U.S. DEPARTMENT OF VETERANS AFFAIRS POLYTRAUMA REHABILITATION CENTERS: MANAGEMENT ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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

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U.S. DEPARTMENT OF VETERANS AFFAIRS POLYTRAUMA REHABILITATION CENTERS: MANAGEMENT ISSUES

TUESDAY, SEPTEMBER 25, 2007

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

The Subcommittee met, pursuant to notice at 10:06 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

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

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. This hearing will come to order. I would like to welcome everyone to the Subcommittee on Oversight and Investigations. This hearing is on the U.S. Department of Veterans Affairs (VA) Polytrauma Rehabilitation Centers.

I want to thank all of you for coming today. I am pleased that so many folks could attend this oversight hearing on the VA Polytrauma Rehabilitation Centers.

The VA polytrauma centers help reintegrate into society servicemembers who have suffered among the worst that war can inflict. The most severely injured servicemembers serving in Iraq and Afghanistan were medivaced out of theater through Germany to Walter Reed, Bethesda Naval Hospital and, when ready, are sent to one of the four polytrauma centers which are located in Richmond, Tampa, Minneapolis, and Palo Alto.

Most polytrauma patients have suffered traumatic brain injury (TBI) in addition to a variety of other serious injuries which must necessitate amputation. The soldiers, sailors, airmen, and marines who are treated at the polytrauma centers have paid a very high price for their service to their country as have their families, both of whom face a long and difficult path to recovery and sometimes a lifetime of care.

The Nation owes these servicemembers and their families everything that a Nation as rich as ours can provide. The Nation has many who need and deserve what we can give.

Survival rates for servicemembers injured in combat are extremely high compared to previous conflicts, partly because of greatly improved protective equipment, but also because the military has moved surgical medical care practically to the front lines.

A soldier injured in an improvised explosive device (IED) blast can be in surgery within 30 to 45 minutes or even less.

With these advances, however, comes the need to treat injuries that would have been fatal in the past. Injuries like traumatic brain injury and post traumatic stress disorder require medical treatment and long-term care of a new kind. The VA polytrauma centers are an essential part of that care.

Congress has provided sufficient resources and is providing more that have enabled the VA to establish and expand polytrauma care. It must be said that the VA has stepped up to the plate to meet this need.

In addition to the four polytrauma centers, the VA has created a network of subacute polytrauma care centers in each of the Veterans Integrated Service Networks and outreach programs throughout the country. This is not to say that everything is as it should be. We would not be having this hearing if that were the case.

Polytrauma care is not perfect. There is also the sharing of electronic medical information and other issues that have been highlighted by Senator Dole and Secretary Shalala that the Subcommittee and full Committee will be addressing in the near future.

But there should be no misunderstanding. We are not here to criticize the VA's care providers or to suggest that the quality of care to the Nation's most severely injured servicemembers is anything less than exemplary. The Subcommittee has found some management issues that need to be addressed and that is why the title of this hearing is what it is. The Subcommittee's oversight is intended to ensure the superb care the VA provides is provided to those who deserve it.

Data provided by the VA shows that the Palo Alto VA's Polytrauma Center from the beginning of this year through July filled only 60 percent of its available beds while the three other polytrauma centers combined have been running at 98 percent capacity. We have found no good reason why that should be.

The VA's Palo Alto Hospital has a beautiful facility and even more beautiful Fisher House where family members can stay and is practically married to the Stanford Medical School. Palo Alto has all the resources it needs to provide the care for all the polytrauma patients it can take.

The Subcommittee has also found the Palo Alto Polytrauma Center would not accept minimally responsive brain-injured patients while the other polytrauma centers did so until the VA created a treatment protocol for those patients in December of 2006 and effectively forced Palo Alto to accept these patients.

This past spring, the VA's Office of Medical Investigations found disarray, morale problems, insufficient programs for families, and lack of leadership. All of these raise obvious issues not just about local management but also about VA's Central Office. Why, for example, did the fact that Palo Alto's failure to fill the beds while the other polytrauma centers were at full capacity not raise a red flag at Headquarters?

We begin today by hearing from the senior management of the Palo Alto Health Care System headed by its Director, Elizabeth

Freeman. Subcommittee staff has spent much time with Ms. Freeman and her team, and they are to be commended for their willingness to meet with and provide information to the Subcommittee.

We hope, indeed expect, that their testimony will describe sufficient progress in addressing the concerns of the Office of Medical Investigations (OMI) and the Subcommittee.

The second panel is headed by William Feeley, Deputy Under Secretary for Health and Operations and Management. The Subcommittee extends its thanks to Mr. Feeley and the VA witnesses with him for their efforts to provide the best care possible to our injured servicemembers and appreciates their cooperation to the Subcommittee in meeting with and providing information to us.

We in no way doubt their good will and dedication, but there are obvious management issues for the Central Office that are raised by the fact that there were empty beds in Palo Alto, and these witnesses will be asked to address these issues.

Dr. Barbara Sigford, Dr. Shane McNamee, both of whom are personally involved in running polytrauma centers, are at the witness table as well. We look forward to hearing from them about the good things that are going on for those who have made great sacrifices for our country.

On Sunday night, the Public Broadcasting System (PBS) began a 15-hour presentation of Ken Burns' documentary on World War II. America achieved great things in that war, but the documentary reminds us, or perhaps more realistically teaches us, of the terrible cost of war.

We, as a Nation, owe a debt that can never be repaid to those who serve, an obligation that must be met to those, who were injured in that service. We are here today to do our part in making sure this happens. No one can doubt the dedication of the men and women in the military and the VA who provide care for our servicemembers.

[The prepared statement of Chairman Mitchell appears on p. 26.]

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

[Witnesses sworn.]

Mr. MITCHELL. Thank you.

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

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. I thank the Chairman very much, and I also thank him for holding this hearing.

I believe that the title of this hearing is very appropriate and I am rather disappointed. I do not know if there are any members of the media, but normally the room is filled because this is a very, very important issue as we talk about our wounded warriors from the Global War on Terrorism. Obviously the quest for excellence should be of the utmost important.

Our Subcommittee staff recently visited several polytrauma rehabilitation centers located in Richmond, Virginia; Minneapolis, Min-

nesota; and the subject center, Palo Alto, California. They did this to provide insight on the level of care being provided to our wounded servicemembers at those units.

Last Congress, while serving as the Chairman of this Committee, Ranking Member Buyer followed injured servicemembers from a combat support hospital in Iraq through the Landstuhl Army Medical Center in Germany, and on to Walter Reed and Bethesda. Mr. Buyer has also visited the Minneapolis VA Medical Center's Polytrauma Rehabilitation Center (PRC) to evaluate care and services received by our most critically injured servicemembers.

What I still see today is of great concern. The tracking of medical records still includes the paperwork and hard copies of medical records accompanying the servicemembers as they transfer stateside and ultimately to the VA.

We know that that is U.S. Department of Defense's (DoD's) fault, but it is still ongoing, Mr. Chairman, and I did not know if you were aware of that. As much as this Committee has said, "Let us move on and have electronic records," they are still doing the old paper records going with the veteran to the veteran facilities.

The Committee hears that not all the critical medical information is being forwarded to the polytrauma units by the DoD and many of the VA facilities are not using or have not heard of the Joint Patient Tracking Application (JPTA) and the Veterans Tracking Application (VTA) systems.

At the PRC in Palo Alto, our staff found several issues relating to lack of staffing and resources. This same concern was detailed in the draft OMI report obtained by our staff prior to their visit to Palo Alto.

I would like to have the witnesses address this deficiency in care to the servicemembers and veterans who are being treated at this facility and I am also interested in learning how widespread this problem is.

During the staff visit to the PRC unit in Minneapolis, the Committee learned about the unusually high turnover rate of active-duty military liaison officers. I am concerned about how this turnover rate affects continuity of care for our severely injured servicemembers.

PRC staff told us that there were also no electronic transfer of records between DoD and PRC in Minneapolis. I am interested in learning what is being done to address this issue.

I know that some of our PRCs are doing a great job while it seems others are still having great difficulties.

How are the best practices being shared between PRCs, the good PRCs to provide the best possible care for our severely wounded servicemembers?

Let me give you one example. The district that I represent is north of Tampa. And when I was down at the Haley Hospital reviewing the polytrauma unit there, which, by the way, is excellent, I met some families from the west coast, not the west coast of Florida, but the west coast, Washington State.

They chose to have their wounded warrior go to Tampa to the polytrauma unit there. When I asked why they did not choose to go Palo Alto, their response was because they wanted the best care available.

It is a shame that veterans and their families do not feel that the best care available is not also the closest care that would be available, namely at the Palo Alto center.

Mr. Chairman, we need to be concerned about the care our wounded servicemembers are receiving as they move from the battlefield through the line of care to our VA facilities.

Congress' responsibility to these men and women in uniform does not end with their care at the PRC units. As the Oversight Subcommittee, we must also ensure that they have a seamless transition from active duty to civilian-veteran status.

I cannot stress enough the importance of working toward a standard Benefits Delivery at Discharge or (BDD) documentation. A standard BDD would include one physical to be shared between the two departments, DoD and the VA, providing servicemembers with documentation as to the benefits for which they may be eligible.

With the use of a shared BDD, we could conceivably have the claims backlog at the VA caught up in a few years. This program was successfully tested between DoD and VA from 1995 to 1997. It is also a strong recommendation coming from the President's Dole-Shalala Commission report.

Again, Mr. Chairman, I thank you for calling for this hearing and I look forward to learning from our witnesses how the VA is working with the DoD to improve the care for our Nation's heroes and how we can better share some of the best practices from the superior polytrauma units to the remaining polytrauma units.

Thank you, Mr. Chairman.

[The prepared statement of Congresswoman Brown-Waite appears on p. 27.]

Mr. MITCHELL. Thank you.

I understand Mr. Walz has to leave early today. So at this time, if there are no objections, I would like to recognize him for his brief opening statement.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Thank you, Mr. Chairman and Ranking Member.

Thank you to each of you for being here today. Thank you for making the choice to serve in the VA, to put your expertise and your careers in service to our veterans and it is truly a noble cause, and for those members from the VA here.

I say it every time we are here that our job is to be partners with you in this. Our job is to help provide the funding and the oversight and the guidance necessary to help you do your jobs. And for what you do, I am truly appreciative of that.

My State of Minnesota is fortunate to have a polytrauma center in Minneapolis and it is one that I have been to many times and am incredibly proud of what has been done.

All of us know that what we are doing, one soldier or one Marine or one airmen or one seaman who does not get the care that they need is one too many, and we are always dealing with a very, very high expectation. But I do think it is important to note how often we do things right and how often you are serving that care.

We are fortunate to have Dr. Sigford. She is here representing today in her position as National Program Director, but she is

based in Minneapolis, and for that, I am very thankful because I have been there many times and I have seen that care. I am looking forward to this discussion.

The one thing that I am encouraged about by the Palo Alto experience is we appear to have the ability to be able to correct and we appear to be making changes in the right direction. And too often in this Committee, we identify issues, we identify what we need to fix, and then it just takes so long to see any changes that the frustration level grows.

And while we are not claiming that we have everything under control, while we are not claiming we are doing things perfectly, we are claiming that, I think, that the communication that is happening between those of us who sat here in our responsibility to provide you the resources and the guidance and those delivering that care is starting to get there. So I thank you for that.

All of us know that our ultimate responsibility, and I always like to quote, I represent the district that the Mayo Clinic is in, and their single charge on the wall everywhere is, "what is best for the patient is what is best." And that comes from Dr. Will Mayo and those quotes and the way they do everything is dependent on that.

And I said when I am up on the floor and the one thing I can tell you that sticks in my mind, my last visit out to the Minneapolis center, I met with a mother. She was from Michigan and she was there with her son who was a double amputee and a TBI patient. And the strain of the care was showing on her and she said the only thing that gets her through is, she said the floor that she was on with her son is staffed by angels.

And that care that she receives up there from those people is absolutely heartwarming. We need to make sure we keep them there. We need to make sure that the turnover rate is lowered. We need to make sure that our nursing staff is adequate and the resources are there. And that is why this oversight of this is so important.

So I thank you all. I am sorry I am going to have to leave a little early for a conflicting meeting. But we do have your written testimony, and to know that this Committee takes very seriously the work you are doing and appreciates it.

I yield back.

Mr. MITCHELL. Thank you.

Mr. Rodriguez.

Mr. RODRIGUEZ. I will yield until the second panel.

Mr. MITCHELL. Thank you.

At this time, I would like to ask unanimous consent that all Members have 5 legislative days to submit a statement for the record. If there are no objections, so ordered.

We will now proceed to panel one. Ms. Elizabeth J. Freeman is the Director of the VA Palo Alto Health Care System. Ms. Freeman has been the Director of Palo Alto since 2001 and has been with the VA since 1983.

We would like to thank you, Ms. Freeman, for being here and for the many years of service to our veterans.

After you introduce your panel members, you will have 5 minutes then to make your presentation. Thank you.

STATEMENT OF ELIZABETH JOYCE FREEMAN, DIRECTOR, VETERANS AFFAIRS PALO ALTO HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LAWRENCE L. LEUNG, M.D., CHIEF OF STAFF, VETERANS AFFAIRS PALO ALTO HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND STEPHEN EZEJI-OKOYE, M.D., DEPUTY CHIEF OF STAFF, VETERANS AFFAIRS PALO ALTO HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. FREEMAN. Thank you. Good morning.

I would like to introduce Dr. Larry Leung, who is our Chief of Staff, and a name that is very difficult to pronounce, Dr. Stephen Ezeji-Okoye, who is our Deputy Chief of Staff, to my left.

And I will go ahead and read my oral statement.

Good morning, Mr. Chairman and other Members of the Subcommittee. Thank you for the opportunity to appear before you today to discuss the polytrauma rehabilitation center or PRC located at the Department of Veterans Affairs, Palo Alto Health Care System.

It is a privilege to be on Capitol Hill to speak and answer questions about this vital program and other issues that are important to veterans who have bravely served in Operation Iraqi Freedom and Operation Enduring Freedom.

I would like to submit my written statement for the record.

The core of the PRC at the VA Palo Alto Health Care System is a 12-bed ward located on the Palo Alto Division Campus. The PRC is frequently the subject of interest by oversight bodies, veterans' advocates, Department of Defense personnel, media, and elected officials.

Nearly every week, we have the honor of hosting visits by distinguished guests. The vast majority of these visits are very positive and generate considerable praise for the PRC and its dedicated staff.

The PRC is also subjected to the oversight of the Veterans Health Administration or VHA. Earlier this year, the VHA Office of the Medical Inspector or OMI came to Palo Alto and assessed the PRC. The OMI reviewed allegations related to a delay in accreditation, inappropriate declinations of referrals, and lack of effective leadership at the program level.

I will comment briefly on these three areas.

Regarding accreditation, Palo Alto has been and continues to be fully accredited. Palo Alto was due for its triennial Commission on Accreditation of Rehabilitation Facilities or CARF survey of rehabilitation programs in February of 2007. Based on internal and external assessments, I determined we needed additional time to prepare for the survey. Consequently, I asked and received approval from CARF to delay its survey for a few months.

I am pleased to report to the Subcommittee that the CARF survey occurred July 19th and 20th, 2007, and resulted in full accreditation for another maximum 3-year period. I would like to emphasize that at no time did our accreditation with CARF lapse.

Regarding referrals, I would like to note that the OMI did not substantiate the allegation that the PRC was inappropriately declining or otherwise cherry picking patients to produce favorable outcomes. Nonetheless, I have instituted changes that will make it easier for referring sites to send us patients.

There is now a single point of contact for referrals to the PRC and a clearly defined physician to accept them. The acceptance decision will be promptly communicated to the referring site, patient, and family. If, for any reason, the referring site disagrees with a decision, the referring site will be encouraged to appeal the decision to the Palo Alto Chief of Staff.

We have improved our process for tracking the disposition of all referrals to the PRC and will report results monthly to the Veterans Integrated Service Network 21 Office and to VA's Central Office.

I have instructed my staff to look for every possible way to accept as many patients as possible in either the PRC or a more appropriate setting. I have also intensified our communication with and outreach to potential referring sites.

Just yesterday, I went to National Naval Medical Center in Bethesda, Maryland, and met with senior medical and social work staff. I was pleased to learn that the VHA Polytrauma System are including the PRC at Palo Alto as their first choice for referrals.

I will followup on this productive meeting by sending a clinical team from my PRC to this and other referring sites to foster collaboration and eliminate any impediments to referrals. I will also invite and encourage referring sites to send a clinical team from their facilities to Palo Alto.

Regarding leadership at the program level, the OMI expressed concerns about the leadership and communication in the PRC. I have addressed leadership challenges in both the short-term and long-term horizons. I have established an Associate Chief of Staff for Polytrauma. The Associate Chief of Staff for Polytrauma will provide clear and stable leadership and the Associate Chief of Staff designation will signal its organizational importance.

I have already started recruitment for the Associate Chief of Staff for Polytrauma and established a Search Committee. I am pleased to report that Stanford University will participate in the recruitment and offer a faculty position to the successful candidate.

In the interim, I have appointed a physician to serve as the PRC Program Director and to be responsible for day-to-day operations in the PRC including the disposition of referrals. This individual has the necessary leadership, team building and interpersonal skills to achieve outstanding clinical results and to meet the expectations of families. The PRC Program Director has already generated widespread support from the PRC staff.

In closing, I would like to emphasize the quality of care provided at the PRC has been and continues to be outstanding. As the referrals and needs of our patients change, the PRC evolves.

My staff and I have developed a forward-looking plan to significantly increase the intensity of services and associated staffing. We have also received funding for significant equipment purchases and infrastructure improvement.

My staff and I are fully committed to making any improvements necessary to meet the needs and exceed the expectations of our Nation's heroes and their families.

Again, thank you, Mr. Chairman, for the opportunity to testify at this hearing. I and the staff who accompanied me would be delighted to address any questions.

