at the medical record exchange between VA and DoD, but also at the various other transition services, the use of the polytrauma centers across the country, and programs available to assist our veterans. This is not the first hearing to look at these issues, and I am certain that it will not be our last.

We here in Congress must do everything we can to make certain that the transition our military personnel undergo is smooth, easy and the programs available are truly helping our Nation's veterans. In the past, it appears that the transition many servicemembers have encountered have not been exactly seamless and certainly not easy or smooth.

Mr. Chairman I appreciate you holding this hearing today. I believe we have much to learn from the witnesses here today.

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

Prepared Statement of Hon. John J. Hall

Thank you Mr. Chairman, and thank you to all the panelists here today to discuss the issue of a seamless transition for our disabled veterans.

It is disappointing to know that as we enter 2010, more than 9 years since we first entered Afghanistan, transitioning our troops to veteran life still remains a challenge.

In particular, we must do better to care for those men and women injured in the line of duty. Heroes like Staff Sergeant Johnson deserve better.

Both the Department of Defense and the VA have improved how they handle transitioning disabled veterans.

The Wounded Warrior Program, and its Warrior Transition Units, has been a great success. The ability to care for our wounded soldiers while keeping them in an active-duty mindset has helped thousands of soldiers since 2007 who have experienced traumatic and life-altering events.

I have visited the Warrior Transition Unit at West Point, and commend the men and women working there for their service.

However, even this example of a success has its shortcomings. There are only 35 WTUs in the country. Servicemen and women from as far away as Vermont have to travel to the WTU in my district to receive treatment.

Also, the VA has a limited presence at the West Point WTU, traveling from VA facilities in the area to give classes on TAP and other benefits programs.

This is why I plan to introduce legislation that I believe will improve the seamless transition this hearing is addressing today.

This legislation will mandate that the VA have a permanent presence on active-duty military facilities, and require one-on-one consultations with active troops as they begin the transition process.

There should be no improperly filled out enrollment forms. This will cut down on processing times, and reduce the ever-growing backlog. Men and women separating from the service deserve to be fully informed of the benefits they have earned. An increased VA presence on these facilities is an important first-step toward a seamless transition for our wounded warriors.

Thank you again, Mr. Chairman, and to the men and women testifying today. I yield back the balance of my time.

Prepared Statement of Staff Sergeant Sean D. Johnson, USA, Aberdeen, SD (OIF Veteran)

Chairman Mitchell, Ranking Member Congressman Roe, and Subcommittee Members, I appreciate the invitation to testify today from my perspective as a severely injured soldier returning from Iraq. I want to speak for those veterans who cannot be here today.

I am a Staff Sergeant with the 452nd Ordnance Co. of the United States Army Reserves. I am currently awaiting a medical review board so I can be medically retired from the military. Following a 15-year career as a Paramedic/Firefighter in my civilian life, I had to take a medical retirement in June 2008 due to my TBI, PTSD, and chronic health issues.

I entered the military on June 22, 1988, and completed basic training at Ft. Leonardwood, MO. I attended the lab technician program in San Antonio, TX, in 1989. I was deployed to UAE during the Persian Gulf War from December 1990–March 1991 with the 311th EVAC Hospital from Minot, ND. I transferred to the 452nd ORD CO in Aberdeen, SD in 1995. From March–November 1997 my unit was deployed to Taszar, Hungary in support of Operation Joint Guard during the Bosnian War. I was called to serve under Operation Iraqi Freedom from June 2005–August 2006 in Balad, Iraq.

Between October 2005 and March 2006, I was in close proximity to one rocket and five mortar attacks where I was within 30 feet of the impact. On March 25th, 2006, around 6:40 AM four mortars were marched in from the outer perimeter into our location with the third landing in the middle of our group and approximately 10 feet from me. The blast knocked me through the air and about 7 feet back. I landed on my neck and shoulders and was unconscious for 3 to 4 minutes. When I awoke I could not hear and was in shock. I looked up through my feet and another mortar hit about 25 feet away. My hearing wasn't right for several hours and I had a severe headache, dizziness, difficulty seeing distance, and light sensitivity throughout the next several days. I was seen in sick call on April 12, 2006, for abdominal pain, dizziness, and headache.

I was hospitalized in 332 EDMGTH on May 11, 2006, for 7 days with extreme abdominal pain, nausea, vomiting, diarrhea, headache, neck pain, and dizziness. There was an initial diagnosis of salmonella poisoning and I was given high doses of antibiotics. During the next month the symptoms persisted and I lost almost 40 pounds. From June 21–July 10, 2006, I was evaluated at Landstuhl Hospital in Germany. The doctors were unable to find the cause of the abdominal problems and I was returned to Iraq for regular duty. I was transported to Germany again on August 7, 2006 and this time was diagnosed with clostridium dificile (c-diff) infection. On August 25, 2006, I was sent back to the states with orders from my doctor that I be sent to Walter Reed Army Medical Center for further evaluation and treatment. Instead, the Army sent me to Ft. Riley, KS, where I was placed in the medical holdover barracks and was told by the physician that I would be treated for irritable bowel syndrome (IBS) as my records did not indicate c-diff infection or other health concerns.

In October 2006, after much insistence on my part, I was seen by a GI doctor in Topeka, KS. After extensive testing he determined the c-diff infection had cleared and that my persistent abdominal pain, nausea, diarrhea, dizziness, and headaches were not caused by anything related to my digestive system.

I remained at Ft. Riley from August 2006 to May 2007 on medical holdover. During this time I had to file several Congressional complaints in order to be evaluated at WRAMC. My symptoms were not improving and the doctors were offering no explanations. I was told, "Just take your pain meds and you'll be fine." On several occasions I was told that if I stopped contacting my state Senators, I would be given medical treatment. The doctors admitted they didn't know exactly what was wrong with me, but were not willing to make the referral to WRAMC or BAMC where specialists might evaluate my case.

In December 2006, I was sent to WRAMC for an evaluation at Deployment Health Clinical Center (DHCC). During this time I was diagnosed with Medically Unexplained Physical Symptoms (MUPS) and was scheduled for the 3-week Specialized Care Program for pain management in February 2007.

In March 2007, with no definitive diagnosis or treatment plan, I began to push for a means to leave med hold and return home to my family. I applied for Community Based Health Care Organization (CBHCO) so I could go home and work at my local reserve center until my health improved or stabilized. My request was denied due to the severity of my symptoms. I was told that my condition was likely to be long-term or not improve and CBHCO is a short-term program for soldiers with less severe health problems. Ft. Riley decided to send me home as they had done all they

could for me. I asked to be reconsidered for CBHCO as I would not be able to meet the physical demands of my civilian job at this time, and was told that my civilian job was not the concern of the Army. I was released from med hold and came home to return to my position as a Lieutenant at the Aberdeen Fire Department. I was placed on light duty within a month of my return home due to my weakened physical state and inability to make decisions and think quickly. I had to accept a medical retirement in June of 2008 after being diagnosed with a TBI.

When I returned home, I contacted my local VA CBOC and began medical treatment in Aberdeen, SD. There was no contact between Ft. Riley and the VA regarding my case. I had to initiate all care and provide the VA with a complete "paper copy" of my military medical files. My wife and I spent many appointments going over my symptoms and the growing problems I was having with memory, concentration, decision-making, confusion, dizziness, and episodes of staring/non-responsiveness and now ask "why were these not picked up" as warning signs of a probable TBI? Also, I was still having daily headaches, persistent nausea, intermittent diarrhea with abdominal pain, and wonder if those were all related to the initial blast forces sustained from the injury in Iraq. The VA continued to search for a GI answer to the problems, despite the previous determination that it was not a digestive track problem. Finally, in December 2007, I was asked a series of questions at the VA concerning falls and blasts that I had encountered in Iraq. My profile was flagged for head injury, and I was referred to Dr. Hof at the Polytrauma Unit at the Sioux Falls, SD VA Hospital. This was the first time since my injury in March 2006 that I had been asked ANY questions about blast injuries. Dr. Hof and Dr. Muntz did a battery of tests and determined I had a mild TBI due to multiple blast exposures in Iraq.

