Chapter 6
Ready or Not, Here It Comes: Navigating Congress and Caring for the Wounded and Their Family Members During War Time

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6.1 Background

Capitol Hill, Washington DC is best known as the place where 535 elected Members of Congress meet to debate proposed changes in law and set budgets (in the form of spending and taxes) for operating the Federal Government. Less well-known is that there are thousands of staff members who serve in either the personal office of an elected member or as a "professional staff member" on one of the dozens of standing committees and subcommittees of the U.S. House of Representative and U.S. Senate. In general, personal office staff focus more on issues of importance to an individual member and the district or state he or she represents, whereas committee staff focus more on advising members with respect to the specific policy issues related to the committee's jurisdiction. From 1997 to 2007, I was privileged to serve in various roles as a professional staff member with the U.S. Senate Committee on Veterans' Affairs. My focus was predominantly on the legislation, statutes, and policies governing operations of the Department of Veterans Affairs (VA) health care system. My perspectives, observations, and opinions stem from my experience advising Senators and collaborating with the dedicated men and women who lead the VA and its health care programs.

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Prior to September 11, 2001 the U.S. military and its Congressional supporters had been admirably focused on the needs of the military family. In the era of an all-volunteer force, the military followed the axiom: recruit a service member, retain a family. The issues of importance to the family of service members were the same issues that occupied the minds of all Americans: good schools, safe neighborhoods, decent pay, and quality health care. During the 1990s, Congress focused on making improvements to all of these areas in concert with the military leadership.

To improve the quality of base housing, the Department of Defense (DoD) partnered with a national builder to construct more attractive homes for military families. To improve educational opportunities for military children, DoD focused time and attention on collaborating with local communities to ensure good schools were available near bases. Perhaps the most significant new public-private partnership to impact military personnel was the expansion of private sector health care options in the military health system. Multiple Base Realignment and Closure Commissions undertaken between 1988 and 1995 had closed or slated for closure nearly 100 military bases, and with them numerous military medical facilities (Lockwood & Siehl, 2004). After a decade of testing the best ways to expand private sector care for the military, DoD awarded its first TRICARE managed care support contracts in 1997. The new and improved TRICARE program would become a key feature in later debates over separating from military service those wounded in action.

During this same time period, the VA also underwent significant changes in delivering services to its beneficiaries. In particular, VA and Congress worked to expand veterans' access to care with changes to both the types of facilities operated by the Veterans Health Administration (VHA) and the scope of care offered to veterans. The changes were heavily influenced by a paper published in 1996 by Dr. Ken Kizer, who served as Under Secretary for Health at VA, called "Prescription for Change" (Kizer, 1996). Dr. Kizer outlined VA's intention to expand access to care for veterans by spending more on operating outpatient clinics in communities all over the country, and less on institutional care delivered in a hospital setting. In response to Dr. Kizer's vision, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, 110 Stat. 3177. Oct. 9 1996), which fundamentally expanded the scope of VA's health care services to veterans. Previously, VA health care was focused on addressing the individual illnesses and injuries resulting from service-connected conditions. The Eligibility Reform Act expanded the mission of the Veterans Health Administration (VHA) to address the full spectrum of health care needs for enrolled veterans, service-connected or not. Following these changes, VA devoted the savings generated from its lower cost of care to a major expansion of its medical footprint all across the country.

Then came September 11, 2001. Following that fateful day, the movement of troops, the logistics of providing them the right equipment, and the readiness of military forces to respond took priority on Capitol Hill and certainly within the walls of the Pentagon. With that, at least for a time, the needs of military families, which had garnered so much focus and attention during the previous 15 years, took

a back seat to the prosecution of the war efforts. VA's mission, however, changed little. On September 12, 2001 there were still millions of veterans from previous wars and conflicts relying on the VA health care system. The general age cohort of those veterans (primarily men who fought during World War II, Korea, and Vietnam), their health care needs, and their families were still the same. So too was the VA's responsibility to care for them. And while the war had changed the focus of the nation, it had not immediately changed the responsibilities of VA.