[The prepared statement of Ms. Freeman appears on p. 28.]

Mr. MITCHELL. Thank you, Ms. Freeman. And I appreciate you being here today. I appreciate it very much.

And we appreciate the good work that all of your colleagues at Palo Alto are doing to provide the care to our veterans. And we are particularly appreciative of the care that Palo Alto's Polytrauma Unit has provided to our most seriously injured Iraq and Afghanistan veterans.

As I said in the opening statement, we are not here to question you or your colleagues' dedication or suggest that the care at Palo Alto's Polytrauma Unit provides anything short of what is the best.

That said, however, we cannot ignore the fact that Palo Alto has a history of empty beds in sharp contrast to the full beds at the other polytrauma centers.

The Office of Medical Investigations may have concluded that Palo Alto has not been cherry picking patients, but that just begs the question of why Palo Alto had empty beds.

I appreciate very much that Palo Alto currently has more than its allocation of polytrauma patients, but I am disappointed that it took the scrutiny of this Subcommittee to make that happen.

I can assure you that the scrutiny that you are getting now will continue and that our staff will be visiting Palo Alto again soon.

What we need and what our servicemembers giving their all to this war need is not only your assurance that Palo Alto will never again have empty beds, but also how your specific plans for operating the polytrauma center will ensure those results. And I heard you outline your plan and what you plan to do hopefully.

When the Subcommittee staff visits you again in a few months, what can we expect them to find?

Ms. FREEMAN. Thank you. Thank you for the question.

We have been aware that our average daily census has been less than 12 and we have 12 beds on the Polytrauma Unit. And the number of beds that are occupied, that average daily census or ADC is dependent on the number of patients we accept and that is dependent on the number of patients that are referred.

And we are now aware of this perception that we had been receiving less referrals. And so the outreach efforts that we have made in order to increase the number of referrals and thus increase the number of admissions is the outreach that I described in my oral statement and by personally reaching out to those at other military treatment facilities beginning with the case managers in trying to identify any difficulties there.

I will follow that up with sending my clinical team to Walter Reed, Bethesda, Madigan, and other referring centers. I will also invite the clinical teams from those centers to come to Palo Alto and to be assured that the quality of care that we provide is excellent.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. I thank the Chairman very much.

I am going to have to leave the Subcommittee to go to a markup, so I will be leaving in a few minutes. But before leave, I had a few questions.

Ms. Freeman, I understand that the Under Secretary for Health asked VHA National Center of Organizational Development to visit all four polytrauma centers and assess current structure and staff.

Would you share with us the findings and recommendations of this visit?

My second question—actually, if you would answer them in reverse—I understand that last February, you asked for a delay in the scheduled triennial accreditation.

Knowing this important accreditation process was upcoming, what were the reasons for the requested delay? And I also understand that you just recently successfully passed the accreditation.

Would you elaborate what specific steps were taken between February and July to mitigate your concerns about passing the accreditation?

Ms. FREEMAN. Certainly. Thank you for that question, and I will go ahead and answer the question about accreditation first.

First of all, I just want to assure the Subcommittee that our accreditation, as I said in my statement, it never lapsed and we remain fully accredited.

We had performed some internal and external assessments. We had an external consultant help us prepare for CARF and she commented that the quality of the care was outstanding, but she thought there were some structural components that needed to be put in place.

So my reason in asking for the delay was to give us time to get the paperwork and other processes in place to be able to demonstrate to CARF that we should continue our accreditation.

And as I reported, when they did visit on July 19th through 20th, we did successfully pass that survey. And they were very, very complimentary.

I would also comment that requesting that sort of delay is something I would do in any other area where we are preparing for an external survey. If I had similar information, I would make the same decision.

Regarding your question on the National Center for Organizational Development (NCOD), we very much appreciated the Under Secretary asking them to come and visit us and the other four polytrauma centers. I think it was terrific for the staff morale. They very much enjoyed it. I believe we had 48 staff on the unit and 43 of them interviewed with the NCOD staff.

And as far as their recommendations, the areas that the staff identified that were of concern to them were most focused on building and maintaining appropriate boundaries between the care team and the families. There were also issues about referral patterns and the discharge process and also concerns about training.

And so we have taken all of those recommendations. We have an internal team that is going to develop action plans on those recommendations. And we are making progress as we speak.

Ms. BROWN-WAITE. And if I may follow-up. Could you elaborate a little bit more on the review that you had where it was suggested that there be a change in structural components? Could you elaborate a little bit more on that?

Ms. FREEMAN. Sure. Thank you for that question.

Some of the structures that we need to put in place were data management and evaluation of data and quality improvement processes. So not that those were not occurring, but the documentation of them and making it easy for a surveyor to identify and recognize and give us credit for.

Ms. BROWN-WAITE. Are you aware of family reluctance to have the polytrauma veteran treated at Palo Alto?

Ms. FREEMAN. I am not aware of any individual case where a family expressed concern about Palo Alto, but I would be very happy to follow-up with you, if I may, after the hearing about that family situation.

Ms. BROWN-WAITE. So no one has ever said, I am not going to go to the polytrauma unit closest to my home city, my home state, but rather travel across the country to another one? You have never heard this? This is the first time you have heard this?

Ms. FREEMAN. I cannot speak for what a family member expressed to a referral coordinator as to their reason as to why they would select one polytrauma center over another.

Ms. BROWN-WAITE. Would you not want that information?

Ms. FREEMAN. I would be very happy to get that information and act on that information and understand what that family's concerns were and correct them.

Ms. BROWN-WAITE. Well, Mr. Chairman, Ms. Freeman, with all due respect, I would think that that would be a primary focus which might help to determine what some of the problems are at Palo Alto.

Well over a year ago, because I have the polytrauma unit so close to me, I began to look at, okay, why are there so few there and there is a waiting list at some of the other facilities. And so this is nothing new to me nor any of the Members who have been on the Committee for a while. So I would think in your position, you would want to know this.

Ms. FREEMAN. Again, I am not aware of any particular family stating that they did not want to be referred to Palo Alto. And if that information was conveyed to me, I would promptly act upon it.

Mr. MITCHELL. Excuse me.

Ms. BROWN-WAITE. I yield back the balance of my time.

Mr. MITCHELL. Thank you.

I would like to just kind of follow-up. Do you know of any other patients that were denied access to Palo Alto but ended up at either Richmond, Tampa, or Minneapolis?

Ms. FREEMAN. One of the programs that we had not initiated that the other four polytrauma centers initiated was in the area of emerging consciousness, so there could have been patients that might have been referred to Palo Alto that were referred to those other programs before we instituted our program.

Mr. MITCHELL. What does that mean?

Ms. FREEMAN. Emerging consciousness?

Mr. MITCHELL. The question was, were there people who were rejected at Palo Alto?

Ms. BROWN-WAITE. Or rejected Palo Alto.

Mr. MITCHELL. Well, yes. You asked that.

But I am saying who you did not accept, did they end up at any of the other polytrauma centers?

Ms. FREEMAN. We have received 173 referrals from the time we became a polytrauma center in February of 2005. And we have accepted 143 or about 81 percent of those patients.

And while I do not recall every instance of the 30 some who were not accepted at our polytrauma center, in general, the reason would be that they might have had—there might have been a more threatening, life-threatening condition that needed to be addressed first before they were referred into the polytrauma unit such as substance abuse or post traumatic stress disorder.

Mr. MITCHELL. Let me follow-up. Excuse me for taking this privilege here.

Would they have been released from Bethesda or Walter Reed under those conditions and sent out to you if they did not feel that they should be in the center?

Ms. FREEMAN. I am sorry. Could you repeat the question?

Mr. MITCHELL. I think the patients that you receive or are referred to you are referred from Walter Reed, Bethesda.

Ms. FREEMAN. Walter Reed, Bethesda, Madigan——

Mr. MITCHELL. Okay.

Ms. FREEMAN [continuing]. Other—of the 173 referrals——

Mr. MITCHELL. Right.

Ms. FREEMAN [continuing]. I described, it is many locations, not just Walter Reed and——

Mr. MITCHELL. And you are saying that some of those referred from those particular hospitals probably should not have been referred? They should have stayed in those hospitals? Why would—just one example—why would Walter Reed refer someone to a polytrauma center that they did not feel was ready to be referred?

Ms. FREEMAN. Some of the referrals that I am speaking of with the other symptoms or other disease states that needed to be treated, they might not have been from Walter Reed or Bethesda. They could have been from another place.

Mr. MITCHELL. Okay. Any of them, any number of them. Are you saying that some of those people would be referred when they should not have been?

Ms. FREEMAN. I am going to ask Dr. Ezeji-Okoye to help me because I am not doing a good job of explaining this to you. But there could be other reasons that I am not explaining.

Mr. MITCHELL. Let me ask this question. The people that you get are referred; is that correct?

Ms. FREEMAN. Yes.

Mr. MITCHELL. And what you are saying is some that are referred, I get the impression, should not have been referred because they were not ready to be referred to this next level of treatment; is that right?

Ms. FREEMAN. Could you help me?

Dr. EZEJI-OKOYE. Sure.

Thank you, Congressman.

The VA operates a polytrauma system of care and that system of care encompasses multiple areas as well as multiple disciplines. Patients are referred in for evaluation and appropriate placement into the correct area within the polytrauma system of care.

Patients who initially may be referred from an outpatient setting, for example, may have conditions, as Ms. Freeman mentioned, such as substance abuse which would interfere or prevent them from being able to fully benefit from the acute inpatient rehabilitation on a PRC and so they are directed to the most appropriate setting either within Palo Alto or within another health care system within VA.

Mr. MITCHELL. So what you are saying is that those hospitals that are doing the referring are not really doing the job they should when they referred them to the next level of treatment; is that correct?

Dr. EZEJI-OKOYE. No, sir. That is not what I was meaning to imply. The centers when they refer in some cases such as many of the cases we get from Walter Reed and Bethesda, it is clear that the patient is suffering from polytrauma and that is the major and overwhelming issue. And they are accepted.

Other sites refer to the polytrauma network or the polytrauma system of care because they want assistance in evaluating what are the deficiencies and deficits that the veteran may be suffering from and help in assessing what the correct placement for that patient may be.

The polytrauma system of care may take that initial admission information and then in reviewing the documentation and discussing with the team make a determination that the most appropriate setting is actually not the PRC but perhaps a substance abuse center or post traumatic stress disorder center, and then after completion of that treatment would then come to the PRC.

Mr. MITCHELL. Would you say that you have a higher level of rejection of those referred than the other centers?

Dr. EZEJI-OKOYE. I do not know the information, sir, on the acceptance and rejection rate of other centers. We have tried to accept every——

Mr. MITCHELL. Excuse me. It seems to me it is kind of obvious when you have 60 percent of the beds filled, the others have in the 90s, that you must be rejecting more or they are just not referring more to you to begin with, one or the other.

Dr. EZEJI-OKOYE. We have not been denying patients. We have been trying to find the most appropriate setting for each of those patients. As Ms. Freeman mentioned, we have been concerned of this recent information about the perception that we were not accepting or were difficult to refer to. And then that is why we have been doing the outreach to the other centers to make sure that perception is not continued.

Mr. MITCHELL. Well, it must be a perception because either one or the other. Either you are rejecting more than everybody else or you are getting less referrals, one or the other.

Thank you.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much.

And let me say that, first of all, I guess, to the next panel, thank you very much. We are looking forward to being the fifth polytrauma center in San Antonio, so we look forward to working with our soldiers that are in need.

Let me just, I guess, from a political perspective, I have always judged politicians based on those that get elected because they want to be there and those that want to make something happen and actually do the work.

One of the biggest problems we find is veterans going and feeling like they are being neglected or not wanted there. And that attitude of, I guess, maybe also that reflects on the work ethic of the people that are there in terms of not wanting to deliver the work.

And that would be, you know, the biggest concerns that I would have. Not only you say there is a perception, but there is a reality also that you have only had 60 percent.

Do you communicate at all with the other four centers? Do you meet at all and discuss, you know?

Ms. FREEMAN. Yes, sir. There are conference calls between our leadership at our PRC and Headquarters that all of the polytrauma sites are participating in.

Mr. RODRIGUEZ. You get to see what the others are doing and not doing?

Ms. FREEMAN. Yes, sir.

Mr. RODRIGUEZ. One of the things that I would be concerned in terms of your staffing there is in terms of their attitudes and, you know, how aggressive they might be or the lack of aggressiveness in terms of responding as to why they are there. And that is to work and work for our veterans.

And so I would be concerned in terms of no matter what you do, if that attitude is not there and it is not brought up from the leadership perspective and if you are just there to be there for the sake of having a job, you know, I tell the staff that I have, and, again, the only analogy I can give you of my own, and that is that when staff comes to me, they are only on board as long as I am there, which is only 2 years at a time, and I expect them to have that aggressive attitude in terms of trying to make things happen versus just being there and biding their time while they are being employed.

And so I would hope that your attitude there is also in terms of service to our constituents and service to our veterans that are out there. And that requires—I do not know how you can change that attitude, but it has to come from the leadership.

Ms. FREEMAN. Yes, sir. And I want to assure you that our staff are highly motivated to accept as many patients as possible. They are extremely, extremely committed to providing outstanding care to those patients. I would invite you to come and visit our unit and see for yourself the close connection between our case managers and the families and the patients that they care for, the close connection among the therapy staff, the physician staff, and the patients and families that we have the honor to serve.

Mr. RODRIGUEZ. Yeah, because nothing worse than an attitude of you do not want to go there, I want to go somewhere else, and/or with the occupancy rates. That also says that if you have the same workload, you know, and the others are carrying much more of a

workload, there is something wrong with that picture also, especially when the need is there.

And I can tell you in San Antonio, we have a large number of veterans at Brooke Army Medical Center and both out there at Wilford Hall and the other trauma centers as well as the Audie Murphy veteran needs in terms of services.

And so we look forward to doing that. So I would, you know, hope that as you move forward, you know, there continues dialog with the others and seeing what they are doing or not doing or whether a shift in staff needs to occur in order to make that happen in terms of the type of clientele.

Now, you mentioned some connection in terms of the type of clients that are being referred and why the others might be at a higher rate and you are not. And you mentioned, was that some type of designation?

Ms. FREEMAN. Emerging consciousness.

Mr. RODRIGUEZ. Yes. Tell me about that.

Ms. FREEMAN. I am going to let Dr. Ezeji-Okoye describe emerging consciousness patients.

Dr. EZEJI-OKOYE. Thank you.

Thank you, Congressman.

The Emerging Consciousness Program is a program that was developed through VA that encompasses family support, the care of the injured patient through programs such as Multi-Sensory Stimulation as well as other rehabilitation efforts.

Palo Alto offered many components or most components of the Emerging Consciousness Program, but we did not offer the Multi-Sensory Stimulation Program. At that time, it was the opinion of our clinical leadership that the evidence was not sufficient to support that program. However, over time and with discussion with the other VA centers, it was agreed that the situation had evolved and that we thought it would be beneficial to also include this service at Palo Alto. And so in the fall of 2006, we began to put in place our own Multi-Sensory Stimulation Program and accepted our first emerging consciousness patient in November of that year.

Mr. RODRIGUEZ. Thank you. I think I have run out of time. Thank you.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you.

You may have said this and I missed it. We are supposed to have a vote and I am trying to find out when I have to leave for the other Committee. But how many current inpatients are there in the polytrauma unit?

Ms. FREEMAN. Actually, as of last night, there were 17. We have 12 beds designated for polytrauma. There are 17 inpatients. We have three polytrauma patients on our spinal cord injury unit and one patient in our intensive care unit.

Ms. BROWN-WAITE. And how many are outpatients? Do you have outpatients in the polytrauma unit?

Ms. FREEMAN. We have a transitional program, and bear with me for just one moment. Within our transitional program, we have 12 beds in the transitional program and I believe—I can check with you for the record the exact number as of yesterday, but we had

five participants who were using our lodger beds and I believe there are others who are using that program but reside in the community.

Ms. BROWN-WAITE. One of the other questions is, I believe I heard you say that you have conferences regularly with the other polytrauma units. I understand that is a weekly teleconference; is that correct?

Ms. FREEMAN. Yes.

Ms. BROWN-WAITE. At some point, do you discuss the patient count, the utilization rate, and has this come up in your conversation with other polytrauma units about the difference in the number of patients that you treat versus the other facilities?

Ms. FREEMAN. Thank you.

I do not personally participate in those conferences. The Program Director and Medical Director participate in the conferences. And so to my knowledge, I have not been personally aware of the difference between the ADC for our center and the other centers until Mr. Bestor brought it up on his visit.

And I do not know if Dr. Ezeji-Okoye wants to comment on that.

Dr. EZEJI-OKOYE. I participated in some of the conference calls and the conference calls have generally focused on making sure that we are developing quality programs across all of the polytrauma centers. And that has been the primary focus of the calls that I have been on.

Ms. BROWN-WAITE. So are best practices shared during these conference calls?

Dr. EZEJI-OKOYE. Part of the conference call has been focusing on each polytrauma site taking a leadership role in developing what would be best practices within the polytrauma sites overall and then sharing those. We have been charged with looking at some of the educational and training portions of the polytrauma system of care and developing those.

Ms. BROWN-WAITE. Thank you.

I yield back, Mr. Chairman.

Mr. MITCHELL. Does anyone have any other questions they would like to ask?

[No response.]

Mr. MITCHELL. Thank you, and thank you very much for being here.

And I do want you to know that, as I mentioned in my opening statement, that members of this Subcommittee staff will probably be out to visit again.

Very good. Thank you.

Ms. FREEMAN. Thank you.

Dr. EZEJI-OKOYE. Thank you very much.

Mr. MITCHELL. At this time, I would like to welcome the second panel to the witness table.

Mr. William Feeley is the Deputy Under Secretary for Health of Operations and Management at the VA and the Chief Operations Officer for the VHA. Deputy Under Secretary Feeley has over 30 years as a career civil servant, spending the majority of that time in the VA.