In June of 2008, my eye exam noted double vision in multiple fields and loss of peripheral vision at 60 degrees. I also had nystagmus and recurrent eye pain. By December of 2008 my double vision was in all visual fields and I had pain behind my eyes daily. On December 17, 2008, I suffered stabbing eye pain and my vision was reduced to colors and shapes. I was treated for optic neuritis with IV steroids which brought some pain relief, but no change in vision loss. My vision was noted at 20/800. I was referred to the Visual Impairment Service Team (VIST) who provided me with some tools to help me magnify reading materials and protect my eyes from bright light. My VIST also made arrangements for me to be a patient at the Central Blind Rehabilitation Center at the Hines VA in Chicago, IL. I was at Hines from February 27, 2009, to May 16, 2009. I learned to do things independently despite my vision loss, and how to use the vision I have left to the fullest. The Hines Blind Center did an excellent job of keeping my wife informed of my progress, and we both appreciated the family program at the end of my stay where my wife was able to experience my program, my blind training was reviewed, and skills learned were demonstrated.

Most recently, I was an inpatient in the PTSD program at the St. Cloud, MN VA as my nightmares of my combat have grown worse. It saddens me that I had to wait 3 years for some of this treatment after hearing the doctor tell me I have an extreme case of PTSD. Think of all the time that I have wasted with my family and not being my best due to the combination of PTSD and TBI, and difficulties encountered in sorting this out since the time of my injury. I feel the program was very beneficial for my well-being; however, there was absolutely no contact between my family and staff members. I was told that if my wife wanted to read through my records (375 pages) she could do so and call with any questions. They did not ask for any input from my family regarding my behaviors at home, nor did they provide any feedback on my progress or treatment plan. At this time, there is a suggested treatment plan, but no programs available in my rural area, even if I am willing to travel 3 hours to the nearest VA Hospital. I am receiving 1:1 counseling once per month.

The impact on my family has been overwhelming. We have three teenage children receiving private counseling and all on anti-depressant and/or anxiety medication. They struggle with the "weird" things dad does, the changes in my personality, the difficulty of helping take care of a blind dad when I should be taking care of them, driving me to and from appointments, helping me shop, explaining how to do things I used to know how to do, and the physical changes. My appointments take my wife and myself away from home, sometimes for days at a time. I have been at Hines and St. Cloud for a total of 5 months this year, which adds to the separation and reintegration problems similar to my deployment. My wife uses most of her sick leave to take me to appointments and like many wounded warriors' families is worried about loss of her job and meeting our financial needs. Although there is a DAV van available in our area that helps me with travel, my memory problems make it difficult to see the doctor on my own effectively. She is a full-time mother, caregiver

to me, and works full-time as a teacher. My wife has spent countless hours researching my conditions, treatments, searching for strategies to help me or to help cope, and looking for information for our children and families.

The most frustrating feeling is having a meeting with a doctor, caregiver, or social worker and being left with confusion and questions not receiving any information from the VA regarding my total care plan, both physical and the PTSD emotional injuries. Verbal descriptions are given, some theories, possible treatment plans, but I feel, probably like many others, that care managers are needed for more complex cases. When a servicemember is diagnosed with TBI or PTSD, the VA should immediately provide something tangible for the family to read and review. It is not right that we are names and case numbers; when we leave the office, the doctor goes on to the next case, but we live with this all day, every day. A wait-and-see approach does not feel very reassuring on the 3-hour drive home. We need tools we can use now for daily care. We need someone to check in and see how things are going. We need to know we are not in this alone.

Again, in conclusion, I am concerned with the lack of continuity or "seamless transition" between active duty, the return home, the VA health care system, and the family. It is unreasonable that an injured soldier who is not able to be rehabilitated for deployment must wait more than 2 years for his medical review board to be completed. As I look back, I find it shocking that it took 21 months for any medical personnel, be it military or VA, to diagnose my exposure to blasts with a TBI head injury while in Iraq then discern the PTSD. I am disheartened that soldiers are brushed aside in medical holding units or at home waiting for repeated exams and claims decisions. After years of work on electronic exchange of medical computer records, it doesn't seem to be any closer than before.

Veterans should be introduced to one Primary Case Manager, then they should consult with one Primary Federal Recovery Coordinator (FRC), so difficult cases are jointly managed at the local level, and for special care programs like the VIST and Blind Rehabilitative Outpatient Specialists (BROS). While every injured servicemember might not need an FRC Coordinator immediately to enable them to make connections with those in charge of their case, there should be a red flag system for polytrauma cases. These people in turn must work with individuals, not numbers or files. Veterans need to be treated with dignity and respect. Many veterans do not know what to ask, what is available, and who can help them.

The VA benefits system should use the experts' written records to make rating decisions permanent, instead of making veterans go through numerous evaluations and exams, as if to make the veteran prove his or her disability again. Providing veterans with certification of all benefits, like adaptive housing and other vehicle grants, would prevent repeated claims from being filed for the same case. These soldiers have paid the price in battle to serve their country selflessly, and they don't deserve the runaround when trying to get the benefits to which they are entitled. As of today, I still do not have my Purple Heart, and can only wonder how many others are "pending reviews" for theirs?

Defense and VA Vision Center of Excellence need adequate funding, staffing today, and operational registry systems. The comprehensive system must include those with hearing, vision, and orthopedic problems along with the new TBI and Mental Health Defense Center of Excellence to ensure the care of the severely injured. More funding is necessary for adequate TBI and vision trauma research. The number of soldiers returning from battle with these combined injuries is staggering, and our country should not rest until we have provided for the needs of every one of them.

The Veterans' Caregiver Bill, S. 1963, would be greatly advantageous to those families who are primarily responsible for the veterans' care, many finding it difficult to work while providing daily care for the veteran. Many have families to raise in addition to providing care, transporting to appointments (increasingly difficult in rural areas with fewer services), and trying to find their way around the VA system.

I speak today not for myself, but for the thousands of veterans who do not have a voice, who are struggling in a faulty system where their concerns go unnoticed, where their specialized medical needs are sometimes delayed, where they are left waiting often months or years for a VA claims review. Timely and accurate diagnosis and treatment of conditions help the claims system. The burden of proof is put back on the veteran and should not be, it should be on the VA. I speak for families struggling with the changes and uncertainty of a future they never imagined when they proudly stood beside their soldier and professed their pride in America. I am but one example of thousands. I hope my story helps as you work on this Committee to find solutions and make the necessary changes. This concludes my testimony and I will try to answer any questions that you have for me.

"To care for him who shall have borne the battle."
Abraham Lincoln

Prepared Statement of Joseph L. Wilson, Deputy Director, Health Care, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present the American Legion's views on seamless transition issues. Since 2001, the Department of Veterans Affairs (VA) Health Care system has undergone a major transformation in an attempt to accommodate the Nation's veterans; to include increasing outpatient and preventive care in its growing network of outpatient clinics. Currently, there are approximately 23.4 million veterans in the United States; of that total, 7.8 million are enrolled in the VA Health Care system. VA treats 5.8 million veterans at more than 150 hospitals and 800 plus clinics.

As we examine the transition process, the American Legion, in its efforts to ensure transitioning servicemembers receive continuous/seamless care, has determined that veterans are facing various challenges, which may irrevocably deter any chance of a successful and smooth transition back into their local communities. An example of challenges include, incomplete Post Deployment Health Reassessment (PDHRA) questionnaires, inability to fully share medical records among the Department of Defense (DoD) and VA Health care facilities, lack of space at VA Medical Facilities, and shortage of staff, to include nurses and physicians.

VA and DoD both play important roles in the transition process. As women and men return from Iraq and Afghanistan facing uncertainty with injuries and illnesses, the American Legion contends that closer oversight must be placed on various programs, such as the PDHRA and Federal Recovery Coordination (FRCP) programs that have been implemented to ensure no one falls through the cracks. We ask Congress to assess these roles to ascertain the appropriateness of functional tools required to accommodate the Nation's veterans, their families, and the complex issues they are met with.

The transition period is very important because many conditions servicemembers are suffering from may go undiagnosed due to being in the emergent stage. The role of DoD and VA must be that of "safety net catalysts" that carefully guide servicemembers and veterans as they transition from active duty military treatment facilities to VA Medical Centers; thereby ensuring every servicemember or veteran is the recipient of adequate and continuous care.

The following are some of the obligations DoD and VA have taken on to support each servicemember and veteran as they transition from active duty to civilian life:

Department of Defense and Seamless Transition:

To ensure that each servicemember's transition is successful, DoD has implemented the following:

- ✔ When transitioning from active duty service to civilian life, servicemembers must undergo final physical examinations before separation which includes: Medical screening (including eye exam);
- ✔ dental examination; and
- ✔ mental health screening.

- They are offered a Medical Board Review for any unfitting conditions. This review is scheduled and performed at the request of the servicemember.