6.2 VA Becomes Relevant to the War

It wasn't until a sizable population of wounded warriors returned home from the battlefield that the pendulum of focus began to swing back towards the need for health care services, benefits, and family support to handle the injuries inflicted by the Global War on Terror. Questions soon arose surrounding the readiness of DoD and VA to care for the injured and their families. As challenges in both departments became clearer to political leaders on Capitol Hill, policy makers (and the two agencies) began trying to address the inadequacies. With two distinct systems (DoD and VA), overseen by six different committees in Congress, the first several years following 9/11 demonstrated that the respective roles of DoD and VA in caring for the injured (and their family members) were anything but clear. The lack of clarity was, quickly, coupled with scandals in both DoD and VA, leading to policy fights and oversight hearings by Congress to focus attention on caring for the wounded, ill, and injured. As is often the case, the spotlight on failures laid the foundation for changes in policies and programs focused on the family members of those whom the nation sent off to war. But, even today, it is still only a foundation.

Proactively establishing clearer expectations about when DoD's responsibilities end, when VA's begin, and how that transition occurs should be the focus of policy makers, advocates, beneficiaries, and budgeteers now—prior to the outset of the next major conflict—much like housing, education, and health care benefit design was in the 1990s. Those discussions should take into consideration the fact that at the start of any war, DoD has the political attention; motivation; flexibility; people; and, most importantly, money to care for the wounded and their families. Therefore, DoD should do it.

Expecting VA to manage that work immediately upon the start of a combat action ignores the reality that VA will not even know what is needed until sometime after the first deployments occur. Following the first troops rotations, it will take time to adjust the focus of a system that simply cannot drop its current workload in favor of a new one. VA needs be provided ample time and funds to simultaneously concentrate on its current patient base, and their families, while making room, literally and clinically, for the needs of its future beneficiaries.

6.3 Congressional Advocacy Is Necessary. But where to Start?

The House of Representatives and the Senate are environments dominated by "turf" and "tenure." That is not necessarily negative. It just is. Responsibilities for the development of policy, agency and program funding, and oversight of those programs and agencies are scattered among more than 180 Congressional committees and subcommittees in the House and Senate. Committees all have Chairs (from the majority party) and Ranking Minority Members (from the minority party), as does each subcommittee of a committee. Those Chairs and Ranking Members have vested interests in doing "something" and whatever they do needs to fit within the confines of their committee or subcommittee's scope and jurisdiction. That is how political reputations are built and maintained.

While it is true that the seniority system does not always determine who is elected Chair or Ranking Minority Member of a committee or subcommittee, there is still a very strong bias towards electing as Chair of any full committee the member of the majority party who has been on the committee the longest. There are exceptions to this bias, but these remained rare on Capitol Hill in the early post-9/11 period. Senators John Warner (R-VA), Arlen Specter (R-PA), Ted Stevens (R-SC), Carl Levin (D-MI), John D. Rockefeller IV (D-WV), and Robert Bird (D-WV) led the Armed Services, Veterans' Affairs, and Appropriations Committees, respectively, in the Senate. In the House of Representatives, Bob Stump (R-AZ); Chris Smith (R-NJ); C.W. "Bill" Young (R-FL); Ike Skelton (D-MO); Lane Evans (D-IL); and David Obey (D-WI), respectively, served in those positions. With the exception of Representative Smith, who was elected in 1980 and born in 1953 and Rep. Evans, elected in 1982 and born in 1951, all of these distinguished members were elected prior to 1980 and all were born before the United States entered World War II. Each was a well-respected member of Congress who had come to their position of power after serving on those committees for decades.

In theory, the committee structure has a number of benefits. Chief among them is that it allows members to focus on certain subject matter policies (for example, military or taxes) instead of trying to learn everything government does. This fact, coupled with longevity driving the election of committee Chairpersons, means that most leaders of committees have spent many years becoming subject matter experts on issues within the jurisdiction of the committees they lead. Additionally, the committee structure allows members to become well-versed in the operations of the agencies subject to the jurisdiction of their committees. This provides the experience needed to question results and hold Executive Branch managers and political appointees accountable.