And I want to thank you, Mr. Feeley, for your commitment to help our Nation's veterans and welcome you.

And before we start your 5-minute presentation, would you please introduce the staff that you brought with you.

Mr. FEELEY. Thank you, Mr. Chairman.

I have Dr. Ed Huycke from the——

Ms. BROWN-WAITE. You might want to turn your microphone on, sir.

Mr. FEELEY. Sorry. I have Dr. Ed Huycke to my right from the Office of Seamless Transition; Dr. Shane McNamee, Medical Director at the Richmond Polytrauma Center. I've got Lu Beck, Chief Consultant of Rehabilitation Services in Headquarters and Dr. Barbara Sigford, National Program Director for Physical Medicine and Rehabilitation.

Mr. MITCHELL. Thank you.

Before you begin, I would like to recognize Mr. Rodriguez, if it is all right.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Thank you for allowing me to make some opening comments that I did not make initially. I just first want to thank you.

And I think it was the right thing for San Antonio to be selected as the next site for the fifth polytrauma center as they announced recently, you know, the fifth one.

But first off, I also want to express my extreme disappointment with the fact that I, and the Committee, were not informed about the new polytrauma center in San Antonio, only after the media inquiry asked me to comment on it. And I think that the VA could have been more courteous to the Members of the Committee especially to letting us know in terms of the selection process.

And since the designation, my office has been in touch with the VA staff. And from what I have been told, the VA has little information in terms of the new facility. And so I am glad today that I will have the opportunity to be able to ask you some questions and be able to dialog with you and work with you to make that happen because there is no doubt that there is a tremendous need out there and we are hoping to fill that need.

So thank you very much for allowing me to make those opening comments. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Feeley.

TESTIMONY OF WILLIAM F. FEELEY, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY EDWARD HUYCKE, M.D., CHIEF DEPARTMENT OF DEFENSE COORDINATION OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; LUCILLE B. BECK, PH.D., CHIEF CONSULTANT, REHABILITATION STRATEGIC HEALTH CARE GROUP, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; BARBARA SIGFORD, M.D., PH.D., NATIONAL PROGRAM DIRECTOR, PHYSICAL MEDICINE AND REHABILITATION, MINNEAPOLIS POLYTRAUMA REHABILITATION CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND SHANE MCNAMEE, M.D., MEDICAL DIRECTOR, RICHMOND POLYTRAUMA REHABILITATION CENTER, HUNTER HOLMES MCGUIRE, VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. FEELEY. Good morning, Chairman and Members of the Subcommittee. I want to thank you for the opportunity to discuss the Veterans Health Administration's ongoing efforts to improve the quality of care that we provide to veterans suffering from traumatic brain injury and complex multiple trauma.

The focus of my testimony today will be on treatment and rehabilitation provided by VA to veterans recovering from TBI and complex multiple trauma and the current initiatives to further enhance these services to our veterans within the system of care.

The mission of the VA Polytrauma System of care is to provide the highest quality of medical rehabilitation and support services for veterans and active-duty servicemembers injured in service to our country.

This integrated, nationwide system of care has been designed to produce access for life-long rehabilitation care for veterans and active-duty servicemembers recovering from polytrauma and TBI.

The four VHA polytrauma centers located in Minneapolis, Palo Alto, Richmond, and Tampa and soon to be San Antonio are the flagship facilities of the polytrauma system of care. These centers serve as hubs for acute medical and rehabilitation care, research and education related to polytrauma and TBI.

During fiscal year 2007, the four PRCs added transitional rehabilitation programs at these sites. These programs serve veterans and active-duty servicemembers with polytrauma and/or TBI who have physical, cognitive, or behavioral difficulties that persist after the acute phase of rehabilitation and prevent them from effectively reintegrating into community or returning to active duty.

Transitional residential rehabilitation offers a progressive return to independent living through a structured program focused on restoring psychosocial and vocational skills in a controlled therapeutic setting.

All remaining VHA medical centers provide an aspect of the continuum of polytrauma system of care based on the levels of intervention available at the site. The definition of these levels was in-

cluded in my written testimony and in the interest of time, I will not elaborate on those definitions now.

The coordination of transition of care is critical. Care management across the entire continuum is a critical function in the polytrauma system of care to ensure lifelong coordination of services for patients recovering from polytrauma and TBI.

At the direction of the Secretary, 100 transitional patient advocates (TPAs) have been recruited nationwide. The TPAs contact the patient and family while in the military treatment facility. One of their responsibilities is to ensure that all questions concerning VA are answered and each case is expedited through the VA benefits process.

If necessary, the transitional patient advocate will travel with the family and veteran from the military treatment facility to their home and provide transportation to all VHA appointments.

Psychosocial support for families of injured servicemembers is paramount as decisions are made to transition from the acute medical setting of a military treatment facility to a rehabilitation setting.

VA social workers or nurse liaisons are located at the ten military treatment facilities including our most frequent referral sources, Walter Reed Army Medical Center and Bethesda National Naval Medical Center. These individuals provide necessary psychosocial support to families during the transition process, advising the families through the process.

The admissions case manager from the polytrauma rehabilitation center maintains personal contact with the family prior to transfer and to provide additional support and further information about the expected care plan.

Upon admission to the VHA PRC, the senior leadership of the facility personally meets with the family and servicemember to ensure that they feel welcomed and that their needs are being met.

A care manager is also assigned to each patient. The care manager coordinates services and addresses emerging needs as the patient engages the various levels and types of VHA services necessary to support their rehabilitation. The care manager will also coordinate the ultimate transition to home.

Mr. MITCHELL. Mr. Feeley, I hate to cut you off, but we are going to be voting pretty soon and I would like to get some questions in. And we have your written testimony, if you do not mind——

Mr. FEELEY. I would be glad to end now and let you ask any questions you might like to ask.

Mr. MITCHELL. Thank you.

Mr. FEELEY. Thank you.

[The prepared statement of Mr. Feeley appears on p. 32.]

Mr. MITCHELL. And I have a couple questions. And I appreciate you being here as well and thanks for your testimony regarding the polytrauma system.

The description you have given is very interesting, very valuable. We have your written testimony.

But the data provided by your staff shows that Palo Alto has been leaving beds empty while other polytrauma centers have been offering full capacity. And this data is not just about last week. It goes all the way back to 2005.

In 2007, Palo Alto had filled 60 percent of its beds while the other polytrauma centers were at full capacity. And you have the data. You understand all this.

And the question is, why wasn't anything done about it?

Mr. FEELEY. I will tell you that my concentration has been on opening up the transitional rehabilitation beds, on making sure that additional resources were added to the polytrauma center, and to assure all the infrastructure and space needs were where they needed to be.

I would indicate that your point is very well taken related to monitoring the number of referrals and the type of referrals and the disposition of referrals.

And starting with this fiscal year 2008, I have asked Dr. Beck to create a monthly report that will show the utilization in each site, the number of referred and the dispositions.

I have looked at the data related to October 1, 2005, to July of 2007, and note the point you are making, so this is a lesson learned for us on a headquarters' level.

Mr. MITCHELL. Is there any legitimate reason why Palo Alto should have been different from any of the other polytrauma centers?

Mr. FEELEY. I really do not have any explanation for why that is the case. I think that your point earlier with the previous panel, it is either the number of referrals in or the outreach may not have been as aggressive. But I am very comfortable that Palo Alto has a very strong leadership team and they have the message. The census today is at 12 beds. The outreach to Bethesda yesterday will be followed by many other outreach efforts to ensure a maximum utilization of bed capacity.

Mr. MITCHELL. And what I heard you say, I thought earlier, was that the reason you really did not do much about this is you were busy doing something else, getting the actual facilities in place, so you were not really looking at——

Mr. FEELEY. What I would say to you, this data did not come to my attention until very recently and there was not a capacity issue with all beds being full throughout the system. We have 48 beds and there was not a complaint coming up through any of our data systems. And it is my understanding there are no waiting lists to get into the program, at least right now.

So what I was trying to convey that my primary interest was developing transitional rehabilitation housing for veterans who had been through acute rehab and needed an additional runway. Palo Alto was one of the first facilities that had the transitional housing put in place because they had one of the first day hospital programs for TBI injured patients.

Mr. MITCHELL. And are you telling us that there will be people looking at this data from now on and that, you know——

Mr. FEELEY. Absolutely correct.

Mr. MITCHELL. Obviously you said you did not get the data, so either no one gave it to you or you just did not look at it, one or the other.

Mr. FEELEY. The data was not coming forward, but it will be starting October 1st on a monthly basis by facility, so I will know what the average daily census is, what the utilization rate is. We

will know who needs to outreach and we will also know what type of dispositions we are challenged with and we may need to beef up our resources to meet those needs.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you very much.

Mr. Feeley, I just talked to another Member of Congress about a clinic that was opening up in their district that the VA never even attempted to cooperate with that Member's schedule. I am embarrassed that you never informed the Member of Congress and Mr. Rodriguez who I served with before on this Committee. I am glad that he is back.

You should not do that. You need to be involved whether it is a Republican or a Democrat. You need to let the Members of Congress know what is going on so they do not hear it from the press. Please take that away and share it with other executives in the VA.

Mr. FEELEY. I understand the lesson learned.

Ms. BROWN-WAITE. Maybe I just instill the fear of God or Ginny Brown-Waite in the people in Florida, but they would never ever do that. Please just do not ever let that happen again.

This question is for Dr. McNamee and/or Dr. Huycke. I understand that our staff paid you a visit a couple of weeks ago and that it went pretty well.

Would you care to touch upon the ability for your staff to receive complete and critical medical information about our wounded warriors transferring to your polytrauma center?

Dr. MCNAMEE. Thank you for the question, ma'am.

I did have the opportunity to meet with Mr. Bestor and Mr. Wu about a week ago and sat them down and went through the transfer of medical records with them and specifically the pieces of medical record that we are indeed receiving.

The item that we use most frequently now which is a complete medical record potentially from what Mr. Bestor told me and with the exception of some psychological data that I had not been able to verify on our end yet, but is a complete medical record that is scanned at both Bethesda and Walter Reed into a PDF file and is loaded into our medical record system at the VA. It can be sorted. It can be searched to some degree and also printed off.

This is direct documentation of medical care at the military treatment facility before they are discharged to us. These documents range anywhere from 500 to I have seen 2,500 pages that come down through. This also is accompanied by full imaging, so all imaging from Bilad and battlefield up through the military treatment facilities are also loaded into our computer system which we use on a very frequent basis which Mr. Bestor and Mr. Wu also had the opportunity to see.

Ms. BROWN-WAITE. One other question. Do you know why DoD installed their server in your facility? Does any other polytrauma center have the same setup to receive medical information from DoD facilities?

Dr. MCNAMEE. I can answer what happens in our facility specifically, ma'am. I would direct your question otherwise for that.

Ms. BROWN-WAITE. So the answer is you do not know why they chose your facility?

Dr. MCNAMEE. I know that they chose our facility because we are receiving these individuals. My answer is, is I do not know what specifically the setup is at the other four polytrauma centers. I would assume that they have the same setup that we do, but I cannot verify that.

Ms. BROWN-WAITE. Mr. Feeley, can you?

Mr. FEELEY. I do not know the answer, but I do not know if any other panel member does.

Dr. SIGFORD. Yes. Is my microphone—there you go. I am sorry. I thought the green light was on.

Yes. All four of the polytrauma rehabilitation centers have the same capacity to receive that scanned PDF file and load it in their electronic record.

Ms. BROWN-WAITE. What about the images? Are they also——

Dr. SIGFORD. Yes.

Ms. BROWN-WAITE [continuing]. Available?

Dr. SIGFORD. Yes.

Ms. BROWN-WAITE. So it comes from DoD?

Dr. SIGFORD. Yes.

Ms. BROWN-WAITE. You can get them though?

Dr. SIGFORD. Yes.

Ms. BROWN-WAITE. Okay. I think this question is for Mr. Feeley. What exactly is the timeline in preparing the newly announced facility in San Antonio? When will patients begin being received there?

Mr. FEELEY. I will be hopeful that I think the dollar amount is $67 to $70 million and hopefully we would be seeing patients the beginning of fiscal year 2011. It is about a 36-month runway. Now, we were pressed to do this sooner. That would be the far-out date.

Ms. BROWN-WAITE. And thank you.

I am going to yield back the balance of my time.

Mr. MITCHELL. Thank you.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Ms. Brown-Waite, for those questions and those comments.

Congressman Chet Edwards on Appropriations, and I sit on Appropriations also, worked and we put $30 million initially to get going on the Supplemental.

Do you have those resources in hand to start up the San Antonio facility?

Mr. FEELEY. I believe those dollars and resources are in hand to get launched.

Mr. RODRIGUEZ. Okay. You should have them in hand. And you are saying it is going to be until 2011?

Mr. FEELEY. It is a huge project with major renovation. So it could be done in 24 months, but I would rather give you the outside number of 36. I think that is more accurate.

Mr. RODRIGUEZ. Okay.

Mr. FEELEY. This is a huge renovation.

Mr. RODRIGUEZ. Is it a priority for the VA in terms of making this happen as quickly as possible?

Mr. FEELEY. Absolutely.

Mr. RODRIGUEZ. Okay. And the priority means at the most, 36 months——

Mr. FEELEY. Correct.

Mr. RODRIGUEZ [continuing]. Less, 24? In spite of the fact that you already have half of that in hand or you should have?

Mr. FEELEY. The half that we have in hand was received——

Mr. RODRIGUEZ. In the Supplemental.

Mr. FEELEY [continuing]. Almost 8 weeks ago. It is not exactly like it arrived 10 months ago.

Mr. RODRIGUEZ. Yeah. The Supplemental.

Mr. FEELEY. But we will accelerate as aggressively as we can to get it done realizing we have the Intrepid Brook and major needs there.

Mr. RODRIGUEZ. Are you putting the next 36 as part of the existing 2008 or 2009 budget?

Mr. FEELEY. That I do not know the answer to, but I can get back to you on that.

[The information was provided in the response to Question 7 in the post-hearing questions for the record, which appears on p. 40.]

Mr. RODRIGUEZ. Okay, because we will have another Supplemental. We will see what we can work out, but I would be glad if you can maybe look at using some of those resources there since you already have the first $30 million.

Mr. FEELEY. We also have an excellent Network Director in Mr. Shay, who was the former Director at San Antonio, who is very committed to this initiative, so——

Mr. RODRIGUEZ. No. He is a great guy. You have some good people there trying to make that happen. So I know they are looking forward to making that a reality. And so I want to thank you for that.

And overall, I know I tell my veterans that there is a new day at the VA and for those that have been shunned in the past to go back, especially a lot of our Vietnam veterans that have had a rough time getting access and, you know, and for a good reason. We also, you know, did not fund it appropriately. But I am hoping that we can start making some inroads to these veterans that are coming out of both Afghanistan and Iraq.

So the indication is hopefully by 2011 or before then. Do you know when we might start breaking ground?

Mr. FEELEY. There is actually a ceremony, I believe, this Friday, the 28th down in San Antonio to make this announcement. But I do not know when the ground breaking would actually occur.

Mr. RODRIGUEZ. Yeah. Again, I would really appreciate if you would let me know when those ceremonies are occurring, you know, since I am on the Committee. So I would appreciate it. And I know that the Secretary, I think, informed the Chairman, I think afterward, but I did not get that until much later.

Mr. FEELEY. I understand how sensitive it is. Thank you.

Mr. RODRIGUEZ. Okay. I would appreciate it. And I would also appreciate if you have any areas of problems, you know, to let us know what we can do because there is nothing worse than for us to find out that in terms of utilization rates that are out there because at those rates, the Capital Asset Realignment for Enhanced Services (CARES) Commission was going around the country, you

know, and closing facilities that were at 50 and 60 percent utilization.

And so if that is the case, then, you know, you got to be looking at that real closely because I remember those recommendations from the CARES Commission that if it was only 60 percent, you know, they were going to get recommended to get closed.

Mr. FEELEY. The Congress has been very benevolent with resources. We have the money to do the job right. We are adding additional staff to all of these programs including Palo Alto. And I understand the need to get capacity up.

Mr. RODRIGUEZ. Yeah. And the fact that, you know, you construct this one in terms of—is 12 beds sufficient?

Mr. FEELEY. I think we are going to go with 12 beds. By history, the same as the other sites, with 12 transitional beds, that will give us, I guess I will describe an accordion capacity to grow if we need to.

In addition, we are going to put additional resources in to be able to treat moderate brain injury that has a need for a lot of psychological support and cognitive work on an outpatient basis. So this is something that is very exciting that is going to happen at San Antonio.

Mr. RODRIGUEZ. Okay. We are looking forward to it and looking forward to working with you. Thank you.

Mr. MITCHELL. Thank you, Mr. Rodriguez.

We have one last question from Ms. Brown-Waite and that will conclude this hearing.

Ms. BROWN-WAITE. As you can tell, we have votes, so we will be leaving for that.

Mr. Feeley, our staff has informed me that not all facilities are using, or not even aware of the use and availability of JPTA and VTA programs to track incoming patients from DoD.

How widely would you say has VA educated the outlying medical centers and outpatient clinics on this patient tracking application? And for the polytrauma units, which obviously this information is very important, how much data is transferred from DoD using this application when a servicemember is transferred between the two organizations?

Mr. FEELEY. Thank you. I am going to let Dr. Huycke comment on that.

Dr. HUYCKE. Ma'am, thank you for the question because I think the JPTA/VTA initiative in the VA has truly been one of a good news story.

Right now in the VA, we have 49 individuals at 15 VA medical centers who have access to the joint patient tracking application. Of course, that is the DoD version. And on top of that, we have more than 1,200 individuals in the VA system spread throughout the country who have access to the veterans tracking application. As you know, the veterans tracking application is the VA image of the joint patient tracking application.