Post-Deployment Health Reassessment Program

The PDHRA program was established to identify and address servicemembers' health concerns that emerge over time following deployments. To be in compliance with DoD's policy, each military service must electronically submit PDHRA questionnaires to DoD's central depository.

However, a recent audit disclosed that the central depository did not contain questionnaires for approximately 23 percent of the 319,000 (OEF/OIF) servicemembers who returned from theater. This means approximately 72,000 servicemembers were without questionnaires in the repository. The response to the absence of the questionnaires concluded that DoD does not have reasonable assurance that servicemembers, to whom the PDHRA requirement applies, were given the opportunity to fill out the questionnaire and identify as well as address health concerns that could emerge over time following deployment.

The American Legion believes the administration of the PDHRA is essential to the success of the servicemember's transition, because the results would disclose

telltale signs of debilitating illnesses, such as the disorders that plague many veterans who have gone undiagnosed at separation from active duty. These illnesses and injuries include Depression, Post-Traumatic Stress Disorder (PTSD), Mood Disorders and Traumatic Brain Injuries (TBI), Spinal Cord Injuries (SCI), Blind Eye Injuries, respectively.

Department of Veterans Affairs and Seamless Transition:

Upon separation from active duty service, VA informs the veteran of the following:

- Eligibility to enroll for health care at any VA Medical Center or clinic within 5 years following military separation date. Upon enrollment, VA will administer health care benefits to the veteran immediately.
- VA provides dental examinations and benefits to veterans with service-related dental conditions. The veteran may be eligible for one-time dental care; however, each veteran must apply for a dental exam within the first 180 days following the separation date.
- Every VA Medical Center (VAMC) has a team ready to welcome Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) servicemembers and help coordinate their care.

Federal Recovery Coordination Program:

The American Legion would also like to ensure that the FRCP is successfully assisting **all** recovering servicemembers and veterans suffered from severe wounds, illnesses and injuries, as well as their families in accessing the care, services, and benefits provided through specifically, DoD and VA.

According to recent VA reports, the greatest challenge for Federal Recovery Coordinators (FRCs) is the integration of Information Technology (IT) access within VA and the Military Training Facility (MTF). Although DoD and VA state that these challenges will be overcome with the implementation of more IT integration between VA and DoD, the American Legion would like to know the status of DoD and VA full IT integration and medical records sharing. Further, the American Legion recommends a strong emphasis by this Subcommittee for expediting the effort be made.

VA Polytrauma of Care, VA Social Worker and Seamless Transition:

VA's Seamless Transition Social Worker, who is assigned to the MTF responsible for caring for the patient, makes contact with staff at the receiving Polytrauma System of Care facility. Vital clinical information is then transmitted to the Admission Case Manager at the Polytrauma Rehabilitation Center for review.

The Admission Case Manager remains in contact with the Seamless Transition Social Worker and the clinical team at the Military Treatment Facility until the patient is transferred to the receiving VA Polytrauma facility. During the servicemember's stay, the VA Case Manager remains in contact with the patient's military branch to keep them informed of progress and/or changes in the patient's condition.

VA and DoD, both ensure open communication and effective coordination through the following resources: phone calls, secure record transfers, and meetings. In addition, physicians in the VA Polytrauma System of Care and at Military Treatment Facilities contact each other directly through teleconferencing, videoconferencing, and through VA social workers assigned to each facility. Although the aforementioned duties are outlined and in place, VA continues to face challenges, such as screening and evaluating veterans for TBI.

More Challenges Transitioning Servicemembers and Veterans Face:

There have been various reports of critical challenges involving veterans who had recently departed from active duty service. These challenges, as reported by RAND, includes barriers to mental health care access in community settings.

More specifically, it was discovered that:

- **Military servicemembers and veterans are often reluctant to seek mental health care. The following reasons being:**
  - Concern that admitting a mental health problem is a sign of weakness
  - Fear that use of mental health services will have negative career repercussions (especially among active-duty personnel, who are required to disclose treatment)
  - Skepticism about the effectiveness of treatment and concerns about the negative side effects of medication.
- **The mental health workforce has insufficient capacity. The following reasons being:**

- Mental health specialty care for conditions such as Post-Traumatic Stress Disorder (PTSD) and Depression are not readily available in many parts of the country.
- Studies also show that most mental health specialists are concentrated in urban areas.
- Even where specialty care is available, limited health plan coverage may reduce access for veterans seeking care outside of the Veterans Health Administration (VHA).

The American Legion "A System Worth Saving" Site Visits:

During the American Legion's 2009 Site Visits, it was discovered that challenges were systemwide when it comes to meeting the needs of OEF/OIF servicemembers turned veterans. Lack of sufficient and appropriate staff to meet increasing workloads, a lack of support for families caring for returning severely injured veterans, and difficulty reaching new veterans who recently separated from active duty military, especially significant number that may be possibly suffering from psychological disorders are among the critical issues. According to VA, during outreach, it was reported that the battlefield mindset may be preventing veterans from seeking health care from the VA by admitting that there is a problem.

When women veterans' experiences include defragmentation of care, this cannot be deemed a successful transition. For example, approximately 49 percent of women veterans continue to split care between VA and the private sector. There continues to be a lack of space for a women veterans' clinic in some VA facilities. A common deterrent for women veterans include, the provision of day care for their children, and women veterans being uninformed of full service provided by VA which, at times, causes available clinics to be underutilized. Currently, an unknown number of veterans, men and women, are missing VA appointments due to childcare challenges.

The American Legion recently passed Resolution No. 29, "Improvements to Implement a Seamless Transition," which recognized gaps in services, and has consistently advocated improvements be made to the process of servicemembers in their transition from active duty to civilian life. The American Legion continues to express that servicemembers and their families are easily overwhelmed when dealing with the bureaucracy of multiple departments. However, a more expeditious process that explicitly focuses on moving servicemembers from point A to point B, i.e., DoD to VA, respectively, would ensure timely and accessible care.

The American Legion believes it is extremely vital that this Nation's servicemembers, before their departure, should be placed in a comparable or full duplex capable, fully compatible, DoD/VA database with appointment reminders to ensure their transition isn't stifled by the unknown; after all, active duty servicemembers have been conditioned to be directed to all military appointments and events.

Upon separation from service, these newly transitioned veterans may continue to have the expectation that everything will be set up for them. Both DoD and VA are working to ensure servicemembers and veterans successfully receive information and treatment respectively. It is the American Legion's contention that the interaction between DoD and VA be heightened, most importantly, by complete shared access of the medical records of servicemembers and veterans, as well as assessments of this relationship.

Let us remember that there is no pause button for veterans. Every moment is critical and must be treated as such. Although the World War II veterans' population is diminishing at approximately 1000 daily; other veterans, to include those from the Vietnam era to current OEF/OIF are presenting to VA with old and new issues. Complacency in communication between DoD and VA and implementation of programs can never be relative.

The American Legion hereby reiterates its position and urge careful oversight of effective communication between DoD and VA, to include, verbal and written, as well as full implementation of programs to ensure no one is left behind during the transition process.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates this opportunity to submit testimony and looks forward to working with you and your colleagues to ensure all servicemembers are met with the best of health care upon transitioning into the community. Thank you.

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

Mister Chairman, Ranking Member, and Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America (IAVA), I thank you for the opportunity to share our views and concerns on some very important issues facing veterans of Iraq and Afghanistan and their families.

Polytrauma and Adaptive Benefits

Veterans of Iraq and Afghanistan regularly receive excellent care in the ever-expanding polytrauma system. However, the DoD and the VA must continue to innovate, develop, and improve methods of care that address the changing nature of injuries from Iraq and Afghanistan. While these centers provide excellent care for servicemembers and veterans, there is a noticeable drop in the quality of care when transferring to community based care near the veteran's home of record. Additionally, the quality of services for the disabled veteran near their home does not match the standards of care that a veteran receives while in a polytrauma center.

Additionally, IAVA is concerned with the structure of the adaptive services benefits that many veterans will use after leaving polytrauma care. Veterans are being forced into debt because of shortcomings in their benefits and the services that the VA provides. Currently, benefits for adaptive housing and automobiles are stuck at 1970's funding levels; most are one-time deals. With about 80 percent of OIF and OEF veterans under the age of 30, a veteran living with permanent disabilities will require more than one automobile in his or her life. The current rate of $12,000 may have bought a van, equipped with adaptive modifications, back in 1972. Today, that might get you a mid size Kia with no adaptive technology. The veterans are left to pay the difference. We cannot tolerate a benefits system that requires a veteran to incur debt to perform everyday functions.