As with most things in politics, though, there are inherent negative consequences. Most notably, the committee structure can at times create a dynamic where members see a problem only through the lens of their respective committees' jurisdictions. If they are not on the committee responsible for the problem being raised, the response is that they cannot help (this is often a response given to national advocacy

groups or organizations, but rarely to hometown constituents). Alternatively, members may seek ways to "carve" an issue important to them into legislative solutions technically within the jurisdiction of their committees. Those two mindsets make it difficult to focus on the kinds of comprehensive policies that are needed to better coordinate services between and among differing agencies of government when those agencies are subject to the jurisdiction of different committees in Congress.

Such was the case in the years following September 11, 2001 in the development of policies and the conduct of oversight in areas impacting wounded service members, those transitioning out of the military, and their families. There was DoD, with its facilities, budget, and policies, all under the watchful eye of the Armed Services and Defense Appropriations Subcommittees. Then there was VA, answerable to the Veterans' Affairs and the VA Appropriations Subcommittees. While the two pairs may have some overlapping members, as organizational institutions, they rarely meet.

In many ways, the results of these challenges can best be seen in the case of a single Army soldier who was injured by an Improvised Explosive Device (IED) early in 2004. His case was the first real indication I had as a staff member on the Senate Committee on Veterans' Affairs that things simply were not working well. Problem was, I did not know for sure where the fault should lie.

When this soldier first came to Capitol Hill with his wife and an advocacy organization's representative, I was the first person with whom he visited. At that time, coming to see me seemed perfectly rational because he was no longer in the military. He was a veteran and the majority of his concerns and complaints were about the medical treatment he was receiving from the VA Health Care system. However, what is readily apparent, in hindsight, is that my focus was on how VA was caring for him and where they were failing, not really considering that the root cause of his problems most likely stemmed from the fact that Congress never considered, let alone decided, when the military's responsibility for treating the injured and caring for their families ended, and when VA's responsibility to assume those duties subsequently began.

When this brave young man was first injured, it was clear that DoD had primary responsibility to stabilize him on the battlefield and transfer him to a military medical facility for his treatment. The Department of Defense (DoD) flew his wife to Germany to be near to her husband as he fought for his life. Then DoD flew them back to the United States to receive more treatment at Walter Reed Army Medical Center. At this point, all was seemingly in order. [As an aside, it bears noting that the military's performance of these functions during the War on Terrorism led to the highest battlefield injury survival rate in U.S. history; Wilson, 2010.]

While at Walter Reed, the Army continued to pay this young soldier and his spouse continued to receive the benefits that come with being part of the active force. However, not long after arriving state-side, it was determined that military medicine was unable to provide the full panoply of services he required. Given the significance of his injuries, it was also pretty clear that he was unlikely to return to active duty. As this point, he was discharged from the Army and transferred to the VA Health Care System. His first stop was a nursing home unit at a VA Medical Center (VAMC) several hours from Walter Reed. As soon as he arrived at the

VAMC, his wife knew things were going to be completely different. The first clue was that his new roommates were World War II Veterans. In fact, most of the patients at the VAMC were elderly residents of the nursing home unit for reasons ranging from the need for everyday palliative care to poststroke rehabilitation. None of them, however, had recently been injured by a roadside bomb.

In some ways, the military's decision to discharge this soldier made perfect sense. He was badly injured, having suffered an amputation and a traumatic brain injury. Historically, the wounded were transferred to the agency established "to care for him who shall have borne the battle" for recuperation and recovery. But, I can attest to the fact that, at this time, few on Capitol Hill had considered what the discharge would mean to his income, housing for his family, or how it would impact the support structure necessary to provide caregiver services when his young wife had to return to the workforce. In fact, very few of us (myself included) had spent much time considering whether VA was truly ready to accept young, traumatically wounded patients into its system. In short, from my perspective, there was little discussion about the "life consequences" of discharge from the military for this era of wounded service members.