We have prioritized the rolling of this capability out to the polytrauma units because of the acuity and the necessity of getting it out to those folks first. And so that is where the priority has been and continues to be. And all of the polytrauma units have

more than a single individual with access to the joint patient tracking application and to VTA.

So on top of that, there have been, for instance, at the last national call, Mr. Feeley's last national call, we put out the information on the veterans tracking application. So although we are probably not where we would like to be with VTA, we believe that to be a very good news story between the collaboration of DoD and VA.

Mr. MITCHELL. Just one follow-up. My understanding is that Palo Alto as well as—who is the other—Minneapolis, have not even heard of these programs. So I do not know if fault lies with them or with you, but I would think that there ought to be better coordination of all of these.

And with that, I want to thank all of you for what you are doing because, you know, our veterans deserve nothing but the very finest from what this country has to offer. And there may be more questions that will be asked by the staff that we did not get to ask today, so it may be in writing, but I want you to know that we are very concerned about this. And so expect some follow-up from both of our staffs.

Thank you, and this meeting is adjourned.

[Whereupon, at 11:22 a.m., the Subcommittee was adjourned.]zzzzz

A P P E N D I X

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

This hearing will come to order.

Thank you all for coming today. I am pleased that so many folks could attend this oversight hearing on VA Polytrauma Rehabilitation Centers. The VA polytrauma centers help mend and reintegrate into society servicemembers who have suffered among the worst that war can inflict. The most severely injured servicemembers serving in Iraq and Afghanistan are medevac-ed out of theater through Germany to Walter Reed and Bethesda Naval Hospitals and, when they are ready, are sent to one of the four polytrauma centers, which are located in Richmond, Tampa, Minneapolis, and Palo Alto. Most polytrauma patients have suffered traumatic brain injury in addition to a variety of other serious injuries, some which necessitate amputation. The soldiers, sailors, airmen, and Marines who are treated at the polytrauma centers have paid a very high price for their service to their country, as have their families, both of whom face a long and difficult path to recovery and sometimes a lifetime of care. The Nation owes these servicemembers and their families everything that a Nation as rich as ours can provide.

The Nation has many who need and deserve what we can give. Survival rates for servicemembers injured in combat are extremely high compared to previous conflicts, partly because of greatly improved protective equipment, but also because the military has moved surgical medical care practically to the front lines. A soldier injured in an IED blast can be in surgery within 30 to 45 minutes or even less. With these advances, however, comes the need to treat injuries that would have been fatal in the past. Injuries like traumatic brain injury and post-traumatic stress disorder require medical treatment and long-term care of a new kind. The VA polytrauma centers are an essential part of that care.

Congress has provided significant resources, and is providing more, that have enabled the VA to establish and expand polytrauma care. It must be said that the VA has stepped up to the plate to meet this need. In addition to the four polytrauma centers, the VA has created a network of sub-acute polytrauma care centers in each of the Veterans Integrated Services Networks and outreach programs throughout the country. This is not to say that everything is as it should be—we would not be having this hearing if that were the case. Polytrauma care is not perfect. There is also the sharing of electronic medical information and other issues that have been highlighted by Senator Dole and Secretary Shalala that the Subcommittee and the Full Committee will be addressing in the near future. But there should be no misunderstanding—we are not here to criticize the VA's care providers or to suggest that the quality of care that the Nation's most severely injured servicemembers is anything less than exemplary. The Subcommittee has found some management issues that need to be addressed—that is why the title of this hearing is what it is. The Subcommittee's oversight is intended to ensure that the superb care the VA provides is provided to those who deserve to receive it.

Data provided by the VA shows that the Palo Alto VA's polytrauma center, from the beginning of this year through July, filled only 60 percent of its available beds, while the three other polytrauma centers combined have been running at 98 percent of capacity. We have found no good reason why that should be. The VA's Palo Alto hospital has a beautiful facility, an even more beautiful Fisher House where family members can stay, and is practically married to the Stanford Medical School. Palo Alto has all the resources it could need to provide care for all the polytrauma patients it can take. The Subcommittee has also found that the Palo Alto polytrauma center would not accept minimally responsive brain injured patients while the other polytrauma centers did so, until the VA created a treatment protocol for those patients in December 2006 and effectively forced Palo Alto to accept these patients. This past spring, the VA's Office of Medical Investigations found disarray, morale problems, insufficient programs for families, and lack of leadership. All of this raises

obvious issues not just about local management but also about VA's central office. Why, for example, did the fact that Palo Alto's failure to fill its beds while the other polytrauma centers were at full capacity not raise a red flag at headquarters?

We begin today by hearing from the senior management of the Palo Alto Health Care system, headed by its Director, Lisa Freeman. Subcommittee staff has spent much time with Ms. Freeman and her team and they are to be commended for their willingness to meet with and provide information to the Subcommittee. We hope, indeed expect, that their testimony will describe significant progress in addressing the concerns of the Office of Medical Investigations and this Subcommittee.

The second panel is headed by William Feeley, Deputy Under Secretary for Health for Operations and Management. The Subcommittee extends its thanks to Mr. Feeley and the VA witnesses with him for their efforts to provide the best care possible to our injured servicemembers and appreciates their cooperation with the Subcommittee in meeting with and providing information to us. We in no way doubt their good will and dedication. But there are obvious management issues for the central office that are raised by the fact that there were empty beds in Palo Alto and these witnesses will be asked to address these issues. Dr. Barbara Sigford and Dr. Shane McNamee, both of whom are personally involved in running polytrauma centers, are at the witness table as well. We look forward to hearing from them about the good things they are doing for those who have made great sacrifices for their country.

On Sunday night, the Public Broadcasting System began a 15 hour presentation of Ken Burns' documentary on World War Two. America achieved great things in that war, but the documentary reminds us, or, perhaps, more realistically, teaches us of the terrible cost of war. We as a Nation owe a debt that can never be repaid to those who serve, and an obligation that must be met to meet the needs of those injured in that service. We are here today to do our part in making sure that this happens.

No one can doubt the dedication of the men and women in the military and the VA who provide care for our servicemembers.

Prepared Statement of Hon. Ginny Brown-Waite,
Ranking Republican Member

Thank you, Mr. Chairman, for yielding.

Mr. Chairman, I believe the title of this hearing is very appropriate. When we talk about our wounded warriors from the Global War on Terrorism, the quest for excellence should be of utmost importance.

Our Committee staff recently visited several Polytrauma Rehabilitation Centers located in Richmond, Virginia, Minneapolis, Minnesota, and Palo Alto, California. They did this to provide oversight on the level of care being provided to our wounded servicemembers at those units. Last Congress, while serving as Chairman of this Committee, Ranking Member Buyer followed injured servicemembers from a combat support hospital in Iraq through Landstuhl Army Medical Center in Germany, and on to Walter Reed and Bethesda. Mr. Buyer has also visited the Minneapolis PRC to evaluate care and services received by our most critically injured servicemembers.

What I still see today is of great concern. The tracking of medical records still includes the paperwork and hard copies of medical records accompanying the servicemembers as they transfer stateside and ultimately to the VA. The Committee hears that not all the critical medical information is being forwarded to the Polytrauma units by the Department of Defense, and many of the VA facilities are not using or have never heard of the Joint Patient Tracking Application and the Veteran Tracking Application systems.

At the PRC unit in Palo Alto, our staff found several issues relating to lack of staffing and resources. This same concern was detailed in the draft OMI report obtained by our staff prior to their visit to Palo Alto. I would like to have the witnesses address this deficiency in care to the servicemembers and veterans who are being treated in this facility, and am interested in learning how widespread this problem is.

During the staff visit to the PRC unit in Minneapolis, the Committee learned about the unusually high turnover rate of the active duty officers' military liaison. I am concerned about how this turnover rate affects the continuity of care for our severely injured servicemembers. PRC staff told us that there were also no electronic transfer of records between the DoD and the PRC in Minneapolis. I am interested in learning what is being done to address this situation. I know that some of our PRCs are doing a great job, while it seems that others are still having great

difficulties. How are best practices being shared between PRCs to provide the best possible care for our severely wounded servicemembers and veterans?

Mr. Chairman, I am quite concerned about the care our wounded servicemembers are receiving as they move from the battlefield through the line of care to our VA facilities. As I have stated in the past, the hand-off between DoD and VA should be seamless and transparent to the servicemembers and their families receiving care and treatment . . . not a fumble. Repeatedly, the Committee has heard that many of these transfers require multiple phone calls, emails, faxes, and videoconferencing. Our veterans must have this seamless transition to maintain a continuum of care between the two departments. Committee Members have been fighting this recurring battle on the home front for our servicemembers and veterans.

Mr. Chairman, Congress' responsibility to these men and women in uniform does not end with their care at the PRC units. As the Oversight Committee, we must also ensure that they have a seamless transition from active duty to civilian/veteran status.

I cannot stress enough the importance of working toward a standard Benefits Delivery upon Discharge (BDD) documentation. A standard BDD would include one physical to be shared between the DoD and the VA, providing servicemembers with documentation as to the benefits for which they may be eligible. With the use of a standard shared BDD, we could conceivably have the claims backlog at the VA caught up in just a few years. This program was successfully tested between DoD and VA from 1995–1997. It is also a strong recommendation for the President's Dole-Shalala Commission report.

Again, Mr. Chairman, thank you for calling this hearing, and I look forward to hearing from our witnesses about how VA is working with the DoD to improve care for our Nation's heroes.

Prepared Statement of Elizabeth Joyce Freeman, Director, Veterans Affairs Palo Alto Health Care System, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss the Polytrauma Rehabilitation Center (PRC) located at the Department of Veterans Affairs Palo Alto Health Care System (VAPAHCS). It is a privilege to be on Capitol Hill to speak and answer questions about this vital program and other issues that are important to veterans who have bravely served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).

Mr. Chairman, I would also like to thank you and your Committee for your advocacy on behalf of our Nation's veterans. The Committee and its staff have been actively involved in many issues affecting veterans this year. Several weeks ago, I had the pleasure of hosting a visit by senior staff from the Committee, including Mr. Geoffrey Bestor and Mr. Art Wu. They toured VAPAHCS and interviewed several patients, family members and staff. I appreciated their interest, insights and suggestions.

Today, I will provide a brief overview of VAPAHCS and the PRC. I will present some of our successes, challenges and upcoming enhancements at the PRC. I will also specifically discuss areas of particular interest and recent scrutiny, including accreditation, referral process, emerging consciousness program, family support and programmatic leadership.

VA Palo Alto Health Care System (VAPAHCS)

VAPAHCS is one of the largest and most complex health care systems in the Veterans Health Administration (VHA). It provides primary, secondary and tertiary care services across a large geographic area (i.e., 10 counties over 13,500 square-miles) in the South San Francisco Bay area. VAPAHCS operates facilities at three inpatient divisions (i.e., Palo Alto, Menlo Park and Livermore) and six outpatient clinics (i.e., Capitola, Modesto, Monterey, San Jose, Sonora and Stockton). VAPAHCS offers most of the highly specialized services in VHA, including traumatic brain injury (TBI), blind rehabilitation, hospice, palliative care, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), gero-psychiatric inpatient care, war-related illness and injuries, domiciliary care and organ transplantation.

In fiscal year (FY) 2006, VAPAHCS had enrolled more than 85,000 veterans and provided care to 53,000 unique veterans. VAPAHCS staff includes nearly 3,000 full-time equivalent employees (FTEE) and more than 1,700 volunteers. The FY 2007

operating budget for VAPAHCS is approximately $600 million. VAPAHCS has particularly strong academic programs, including the third most highly funded research program in VHA. VAPAHCS and the veterans it proudly serves benefit from a balanced relationship with Stanford University School of Medicine and affiliations with more than 100 other academic institutions.

Polytrauma Rehabilitation Center (PRC)

VA established the Polytrauma System of Care (PSC) in 2005 to address the biopsychosocial needs of the most severely injured OEF/OIF veterans. The PSC consists of PRCs, Polytrauma Network Sites (PNSs), Polytrauma Support Clinic Teams (PSCTs) and Polytrauma Points of Contact (PPOCs). PRCs serve as a regional referral center for acute medical and rehabilitative care for patients with polytrauma (defined as two or more injuries, one of which might be life threatening, resulting in significant physical, cognitive, psychological or social impairments and functional disability) and TBI. PRCs maintain a full team of dedicated rehabilitation specialists and experts from other specialties related to polytrauma. PRCs also serve as consultants to other facilities across the PSC.

The PRC at VAPAHCS is one of four PRCs in VHA (the other three are located in Minneapolis, MN; Richmond, VA; and Tampa, FL). A fifth polytrauma site was just recently announced for San Antonio, TX. The PRC offers a continuum of acute rehabilitative services in a variety of venues, including inpatient wards, outpatient clinics and residential transitional settings. Clinical care is provided by a dedicated interdisciplinary team with specific expertise in physiatry, rehabilitation nursing, neuro-psychology, psychology, speech-language pathology, occupational therapy, physical therapy, social work, therapeutic recreation therapy, prosthetics, SCI, blind rehabilitation and PTSD.

The core of the PRC at VAPAHCS is a 12-bed ward located in Building 7D on the campus of the Palo Alto Division. The PRC building also has four general rehabilitation beds that are available to polytrauma patients on a priority basis, plus two additional beds for residential rehabilitation and/or women veterans. Since its inception (i.e., from February 2005 through early September 2007), the PRC has accepted 143 patients. The average daily census (ADC) has steadily increased since FY 2005. Through the third quarter of FY 2007, the PRC ADC has been 7.9 for an occupancy rate of 65 percent.

Another important component of the PRC is the Polytrauma Residential Transitional Rehabilitation Program (PRTRP). PRTRP is designed for veterans and active duty servicemembers who have completed their acute rehabilitation but have lingering impairments that prevent them from safely re-integrating into their community or returning to active duty. PRTRP has the goal of establishing independent living through a structured program that focuses on restoring home, community, leisure, psychological and vocational skills in a controlled, therapeutic setting. Services typically provided include individual and group therapies, case management, care coordination and vocational rehabilitation. Through the third quarter of FY 2007, the ADC in the PRTRP has been 4.7 and therefore the combined ADC for both the PRC and PRTRP is 12.6.

In part due to the ongoing war in southwest Asia and our country's deep concern for injured veterans, the PRC at VAPAHCS has received considerable attention from domestic and international media outlets. Since the establishment of the PRC in 2005, more than 200 print and broadcast stories have been disseminated about the PRC, its patients and its staff. Stories from respected organizations such as Associated Press, New York Times, Jim Lehrer NewsHour, National Public Radio, NBC Nightly News and British Broadcasting Company, have all portrayed the quality of the care at the PRC as outstanding.

One poignant example is the story of Marine Corps Corporal (Cpl.) Jason Poole. Cpl. Poole was on his third tour in Iraq in 2004, 10 days shy of coming home, when his patrol was hit by a roadside bomb. The explosion and resulting injuries (e.g., shrapnel went into his left ear and out his left eye) left him in coma for two months. When he arrived at VAPAHCS, he was unable to walk, talk or breathe without a tube in place. Two years and seven reconstructive surgeries later, he was interviewed by the local NBC news affiliate. "I've been treated amazingly here," he said. "These people [staff at the PRC at VAPAHCS] gave me my life. They are everything to me. I would not be where I am today without their help."[1] The accomplishments of Cpl. Poole and so many other courageous men and women at the PRC are extraordinarily gratifying to me.

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[1] NBC Channel 11: "The Bay Area at 11", KNTV–San Francisco 02/07/2007.

Challenges and Improvements

While the PRC at VAPAHCS has enjoyed considerable success, it has experienced and continues to face challenges. Staffing is a major area of concern. VAPAHCS expends considerable effort to attract and retain the "best and the brightest." The health care labor market in the greater San Francisco Bay Area is highly competitive and compounded by an exceedingly high cost of living. In part due to our affiliations with prestigious academic partners such as Stanford University School of Medicine, Washington State University and the University of California San Francisco School of Medicine; VAPAHCS generally has been successful in recruitment. However, recruitment for some positions (e.g., physiatry) has been especially problematic.

While work on the PRC is fulfilling, it is also inherently demanding. Knowledgeable and well-intended individuals can have different opinions and these differences can be exaggerated in the PRC environment. Consequently, the VHA Under Secretary for Health (USH) recently asked the VHA National Center of Organizational Development (NCOD) to visit all four PRCs to assess current structure and staff. NCOD came to VAPAHCS and met with senior leadership and front line staff. The initial visit was beneficial and we look forward to continuing our partnership with NCOD.

Also, as noted earlier, the PRC is a highly visible endeavor. The PRC is frequently the subject of scrutiny by oversight bodies, veterans' advocates, Department of Defense (DoD) personnel, media and elected officials. Nearly every week, VAPAHCS has the honor of hosting visits by interested parties. The vast majority of these visits are very positive and generate considerable praise and compliments for PRC staff and leadership.

However, earlier this year, the VHA Office of the Medical Inspector (OMI) received a letter from the Senate Committee on Veterans' Affairs expressing concern about the delivery of care at the PRC at VAPAHCS. OMI was asked to look into several allegations, including delays in accreditation, inappropriate declinations of referrals and lack of effective leadership at the program level. As a result, OMI came to VAPAHCS in March 2007 and assessed the PRC. Some of the allegations were validated (e.g., delay in accreditation survey), while others were not substantiated (e.g., OMI concluded VAPAHCS did not "cherry pick" referrals). I will discuss these and other issues in the following sections.

Accreditation. One of the concerns expressed in the OMI report was the delay in the accreditation survey by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF confers up to (i.e., a maximum) 3-year accreditation status to rehabilitation facilities that undergo a successful survey. VAPAHCS was due for its triennial CARF survey of rehabilitation programs (including the PRC) in February 2007. Based on internal and external assessments (e.g., a "mock survey" by a contracted private health care organization), I determined we needed additional time to prepare for the survey. Consequently, I asked CARF to delay its survey for a few months.