Finally, many veterans, wounded in Iraq and Afghanistan, are not homeowners and must return to their family homes to recover. They are then faced with a choice during a critical time in their recovery. The must choose between adapting the home where they are recovering, or save that benefit for the home where they will eventually settle. The need for these services is obvious, and the figures that require upgrading are known. There is no excuse for leaving a veteran with substandard benefits.

Social Work Case Management

VA Social Workers play an indispensible role in the treatment of veterans recovering from multiple traumatic injuries. The VA must rapidly expand their numbers. As more and more OIF and OEF veterans enter the VA health system their overall needs will continue to inundate the overworked and understaffed cadre of social work professionals within the VA system. Private sector social workers, on average, work on a caseworker to client ratio of 1:10 to 1:15. In comparison, in-house VA social workers operate near a ratio of 1:35. The VA must address this issue before the ratios expand further. These caseworkers cannot properly address the needs of our veterans and their families under these currently crushing workloads.

Dependent & Survivor Education Services

To the spouses and dependents of veterans who gave their last full measure of devotion to this country the VA provides educational benefits under Chapter 35, the Survivors' and Dependents' Education Assistance Act (DEA). This benefit is limited to family members of veterans who died or became permanently and totally disabled due to a service-connected disability. In 2008, the VA reported that 80,191 family members took advantage of this program. This is more than the number of reservists using Chapter 1606.

Unlike the generous Post-9/11 GI Bill or the recently increased Montgomery GI Bill, DEA provides a paltry sum of $925/month, which will cover less than 60 percent of a public school education. The Post-9/11 GI Bill has become a game changer for many spouses and dependents that can now utilize their veteran's unused education benefits to attend any public school in the country. IAVA believes that DEA benefits rates should be aligned with the generous benefits of the new GI Bill, to include tuition/fees, a living allowance and a book stipend. These changes will help prevent the creation of a two-tiered benefits system. The first tier being family members that can afford to go to school using the new GI Bill, because they meet the criteria under the Marine Gunnery Sergeant Fry Scholarship. The second tier being family members who are left to use DEA and will have to take out student loans just to attend a community college.

Last, we believe that the definition of a "child" used under Chapter 35 and new Post-9/11 GI Bill, which requires dependents who have started college before the age

of 23, unfairly excludes a number of dependents who simply got a late start attending college and should not be punished for doing so.

VA Outreach Efforts

Since early 2008, we have seen a noticeable shift in how the VA educates veterans about the care and services that they offer. Beginning with the suicide prevention ads in the DC region, the VA has continued to rethink how it communicates with the veteran population at large. I have personally met with representatives from the VHA, VBA and the VA Business Office to discuss how the VA can better reach out to veterans of Iraq and Afghanistan. While there has been visible improvements with online and television advertisement, there is a clear lack of coordination between VA departments. Within the VA there is talent, will and desire to change the passive nature of VA communication, however there are still substantial cultural and structural hurtles that must be overcome.

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

Thank you once again for the chance to communicate our opinions on several of the issues facing veterans of Iraq and Afghanistan. We look forward to continuing to work with the Committee and I appreciate your time and attention.

Prepared Statement of Captain Jonathan Pruden, USA (Ret.), Area Outreach Coordinator, Wounded Warrior Project

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project to share its perspective on issues of "Seamless Transition" between the Departments of Defense and Veterans Affairs.

I was an Army captain who in 2003 became one of the first IED casualties of Operation Iraqi Freedom, and have made that transition myself. Now, after 20 operations at 7 different hospitals including amputation of my right leg, I am an Area Outreach Coordinator with WWP, working with hundreds of wounded warriors and covering Florida, Georgia, South Carolina and Alabama.

Over the past 6 years DoD and VA have made significant progress in care coordination and information sharing. I have seen firsthand real dedication to wounded warriors and their families. Certainly this Subcommittee's steady focus on these issues has helped achieve greater "seamlessness" for wounded warriors in making a transition from the military to VA care and to receipt of VA benefits.

The Goal: That Warrior's Thrive

Even the most well coordinated, "seamless" handoff to a welcoming VA will not change the fact, however, that for many wounded warriors this transition feels like having been thrown off a cliff. In short, more work needs to be done by the departments and by the Congress to achieve not only "seamlessness" but to ensure that our new veterans have a successful transition and reintegration into the community.

Certainly much progress has been made in coordinating the clinical care of the severely injured servicemember. The DoD–VA Disability Evaluation System pilot program has also had success in expediting VA disability ratings. But while the departments can take pride in certain areas of real progress, wounded warriors leaving the service continue to face programmatic, cultural, and structural barriers at VA. It is critical, in our view, that those barriers be toppled and that key VA programs and service-delivery mechanisms be re-engineered, as necessary, to help wounded warriors not simply to recover from their injuries but to thrive physically, psychologically and economically.

Meeting Warrior's "Co-occurring" Needs

More specifically, critical VA programs, benefits, and service-delivery models fall short in many instances of providing the array of 21st century services wounded warriors need. We work with men and women who are not only combating co-occurring PTSD and substance-use problems, but "co-occurring" traumatic brain injury, burns and amputations. Often, they're also dealing with pain, anger, depression, un-

employment and lack of employment opportunity, lack of permanent housing, and more. In some cases, behavioral health problems have resulted in difficulties with the law.

VA has an array of programs targeted at specific problems, but little in the way of a holistic coordinated approach to turn these lives around. The goal of "One VA" a department that provides "wraparound" services that seamlessly and effectively integrate Veterans Health Administration (VHA) services and Veterans Benefits Administration (VBA) benefits seems sadly remote. Yet, as a panel of the National Academy of Public Administration has observed, care and benefits to veterans could be improved if VA management, organization, coordination, and business practices were transformed with the aim of improving outcomes for veterans, rather than simply aiming to improve operational processes.[1] Most importantly, that National Academy panel has provided VA detailed recommendations constituting a comprehensive blueprint for that needed transformation.[2] At its core is its emphasis on the importance of leadership commitment to creating and maintaining veteran-centered systems, including a "no wrong door" policy to ensure receipt of appropriate guidance regardless of point of contact. The Academy has provided VA a vision, strategy and detailed recommendations for organizing and delivering veteran-centered services. We urge the Committee to press VA to implement these important recommendations.

Bridging Programmatic Gaps

The Academy report aptly cites the need to strengthen VA's system of care, including its care-management tools.[3] The need for better coordination between VHA programs serving wounded warriors is aptly illustrated by reference to the separate development and separate administration of its specialized PTSD programs and its polytrauma system of care. As VA researchers observed in a recently published paper,[4] the Department has not developed a systemwide program or set of guidelines for treating the many OEF/OIF veterans who may have both combat-related stress disorders and mild explosive-induced concussive injury. Researchers pursuing this important subject initiated interviews with VA clinicians who provide specialized PTSD or TBI services with the aim of helping to identify systemwide approaches to improve services offered to OEF/OIF veterans with mild TBI and PTSD. Highlighting just some of the findings, the interview data reportedly suggested considerable variation in the degree and type of collaboration between PTSD and polytrauma teams, and indicated that coordinating assessment and treatment depend on individual clinician initiative and can take considerable time, as well as entail potential problems in managing medications across teams and care-settings.[5] Of particular note, many providers emphasized that TBI/PTSD can co-occur with other clinical problems, and expressed particular concern about the lack of adequate treatment availability for pain and sleep-related problems.[6] To their credit, providers also cited a need for vocational services for these veterans, noting that employment difficulties are a significant problem for them.[7]

While it is encouraging that VA researchers are searching for best practices for treating these two, often co-occurring "signature wounds" of this war, what does this knowledge-gap say about care-coordination for wounded warriors with even more complex co-occurring problems?

In that regard, we applaud the Department for having initiated the Federal Recovery Coordination (FRC) program, which plays an important coordinating role for those it serves. But with only about 15 Federal Recovery Coordinators already carrying full workloads, many severely injured warriors, who are still struggling years after their injuries, are unable to benefit from such efforts. We see a real need to augment the number of FRC's assigned to help wounded warriors, but more profound system changes are also needed. To illustrate, the most able FRC or other case-manager cannot solve such problems as a systemwide lack of treatment capacity, whether in the area of treatment of pain or sleep-disorder, or of co-occurring

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[1] National Academy of Public Administration, "*After Yellow Ribbons: Providing Veteran-Centered Services*," October 2008, p. ix.