As the war progressed, and the injured multiplied, it became clear that no committee or group of members had sat down to thoroughly consider the nation's overall policies for caring for the wounded. Issues such as: who should be responsible and why, when should wounded service members be discharged quickly from military service, and under what circumstances should the military take the time to conduct a Military Evaluation Board proceeding to determine whether the injuries are something from which the service member can recover and return to active duty, and what are the strategic military considerations for making those decisions and what would be the impact of those decisions on service members and their families? To some degree the problem still plagues us today.

Congress, as an institution, is certainly aware of the consequences (both positive and negative) of the committee system. But, there is little acknowledgement of the deficiencies, let alone any effort made to correct them. Instead, there is only a recognition of its existence and how one must operate within it. That is to say, as a member or staff, you solve the problems you can solve within the Congressional structure you have. As previously noted, Congress provided little guidance to determining when DoD responsibilities to care for the wounded ended and when VA's began. Perhaps no situation highlighted the challenge caused by that lack of clarity more than the revelation of the conditions that existed for wounded service members "recovering" at Walter Reed Army Medical Center. The troubling environment in which service members lived at the time was well documented in a February 19, 2007 article in the Washington Post written by reporters Dana Priest and Anne Hull (2007).

Congress and the Pentagon responded with great alarm and concern. Hearings were called by the Senate Armed Services Committee, generals were relieved of command, and President Bush appointed a commission to make recommendations on the care and treatment of America's Wounded Warriors. The Commission would be chaired by former Senator Robert Dole (R-KS) and former Secretary of Health and Human Services, Donna Shalala. The military had to fix this problem.

To those of us who served as Congressional staff, the issues presented by the reporters' piece were much deeper than the condition of the facilities of Walter Reed or the medical staff's failure to review patient records and provide disability ratings in a timely manner. The questions some of us on the VA Committee were asking ourselves included: why is the military responsible for continuing to treat wounded service members for prolonged periods of time, is any service branch even equipped, from a staffing perspective to do that, or did we just assume that, like the military always does, "they'll figure it out." Perhaps even more existentially, we wanted to know why there were two disability adjudication systems for service members. Why were they not going through VA's program called "Benefits Delivery at Discharge" (BDD) and then transitioned to VA in a timely manner? Was the problem that service members did not trust VA to provide quality care and services? Or were service members and their families simply not ready to "give up" their military careers?

Many in Congress began wondering whether the compensation system in the military was influencing the desire of those in uniform to make every effort to obtain a disability rating that came with military retirement. What we quickly saw was that military retirement brought with it access to the TRICARE program, which covered not just the service member but also his or her spouse and minor children. Equally important, it preserved access to the Military Health System. This is distinct from VA, which typically covers only the veteran (and in rare instances a spouse and minor children) and generally does not afford beneficiaries an opportunity to access Military Treatment Facilities. These and other questions led us to focus on where or when DoD and VA were truly failing versus where or when the agencies were simply failing to meet the evolving needs and expectations of service members, veterans, and their families in the midst of largest US military engagement since Vietnam.

Gordon Mansfield served in the VA during this turbulent time, first as an Assistant Secretary for Congressional and Legislative Affairs and then as Deputy Secretary and ultimately Acting Secretary. Secretary Mansfield was a wonderfully affable man with a warm heart and a big smile, who I first encountered during his tenure as Executive Director of the Paralyzed Veterans of America. Secretary Mansfield was also a combat wounded paraplegic, whose heroism in Vietnam after being shot in the back twice, earned him the Distinguished Service Cross (McDonough, 2013). In short, he had firsthand experience dealing with many of the challenges now being faced by seriously wounded service members and their families.

Secretary Mansfield was pained by the perception that VA was unprepared to deliver needed care and treatment to wounded service members and also care for their families. During one conversation he and I had on the topic, he shared with me a story about meeting a soldier in the waiting room of a VA Medical Center who had been recently been discharged from the Army. The soldier had spent one of his last few days in the Army being honored on the field of a professional baseball stadium by nearly 40,000 fans. The veteran, he noted, seemed melancholic to be out of the military and was now just among the many veterans sitting in a VA waiting room. Moreover, his spouse was frustrated that her husband was no longer receiving the

level of attention he had previously been provided. Secretary Mansfield observed that VA cannot compete with Yankee Stadium. Moreover, he shared his belief that the perception of inferior customer service and attention was possibly true. But, it was also possible it was an evolution of transition to VA where celebrity visits are less common and the clinical focus is more often on helping veterans manage the lifelong impact of traumatic injuries. He strongly believed that VA provided veterans world-class health care. Unfortunately, not enough people outside of VA believed that, which was becoming a growing problem.