I am pleased to report to the Committee that the CARF survey occurred July 19–20, 2007, and resulted in full accreditation for the maximum 3-years for all of the four programs surveyed (i.e., outpatient, inpatient and residential brain injury rehabilitation, as well as inpatient rehabilitation). As noted in the August 24, 2007, notification letter from CARF, "This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of practice excellence." I am especially pleased that areas that were previously considered weaknesses (e.g., program leadership, staff education), are now cited by CARF to be organizational strengths.

Referrals. I and my staff at VAPAHCS consider our selection as a PRC site to be a distinct privilege. We are fully committed to having an active, vibrant and highly effective rehabilitation program. We recognize that the historical level of activity at the PRC has been below capacity and we have evaluated the circumstances associated with this situation.

I would like to emphasize that we are highly motivated to receive referrals to our PRC and we make every effort to accept them. Since the PRC began operations in 2005 (through September 14, 2007), VAPAHCS has received a total of 177 referrals to its PRC and accepted 143 patients (81 percent). The PRC declined or redirected 25 patients (14 percent) and the referring site withdrew 9 referrals (5 percent). The most common reasons for the PRC not accepting referrals have been another form of treatment was needed (e.g., care for PTSD, substance abuse treatment), another venue was more appropriate (e.g., Polytrauma Network Site, different PRC for geographic reasons) or the desired service was not available at the time (e.g., coma

stimulation). I would like to emphasize that the OMI reviewed this issue earlier this year and concluded that the disposition of referrals was appropriate. And, while the acceptance of some referrals was delayed due to concerns regarding medical stability (in the context of long flights from the East Coast), OMI did not substantiate the allegation that VAPAHCS was "cherry picking" referrals to achieve good outcomes.

Currently, recent changes I have initiated will make it easier for referring sites to send us patients. There is now a single point of contact for all PRC referrals at VAPAHCS who has the requisite customer service skills. This individual collects all of the relevant information and presents it to an interdisciplinary team of polytrauma experts. The team makes a recommendation to the PRC Program Director and the PRC Program Director makes a decision within 2 business days from the time of the referral (i.e., when the needed medical information is available). I have instructed my staff to look for every possible way to accept all patients to VAPAHCS, either at the PRC or another program (e.g., PRTRP, National Center for PTSD). The decision will be promptly communicated to the referring site. If for any reason the referring site disagrees with the decision, the referring site will be encouraged to appeal the decision to the Chief of Staff, VAPAHCS. We will fully document the disposition for each referral and will report the outcomes to the Veterans Integrated Service Network (VISN) 21 Office and VA Central Office (VACO) monthly.

Emerging consciousness program. VHA formally introduced the Emerging Consciousness (EC) following its polytrauma conference in December 2006. EC is a program developed by VHA to optimize the long-term functional outcomes of brain-injured patients by attempting to improve responsiveness, return to consciousness and advance to the next level of rehabilitation care. EC is intended for patients who range from fully comatoese to minimally conscious. EC utilizes appropriate medical and nursing rehabilitation services, individualized multisensory stimulation and prevention of complications related to immobilization. EC also emphasizes support to families and caregivers. Some patients in the EC program, even with the most optimal care may not regain consciousness or advance to the next level of care.

The PRC at VAPAHCS has been providing many components of the EC program since its inception (e.g., rehabilitation services, prevention of complications and family support). However, the PRC at VAPAHCS did not initially offer the multisensory component. In the summer of 2006, VAPAHCS noted anecdotal reports of the success of multisensory stimulation and reassessed its potential value. VAPAHCS began offering this service in November 2006 and fully instituted the EC program following the polytrauma conference in December 2006. The PRC has accepted 12 patients into its EC program since November 2006, including a patient declined by private rehabilitation sites. At the time of this testimony, VAPAHCS had a census of six EC patients with five in the PRC and one in the intensive care unit.

Family support. VAPAHCS recognizes that the presence and support of family members are critical components of the successful rehabilitation of injured patients. VA has inherent constraints on its ability to provide certain services to non-veteran family members. Fortunately, since the PRC began operations, VAPAHCS has developed innovative programs to support families of PRC patients.

A wonderful example is the construction and opening of a Fisher House™ directly across from the PRC on the VAPAHCS campus. Fisher Houses™ are "comfort homes" with individual rooms for families of patients receiving medical care at major military and VA medical centers. Prior to the opening of the Fisher House™ in April 2006, many families complained of the inability to find affordable accommodations near VAPAHCS. Thanks to the generosity of donors and the Fisher House Foundation, families of OEF/OIF patients now have access to a stunning 21-suite Fisher House™. There is no charge to guests and families of OEF/OIF patients are given priority admission. The Fisher House™ is filled to capacity nearly every night.

We have also been able to provide limited monetary support from donations to our General Post Fund. The donations come from individuals and organizations such as Rotary Club. We have established a Fisher House™ Fund and an OEF/OIF Fund. These funds are used to pay for lodging, groceries, rental cars, day care for children and other incidentals.

As part of our ongoing reorganization and staffing enhancements, we are increasing the support and services to families who are with their loved ones in the PRC. We are enhancing access to the Internet (e.g., to check e-mails, communicate with other family members), offering caregiver education and training, providing a "quiet room," offering family counseling, spiritual support (e.g., chaplain services) and assistance with recreational activities. Another important benefit to families has been the placement of Department of Defense (DoD) liaisons in the PRC. The DoD liai-

sons are able to assist active duty patients and their families with myriad questions and services important to them.

Organization and leadership. In response to recommendations by both internal and external entities (OMI, CARF) we continue to evaluate services and shape our service delivery to meet the needs of our patient population.

In closing, Mr. Chairman, I would like to note that it is an incredible honor to host one of the four (soon to be five) PRCs in VHA. I am very proud of the talented and dedicated staff at VAPAHCS who provide outstanding and compassionate care to our Nation's heroes. They do incredible work in challenging circumstances. I believe we have made a positive difference in the lives of so many veterans and their families. I acknowledge that we are not perfect. In VHA, when mistakes occur we "own them" and make the requisite system changes. This same philosophy holds true in the PRC at VAPAHCS and our investment of resources, service enhancements and organizational changes are evidence of that approach.

Again, Mr. Chairman, thank you for the opportunity to testify at this hearing. I and the staff who accompany me would be delighted to address any questions you might have for us.

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

Good morning Mr. Chairman and Members of the Committee.

Thank you for this opportunity to discuss the Veterans Health Administration's (VHA) ongoing efforts to improve the quality of care that we provide to veterans suffering from traumatic brain injury (TBI) and complex multiple trauma. Joining me today is Dr. Edward Huycke, Chief Officer for VA's Office of Seamless Transition, Dr. Lucille Beck, VA's Chief Consultant for Rehabilitation Services, and Dr. Barbara Sigford, National Program Director for Physical Medicine and Rehabilitation.

VA offers comprehensive primary and specialty health care to our veterans and active duty servicemembers, and is an acknowledged national leader in providing specialty care in the treatment and rehabilitation of TBI and polytrauma. Since 1992, VA has maintained four specialized TBI Centers that have served as the primary VHA receiving facilities for military treatment facilities seeking specialized care for brain injuries and complex polytrauma. In 2005, VA established its Polytrauma System of Care, leveraging and enhancing the existing expertise at these TBI centers to meet the needs of seriously injured veterans and active duty servicemembers from operations in,, and elsewhere. This new era of combat and the resulting casualties have required adaptations in our approaches to care that we provide for this brave new generation of veterans. We readily accept the challenge and opportunity to adapt VA's existing integrated system to provide the best available continuum of care. The focus of my testimony today will be on treatment and rehabilitation provided by VA for veterans recovering from TBI and complex multiple trauma, and the current initiatives to further enhance these services to our veterans within this system of care.

Polytrauma System of Care

The mission of the Polytrauma System of Care is to provide the highest quality of medical, rehabilitation, and support services for veterans and active duty servicemembers injured in the service to our country. This integrated nationwide system of care has been designed to provide access to lifelong rehabilitation care for veterans and active duty servicemembers recovering from polytrauma and TBI.

Component 1—Regional. Currently the four Polytrauma/TBI Rehabilitation Centers (PRC)—located in Minneapolis, MN; Palo Alto, CA; Richmond, VA; and Tampa, FL—are the flagship facilities of the Polytrauma System of Care. A fifth polytrauma site was just recently announced for San Antonio, TX. These centers serve as hubs for acute medical and rehabilitation care, research, and education related to polytrauma and TBI. The specialized services provided at each PRC include: comprehensive acute rehabilitation care for complex and severe polytraumatic injuries, emerging consciousness programs, outpatient programs, and residential transitional rehabilitation programs. Clinical care is provided by a dedicated staff of rehabilitation specialists and medical consultants with expertise in the treatment of the physical, mental and psychosocial problems that accompany polytrauma and TBI. This team includes specialists in physiatry, rehabilitation nursing, neuropsychology,

psychology, speech-language pathology, occupational therapy, physical therapy, social work, therapeutic recreation, prosthetics, and blind rehabilitation.

One of the newest programs within the PRCs is the treatment program for patients with severe disorders of consciousness. Provision of rehabilitation services for patients who are minimally conscious or minimally responsive is currently based on expert opinion rather than scientific evidence. Cornerstones of treatment for patients with severe disorders of consciousness include: aggressive medical care to treat potential reversible causes of impaired consciousness (infection, sedation, etc.); prevention of complications (contracture, pressure sores, malnutrition); family support and education. Additional interventions often include structured sensory stimulation, and trials with medications to increase responsiveness. Programs providing specialized care for severe disorders of consciousness must also have a mechanism for monitoring response to treatment. A commonly used instrument for this purpose is the Disorders of Consciousness Scale (DOCS). VA developed its program through a process of reviewing the experience and expertise developed at those VA sites that had an established protocol, reviewing the literature, and consulting with private expert professionals providing these services. Development of the formalized program culminated with a face-to-face working conference in December 2006, at which time the protocol was established that is currently being utilized, and the requirement was set that all Polytrauma Rehabilitation Centers would participate. The workgroup for this new program continues to meet monthly.

In 2007, staffing for the PRC teams was increased at each center in response to increased demands of patient workload, coordination of care, and support for family caregivers. The PRCs have affiliations and collaborative relationships with academic medical centers. A significant number of PRC clinical providers share VA and affiliated positions in training and medical rehabilitation. The inpatient rehabilitation programs at the PRCs maintain accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) for both Traumatic Brain Injury and Comprehensive Rehabilitation.

Component 2—Network. The Polytrauma/TBI Network Sites (PNS), designated in December 2005, represent the second echelon within the Polytrauma System of Care, with one PNS located within each of VA's 21 Veterans Integrated Service Networks (VISN). The PNS provides key components of post-acute rehabilitation care for individuals with polytrauma/TBI, including, but not limited to inpatient and outpatient rehabilitation, and day programs. The PNS is responsible for coordinating access to VA and non-VA services across the VISN to meet the needs of patients recovering from polytrauma and TBI, and their families. The PNS consults, whenever necessary, with the PRC.

Components 3 and 4—Facility. The Polytrauma System of Care network was expanded in March, 2007, to include two new components of care: Polytrauma Support Clinic Teams (PSCT) and Polytrauma Points of Contact (PPOC). With their geographical distribution across the VA, the 75 Polytrauma Support Clinic Teams facilitate access to specialized rehabilitation services for veterans and active duty servicemembers at locations closer to their home communities. These interdisciplinary teams of rehabilitation specialists are responsible for managing the care of patients with stable treatment plans, providing regular follow-up visits, and responding to new medical and psychosocial problems as they emerge. The PSCT consults with their affiliated Polytrauma Network Site or Polytrauma Rehabilitation Center when more specialized services are required.

The remaining 54 VA medical centers have an identified Polytrauma Point of Contact who is responsible for managing consultations for patients with polytrauma and TBI, and assisting with referrals of these patients to programs capable of providing the appropriate level of services.

The Polytrauma Rehabilitation Centers and the Polytrauma Network Sites are linked through the Polytrauma Telehealth Network (PTN) that provides state-of-the-art multipoint videoconferencing capabilities. This Network ensures that polytrauma and TBI expertise are available throughout the system of care, and that care is provided at a location and time that is most accessible to the patient. This Network further provides such clinical activities that include remote consultations and evaluations of patients, and education for providers and families.

Coordination and Transition of Care

Care management across the entire continuum is a critical function in the Polytrauma System of Care to ensure lifelong coordination of services for patients recovering from polytrauma and TBI. Consistent, comprehensive procedures and processes have been put in place to ensure transition of patients from military treat-

ment facilities to VA care at the appropriate time, and under optimal conditions of safety and convenience for the patients and their families.

At the direction of the Secretary, 100 Transition Patient Advocates (TPAs) have been recruited nationwide. The TPAs contact the patient and family while in the Military Treatment Facility. One of their responsibilities is to ensure that all questions concerning VA are answered and the case is expedited through the VA benefits process. If necessary, the TPA will travel with the family and veteran from the MTF to their home, and provide transportation to all VHA appointments.

The VA assigns a care manager to every patient admitted within the VA Polytrauma System of Care. This care manager maintains scheduled contacts with veterans and their families to coordinate services and to address emerging needs. As an individual moves from one level of care to another, the care manager at the referring facility is responsible for a "warm hand off" to the care manager at the receiving facility closer to the veteran's home. The assigned care manager functions as the point of contact for emerging medical, psychosocial, or rehabilitation coordination of care, and provides patient and family advocacy.

To facilitate continuity of medical care, the Polytrauma Rehabilitation Center receives advanced notice of potential admissions to their sites. Upon notification, the PRC team initiates a pre-transfer review and follows the clinical progress until the patient is ready for transfer. PRC clinicians are able to complete pre-transfer review of the military treatment facility medical record, including up to date information about medications, laboratory studies, and daily progress notes. In addition to record review, clinician-to-clinician communication occurs to allow additional transfer of information and resolution of any outstanding questions.

DoD and VA also have made significant progress sharing available electronic health information to further coordinate care of these patients. DoD and VA are now supporting the electronic transfer of DoD inpatient data to VA clinicians at polytrauma centers. DoD is currently transferring DoD medical digital images and electronically scanned inpatient health records to the VA polytrauma centers from Walter Reed Army Medical Center, National Naval Medical Center Bethesda and Brooke Army Medical Center. This effort provides VA clinicians receiving these combat veterans with immediate access to critical components of their inpatient care at DoD military treatment facilities. In the future, VA hopes to add the capability to provide this data bidirectionally to support any patients returning to DoD for further care. Additionally, VA and DoD are supporting the secure direct connection of authorized providers at VA polytrauma centers into the health information systems at Walter Reed Army Medical Center and National Naval Medical Center. This direct connection provides the most timely access to much needed DoD clinical information in support of care of critically injured patients coming from combat theaters.

Psychosocial support for families of injured servicemembers is paramount as decisions are made to transition from the acute medical, life and death, setting of a military treatment facility to a rehabilitation setting. This encompasses psychological support, education about rehabilitation and the next setting of care, and information about benefits and military processes and procedures. VA social worker or nurse liaisons are located at 10 military treatment facilities, including our most frequent referral sources, Walter Reed Army Medical Center and National Naval Medical Center. These individuals provide necessary psychosocial support to families during the transition process, advising the families through the process. In addition, VA has a Certified Rehabilitation Registered Nurse assigned at Walter Reed Army Medical Center to provide education to the family on TBI, the rehabilitation process, and the PRCs. The Admission Case Manager from the PRC maintains personal contact with the family prior to transfer to provide additional support and further information about the expected care plan. VA also has Benefit liaisons located at the commonly referring military treatment facilities to provide an early briefing on the full array of VA services and benefits to the patients and families.

Upon admission to the PRC, the senior leadership of the facility personally meets the family and servicemember to ensure that they feel welcome and that their needs are being met. Additionally, a uniformed active duty servicemember is located at each PRC. The Army Liaison Officers support military personnel and their families from all Service branches by addressing a broad array of issues, such as travel, nonmedical attendant orders which pay for family members to stay at the bedside, housing, military pay, and movement of household goods. They are also able to advise on Medical Boards and assist with necessary paperwork.

The transition from the PRC to the home community is of critical importance to ensure that the treatment plan, including continued rehabilitation and medical care, psychosocial and logistical support is maintained. Records for VA medical care are readily available through remote access across the VA system. Follow up appointments are made prior to discharge, and the transferring practitioners are readily

available for personal contact with the receiving provider to ensure full and complete communication. Care managers at the Polytrauma Network Site and the home VA medical center provide for ongoing support and problem resolution in the home community, while continually assessing for new and emerging issues. Finally, each PRC team carefully assesses the expected needs at discharge for transportation, equipment, home modifications, and other such needs and makes arrangements for assessed needs.

Conclusion

The VA Polytrauma System of Care is a recognized leader in health care for its expertise in treating combat-related injuries, and managing the overlapping effects of combat stress response. Today, an expanded system of care is available to provide more services and to develop new, innovative approaches to these potentially debilitating conditions. Our clinicians and researchers strive to provide the highest standard of rehabilitation care for those recovering from polytrauma and TBI, while concurrently evaluating ways to enhance services. The VA continually assesses the unique needs of all polytrauma patients, and has responded decisively to the increased demand for services with this new generation of combat-injured veterans. The VA is committed to providing the necessary level of resources and scope of services that ensure a continuum of world-class, lifelong care extending from acute rehabilitation to vocational and transitional community rehabilitation programs for veterans at locations closer to their home communities.

Thank you for your time and attention. I will be glad to respond to any questions that you or other Members of the Committee may have.

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
October 24, 2007

Honorable Gordon H. Mansfield
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Mansfield:

On Tuesday, September 25, 2007, the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs held a hearing on VA's Polytrauma Rehabilitation Centers: Management Issues.