[2] Ibid.

[3] Ibid, p. 51 et seq.

[4] Nina Sayer, Nancy Rettmann, Kathleen Carlson, Nancy Bernardy, Barbara Sigford, Jessica Hamblen, Matthew Friedman, "Veterans with History of mild traumatic brain injury and posttraumatic stress disorder: Challenges from provider perspective," *Journal of Rehabilitation Research & Development* 46 (Nov. 6, 2009).

[5] Ibid., 710.

[6] Ibid., 711.

[7] Ibid.

PTSD and substance-use disorder. Individual case-management assistance afforded by an FRC is surely no substitute for the kind of delivery-system changes needed to most effectively help individuals who, for example, may be struggling with "co-occurring" polytraumatic injury, behavioral health problems, and unemployment.

The importance of VA's developing more holistic, integrated systems' approaches to help wounded warriors thrive should not, however, detract from improving targeted programs.

Mental Health: An Example of Need for Programmatic Change

Much more must be done, for example, to make VA mental health care more "veteran-centric," a yet-to-be realized VA policy goal. VA mental health policy (articulated in a recent VHA publication establishing uniform mental health services requirements for VA facilities) is clear: "Mental health services must be recovery-oriented."[8] The policy explains that "recovery-oriented care" is individualized, person-centered care; care that empowers the individual and builds on his or her strengths; and is aimed at enabling the person to live a meaningful life in the community.[9] But too many veterans under VA care for PTSD or other mental health problems are still simply being given pills to manage their symptoms. That has to change.

One concrete step VA can take toward realizing a recovery-orientation for returning veterans who need mental health care is to employ a cohort of OEF/OIF veterans to provide peer-outreach and peer-support. VA policy recognizes that peer-support is one of the fundamental components of recovery,[10] but only requires that that service be provided to veterans with "serious mental illness."[11] Peer-support and peer-mentoring, however, are as beneficial to veterans struggling with PTSD as to veterans with so-called "serious mental illnesses," and should be a widely available, integral component of VA mental health care afforded OEF/OIF veterans.

To offer another example of a need for change, our own work with wounded warriors has highlighted the difficulties facing those who have severe PTSD (and often co-occurring substance use problems) and need residential treatment. Too often, those veterans' circumstances do not "fit" VA placement criteria for specialized PTSD care. In essence, OEF/OIF veterans in the greatest need of mental health care too often confront barriers that effectively deny them access to the very care they need. In short, they seem to be experiencing "barrier-centric care" rather than "veteran-centered care." Let me illustrate my point. VA inpatient PTSD programs lack systemwide uniformity in admissions policy; they appear instead to be governed by an array of differing rules that have barred warriors from needed specialized inpatient care based on such diverse requirements as that the veteran?

- have had success in outpatient group therapy for 3 to 6 months to qualify for admission;
- must have no suicidal attempts or ideations in the past 6 months;
- not be on benzodiazepines (a drug some physicians use for treating the anxiety that accompanies PTSD);
- must first complete outpatient anger management treatment;
- must be substance-free for a certain amount of time; and
- must first be interviewed and, if accepted, will be admitted at a later date.

Tragically, many OEF/OIF veterans have suffered with severe PTSD for some time before VA encounters them. In such instances, an individual may be barely hanging on, and cannot wait for a residential PTSD program admission date which is anywhere from a few weeks to several months away. In such instances, the individual is generally too acutely ill to benefit from outpatient treatment, and due to unavailability of services are generally seen once every 2 to 6 weeks for ongoing therapy. During that time they often relapse, and may be readmitted to the psychiatric unit, become involved with the justice system or experience severe deterioration of their condition.

Wounded Warrior Project field staff has considerable experience in helping OEF/OIF veterans get needed mental health care from VA facilities, but we have encountered great difficulty in attempting to facilitate needed placements under circumstances where a veteran's condition poses a relatively urgent need for specialized inpatient treatment for PTSD (or co-occurring PTSD and substance-use problems).

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[8] Department of Veterans Affairs, Veterans Health Administration, *Uniform Mental Health Services in VA Medical Centers and Clinics, VHA Handbook 1160.01*, September 11, 2008, 5.
[9] Ibid.
[10] Ibid.
[11] Ibid., 30.

The most pronounced of these cases have involved veterans who have been jailed because of behaviors linked to PTSD and substance use, and whose cases have come before a judge who is open to having the veteran undergo treatment rather than incarceration. In several such cases, however, VA medical center personnel who have attempted to help facilitate such placements have been stymied by long waiting lists at specialized inpatient facilities in their network (VISN). On numerous occasions, our field staff have inquired on behalf of our warriors about placement options for specialized inpatient PTSD care beyond the confines of the particular VISN, only to learn that VA staff have no national data base or centralized information source to which to turn to identify other potential VA placement sources. Yet I'm aware of an instance in which a VA facility's inpatient PTSD/substance-use treatment program had 125 veterans on its waiting list while a similar program 180 miles away in a neighboring VISN had open beds.

In light of this troubling information-gap, we have urged the Department to establish a regularly updated "clearinghouse" on all specialized VA PTSD programs to provide relatively real-time placement information, to include nature of the program (such as whether the program provides treatment for dual-diagnosis patients; program requirements; length-of-stay limits; etc.); capacity; bed availability; length of any waiting list; OEF/OIF veteran census; and contact-personnel. Such a resource should be available and accessible to VA personnel as well as to veterans' advocates. To date, however, our recommendation has elicited no response.

Employment: Programmatic Gaps

We have highlighted some of the programmatic gaps relating to VA mental health, not because these programs are uniquely flawed, but because mental health is so important to overall health and to whether wounded warriors are thriving. To cite another area that cries out for programmatic improvement, employment is certainly key to successful reintegration. Yet even in programs targeted at helping disabled veterans gain Federal employment, wounded warriors encounter obstacles in gaining employment. It is particularly painful to find that warriors encounter problems in seeking employment with VA, the one Federal department one would expect to go the extra mile. VA certainly appears to have the needed legislative authority to be a leader in employing wounded warriors. As you know, Mr. Chairman, service-connected disabled veterans (and those retired from service on disability) are entitled to a ten-point preference in Federal hiring (in a system using 100 as the top score), and are entitled to hiring preference over other applicants with the same or lower scores. But those extra points seem to give veterans little or no practical help. Instead, the complex hurdles associated with demonstrating one's qualifications for a particular Federal job (in particular, demonstrating that one has the requisite "KSAO's," namely the Knowledge, Skills, Abilities, and Other Characteristics) often knock otherwise qualified wounded warrior applicants out of contention, even in VA. Surely the Department could establish mechanisms to help overcome such hurdles. But wounded warriors encounter frustration with VA even when they get jobs through a Veterans Recruitment Appointment (VRA), a special authority by which a Federal department or agency can employ a disabled veteran without competition. While the VRA authority has occasionally provided warriors jobs, such VA appointments seldom tap the leadership and other skills wounded warriors developed in service.

In short, Mr. Chairman, to achieve its ultimate goals, "seamless transition" will not only require more work to close the remaining gaps between DoD and VA, but substantial transformation within VA in the area of mental health programming, vocational rehabilitation and employment, and many other areas to make warriors' transition an easier journey to successful community reintegration.

That concludes my testimony; I would be happy to answer any questions you may have.

Prepared Statement of Hon. Noel Koch, Deputy Under Secretary of Defense, Wounded Warrior Care and Transition Policy, U.S. Department of Defense

Mr. Chairman, thank you for inviting me to join you today to discuss how the Department of Defense (DoD) transitions our Wounded, Ill and Injured Servicemembers to the care of the Department of Veterans Affairs (VA). The Departments continue to work together to address these issues through the auspices of the DoD/VA Senior Oversight Committee and the Joint Executive Council.

The Office of Wounded Warrior Care and Transition Policy's (WWCTP) mission is to ensure Wounded, Ill, Injured & transitioning Warriors receive the highest qual-

ity care and seamless transition support. Some of our Wounded, Ill or Injured Servicemembers may be able to return to active duty following their recovery, and may choose to do so, while others may leave military service. But while in the care of DoD, it is my office's job to develop policy and provide oversight of several parts of a Servicemember's care, recovery and transition.

As you are aware, one of the most important efforts we have made was in response to the recommendations sent forth by the President's Commission on Care for America's Returning Wounded Warriors and required by the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) to provide a single point of contact for recovering Servicemembers and their families. In response to the NDAA requirement, we launched the Department of Defense Recovery Coordination Program (RCP).