In 2005, then-Major, now Lieutenant Colonel (Ret.) and U.S. Senator (D-IL), Tammy Duckworth testified before the Senate Committee on Veterans' Affairs. Her experience highlights one of the reasons for the perception of inferiority in VA care. Major Duckworth was grievously wounded when her helicopter was struck by a rocket propelled grenade in Iraq in 2004. In the resulting crash and explosion, she lost both of her legs and partial use of her right arm (Duckworth, 2005). Setting aside her military experience and heroic recovery, Major Duckworth was an extraordinary and compelling witness, who convincingly demonstrated that in the area of prosthetic care and technological advancement, DoD's quality and capabilities had far surpassed VA. And, it had done so without much awareness on the part of the Veterans' Affairs Committee.

For many years, VA held a reputation as a forward-leaning, research-focused organization in the field of prosthetics. VA officials routinely touted the agency's involvement in the development of the "Seattle foot" as far back as 1985. That invention is credited with forever changing the landscape of prosthetic devices. Yet, here sat a decorated female helicopter pilot who had lost both of her legs in combat pointing out to the Veterans' Affairs Committee how fantastic DoD, including the prosthetics team at Walter Reed, had been in providing her with the most advanced products available. Her simple observation was that no one understood the types of injuries suffered by combat veterans like military medicine. She noted "[t]he VA will have to face the challenge of providing care at the high level set by the military healthcare facilities. This is a challenge that the VA can meet if it is given enough resources and if it listens to disabled service members and puts forth the effort to meet our needs" (Duckworth, 2005). The message to the Committee and the public was clear. No longer were VA researchers proactively focused on injuries that might be experienced by the next generation coming back from a war and how to treat them. Instead, VA's research efforts and dollars were predominately devoted to the ailments and diseases of elderly from previous conflicts.

Even with an immediate shift after the hearing, a change in focus for VA research would take time. As late as 2006, during a hearing of the Senate Committee on Veterans Affairs, Dr. Jonathan Perlin was touting VA's cutting edge research on cardiac defibrillators, diabetes, hypertension, and chronic disease. Fortunately, however, during that same hearing, VA also showed that it was beginning to prioritize research the improve care and treatment for the illnesses and injuries from the more recent wars. Nearly 5 years after the start of the war in Afghanistan, the VA system was finally beginning to respond to the medical consequences.

6.4 Making Progress… Slowly

While it may seem as though Congress spent too many years discovering problems and not enough time solving them, such is actually not the case. Victories came in the form of small and incremental changes. The first of those was enactment of the Traumatic Service Members Group Life Insurance program in May 2005. Just a few months prior to the legislation's enactment, advocates from the Wounded Warrior Project® brought forward to the Chairman and staff of the Senate Committee on Veterans' Affairs three traumatically injured service members. All of the men noted that the greatest fear they had while serving in combat was not that they would be killed—although that was certainly a fear—but rather that they would return home severely wounded and need to adjust to life with those new realities, likely unable to assist with the needs of their family. These veterans were not focused solely on the long-term challenges of severe injury (a topic which fits more squarely in the jurisdiction of the Veterans' Affairs Committee), but they were also concerned with the impact the injuries had on their families. They knew that VA administered a benefit for active duty service members that provided cash benefits to policy beneficiaries (typically a spouse and/or children) in the event a service member dies on active duty. Known as the Servicemembers Group Life Insurance (or SGLI), active duty service members are automatically enrolled for the benefit upon joining the military. Following enrollment, service members pay premiums each month based on the level of coverage ($50,000–$400,000) desired. The advocates sought to update the scope of coverage provided by SGLI to include benefits for traumatically disabled service members.