During the hearing, the Subcommittee heard testimony from William F. Feeley, Deputy Under Secretary for Operations and Management; and Elizabeth J. Freeman, Director of the Palo Alto Health Care System (PAHCS). Mr. Feeley was accompanied by Dr. Edward Huycke, Chief Department of Defense Coordination Officer for VHA; Dr. Lucille B. Beck, the Chief Consultant for Rehabilitation Services; Dr. Barbara Sigford, National Program Director for Physical Medicine and Rehabilitation; and Dr. Shane McNamee, Medical Director of the Richmond Polytrauma Rehabilitation Center. Ms. Freeman was accompanied by Dr. Lawrence Leung, Chief of Staff for the PAHCS; and Dr. Stephan Ezeji-Okoye, Deputy Chief of Staff for the PAHCS. As a follow-up to that hearing, the Subcommittee is requesting that the following questions be answered for the record:

1. Prior to the hearing, VA provided Subcommittee staff with a spreadsheet showing referrals to the PAHCS Polytrauma Rehabilitation Center (PRC). The spreadsheet included, along with other information, a column entitled "Referral Decision (Accepted or Declined)" and another entitled "Admission Date and Location." For patients listed in rows numbered 1, 3, 4, 12, 20, 34, 43, 47, 50, 57, 59, 70, 82, 91, 98, 102, 111, 121, 126, 127, 132, 137, 149, 150, 125, and 154, please provide information about the medical treatment of the patient subsequent to PAHCS PRC's decision to decline acceptance, including whether the patient was referred to/accepted by another medical facility and the outcome of any subsequent treatment.
2. Mr. Feeley testified at the hearing that, beginning with FY08, he will be receiving a report on the utilization of and disposition of referrals to each of the PRCs. Please provide the Subcommittee with a copy of the first two reports.
3. Please provide the Subcommittee with an update on the hiring of the Associate Chief of Staff for PAHCS's Polytrauma System of Care. In the event that

PAHCS has not yet hired someone for this position, please provide the Subcommittee periodic updates (not less than once every 2 months) on the hiring process.

4. Prior to the hearing, VA provided Subcommittee staff with PAHCS's list of polytrauma staffing requests, which included the ACOS for the overall program, the Polytrauma Medical Director, social workers, therapists, and others (a total of 38 FTEs). Please provide the status (*e.g.*, approved or not; advertised; position filled) for each one of these positions.
5. Each PRC currently has 12 beds. Given the continued operations in OIF/OEF. Is this a sufficient number of PRC beds?
6. In Secretary Nicholson's letter to House Committee on Veterans' Affairs Chairman Bob Filner informing the Chairman of the designation of San Antonio for the next Polytrauma Rehabilitation Center site, the Secretary stated that Audie Murphy VA Medical Center would be the host for the new PRC. Will the new PRC be located adjacent to the hospital or is it possible that the PRC will be placed at a location outside of the medical campus?
7. One of the major obstacles in funding of any project is how the administration prioritizes its proposed budget to Congress. The VA recently received $30 million toward the new San Antonio PRC as part of the Iraq supplemental bill enacted earlier this year. From what funding source does the Administration intend to request the additional $67 million needed to build the PRC?
8. When does the VA expect the new PRC to be operational? Is there any way, for example, by accelerating funding, to complete the project earlier?
9. In Dr. Feeley's testimony, it was mentioned that each Polytrauma Center has a physiatrist on staff. Are all centers staffed accordingly? What are critical staff vacancies at any of the PRCs that need to be filled? What is the process for hiring staff at such centers? What criteria are used to base the hiring decisions on for these positions? Please list all vacant positions during the last 180 days, and length of vacancies.
10. Please provide the Committee with a listing of the locations of the Polytrauma Support Clinic Teams (PSCT) and Polytrauma Points of Contact (PPOC).
11. On average how many patients are assigned to each care manager? Are the care managers able to handle their current caseloads, or does VHA need additional funding to increase the number of care managers at the VAMCs, particularly those with the Polytrauma units?
12. What is the relationship of the Palo Alto VAMC with the Department of Defense, and please provide the sharing agreement that is in place.
13. Does the PRC in Palo Alto use VTA/JPTA to track the patients being transferred from DoD?
14. When Subcommittee staff traveled to Palo Alto in August, one of the issues discussed was the transportation of patients from the East Coast Washington, DC Metro Area (Bethesda/Walter Reed) to the PRC, they were told much of this transport went through Travis Air Force Base. Please provide some specifics on how the transfer of patients occurs, *e.g.*, how the transfer works, who coordinates the transfer to VA, and patient medical care during travel. What problems have arisen during transfer of patients from the East Coast to the West Coast, and have there been problems with continuity of care en route? Furthermore, how well does the handoff from the Department of Defense work?

We request you provide responses to the Subcommittee no later than close of business, Monday, November 26, 2007.

If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Staff Director, Geoffrey Bestor, Esq., at (202) 225–3569 or the Subcommittee Republican Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

HARRY E. MITCHELL
Chairman

GINNY BROWN-WAITE
Ranking Republican Member

Questions for the Record
Hon. Harry E. Mitchell Chairman and Hon. Ginny Brown-Waite,
Ranking Republican Member
Subcommittee on Oversight and Investigations,
House Committee on Veterans' Affairs
September 25, 2007

VA's Polytrauma Rehabilitation Centers: Management Issues

Question 1: Prior to the hearing, VA provided Subcommittee staff with a spreadsheet showing referrals to the PAHCS Polytrauma Rehabilitation Center (PRC). The spreadsheet included, along with other information, a column entitled "Referral Decision (Accepted or Declined)" and another entitled "Admission Date and Location." For patients listed in rows numbered 1, 3, 4, 12, 20, 34, 43, 47, 50, 57, 59, 70, 82, 91, 98, 102, 111, 121, 126, 127, 132, 137, 149, 150, 152, and 154, please provide information about the medical treatment of the patient subsequent to PAHCS PRC's decision to decline acceptance, including whether the patient was referred to/accepted by another medical facility and the outcome of any subsequent treatment.

Response: The information requested includes personally identifiable information that is protected under the Privacy Act. Accordingly, this information will be provided to Chairman under separate cover.

Question 2: Mr. Feeley testified at the hearing that, beginning with FY08, he will bereceiving a report on the utilization of and disposition of referrals to each of the PRCs. Please provide the Subcommittee with a copy of the first two reports.

Response: Each polytrauma rehabilitation center (PRC) tracks bed census and submits a monthly report. The following is the summary report per site for the month of October 2007:

Average Weekly Bed Census—October 2007

PRC	Number of patients	Number of new admissions	Number of discharges	Number of new referrals	Number accepted/awaiting transfer	Not admitted	
						Needed a more appropriate level	Chose to go elsewhere
Richmond	11.5	2.5	1.5	5.5	3.0	2.0	.5
Tampa	16.0	1.5	1.0	6.0	5.25	0.5	0.75
Minneapolis	7.5	1.25	1.75	2.75	2.0	0.75	0.75
Palo Alto	8.25	0.25	0.5	1.0	1.75	0	0.5

Question 3: Please provide the Subcommittee with an update on the hiring of the Associate Chief of Staff (ACOS) for PAHCS's Polytrauma System of Care. In the event that PAHCS has not yet hired someone for this position, please provide the Subcommittee periodic updates (not less than once every 2 months) on the hiring process.

Response: Dr. Jerome Yesavage, Chief of Psychiatry at the VA Palo Alto Health Care System (PAHCS), is serving as the Chair of the Search Committee for the ACOS for Polytrauma and Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Program. The search Committee met for the first time on October 11, 2007, to review the general guidelines associated with the recruitment and interview process, and to establish the role of committee members. Additionally, Committee members reviewed the functional statement associated with the position, the vacancy announcements and advertisements, and performance based interview (PBI) questions.

Dr. Lawrence Leung, Chief of Staff at the VA PAHCS, stated in the October 11, 2007, search committee meeting that filling this position is of the highest priority. The search committee is conducting a national search and has advertised in several relevant journals.

The search committee's next meeting was held on Wednesday, December 12, 2007, at 10:00 a.m. At this meeting, search committee members prioritized the applications that have been received and ranked. The search committee plans on con-

ducting in-person interviews with the best qualified candidates the week of January 7, 2008.

Question 4: Prior to the hearing, VA provided Subcommittee staff with PAHCS's list of polytrauma staffing requests, which included the ACOS for the overall program, the Polytrauma Medical Director, social workers, therapists, and others (a total of 38 FTE's). Please provide the status (*e.g.*, approved or not; advertised; position filled) for each one of these positions.

Response: All 38 positions are approved.

Program	Position title	Status
Polytrauma System of Care (PSC)/OEF/OIF	ACOS for Polytrauma System of Care/OIF/OEF	Advertised, national search underway
PSC/OEF/OIF	Administrative Officer	Filled
PSC/OEF/OIF	Health Sys Specialist/Research Coordinator	On hold until ACOS search is complete
PRC—Inpatient	Nurse Educator	Advertised
PRC—Inpatient	Clinical Nurse Specialist	Advertised
PRC—Inpatient	Staff Physician (Pain Management)	Filled
PRC—Inpatient	Staff Physician (ENT Vestibular Specialist)	Filled
PRC—Inpatient	Staff Physician (Orthopedics)	Filled
PRC—Inpatient	Physical Therapist #4	Advertised
PRC—Inpatient	Physical Therapist #5 (evening/weekend)	Filled with contract staff
PRC—Inpatient	Physical Therapist #6 (evening/weekend)	Filled with contract staff
PRC—Inpatient	Physical Therapy Aide	Advertised
Polytrauma Unit	Physical Therapy Assistant	Advertised
PRC—Inpatient	Speech/Lang Path #4	Filled
PRC—Inpatient	Speech/Lang Path #5	Filled
PRC—Inpatient	Lead Recreation Therapist (Community/Volunteer Coord/Family Care Coord)	Advertised
PRC—Inpatient	Occupational Therapist #4	Advertised
PRC—Inpatient	Occupational Therapist #5 (evening/weekend)	Advertised
PRC—Inpatient	Massage Therapist—Health Technician	Filled with contract staff
PRC—Inpatient	Recreation Therapist #1 (Supervisor)	Advertised
PRC—Inpatient	Recreation Therapist #4	Advertised
PRC—Inpatient	Rec Therapist #5 (evening/weekend)	Advertised
PRC—Inpatient	*Family Therapist*—Social Worker (SocWk) **or** Clinical Psychologist (Psychology)	Advertised

Program	Position title	Status
PRC—Inpatient	*Staff Support*—Clinical Psychologist (Psychology) **or** Social Worker (SocWk)	Advertised
PRC—Inpatient	*Sexuality Therapist—specializing TBI*—Clinical Psychologist (Psychology) **or** Physician-Urologist (Surgical)	Advertised
OEF/OIF Program	Program Manager	Filled
OEF/OIF Program	Program Support Asst	Advertised
OEF/OIF Program	OIF/OEF Social Work Case Manager/Outreach Duty station: Palo Alto	Filled
OEF/OIF Program	OIF/OEF Social Work Case Manager/Outreach Duty station: San Jose/Monterey	Advertised
OEF/OIF Program	OIF/OEF Social Work Case Manager/Outreach Duty station: Livermore	Filled
OEF/OIF Program	OIF/OEF Nurse Case Manager Duty station: Livermore	Advertised
Polytrauma Network Site (PNS)—Outpatient	Physiatrist: Increase to 1.0	Advertised
PNS—Outpatient	Social Worker—Case Mgr	Filled
PNS—Outpatient	Psychologist (Neuro)	Filled
PNS—Outpatient	Occupational Therapist	Filled
PNS—Outpatient	Physical Therapist	Filled
PNS—Outpatient	Speech/Lang Path	Filled
PNS—Outpatient	Program Support Asst	Advertised
PNS—Outpatient	RN Case Manager	Advertised
PNS—Outpatient	Recreation Therapist	Advertised
PNS—Outpatient	Social Worker	Advertised
PSC	Supr. Orthotist Prosthetist (PAD)	Filled
	This represents a total of 38 FTE, as some positions will be part time	
Total 38		

Question 5: Each PRC currently has 12 beds. Given the continued operations in OEF/OIF, is this a sufficient number of PRC beds?

Response: Yes. Currently, there is a sufficient number of PRC beds, and bed capacity is increased as necessary. The PRCs at Minneapolis, Palo Alto and Richmond currently operate 12 beds. Tampa PRC increased capacity and began operating 18 beds on November 5, 2007. Average occupancy rate at the PRCs is 81.6 percent (range 62.5 percent–95.8 percent). Occupancy rate for October, 2007 is generally consistent with the trend observed during the last two quarters of fiscal year (FY) 2007. All four existing PRCs have the flexibility of using some of its comprehensive inpatient rehabilitation beds for patients with polytrauma/traumatic brain injury (TBI), if needed.

In addition to the four existing PRCs, construction of a new PRC in San Antonio is expected to be complete in December 2010.

Question 6: In Secretary Nicholson's letter to House Committee on Veterans' Affairs Chairman Bob Filner informing the Chairman of the designation of San Antonio for the next Polytrauma Rehabilitation Center site, the Secretary stated that Audie Murphy VA Medical Center would be the host for the new PRC. Will the new

PRC be located adjacent to the hospital or is it possible that the PRC will be placed at a location outside of the medical campus?

Response: The new PRC will be located on the medical center grounds.

Question 7: One of the major obstacles in funding of any project is how the administration prioritizes its proposed budget to Congress. The VA recently received $30 million toward the new San Antonio PRC as part of the Iraq supplemental bill enacted earlier this year. From what funding source does the Administration intend to request the additional $67 million to build the PRC?

Response: The new PRC in San Antonio will require $66 million in major construction funding. VA does not intend to request additional construction funds for the new PRC because section 230 of Div. I of the Consolidated Appropriations Act, 2008, rescinded $66 million from the Medical Services account appropriated by Public Law 110–28 and re-appropriated the $66 million to the Construction, Major Projects account.

Question 8: When does the VA expect the new PRC to be operational? Is there any way, for example, by accelerating funding, to complete the project earlier?

Response: Construction of the new PRC is expected to be completed in December 2010. The project will not likely be completed earlier, even with accelerated funding, due to time required to comply with government regulations and procedures, and to design, develop and build the PRC. The current project schedule is as follows:

Activity	Date
Architect & Engineer (AlE) Advertisement (completed)	10/07
Select AE Team	2/08
Award AlE Contract	4/08
Begin Schematic Design	4/08
Complete Schematic Design	8/08
Begin Design Development	8/08
Complete Design Development	12/08
Begin Construction Documents	12/08
Complete Construction Documents	4/09
Award Construction Contract	6/09
Complete Construction*	12/10

*18 month anticipated construction contract

Question 9: In Mr. Feeley's testimony, it was mentioned that each Polytrauma Center has a physiatrist on staff. Are all centers staffed accordingly? What are critical staff vacancies at any of the PRCs that need to be filled? What is the process for hiring staff at such centers? What criteria are used to base the hiring decisions on for these positions? Please list all vacant positions during the last 180 days, and length of vacancies.

Response: The four PRCs have a full time physiatrist, who leads the interdisciplinary rehabilitation team. Veterans Health Administration (VHA) Directive 2005–024 *Polytrauma Rehabilitation Centers* recommends a staffing model with 36 dedicated positions representing all rehabilitation specialty areas. The PRCs have had stable dedicated teams, with occasional vacancies as listed in the table below.

Core PRC Staffing Vacancies

Core PRC Staff Type	Target 36 positions	Palo Alto		Minneapolis		Richmond		Tampa	
		# vacant in last 180 days	# mths vacant	# vacant in last 180 days	# mths vacant	# vacant in last 180 days	# mths vacant	# vacant in last 180 days	# mths vacant
Physiatrist	1	0	0	0	0	0	0	0	0
RN's	11	0	0	0	0	0	0	0	0
LPN's/CNA's	8	0	0	0	0	0	0	0	0
Admission & F/U CRRN Case Manager	1	1	1	0	0	0	0	1	4
Counseling Psychologist	1	1	5	0	0	0	0	0	0
Neuropsychologist	3	0	0	0	0	0	0	0	0
SW Case Manager	3	1	6	0	0	0	0	0	0
Physical Therapist	2.5	1	3	1	4	0	0	0	0
Occupational Therapist	2.5	2	3	0.5	1	0	0	0	0
Speech Therapist	2	0	0	0	0	0	0	0	0
Recreation Therapist	2	2	0	0	0	0	0	0	0
BROS	1	0	0	0	0	1	3	0	0
Total	**36**	**8**		**1.5**		**1**		**1**	

Hiring actions for PRCs follow guidelines established by the Office of Human Resource Management, and hiring is based on the applicants' qualifications and specialized experience. Recruiting efforts typically include internal and external job postings, specialized advertising in trade publications, and local newspaper advertising that feature information about the rewarding work of the PRCs.

Question 10: Please provide the Committee with a listing of the locations of the Polytrauma Support Clinic Teams (PSCT) and Polytrauma Points of Contact (PPOC).