The RCP places Recovery Care Coordinators (RCCs) in each Military Department's Wounded Warrior Program. The RCCs support eligible Wounded, Ill and Injured Servicemembers, including members of the Reserve Component, and their families, by ensuring their non-medical needs are met along the road to recovery.

With the Servicemember's Recovery Team, including the Commander, Non-medical Care Manager and Medical Care Case Manager, the Recovery Care Coordinator oversees the development and completion of a Recovery Plan. The patient-centered Recovery Plan identifies the Servicemember's and family's goals and action steps and points of contact to achieve them. Effectively, the plan is a roadmap guiding the recovering Servicemember and family along the process of recovery, rehabilitation, and reintegration. It may include information to assist the family member serving as the primary caregiver in receiving compensation, financial assistance, job placement services, support with child care, counseling, respite services, and other benefits and services available from Federal, state, and local governments, as well as our non-profit partners.

The Recovery Coordination Program is guided by a new DoD Instruction (1300.24) on the Recovery Coordination Program, which was drafted by my office with input from a Policy Working Group composed of representatives from across the Military Departments, the Office of the Secretary of Defense and the Department of Veterans Affairs. The policy provides uniform guidelines and procedures for our Military Service Wounded Warrior Programs and assigns responsibilities for implementation of the Recovery Coordination Program. It establishes parameters for determining the type of care a Servicemember needs, provides the support of a Recovery Care Coordinator and lays out the process for developing a Recovery Plan. It also requires that the same support be provided to qualified Reserve Component Servicemembers. In addition to the Recovery Plan, the Recovery Care Coordinators bring to bear several other resources for our recovering Servicemembers and their families through a variety of Web sites and publications. Our Recovery Coordinators, Recovery Teams and providers, Servicemembers and their families all make use of these resources, including:

- The National Resource Directory (NRD): A successful tri-agency initiative including DoD, VA, and the Department of Labor, the National Resource Directory is an online resource linking Servicemembers, care providers and family caregivers to information on more than 12,000 Federal, state and local support services. The NRD provides information on state-by-state resources and benefits.
- The Compensation and Benefits Handbook: This book includes a section dedicated exclusively to caregivers. It provides community options such as transportation services, respite care, financial assistance, and counseling resources.

Surveys of our Recovery Care Coordinators and providers indicate over 90 percent utilize these resources as they develop and execute recovery plans.

The Disability Evaluation System (DES) Pilot is another program that my office coordinates with VA. As of the first week of January, 138 Servicemembers entered the DES Pilot from 21 Military Treatment Facilities (MTFs) during the reporting week for a cumulative enrollment of 6,408 Servicemembers since November 26, 2007, when the DES Pilot began. Of those, 1,164 Servicemembers completed the DES Pilot and returned to duty, separated from service, or retired, and 212 Servicemembers were removed from the DES Pilot for reasons such as additional medical treatment or case terminated pending administrative discharge processing. 5,032 Servicemembers are currently enrolled in the DES Pilot.

Active Component Servicemembers who completed the DES Pilot averaged 275 days from Pilot entry to a VA benefits decision, excluding pre-separation leave. Including pre-separation leave, Active Component Servicemembers completed the DES Pilot in an average of 291 days. This is 1 percent faster than the goal established for Active Component Servicemembers and is 46 percent faster than the current

DES and VA claim process. Reserve Component Servicemembers who completed the DES Pilot averaged 279 days from Pilot entry to issuance of a VA Benefits Letter, which is 9 percent faster than the projected 305 day timeline.

Survey results show that across all Servicemembers, Pilot participants were significantly more satisfied with DES Pilot Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), and Transition processes than non-Pilot participants. Soldiers in the Pilot were significantly more satisfied with MEB, PEB, and Transition processes than Soldiers in the non-Pilot. Sailors and Marines were significantly more satisfied with the Pilot than non-Pilot MEB and PEB processes. Pilot participants reported DES Pilot MEB and PEB processes to be significantly fairer than did non-Pilot participants.

In September 2009, six additional sites were approved for expansion of the DES Pilot between January and March 2010. The Departments of the Army and Navy completed initial site assessments and are currently conducting site visits to each of these locations. Upon expansion of the DES Pilot to these locations, approximately 46 percent of all new DES enrollees will be covered under the Pilot. We are conducting a joint DoD/VA evaluation of the Pilot that will help us determine the best way to expand the DES "Pilot Model" worldwide, the results of which will provide the basis for the final report on the Pilot due to Congress in May.

But these programs notwithstanding, much remains to be done. Both DoD and VA are aware that we can improve how we care for our Servicemembers and Veterans, be it through further research, continuing to ease access to benefits for those who earned them, and better support for our Caregivers.

Mr. Chairman, we are reminded daily of our obligation to our Servicemembers and their families, and particularly to the Wounded, Ill and Injured, and those who bear the greatest burden of caring for them. We are committed to providing the support they need to help ensure a successful transition through recovery and rehabilitation and back to active duty or reintegration into their communities.

We appreciate the opportunity to come before you today to discuss a subject which the Secretary of Defense has said repeatedly is a Departmental priority second only to the wars in which we are engaged. I will be happy to answer your questions.

Thank you.

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

Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) efforts to help returning servicemembers transition back to civilian life. I am accompanied today by Dr. Karen Guice, Executive Director of the Federal Recovery Coordination Program, and Mr. Paul Hutter, Chief Officer, Office of Legislative, Regulatory and Intergovernmental Affairs.

VA's primary mission is to care for those who have borne the battle. As science and technology have advanced, more and more of our brave heroes survive what would have been fatal wounds in previous conflicts. However, survival is only the immediate goal—our job is to restore Veterans to the greatest level of health, independence and quality of life that is medically possible. To facilitate a smooth transition from the Department of Defense (DoD), VA has stationed 33 health care liaisons at 18 Military Treatment Facilities to facilitate the transfer of care to VA facilities. This program grew considerably during 2009 with six additional liaisons at five new sites. Altogether these liaisons have assisted more than 20,000 servicemembers in transitioning from DoD to VA since 2004. We continue to work with DoD to identify additional sites that have increasing numbers of wounded warriors who may benefit from these services.

My testimony today will describe the advances made in VA's Polytrauma System of Care, which provides coordinated inpatient, transitional, and outpatient rehabilitation services; our care management system, which coordinates complex components of care for ill and injured servicemembers, Veterans and their families, as well as the education services VA provides to dependents and family members of injured Veterans; the Federal Recovery Coordination Program; and VA's outreach efforts to returning servicemembers and Veterans.

Polytrauma System of Care and Specialty Care

Polytrauma refers to complex, multiple injuries occurring as a result of the same event. Some examples of polytrauma injuries include Traumatic Brain Injury (TBI), amputations, severe musculoskeletal injuries, burns, hearing loss or tinnitus, mem-

ory loss, visual impairment, cognitive impairment, pain, fatigue, or mental health conditions such as post-traumatic stress disorder (PTSD). Individuals with polytrauma require extraordinary levels of integrated and coordinated medical, rehabilitation and support services. To respond to these unique patient needs, VA developed a comprehensive model of care that includes interdisciplinary teams of health care providers that coordinate care as the patient moves from a Military Treatment Facility to a VA Polytrauma Rehabilitation Center, a local VA hospital, and reintegration into the Veteran's or servicemember's home community.

Since the designation of VA's TBI Centers as Polytrauma Rehabilitation Centers in 2005, VA has continued to expand its Polytrauma System of Care by adding new specialized rehabilitation programs and teams of rehabilitation specialists at sites across the country. The VA Polytrauma System of Care has four levels of facilities: Polytrauma Rehabilitation Centers, Polytrauma Network Sites, Polytrauma Support Clinic Teams, and Polytrauma Points of Contact.

The four Rehabilitation Centers (located in Minneapolis, MN; Tampa, FL; Richmond, VA; and Palo Alto, CA) provide comprehensive medical and rehabilitation services on both an inpatient and outpatient basis for Veterans and servicemembers with the most complex and severe injuries. These facilities typically have between 12 and 18 inpatient beds staffed by specialty rehabilitation teams that provide acute interdisciplinary evaluation, medical management and rehabilitation services. A fifth Rehabilitation Center is currently under construction in San Antonio, Texas and is expected to be completed in 2011.