As noted previously, there was little disagreement in Congress that the military is the organization responsible for the care and treatment of an injured service member immediately following the injury, including the provision of support to his or her family. Yet, here was the Veterans' Affairs Committee Chairman, Larry Craig (R-ID) being asked to add a VA benefit to cover unmet needs confronting these still active duty service members. It can be argued that the Chairman of the Veterans' Committee should have approached the Armed Services Committee and discussed what he had learned. He could have asked for joint hearings or a meeting of the members of the two committees to discuss the perceived (and likely real) shortcomings in the benefits made available by the DoD to those who are severely injured. He did neither. Instead, he approached Senator Ted Stevens (R-AK), Chairman of the Senate Appropriations Committee, himself a Veteran of World War II, and advocated for legislation creating the Traumatic Servicemembers Group Life Insurance (TSGLI) program to be included in the so-called "Supplemental Appropriations bill" that was nearing passage on the floor of the Senate. Chairman Stevens agreed to support the legislation as an amendment to the appropriations bill. And on May 5, 2005, TSGLI become the law of the land. Unfortunately, other needed policy changes would not come so easily.

Another key improvement to support military families took more than 5 years to understand and "get right." That was the provision of caregiver assistance. VA, as an

agency, had long supported policies and programs recognizing that those severely injured in service to the nation may require long-term assistive care. Typically, that service is provided through a contract arrangement with a home health agency near a veteran's home, which sends a licensed, trained, and insured caregiver to provide services. If the parent or spouse of a veteran wanted to be paid for providing assistance, VA was not necessarily opposed. However, from VA's perspective, that did not change the requirement to be licensed, trained, and work under the supervision of an agency. While such a stance might seem extreme, VA had long believed it was important to maintain the line between paying for health care services rendered by a licensed and trained provider, and simply paying friends or family members of severely disabled veterans to stay home with them. To VA, it was imperative for the protection of the veteran.

Further, and perhaps equally important, it generally was not—and still is not—VA's mission to provide care or services for the spouse, minor children, or family members of a veteran, with limited exceptions in the case of health benefits and some education benefits for the spouses and minor children of severely disabled veterans. Of course, VA also provides adaptive housing, automobile, and clothing allowances for severely disabled veterans. But, while one or more of those benefits may be helpful to the spouse or child of a veteran, the primary purpose is to assist the veteran. Yet, the longer spouses, parents, and other family members served in the role of primary caregiver for severely wounded service members (now veterans), the clearer the picture became of what life would require of them over the long run. The picture was one constant need for care provision to the veteran… but it was also one that would require assistance for caregivers in order to be sustainable. Without such assistance, it was not realistic to think family members could perpetually sustain the levels of effort required to care for wounded veterans in the years to come. It would be exhausting and possibly unbearable financially, emotionally, and physically. When the needed support became unsustainable, the impact would fall squarely on the veteran.

Thankfully, in 2010, despite the concerns of some advocates and the cautious (and perhaps reasonable) opposition of VA, Congress passed the Caregiver and Veterans Omnibus Health Services Act of 2010. The bill provided a range of benefits to a primary family member, caregiver so designated by the veteran. In a nod to the legitimate quality concerns of VA, the program requires that the caregiver receive some training. Meanwhile, in a nod to the realities these caregivers face, the program also provides benefits, such as a monthly stipend, travel expenses (including lodging and per diem while accompanying veterans undergoing care), access to health care insurance, (if the caregiver is not already entitled to care or services under a health care plan), as well as mental health services and counseling. Passage of the bill was a tremendous victory for advocates who, historically, had found VA a fairly insular agency with a more limited mission in the provision of services to family members. Now, the aperture is open and the key is to capitalize on the momentum built by that effort.

6.5 Recommendations for the Future

Recommendations for improving the response of members and staff to the outbreak of a war in the future must take into consideration that Congress, as an entity, is a conservative organization. It is not conservative in the sense that everyone favors lower taxes and less government, but rather in the sense that it does not change easily, either organizationally or operationally. With that in mind, recommendations for improvements that would require substantial or even modest changes to the organization of Congress or its operations are, in my mind, at best a fool's errand and at worse too long-term to prioritize here. Instead, my recommendations focus on accepting the organization and operations as they are and suggesting ways to achieve faster and more focused outcomes from the start of any conflicts. My recommendations focus on establishing clearer lines of responsibility and better coordination between the agencies responsible for caring for wounded, ill, and injured.