Response:

Regional Polytrauma/TBI Rehab Center	VISN	Polytrauma/ TBI Network Site	Polytrauma/ TBI Support Clinic Teams	Polytrauma/ TBI Point of Contact
Richmond	VISN 1	Boston	West Haven Togus White River	Bedford Manchester Providence North Hampton
	VISN 2	Syracuse	Albany Buffalo Bath Canandaigua	

Regional Polytrauma/TBI Rehab Center	VISN	Polytrauma/ TBI Network Site	Polytrauma/ TBI Support Clinic Teams	Polytrauma/ TBI Point of Contact
	VISN 3	Bronx	Hudson Valley HCS/ Montrose Hudson Valley HCS/Castlepoint NJHCS/East Orange NJHCS/Lyons NY Harbor HCS/New York NY Harbor HCS/Brooklyn NY Harbor HCS/St Albans Northport VAMC	**All facilities in VISN 3 have appropriate service levels to be classified as at least a Polytrauma Support Clinic Team.
	VISN 4	Philadelphia	Pittsburgh Wilmington Erie Lebanon Coatesville Altoona Butler Wilkes-Barre	Clarksburg
	VISN 5	Washington, DC	Baltimore Martinsburg	**All facilities in VISN 5 have appropriate service levels to be classified as at least a Polytrauma Support Clinic Team.
	VISN 6	Richmond	Hampton Salisbury Durham	Ashville Beckley Fayetteville Salem
Tampa	VISN 7	Augusta	Tuscaloosa Columbia Charleston Atlanta Birmingham	Dublin Tuskegee
	VISN 8	Tampa San Juan	Bay Pines Gainesville Miami West Palm	Orlando
	VISN 9	Lexington	Huntington Louisville Memphis TVHC–Nashville TVHC–Murfeesboro TVHC–Mountain Home	**All facilities in VISN 9 have appropriate service levels to be classified at least a Polytrauma Support Clinic Team.
	VISN 16	Houston	Alexandria Jackson Central Arkansas-Little Rock Muskogee Shreveport	Gulf Coast (Biloxi) Fayetteville, AR New Orleans Oklahoma City Waco
	VISN 17	Dallas	Temple San Antonio	Kerrville

Regional Polytrauma/TBI Rehab Center	VISN	Polytrauma/ TBI Network Site	Polytrauma/ TBI Support Clinic Teams	Polytrauma/ TBI Point of Contact
Palo Alto	VISN 18	Southern Arizona HCS (Tucson)	New Mexico HCS–Albuquerque	Amarillo West Texas HCS (Big Spring) El Paso Northern Arizona HCS (Prescott) Phoenix
	VISN 19	Denver	Salt Lake Grand Junction	Cheyenne Montana HCS–Ft. Harrison Sheridan
	VISN 20	Seattle	Portland Boise	Alaska American Lake Roseburg Spokane Walla Walla White City
	VISN 21	Palo Alto	Sacramento San Francisco	Sierra Nevada HCS Honolulu Manila Central California HCS (Fresno)
	VISN 22	West LA	Long Beach San Diego Loma Linda	Southern Nevada HCS Sepulveda
Minneapolis	VISN 10	Cleveland	Cincinnati Dayton	Columbus Chillicothe
	VISN 11	Indianapolis	Detroit Danville (Iliana) Ann Arbor	Battle Creek NICHS–Marion Saginaw
	VISN 12	Hines	Milwaukee North Chicago Tomah Madison Chicago HCS (Jesse Brown)	Iron Mountain
	VISN 15	St. Louis	Kansas City	Wichita Poplar Bluff Columbia, MO Eastern Kansas/Topeka Marion
	VISN 23	Minneapolis	Sioux Falls Black Hills Iowa City Central Iowa-Knoxville	Fargo St. Cloud Central Iowa-Des Moines Greater Nebraska-Grand Island Greater Nebraska-Lincoln Omaha

Question 11: On average how many patients are assigned to each care manager? Are the care managers able to handle their current caseloads, or does VHA need

additional funding to increase the number of care managers at the VAMCs, particularly those with the Polytrauma units?

Response: A ratio of one social worker care manager to six polytrauma inpatients is the established standard determined to be sufficient to ensure appropriate care management of OEF/OIF inpatients (VHA Directive 2006–043 *Social work case management in VHA Polytrauma Centers).* The PRC staffing model is consistent with this recommended ratio, and the social worker case manager to patient ratio at the PRCs ranged from 1:3 to 1:6 in October 2007.

Question 12: What is the relationship of the Palo Alto VAMC with the Department of Defense, and please provide the sharing agreement that is in place.

Response: VA Palo Alto Health Care System (PAHCS) has a longstanding relationship with the Department of Defense (DoD). VA PAHCS has served as one of four lead traumatic brain injury (TBI) centers and as a Defense and Veterans Brain Injury Center (DVBIC) site since 1992. The mission of DVBIC is to serve active duty military, their dependents and veterans with TBI through state-of-the-art medical care, innovative clinical research initiatives and educational programs. In 2005, VA PAHCS was designated as a PRC and has continued to build a relationship with DoD. VA liaisons, located at each military treatment facility (MTF), play a central role in facilitating referrals to the PRC as well as participating in a pre-transfer video teleconferences for patients, families, and the treatment teams to discuss pertinent clinical or psychosocial challenges. The Palo Alto PRC program director continues to build relationships with MTF referring physicians. The Walter Reed Army Medical Center (WRAMC) Physical Medicine and Rehabilitation Director works directly with the PRC program director to ensure a smooth transition during patient transfers. VA's PAHCS PRC program director and chief of neurosurgery are in direct and frequent communication with the neurosurgeon at National Naval Medical Center (NNMC), regarding patients transferring between the two medical centers. The Palo Alto PRC program director visited NNMC and WRAMC on November 7 to continue to enhance the working relationships with the referring physicians.

The Memorandum of Agreement is attached (see Attachment 1 at the end).

Question 13: Does the PRC in Palo Alto use VTA/JPTA to track the patients being transferred from DoD?

Response: The PRC receives an e-mail notification from the VA liaison to access veterans tracking application (VTA) for severely injured servicemembers for admission to the PRC. These patients are contacted and assigned a PRC case manager within 7 days. Through the joint patient tracking application (JPTA), the PRC military liaison can view the servicemember's status, location (operating room/emergency room/intensive care unit), date of status, facility location (combat support hospital, medical brigade, Landstuhl Regional Medical Center (LRMC), WRAMC) and view the dates of the evacuation transport itinerary. The PRC military liaison uses VTA in much the same way to view notes annotating the servicemember's record through their transition (combat support hospital, medical brigade, LRMC, etc.).

Question 14: When Subcommittee staff traveled to Palo Alto in August, one of the issues discussed was the transportation of patients from the East Coast Washington, DC Metro Area (Bethesda/Walter Reed) to the PRC, they were told much of this transport went through Travis Air Force Base. Please provide some specifics on how the transfer of patients occurs, *e.g.*, how the transfer works, who coordinates the transfer to VA, and patient medical care during travel. What problems have arisen during transfer of patients from the East Coast to the West Coast, and have there been problems with continuity of care en route? Furthermore, how well does the handoff from the Department of Defense work?

Response: Transfers from WRAMC and NNMC to the Palo Alto's VA PRC are coordinated by DoD Military staff through the Med Evac system at the MTF. The VA liaison at the MTF communicates with the MTF treatment team when servicemembers/veterans are accepted for admission to Palo Alto. DoD coordinates the transportation through military staff and information such as the accepting VA physician's name and contact number, receiving ward and contact number as well as a 24 hour travel number at the receiving PRC is provided at the time of coordination.

The point of contact at the accepting PRC or the transportation coordinator arranges for transportation from the Air Force Bases (AFB) to the PRC. For example, once the flight arrives at Travis AFB, patients are often kept overnight to assess how the patient tolerated the flight and to allow the patient to rest as it is approximately a 3 hour drive to the Palo Alto PRC. To further enhance the transportation

process from the East Coast MTFs to Palo Alto PRC, both WRAMC and NNMC have recently made arrangements to include staff from Travis AFB on the video teleconferences that take place with the PRC prior to the patient's transfer. Palo Alto PRC does not report any problems with continuity of care in between DoD and VA. The major challenge is pain management due to the length of the trip.

VA defers to DoD for more specific details regarding procedures and processes associated with their Med Evac system.

ATTACHMENT 1
MEMORANDUM OF AGREEMENT

Department of Veterans Affairs (VA) and Department of Defense (DoD) Memorandum of Agreement (MOA) Regarding Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services

1. **PURPOSE:** This document establishes procedures regarding active duty military personnel with spinal cord injury (SCI), traumatic brain injury (TBI), or blindness treated at VA medical facilities under direct resource sharing agreements under the authorities noted in paragraph 2. Active duty military personnel will receive timely and high quality specialty care within a continuum of health care dedicated to the needs of persons with SCI, TBI, and blindness. Note: This MOA does not pertain to the transfer of active duty military personnel to VA facilities for care or treatment related to alcohol or drug abuse or dependence in accordance with Title 38 U.S.C §620A(d)(l). This MOA pertains to direct resource sharing agreements only, and not to agreements between the VA and TRICARE Managed Care Support Contractors (MCSCs).

2. **AUTHORITIES:**

   a. Department of Veterans Affairs (VA) and Department of Defense (000) Health Resources Sharing and Emergency Operations Act (38 U.S.C. §8111)
   b. Section 3–105 of the VA/DoD Health Care Resource Sharing Guidelines of July 29, 1983.

3. **BACKGROUND:** There has been a longstanding MOA between VA and DoD associated with specialized care for active duty sustaining BCI, TBI, and blindness. VA is known for its integrated system of health care for these conditions. The VA/DoD Health Executive Council has identified the need for referral procedures governing the transfer of active duty military inpatients from military or civilian hospitals to VA medical facilities, and the treatment of active duty military patients at such facilities. This MOA supersedes all previous VA/DoD MOAs relating to active duty military referrals to VA health care facilities for TBI, SCI, and blindness.

4. **DoD RESPONSIBILITIES:**

   a. Care management services will be provided by the Military Medical Support Office (MMSO), the appropriate Military Treatment Facility (MTF), and the admitting VAMC as a joint collaboration as appropriate to each individual servicemember's case. The referring MTF and the VA health care facility shall notify MMSO when a member is referred for care under this agreement. MMSO will provide any required care authorizations relating to care provided under this MOA once the member is admitted to a VA facility.
   b. The referring MTF will identify and contact the VA TBI (Appendix A), SCI (Appendix B), or Blind Rehabilitation Center (Appendix C) as soon as possible to begin the referral process, to present the case, and to gain admission approval. The medical and administrative personnel of the MTF must establish immediate contact with their counterparts at the designated VA health' care facility to discuss and make specific arrangements. Whenever possible the VA health care facility closest to the active duty member's home of record or location selected by the active duty member, guardian, conservator, or designee should be contacted first. The servicemember's command ordinarily determines whether the servicemembers injury and/or condition occurred while in the line of duty and not due to own misconduct which may affect eligibility for VA health care according to provisions of Title 38 U.S.C. Chapter 17.

c. The referring MTF will provide a copy of all pertinent patient medical record documentation requested by the VA health care facility needed to make a medical decision. This includes the patient's history and physical, diagnostics, laboratory findings, hospital course, daily documentation of progress, etc. When the VA facility accepts a patient, the referring DoD/MTF case manager will provide the VA case manager with current clinical information along with the case management plan of care and discharge plan.

d. Pre-requisites for transfer, in addition to identifying an accepting staff physician at the VA health care facility, are stabilization of the patient's injuries and, the acute management of the medical and physiological conditions associated with the Sel, TBI, or blindness. Stabilization is an attempt to prevent additional impairments while focusing on prevention of complications. The criteria for the transfer of patients with SeI, TBI, or blindness require:
   1. Attention to ailWay and adequate oxygenation;
   2. Treatment of hemorrhage, no evidence of active bleeding;
   3. Adequate fluid replacement;
   4. Maintenance of systolic blood pressures (>90 mm mercury hydrargyrum (Hg));
   5. Foley catheter placement, when appropriate, with adequate urine output;
   6. Use of an asogastric tube, if paralytic ileus develops;
   7. Maintenance of spinal alignment by immobilization of the spine, or adequate stabilization to prevent further neurologic injury (traction, tongs and traction, halo-vest, hard cervical collar, body jacket, etc.); and
   8. Approval by the SCI Center Chief, TBI Center Medical Director or Designee, or Blind Rehabilitation Chief in consultation with other appropriate VA specialty care teams.

e. The referring MTF must notify the VA health care facility of any changes in medical status. Patients are not to be transferred if there is:
   1. Deteriorating neurologic function; incomplete;
   2. An inability to stabilize the spine, especially if the neurologic injury is
   3. Bradyarrhythmias are present;
   4. An inability to maintain systolic blood pressure >90 mm Hg;
   5. Acute respiratory failure is present; or
   6. New onset of fever, infection and/or change in medical status (e.g., deteriorating physiological status).

f. Following the VA health care facility's agreement to accept the patient, the MTF commander or designee is responsible for arranging transportation to the VA facility in accordance with governing policies for movement of patients. This normally will include notifying and submitting a patient movement request to the Global Patient Movement Requirements Center (GPMRC), or when overseas, to the Theater Patient Movement Requirement Center (TPMRC), without regard to weekend or holiday, to schedule the transport of the patient from either an MTF or a civilian hospital. If the patient is moved by other than an Air Force aircraft or is an emergency patient, information reported to GPMRC will be the minimum required to allow GPMRC to develop referral patterns. This notification may be made after the fact for emergency patients.

g. The MTF commander and GPMRC are responsible for coordination with the receiving VA facility for ground transportation from the airfield to the VA facility. Whenever possible, the originating MTF should arrange with any MTF within a reasonable distance to provide needed transportation. If that is not possible, the receiving VA health care facility shall obtain appropriate local transportation. NOTE: DoD will be responsible for payment of any costs incurred by VA for the transport of active duty personnel.

h. To ensure optimal care, active duty patients are to go directly to a VA medical facility without passing through a transit military hospital.

i. In emergencies, GPMRC will expedite transfers from MTFs or civilian hospitals to VA facilities through telephone communications. MTFs will report directly to the GPMRC for CONUS transfers, but MTFs will report to the TPMRC at Ramstein Air Base, or to the TPMRC at Yokota Air Base for a-CONUS transfers. The TPMRC will then coordinate with the GPMRC for transportation. An after-the-fact report will be made to GPMRC within 48 hours.

j. DoD will ensure meeting the goal of transfer within 3 days (4 days from overseas), whenever the patient's medical condition permits, but not ex-

ceeding 12 days. The ability to complete medical review board processing is not a prerequisite for transfer to a VA medical facility.

k. DoD will assure that each Surgeon General's office or her/his designee provides necessary assistance to VA facilities in the preparation and transmittal of the patient's medical boards or as a point of contact should problems arise.

l. DoD will assure that the appropriate Service provide telephone and written notification to VA facilities when active duty members are discharged or released from active duty. This notification shall be made before the separation date and will include the date, type of separation, and the periods of active duty served. The DD214 will be provided to VA in a timely manner.

5. **VA RESPONSIBILITIES:**

a. The Rehabilitation Services Chief Consultant and the Spinal Cord Injury and Disorders Chief Consultant will provide annually to DoD, a list of VA Spinal Cord Injury Centers, Traumatic Brain Injury Lead Centers, and Blind Rehabilitation Centers including their telephone numbers and points of contact. These lists will be updated if changes occur.

b. The Veterans Integrated Service Network (VISN) Directors will adhere to policies in this MOA.

c. The designated VA facility with an SCI Center, TBI Center, or Blind Rehabilitation Center will assist military authorities in the following manner:

1. Respond (following receipt of necessary medical records) to requests for admission from military medical authorities or their designees without regard to weekends or holidays. NOTE: Concurrent notification of the GPMRC will be provided.
2. Accept appropriate active-duty patients without regard to hour of the day, day of the week, or holidays. NOTE: The acceptance of local transfers from MTFs to VA facilities should be mutually agreed upon. At MTF's where VA staff are assigned, the VA/DoD Social Worker liaison will assist with the transfer.
3. Coordinate the transfer of active duty patients to VA health care facilities with the MTFs and GPMRC. NOTE: Concurrent notification of the GPMRC will be provided.
4. Coordinate with civilian hospitals and GPMRC so that active duty patients, who are ready for transfer to a VA specialty care center are transported directly from a civilian hospital to the appropriate VA facility.
5. Assist the MTF in identifying the most appropriate VA SCI, TBI, or Blind Rehabilitation Center. Active duty patients need to be referred to the designated VA medical facility closest to the active duty member's home of record or location selected by the active duty member, guardian, conservator, or designee, subject to availability of beds. If the preferred Center is unable to accept the patient, that VA medical facility will assist in locating an appropriate placement. NOTE: The Chief Consultant, Rehabilitation Services, or Chief Consultant, SCI&D Services, VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420, will assist when necessary.
6. The accepting VA staff physician will review military transportation arrangements and make recommendations if it is believed that the patient's care will be compromised due to delays or other clinical considerations. VA will assist referring military authorities and GPMRC in coordinating the medically indicated mode of transportation and arranging local ground transportation to VA facilities, such as from local airfields.
7. Provide immediate notification to the appropriate MTF Case Manager and MMSO, when an active duty member is admitted. The VA will assign a case manager responsible for coordinating care through a continuum of health care services for each member admitted. The VA case manager will provide the DoD/MTF case manager periodic updates, no less than once a month depending on the acuity or complexity of the case, until the medical determination or the medical board process is complete. This continued coordination is necessary to aid in communication to the DoD, primary care manager, command, other program managers, and medical board personnel.
8. Coordinate the hospital discharge of an active duty member with the appropriate MTF and the Military Medical Support Office (MMSO).

9. Assist with medical boards when requested by the military authority having cognizance over the member.
10. Notify DoD of the active duty member's absences, medical discharge, and change of location.
11. Prior to discharge, the VAMC where the patient is being treated will facilitate the patient appropriately enrolling to TRICARE in the region of his/her final destination.

