STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman, Ranking Member Brown, and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this hearing of the Subcommittee on Health, titled "Healing the Physical Injuries of War." We appreciate the Subcommittee's leadership in enhancing the Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely, and the opportunity to comment on how the VA is caring for the severely injured service members and veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) through its specialty programs. We also appreciate the Subcommittee's interest in identifying any gaps in care or services that may exist within these programs. We are specifically focusing our testimony on VA's Polytrauma/Traumatic Brain Injury (TBI) System of Care.

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

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

As reported by the Army Office of the Surgeon General, from September 2001 to January 12, 2009, there were 1,184 amputations in personnel deployed to OIF and OEF, nearly three-quarters of which were major amputations. IEDs caused 55% of the 1,184 OEF/OIF amputations.[4] Through our research we have found it difficult to come up with a firm number representing the total number of *severely* wounded from OEF/OIF as it appears that VA and

Department of Defense (DoD) track veterans and service members separately, with VA using only the number of service members or veterans who have been treated in one of its Polytrauma Centers. We suggest that VA and DoD collaborate to provide an accurate accounting of the number of severely wounded, how they classify a person in this category, where they were treated, as well as their active duty or veteran status at the time of accounting.

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

Today's injured military service members are experiencing higher survival rates than in previous wars, with the overall survival rate among wounded troops being about 90 percent. This increase is attributed to the widespread use of body armor, improved battlefield triage procedures and expedited medical evacuation.[7] For a majority of our wounded service members, the first level of complex intervention on their journey to a VA PRC normally occurs at the Landstuhl Regional Medical Center in Germany, operated by the US Army. Up until 2009, VA received little to or information about wounded service member transport, the full extent of the acute care process that service members had undergone, or the stress that these patients had experienced before arriving at a VA PRC. However, in October of 2009, a team of two VA physicians and two nurses from VA's Polytrauma System of Care spent four days at Landstuhl to gather information and put a system in place to establish a regular exchange of information between medical teams in the military and VA's PRCs. The PRCs are now able to track patients from the beginning of their journeys and can identify medical complications much earlier. This system of coordination has established a continuum of care that is not proprietary to the DoD or VA, and has aided them to develop one system that benefits our wounded personnel and veterans.[8] We are pleased with this relatively new development and believe it addressed one key area where gaps in care were evident for those who were treated before its implementation at VA PRCs.

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

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

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

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

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

According to the IOM, the array of potential health outcomes associated with TBI suggests that injured service members and veterans will present long-term medical and psychosocial needs from the persistent physical disability as well as cognitive deficits and psychosocial problems that may develop in later life. Access to rehabilitation therapies are essential—including psychological, social, and vocational services. Although VA has established a comprehensive system of rehabilitation services for polytrauma and severe TBI patients that addresses acute and chronic needs that arise in the initial months and years after injury—protocols and programs to manage the devastating lifetime effects that many of these veterans must live with are not in place and have not been studied for either military or civilian populations. We concur with IOM that as in other chronic health conditions, long-term management of TBI may be effective in reducing mortality, morbidity, and associated costs of VA's caring for this extraordinary population.[10]

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

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

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

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

We understand this proposal is pending consideration within VA but not yet formally approved or funded. We ask that the Subcommittee inquire about this exceptional idea in order to clarify VA's intent. Clearly, an offsite VA therapeutic residential facility of this type is

needed to ensure the ongoing recovery of this uniquely and catastrophically disabled veteran population, and as an aid to their families. VA's mission is to provide leadership excellence for therapeutic, rehabilitative, vocational, and recreational services to sick and disabled veterans, and as a nation, it is our duty to ensure that a proper life-time age appropriate care center is established within VA for these men and women who courageously served the nation and nearly made the ultimate sacrifice. DAV has testified in the past before this Committee to support VA's development and deployment of therapeutic residential care facilities for our newest war generation. On May 7, 2007, Adrian Atizado, DAV Assistant National Legislative Director, gave the following testimony:

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

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

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

Likewise, although much of the knowledge DoD and VA have gained on TBI is likely to transfer to the care of polytrauma patients, the information needs of caregivers of patients with catastrophic injuries may be distinct from those with TBI because the context, number and

severity of the injuries and the amount and type of medical information required to treat them are more vast and complex. Similarly, administrative information is complex because patients are often involved in two, or sometimes three, health care and benefit systems simultaneously, including DoD and TRICARE, VA, and private, contract hospitals or clinics in their home communities. Research is needed to assess the specific information needs of caregivers who face these complexities.[13]

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

As required by section 1702 of Public Law 110-181, the National Defense Authorization Act of 2008, and according to VA in testimony earlier this year, VA has developed and implemented a national template to ensure that it provides every veteran receiving inpatient or outpatient treatment for TBI who requires ongoing rehabilitation, an individualized rehabilitation and community reintegration plan. VA integrates this national template into its electronic health record, and includes in the record results of the comprehensive assessment, measurable goals that were developed as a result of the plan, and recommendations for specific rehabilitative treatments. The patient and family participate in developing the treatment plan and are provided a copy of the plan. According to VA, since April 2009, in consonance with this mandate, 8,373 of these individualized plans have been completed and filed for veterans who receive ongoing rehabilitative care in VA.[15]

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

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

1. Ensuring that blast-exposed veterans receive screenings and evaluation for high-frequency, invisible sonic wounds that may produce mild TBI, PTSD, and other psychiatric problems, or pain and sensory loss;

2. Promoting identification and evaluation of potentially the best practices for polytrauma rehabilitation, including those that optimize care coordination and transition across care systems and settings such as DoD and VA;
3. Optimizing the ability of caregivers and family members to provide supportive assistance to veterans with impairments resultant from polytrauma and blast-related injuries;
4. Identifying and testing methods for improving process of care and outcomes, even when the evidence base is not well established; and
5. Identifying and testing methods for measuring readiness to implement and sustain practice improvements in polytrauma care.[17]

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

We appreciate VA's efforts to standardize family-centered care and improve communications for this population and urge VA to move forward quickly to make this important information available to these families. Overall, based on our monitoring of their progress and as reviewed in this testimony, we believe that in most cases DoD and VA PRCs are collaborating well with respect to the most severely injured and are providing comprehensive, coordinated care in PRCs for this relatively small population. However, DAV remains concerned about the gaps that exist in the Federal Recovery Coordination Program and social work case management essential to coordinating complex components of care for polytrauma patients and their families. These gaps were highlighted by disabled veterans and their families in hearings held by the House Veterans' Affairs Subcommittee on Oversight and Investigation in 2009 and 2010 and warrant continued oversight and evaluation.

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

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

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

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

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

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

modeled on the Tampa proposal for the sustained and unique care of the most severely injured OEF/OIF veterans who will not easily or possibly ever be able to return to their homes.

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

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[3] VA QUERI Fact Sheet; *Polytrauma & Blast-Related Injuries;* June 2010.
[4] Institute of Medicine; *Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*; Ch. 5, March 31, 2010.
[5] VA QUERI Fact Sheet; *Polytrauma & Blast-Related Injuries;* June 2010.
[6] L. Beck, PhD., Chief Consultant, Office of Rehabilitation Services, Office of Patient Services, Veterans Health Administration, Department of Veterans Affairs; *Testimony before the United States Senate Committee on Veterans' Affairs*; May 5, 2010.
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