Occupancy rates at these centers fluctuate over time and location. The average length of stay is 30 days, but for the most severely injured the average is 67 days. Upon discharge from a VA Polytrauma Rehabilitation Center, patients may be transferred to another facility, although more than 70 percent are discharged to their home. From March 2003 through fiscal year (FY) 2009, the Centers have treated approximately 1,500 inpatients with severe injuries; approximately 56 percent of these patients have been active duty servicemembers. Slightly more than half of the patients treated in the Polytrauma Rehabilitation Centers were injured in non-combat, non-deployed incidents.

Recent new specialized rehabilitation initiatives at the Polytrauma Rehabilitation Centers include:

- In July 2007, 10 bed residential Transitional Rehabilitation Programs were established at the four Centers to provide rehabilitation in a home-like environment to facilitate community reintegration for Veterans and their families.
- Beginning in 2007, VA implemented a specialized Emerging Consciousness care path at each of the four Polytrauma Rehabilitation Centers to serve those with severe TBI who are slow to recover consciousness. These patients require complex and intensive medical services and resources to improve their level of responsiveness and reduce medical complications. VA collaboratively developed this care path with subject matter experts from the Defense and Veterans Brain Injury Center (DVBIC) and the private sector. VA and DVBIC continue to collaborate on research in this area, and our models of care continue to be updated in response to scientific advances.
- In October 2008, all inpatients with TBI at VA Polytrauma Rehabilitation Centers began receiving special ocular health and visual function examinations. To date, 649 inpatients have received these examinations.
- In April 2009, VA began an advanced technology initiative to establish assistive technology laboratories at the four Polytrauma Rehabilitation Centers. These facilities will serve as a resource for VA health care and provide the most advanced technologies to Veterans and servicemembers with ongoing needs related to cognitive impairment, sensory impairment, computer access, communication deficits, wheeled mobility, self care, and home telehealth.
- VA continues to optimize its Polytrauma Telehealth Network to facilitate provider-to-provider and provider-to-family coordination, as well as consultation from Polytrauma Rehabilitation Centers and Network Sites to other providers and facilities. Currently, about 30 to 40 videoconference calls are made monthly across the Network Sites to VA and DoD facilities. New Polytrauma Telehealth Network initiatives in development include home buddy systems to maintain contact with patients with mild TBI or amputation, and remote delivery of speech therapy services to Veterans in rural areas.
- The Polytrauma Rehabilitation Centers have been renovated to optimize healing in an environment respectful of military service. Military liaisons located at the Centers support active duty patients and coordinate interdepartmental issues for patients and their families. Working with the Fisher House Foundation, we are also able to provide housing and other logistical support for family

members staying with a Veteran or servicemember during his or her recovery at one of our facilities.

The remaining components of the VA Polytrauma System of Care include 22 Polytrauma Network Sites, 82 Polytrauma Support Clinic Teams, and 48 Polytrauma Points of Contact. The Polytrauma Network Sites are available in each Veterans Integrated Service Network (VISN), as well as San Juan, Puerto Rico. These sites develop and support a patient's rehabilitation plan through comprehensive, interdisciplinary, specialized teams; provide both inpatient and outpatient care; and coordinate services for Veterans with TBI and polytrauma throughout the VISN.

In 2008, the Polytrauma Support Clinic Teams expanded to 82 VA facilities. These interdisciplinary teams of rehabilitation specialists provide dedicated outpatient services closer to home and manage the long-term or changing rehabilitation needs of Veterans. These teams coordinate clinical and support services for patients and their families. They also conduct comprehensive evaluations of patients with positive TBI screens, and develop and implement rehabilitation and community reintegration plans.

VA Polytrauma Points of Contact are available at 48 VA medical centers without specialized rehabilitation teams. These Points of Contact, established in 2007, are knowledgeable about the VA Polytrauma System of Care and coordinate case management and referrals throughout the system.

In addition to enhancements to its Polytrauma System of Care, VA has implemented several other recent initiatives to improve care for Veterans and servicemembers with TBI:

- In 2009, VA developed clinical practice guidelines for mild TBI in collaboration with DoD and deployed them to VA health care providers. VA also developed recommendations in the areas of cognitive rehabilitation, drivers' training, and managing the co-occurrence of TBI, PTSD and pain.
- In 2009, VA began collaborating with the National Institute on Disability and Rehabilitation Research TBI Model Systems to collect rehabilitation outcomes data and establish a TBI Veterans Health Registry.
- Since April 2009, VA has developed an individualized rehabilitation and community reintegration plan for every outpatient Veteran with TBI who requires ongoing rehabilitation care. This national template is integrated into the electronic medical record and includes the results of a comprehensive assessment, measurable goals, and recommendations for specific rehabilitative treatments. The patient and family participate in crafting the treatment plan and receive a copy of the plan.
- VA regularly collaborates with private sector facilities to successfully meet the individualized needs of Veterans and complement VA care in cases when VA is not readily able to provide the needed services or the required care in geographically inaccessible areas. VA medical facilities have identified private sector resources within their catchment area that have expertise in neurobehavioral rehabilitation and recovery programs for TBI. In FY 2009, 3,708 Veterans with TBI received inpatient and outpatient hospital care and medical services from public and private entities, with a total disbursement of over $21 million.
- Several educational materials for patients and families are in the final stages of being developed and distributed nationally including: TBI Family Education Manual, TBI Information Brochure, TBI Screening Brochure, and the Family Care Map. VA and DVBIC also collaborated to develop a training curriculum for family members in providing care and assistance to Servicemembers and Veterans with TBI.

VA has also established an Amputation System of Care and the Blind Rehabilitation System of Care to provide specialty care for Veterans and servicemembers. The Amputation System of Care is composed of 7 Regional Amputation Centers, 15 Polytrauma Amputation Network Sites, 100 Amputation Clinic Teams, and 30 Amputation Points of Contact. These resources have been dedicated to reduce variance and improve access across VA to amputation rehabilitation care. More than 43,000 Veterans have major limb amputations, of which about 950 are Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) Veterans.

Blind Rehabilitation Outpatient Specialists are assigned to Polytrauma Rehabilitation Centers and Network Sites, and patients with severe visual impairments receive further comprehensive services at any of our 10 inpatient Blind Rehabilitation Centers. In addition to these Centers, VA has 77 Blind Rehabilitation Outpatient Specialists and 137 Visual Impairment Services Coordinators. VA has also assigned

Blind Rehabilitation Outpatient Specialists to Walter Reed Army and Bethesda Naval Medical Centers to serve visually impaired servicemembers.

VA works closely with DoD to support high quality integrated care for severely injured servicemembers and Veterans. The two Departments recently developed revisions to clinical codes to improve identification and tracking of TBI. In 2009, a 5 year pilot project to provide assisted living services for Veterans with severe TBI was initiated in collaboration with the DVBIC. We have placed three Veterans in Virginia, Florida and Wisconsin, and enrollment is pending for two Veterans in Texas and Kentucky.

VA Care Management and Education Services

Care management refers to a patient- and family-centered approach to care by an interdisciplinary team of professionals with specialized knowledge in the management of patients with complex care needs. VA has developed a robust care management system for OEF/OIF Veterans. Each VA medical center has an OEF/OIF Program Manager, OEF/OIF Case Managers, and Transition Patient Advocates. The Program Manager coordinates clinical care and oversees the transition and care for this population. The Program Manager also serves as the primary point of contact for all referrals from the VA Liaisons for Health Care. OEF/OIF Case Managers coordinate patient care activities and ensure that all clinicians providing care to the patient are doing so in a cohesive and integrated manner. Transition Patient Advocates help Veterans navigate the VA system and Veterans Benefits Administration (VBA) team members assist Veterans with the benefit application process and education about VA benefits.

All severely ill and injured OEF/OIF servicemembers and Veterans receiving care at VA facilities are provided a case manager. All others are screened for case management needs and, based upon the results of the assessment; a case manager may be assigned as indicated. In addition, OEF/OIF servicemembers and Veterans with special needs, including polytrauma, spinal cord injury, and blindness, are served by a specialty case manager. The patient and family serve as integral partners in the assessment and treatment care plan. Since many of the returning OEF/OIF Veterans connect to more than one specialty case manager, VA introduced a new concept of a "lead" case manager. The lead case manager serves as a central communication point for the patient and his or her family. Our case managers maintain regular contact with Veterans and their families to provide support and assistance to address any health care and psychosocial needs that may arise. As of December 31, 2009, 2,484 OEF/OIF severely ill and injured servicemembers and Veterans were receiving on-going case management services, an increase of 49 percent in 2009. Case managers collaborate with VA, DoD and community resources to address the needs of OEF/OIF Veterans.