6. **PROGRAM DESCRIPTIONS:**

a. Spinal Cord Injury and Disorders: The mission of the Spinal Cord Injury and Disorders Program within VA is to promote the health, independence, quality of life, and productivity of individuals with spinal cord injury and disorders. There are twenty SCI Centers available throughout VA to provide acute rehabilitative services to persons with new onset SCI (see Appendix B). VA offers a unique system of care through SCI Centers, which includes a full range of health care for eligible persons who have sustained injury to their spinal cord or who have other spinal cord lesions. Persons served in these centers include those with: stable neurological deficit due to spinal cord injury, intraspinal, nonmalignant neoplasms, vascular insult, cauda equina syndrome, inflammatory disease, spinal cord or cauda equina resulting in nonprogressive neurologic deficit, demyelinating disease limited to the spinal cord and of a stable nature, and degenerative spine disease.

b. Traumatic Brain Injury: VA offers a full range of traumatic brain injury rehabilitation to ensure that military and veteran personnel with brain injuries receive coordinated, comprehensive care. The goal is to return the brain injury survivor to the highest level of function and to educate family and caregivers in the long-term needs of the patient. VA has four lead Traumatic Brain Injury Centers (see Appendix A). These facilities provide comprehensive assessment, medical care, TBI specific acute rehabilitation, access to state of the art treatment, clinical trials, and leadership for a nationwide system of TBI care through case management. Each participating medical center has a designated TBI case manager who facilitates patient participation in the program and expedites facility transfers and community placement. Persons served in these Centers and covered under this MOA include individuals sustaining a brain injury caused by an external physical force resulting in open and closed injuries, and damage to the central nervous system resulting from anoxic/hypoxic episodes, related to trauma or exposure to chemical or environmental toxins that result in brain damage. This MOA does not include brain injuries/insult related to chronic illnesses (i.e., hypertension, tumors, diabetes, etc.). Patients with other acquired brain injury due to chronic disease or infectious processes are not covered under this MOA, but are eligible for care in these centers.

c. Blind Rehabilitation: Blind Rehabilitation Service offers a coordinated educational training and health care service delivery system that provides a continuum of care for veterans with blindness that extends from their home environment, to the local VA facility, to the appropriate rehabilitation setting. These services include adjustment to blindness counseling, patient and family education, benefits analysis, assistive technology, outpatient programs, and residential inpatient training. There are ten residential, inpatient VA Blind Rehabilitation Centers (BRCs) (see Appendix C). The mission of each BRC program is to educate each veteran on all aspects of Blind Rehabilitation and address the expressed needs of each veteran with blindness so they may successfully reintegrate back into their community and family environment. To accomplish this mission, BRCs offer a comprehensive, individualized adjustment-training program along with those services deemed necessary for a person to achieve a realistic level of independence. BRCs offer a variety of skill courses including: orientation and mobility, communication skills, activities of daily living, manual skills, visual skills, leisure skills, and computer access training. The veteran is also assisted in making an emotional and behavioral adjustment to blindness through individual counseling sessions and group therapy meetings. Each VA medical center has a Visual Impairment Services Team Coordinator who has major responsibility for the coordination of all services for visually impaired veterans and their families. Duties include arranging for the provision of appropriate treatment modalities (*e.g.* referrals to Blind Rehabilitation Centers and/or Blind Rehabilitation Outpatient Specialists) and being a resource for all local service delivery systems in order to enhance the func-

tioning level of veterans with blindness. Referrals can be directed to the Program Analyst in the Blind Rehabilitation Program Office in the VA Central Office at 202–273–8482.

7. **DURATION:**
   a. This MOA will remain in force unless terminated at the request of either party after thirty (30) days written notice. In event this MOA is terminated, DoD shall be liable only for payment in accordance with provisions of this agreement for care provided before the effective termination date.
   b. This agreement supersedes all local resource sharing agreements.
8. **REIMBURSEMENT:**
   a. DoD will reimburse CHAMPUS Maximum Allowable Charge (CMAC) rates less 10 percent (CMAC–I 0%) for outpatient and professional care. Inpatient care will be reimbursed using the VA interagency rates approved by the Office of Management and Budget, which is periodically updated. Updates are provided via a Federal Register Notice. Although the Federal Register Notice indicates that the interagency billing rates do not apply to sharing agreements between VA and DoD, it has been determined that these rates are appropriate for care provided under this MOA. VAMCs will provide all documentation required for billing medical claims. At a minimum, this will include an itemized bill for each member on Form CMS 1500 for outpatient/professional services and Form DB 92 for inpatient services. Transportation, prosthetics, durable medical equipment, orthotics, dental services, home care, personal care attendants and extended care/nursing home care will be billed at the interagency rate if one exists, or at actual cost as appropriate.
   b. VA facilities providing care to active duty servicemembers in accordance with this agreement will be paid by the TRICARE Managed Care Support Contractors (MCSCs). Claims should be forwarded to the MCSC for the TRICARE Region to which the member is enrolled in TRICARE Prime. If the member is not enrolled, the claim will be paid by the regional MCSC where the member resides. Prior to paying a claim, MCSCs will verify that the care is payable through MMSO. MMSO can be reached at 888–647–6676, P.O. Box 88699, Great Lakes, IL 60088–6999.
   c. The VAMC will obtain authorization for non-network care from MMSO for the billing to go to the VAMC and be forwarded to the MCSC for payment. This is particularly applicable if there are no TRICARE providers, MTFs, or VAMCs/clinics capable of providing the needed services in the destination area.
   d. VA facilities should send claims for payment to:
      - North Region: North Region Claims, PGBA, P.O. Box 870140, Surfside Beach, SC 29587–9740.
      - South Region: TRICARE South Region, Claims Department, P.O. Box 7031, Camden, SC 29020–7031.
      - West Region: WPS/West Region Claims, P.O. Box 77028, Madison, WI 53707–7028.
9. **EFFECTIVE DATE:** This MOA is effective 1 January 2007.

William Wikenwerder, Jr., M.D.
Assistant Secretary for Health Affairs
Department of Defense
Date: 27 November 2006

Michael J. Kussman, MD, MS, MACP
Acting Under Secretary for Health
Department of Veterans Affairs
Date: 13 December 2006

VA–DoD MOA Appendix A

TRAUMATIC BRAIN INJURY (TBI) CENTERS ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Minneapolis VA Medical Center (117), One Veterans Drive, Minneapolis, MN 55417, Telephone 612–467–3562.

2. VA Palo Alto HCS (117), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650–447–7114.
3. HH McGuire VA Medical Center (117), 1201 Broad Rock Boulevard, Richmond, VA 23249, Telephone 804–675–5332.
4. James A. Haley VA Medical Center (117), 13000 Bruce B. Downs Blvd., Tampa, FL 33612–4798, Telephone 813–972–7668 or 1–866–659–2156.

VA–DoD MOA Appendix B

SPINAL CORD INJURY (SCI) CENTERS ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Department of Veterans Affairs (VA) New Mexico Health Care System (HCS) (128), 1501 San Pedro Southeast, Albuquerque, NM 87108, Telephone 505–256–2849.
2. Augusta VA Medical Center (128), One Freedom Way, Augusta, GA 30904–6285, Telephone 706–823–2216.
3. VA Boston HCS (128), 1400 VFW Parkway, West Roxbury, MA 02132, Telephone 617–323–7700 Extension 5128.
4. VA Medical Center (128), 130 West Kingsbridge Road, Bronx, NY 10468.
5. Louis Stokes VA Medical Center (128W), 10701 East Boulevard, Cleveland, OR 44106.
6. VA North Texas HCS (128), 4500 South Lancaster Road, Dallas, TX 75216.
7. Edward Hines, Jr. VA Medical Center (128), Fifth Avenue and Roosevelt Road, Hines, IL.
8. Houston VA Medical Center (128), 2002 Holcombe Boulevard, Houston, TX 77030–4298.
9. VA Long Beach RCS (128), 5901 East 7th Street, Long Beach, CA 90822.
10. VA Medical Center (128), 1030 Jefferson Avenue, Memphis, TN 38104.
11. VA Medical Center (128), 1201 Northwest 16th Street, Miami, FL 33125.
12. Clement J. Zablocki VA Medical Center (128),5000 West National Avenue, Milwaukee, WI 53295, Telephone 414–384–2000 Extension 41230.
13. VA Palo Alto HCS (128), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650–493–5000 Extension 65870.
14. HH McGuire VA Medical Center (128), 1201 Broad Rock Boulevard, Richmond, VA, Telephone 804–675–5282.
15. South Texas Veterans HCS (128), 7400 Meront Minter Blvd., San Antonio, TX 78284, Telephone 210–617–5257.
16. VA San Diego HCS (128), 3350 La Jolla Village Drive, San Diego, CA 92161, Telephone 858–642–3117.
17. VA Medical Center (128), 10 Casia Street, San Juan, PR 00921–3201, Telephone 787–641–7582 Extension 14130.
18. VA Puget Sound RCS (128), 1660 South Columbian Way, Seattle, WA 98108–1597, Telephone 206–764–2332.
19. Saint Louis VA Medical Center (128JB), One Jefferson Barracks Drive, St. Louis, MO 63125, Telephone 314–894–6677.
20. James A. Haley VA Medical Center (128), 13000 Bruce B. Downs Blvd., Tampa, FL 33612–4798, Telephone 813–972–7517.

VA–DoD MOA Appendix C

BLIND REHABILITATION CENTERS (BRC) ACCEPTING DEPARTMENT OF DEFENSE REFERRALS

1. Augusta VA Medical Center (324), One Freedom Way, Augusta, GA 30904–6285, Telephone 706–733–0188 Extension 6660.
2. Birmingham VA Medical Center (124), 700 South 19th Street, Birmingham, AL 35233, Telephone 205–933–8 101.
3. Edward Hines, Jr. VA Medical Center (124), Fifth Avenue and Roosevelt Road, Hines, IL 60141–5000, Telephone 708–202–8387 Extension 22112.
4. Central Texas VA Health Care System, 1901 Veterans Memorial Drive, Temple, TX 76504, Telephone 254–297–3755. Blind Rehabilitation Center, 4800 Memorial Drive, Waco, TX 76711. Telephone 254–297–3755.
5. San Juan VA Medical Center (124), 10 Casia Street, San Juan, PR 00921–3201, Telephone 787–641–8325.

6. Southern Arizona VA Health Care System (3–124),3601 South 6th Avenue, Tucson, AZ 85723, Telephone 520–629–4643.
7. VA Connecticut Health Care System (124), West Haven Campus, 950 Campbell Avenue, West Haven, CT 06516, Telephone 203–932–5711 Extension 2247.
8. VA Palo Alto RCS (124), 3801 Miranda Avenue, Palo Alto, CA 94304, Telephone 650–493–5000 Extension 64218.
9. VA Puget Sound RCS (124), 1660 South Columbian Way, Seattle, WA 98108–1597, Telephone 253–583–1203. (A–l12–BRC), American Lake Division, 9600 Veterans Drive, Tacoma, WA 98493, Telephone: 253–983–1299.
10. West Palm Beach VA Medical Center (124), 7305 North Military Trail, West Palm Beach, FL 33410–6400, Telephone 561–422–8425.

[Federal Register: January 7, 2004 (Volume 69, Number 4)] [Notices]

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OFFICE OF MANAGEMENT AND BUDGET

Charges to Tortiously Liable Third Parties for Hospital, Medical, Surgical, and Dental Care and Treatment Furnished by the United States (Department of Veterans Affairs)

AGENCY: Office of Management and Budget, Executive Office of the President.

ACTION: Notification of charges to tortiously liable third parties for hospital, medical, surgical, and dental care and treatment furnished by the Department of Veterans Affairs.

SUMMARY: By virtue of the authority vested in the President by section 2(a) of the Federal Medical Care Recovery Act, Public Law 87–693 (76 Stat. 593; 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970 (35 FR 10737), the charges to tortiously liable third parties for hospital, medical, surgical, and dental care and treatment (including prostheses and medical appliances) furnished by the Department of Veterans Affairs are the "reasonable charges" generated by the methodology set forth in 38 CFR 17.101 and published from time to time in the Federal Register, most recently on April 29, 2003 (68 FR 22774). These charges are for use in connection with the recovery from tortiously liable third persons of the reasonable value of hospital, medical, surgical, and dental care and treatment furnished by the United States through the Department of Veterans Affairs (28 CFR 43.1–43.4). These charges have been established in accordance with the requirements of OMB Circular A–25, which requires charges that are at least as great as the full cost of the services provided.

There are two basic reasons for this change. First, VA's community-based "reasonable charges" more accurately reflect the reasonable value of the medical care and treatment furnished by VA to the injured person, consistent with 42 U.S.C. 2651 and 2652, than do VA's cost-based per-diem tort rates.

Second, VA's present dual-rate billing system (tort feasor and health plan), using significantly different charges, is confusing and difficult to justify. VA claims, for example, may be made both against the tort feasor who caused the injury, using the current FMCRA per-diem rates, and against the veteran's health plan, using the significantly higher reasonable charges, for the same VA medical care. This not only is confusing to VA billing officials and makes settling claims more difficult, but such dual billing also may disadvantage veterans by providing a per-diem rate bill to assert against the tort feasor while exposing veterans to subrogation claims from their health plans who paid at the higher reasonable charges rates. Making the charges billed to all liable parties in FMCRA cases uniform will eliminate confusion and remove an impediment to allowing injured veterans to assert the higher reasonable charges rates for their causally related health care as a necessary and proper element of damages in their cases against the responsible tort feasors.

Beginning on January 7, 2004, the charges prescribed herein supercede those established by the Director of the Office of Management and Budget for the Department of Veterans Affairs on November 1, 1999 (64 FR 58862).

Joshua B. Bolten, Director.

[FR Doc. 04–317 Filed 1–6-04; 8:45 am]

BILLING CODE 3110–01–P

OFFICE OF MANAGEMENT AND BUDGET
DEPARTMENT OF VETERANS AFFAIRS

Cost-Based and Interagency Billing Rates for Medical Care or Services Provided by the Department of Veterans Affairs

AGENCIES: Office of Management and Budget, Executive Office of the President and the Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: This document provides cost-based and interagency billing rates for medical care or services provided by the Department of Veterans Affairs (VA):

(a) In error or on tentative eligibility;
(b) In a medical emergency;
(c) To pensioners of allied Nations;
(d) For research purposes in circumstances under which VA medical care appropriation is to be reimbursed by VA research appropriation; and
(e) To beneficiaries of the Department of Defense or other Federal agencies, when the care or service provided is not covered by an applicable sharing agreement.

In addition, until such time as charges for outpatient dental care and prescription drugs are implemented under the provisions of 38 CFR 17.101, the applicable cost-based billing rates provided in this notice will be used for collection or recovery by VA for outpatient dental care and prescription drugs provided under circumstances covered by that section. This notice is issued jointly by the Office of Management and Budget and the Department of Veterans Affairs.

EFFECTIVE DATE: The rates set forth herein are effective January 7, 2004, and until further notice.

FOR FURTHER INFORMATION CONTACT: David Cleaver, Chief Business Office (168), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 254–0361. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: VA's medical regulations at 38 CFR 17.102(h) set forth a methodology for computing rates for medical care or services provided by VA:

(a) In error or on tentative eligibility;
(b) In a medical emergency;
(c) To pensioners of allied Nations;
(d) For research purposes in circumstances under which VA medical care appropriation is to be reimbursed by VA research appropriation; and
(e) To beneficiaries of the Department of Defense or other Federal agencies, when the care or service provided is not covered by an applicable sharing agreement.

Two sets of rates are obtained via application of this methodology: Cost-Based Rates, for use for purposes (a) through (d), above, and Interagency Rates, for use for purpose (e), above. Government employee retirement benefits and return on fixed assets are not included in the Interagency Rates, and the Interagency Rates are not broken down into three components (Physician; Ancillary; and Nursing, Room, and Board), but in all other respects the Interagency Rates are the same as the Cost-Based Rates.

When medical care or service is obtained at the expense of the Department of Veterans Affairs from a non-VA source under circumstances in which the Cost-Based or Interagency Rates would apply if the care or service had been provided by VA, then the charge for such care or service will be the actual amount paid by VA for that care or service.

Inpatient charges will be at the per diem rates shown for the type of bed section or discrete treatment unit providing the care. Prescription Filled charge in lieu of the Outpatient Visit rate will be charged when the patient receives no service other than the Pharmacy outpatient service. This charge applies whether the patient receives the prescription in person or by mail.

Current rates obtained via the above methodology are as follows:

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	Cost-based rates	Interagency rates
A. Hospital Care, Rates Per Inpatient Day		
General Medicine:		
All Inclusive Rate	$1,815	$1,668
Physician	217	
Ancillary	473	
Nursing, Room and Board	1,125	
Neurology:		
All Inclusive Rate	2,289	2,098
Physician	335	
Ancillary	604	
Nursing, Room, and Board	1,350	
Rehabilitation Medicine:		
All Inclusive Rate	1,723	1,574
Physician	196	
Ancillary	526	
Nursing, Room, and Board	1,001	
Blind Rehabilitation:		
All Inclusive Rate	1,254	1,162
Physician	101	
Ancillary	623	
Nursing, Room, and Board	530	
Spinal Cord Injury:		
All Inclusive Rate	1,237	1,136
Physician	153	
Ancillary	311	
Nursing, Room, and Board	773	
Surgery:		
All Inclusive Rate	3,513	3,255
Physician	387	
Ancillary	1,065	
Nursing, Room, and Board	2,061	
General Psychiatry:		
All Inclusive Rate	971	888
Physician	92	
Ancillary	153	
Nursing, Room, and Board	726	

	Cost-based rates	Interagency rates
Substance Abuse (Alcohol and Drug Treatment):		
All Inclusive Rate	1,206	1,106
Physician	115	
Ancillary	279	
Nursing, Room, and Board	812	
Psychosocial Residential Rehabilitation Treatment Programs:		
All Inclusive Rate	276	252
Physician	17	
Ancillary	29	
Nursing, Room, and Board	230	
Intermediate Medicine:		
All Inclusive Rate	801	733
Physician	39	
Ancillary	118	
Nursing, Room, and Board	644	
B. Nursing Home Care, Rates Per Day		
All Inclusive Rate	451	411
Physician	14	
Ancillary	61	
Nursing, Room, and Board	376	
C. Outpatient Medical and Dental Treatment		
Outpatient Visit (other than Emergency Dental)	300	282
Emergency Dental Outpatient Visit	185	167
D. Prescription Filled, Per Prescription	45	45

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Beginning on the effective date indicated herein, these rates supercede those established for the Department of Veterans Affairs by the Director of the Office of Management and Budget on November 1, 1999 (64 FR 58862).

Approved: September 17, 2003.

Anthony J. Principi, Secretary, Department of Veterans Affairs. Approved: December 30, 2003.

Joshua B. Bolten, Director, Office of Management and Budget.

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