VA is training its staff and developing new models to support better care for severely injured and ill servicemembers and Veterans. We have implemented Web-based training to disseminate best practices and guidelines, and a mentoring program for OEF/OIF Program Managers to share expertise. VA updated policies for transitioning and care managing OEF/OIF Veterans and servicemembers with new handbooks published in October and November 2009. We will continue to integrate these services with our Post-Deployment Integrated Care Clinics and other specialty care such as mental health and polytrauma.

VA has adopted the Care Management Tracking and Reporting Application (CMTRA), a Web-based tracking system that includes a care management schedule for each Veteran, identifies a lead case manager, produces management reports and creates data to assist VA in measuring performance. While CMTRA initially focused on the severely ill and injured, CMTRA has now been extended to track case management of non-severely ill or injured OEF/OIF servicemembers and Veterans.

VA works with family members and Veterans prior to discharge to train and educate them on specific health care needs and issues. For example, prior to discharge from a Polytrauma Rehabilitation Center, family members may be scheduled to stay with the Veteran in a family training apartment or the Veteran may participate in the Transitional Rehabilitation Program. This allows the family member to experience what the return home will be like for their loved one while still having rehabilitation staff and nursing staff available to answer questions, address unexpected problems, and provide the emotional support a family may need as they prepare for the next phase of rehabilitation.

VA case managers are actively involved in assisting ill and injured Veteran's with re-integration into their home communities. VA provides skilled home care, homemaker/home health aide services, and a variety of respite care options to support Veterans and their families who require additional assistance at home. In FY 2009, VA Home-Based Primary Care interdisciplinary teams provided comprehensive pri-

mary care in the homes of 431 OEF/OIF Veterans. VA provides home modification grants and special adaptive equipment as needed to ensure a safe home environment. For OEF/OIF ill and injured Veterans who are unable to remain in their own homes, VA has developed an in-home alternative to nursing home care, the Medical Foster Home. VA is rapidly expanding its Medical Foster Home initiative, also known as "Support at Home: Where Heroes Meet Angels," across the Nation. There are several OEF/OIF Veterans who would otherwise have required nursing home placement that have been served in the Medical Foster Home program this year.

VA recognizes the significant sacrifices made by family caregivers of severely ill and injured OEF/OIF Veterans. With support from Congress, VA was able to conduct eight caregiver support pilot programs at 39 VA medical centers across the country. The lessons learned from these pilot programs have provided us with the foundation to develop a comprehensive caregiver support program that will enhance caregiver education and training while providing a flexible menu of respite care options to reduce caregiver burden and improve the quality of life of Veterans and their caregivers.

Federal Recovery Coordination Program

The Federal Recovery Coordination Program (FRCP), a joint VA/DoD program, helps coordinate and access Federal, state and local programs, benefits and services for seriously wounded, ill and injured servicemembers, Veterans, and their families through recovery, rehabilitation, and reintegration into the community. As of January 11, 2010, 15 Federal Recovery Coordinators (FRCs) were coordinating care for 425 severely wounded, ill or injured servicemembers and Veterans; another 38 individuals were being evaluated for program enrollment. Five (5) new FRCs completed their orientation in early January, bringing the total number of FRCs to 20. FRCs are located at Walter Reed Army Medical Center, National Naval Medical Center, Naval Medical Center San Diego, Camp Pendleton Naval Hospital, San Antonio Military Medical Center, Eisenhower Army Medical Center, Houston VA Medical Center, and Providence VA Medical Center.

Recovering servicemembers and Veterans are referred to the FRCP from a variety of sources, including from the servicemember's command, members of the multidisciplinary treatment team, case managers, families already in the program, Veterans Service Organizations and non-governmental organizations. Generally, those individuals whose recovery is likely to require a complex array of specialists, transfers to multiple facilities, and long periods of rehabilitation are referred to FRCP. After referral, an FRC conducts an evaluation that serves as the basis for problem identification and determination of needed services. After enrollment in FRCP, clients develop a Federal Individual Recovery Plan (FIRP) with their FRC.

FRCs have the delegated authority for oversight and coordination of the clinical and non-clinical care identified in each client's FIRP. Working with a variety of case managers, FRCs assist their clients in reaching their goals as identified and tracked in the FIRP. The FRC and the relevant case manager determine responsibility and timeline for implementing the steps necessary to reach a goal. The FRC then monitors progress with the case manager and the client, providing support and additional resources to both, until the goal is reached. FRCs frequently organize meetings with providers, case managers and clients to make sure objectives and expectations are clear. The plan and goals change as a client progresses through the stages of recovery, rehabilitation and reintegration. The FRC provides a single, consistent point of coordination through this progression.

Outreach

VA is continuously looking for ways to improve and achieve a smooth and seamless transition for servicemembers and their families. VA conducts numerous outreach activities to support this seamless transition. In FY 2009, VA conducted over 8,500 Transition Assistance Program and Disabled Transition Assistance Program briefings attended by over 356,800 servicemembers and their families. VA launched a pre-discharge program home page (http://www.vba.va.gov/predischarge/) on June 9, 2009 to complement its Benefits Delivery at Discharge and Quick Start programs. In addition, VA launched the eBenefits portal on October 22, 2009 to streamline information to servicemembers, Veterans and families (www.ebenefits.va.gov/ebenefits-portal/).

VA also conducts outreach to returning Reserve Component servicemembers through different approaches and settings, including: 61 demobilization sites; the Yellow Ribbon Reintegration Program events at 30, 60, and 90 days post-demobilization; Post-Deployment Health Reassessments, including those conducted at VA facilities; partnerships with the National Guard; Individual Ready Reserve musters,

through the Combat Veteran Call Center Initiative; and for all servicemembers, the VA OEF/OIF Web site (http://www.oefoif.va.gov/).

Additionally, VA establishes contact and provides assistance through annual focus groups held at VA medical centers, annual Welcome Home events held by each medical center, and community partnerships with providers, colleges and universities, job fairs, and other activities.

Our outreach efforts have provided Veterans with knowledge and access to VA services and benefits. Of the 1,100,000 Veterans who have separated since 2002, 48 percent have used VA health care services. Between 2005 and September 2009, more than 86,000 referrals to VA were made through DoD's Post-Deployment Health Reassessment, and since 2008, more than 70,000 Veterans have enrolled in VA health care prior to leaving a demobilization site. We also are reaching and conversing with Veterans through social media, including Facebook, Twitter, YouTube, Flickr, and blogs. Currently, VA has the fastest growing Facebook page among cabinet-level agencies with over 11,000 fans, most of whom have been gained since Veterans Day (over 1,000 fans per week). VA participation on Facebook is expanding. Each Administration has its own page for topic-specific conversations, as do a dozen VA medical centers. VA has plans to launch a Facebook page for every VA medical center.

VA now has four separate official Twitter feeds for the Department and each of the administrations. In the past 2 months, VA's primary Twitter feed has added followers at a higher growth rate than any other cabinet-level agency: nearly 2,000 have joined in that time. Half a dozen VA medical centers have active *Twitter* feeds. As with *Facebook*, VA plans to expand Twitter feeds to all medical centers beginning in 2010. VA just launched the first official Twitter feed for a VA principal in January, with Assistant Secretary Tammy Duckworth now engaging regularly with the public via her own VA Twitter account.

VA also has embraced video- and photo-sharing media with the use of *YouTube* (videos) and *Flickr* (photos). VA began posting each segment from its news magazine program *The American Veteran* on *YouTube*, while showcasing a selection of them on the VA homepage. At the same time, VA has a separate health care-related YouTube channel (administered by VHA) which has posted more than 90 videos, has 1,300 subscribers and more than 58,000 views.

In terms of blogging, VA has thus far been spreading its message via other sites—with pieces published at the *White House Blog*, and others with messages posed by Secretary Shinseki and Assistant Secretary Duckworth at outlets like *Military.com*.

VA's main Web site has also been rebuilt to make it more user-friendly for Veterans. Up-to-date information about benefits and services is added daily. Reaching returning Veterans through their expected and familiar modes of communication is a priority. The OEF/OIF generation expects a communication style that allows conversation and engagement, and these resources help VA enhance information sharing with this group of Veterans, as well as other stakeholders.

Conclusion

VA is focusing its resources and attention to meet the needs of Veterans and their families and to ensure that as servicemembers return home, they receive the care and support they have earned.

Thank you again for the opportunity to speak about VA's efforts to support transitioning servicemembers and Veterans. My colleagues and I are prepared to answer your questions at this time.