First, Congress should make clear (and advocates should focus on the fact) that DoD is expected to lead the way in caring for wounded, ill, and injured service members for a substantial period of time following the start of any major conflict, while VA begins coordinated engagement with DoD to prepare for the eventual transition of those service members.

Second, DoD should be charged with caring for any seriously wounded service member and their families for an established duration (for example, 24 months) following a serious injury.

These two recommendations may seem simplistic. But, in my view, both would greatly reduce the confusion and blurred lines of responsibilities experienced immediately following September 11, 2001. Additionally, they would help Members of Congress, staff, and committees focus their energies and attention on areas of responsibility within their respective committees. In these cases, the immediate needs of those injured would fall to the Armed Services Committees and Defense Appropriations subcommittees to oversee and fund. Whereas preparing for the future needs of those injured (after the fixed duration of time) would fall to the Veterans' Affairs Committees and VA Military Construction Appropriations subcommittees.

Additionally, outlining responsibilities more clearly and establishing fixed durations of time should improve communication and coordination between and among the members and staffs of differing committees. That's not to say there is poor communication now. To the contrary, in my decade of service on the Senate Veterans' Affairs Committee, I had countless conversations with my counterparts on the Senate Armed Services Committee. However, many of those discussions were prompted by the need to resolve "issues of the moment" rather than thoughtful coordination based on an understanding of committee and agency responsibilities. Maybe the clearer lines of responsibility will not change this. But, as noted above, it will clarify responsibilities among committee members and their staff.

Finally, this change would align the expectations of troops and their families with the proper targets in Congress for advocates. Notwithstanding the fact that much of the general public might see VA as the agency required to care for "him

who shall have born the battle," for many troops and their families, they expect that "their Army" or "their Corps" will take care of them if they are injured in battle. Quickly moving injured troops out of the military and into the VA would likely greatly trouble service members who see military medicine as "their system." As then-Major Duckworth pointed out in her testimony before the Senate Committee on Veterans' Affairs in 2005, "I would like to take a moment to stress the unique nature of the military healthcare system. While civilian professionals are an important component in that system, there is no substitute to being treated by, and recovering with fellow Soldiers. Only a fellow service member can understand the stresses and wounds of combat." There, anything seen as an abdication of responsibility or a breakdown in the trust between military leaders and enlisted men and women could, literally, lead to a breakdown in the willingness of young men and women to volunteer to fight. Making it clear that DoD is the responsible entity would meet the expectations of the troops and their families.

One of the unfortunate realities of politics is that elected officials often believe that in order to effect positive change at an agency of government, they must first demonstrate that the agency is failing. Highlighting failures creates the momentum needed to rally support for the proposals a member of Congress has for making changes. Unfortunately, that has sizable downstream impacts on the public's belief in the institutions of government. In the case of VA, it meant pointing out that the agency wasn't ready to treat the veterans of Iraq and Afghanistan—in order to get them ready to treat those veterans. Not exactly confidence inducing. For all of these reasons, I strongly recommend Congressional policy and legislation that clearly denotes that the military is primarily responsible for caring for injured troops and their families for a fixed period of time at the start of a conflict and, in all case, at least 2 years following an initial traumatic injury.

My third recommendation is not one of policy change, but rather advice for advocates that goes hand in hand with my recommendations for an early focus on DoD as the source for care. Advocates should focus on DoD. It is the agency with the money.

In any conflict, Congress can more easily justify spending on the military through the DoD appropriations budget than spending on any other agency. The public supports our troops, even when they do not always support the justification or cause of a war. It takes money to launch new programs or make improvements to existing ones and DoD has the money or they will get it.

My recommendation is not based solely on the fact that it is easier, politically, to give money to DoD (although in my opinion that is true). But, more importantly, Congress tolerates trial and error from the military far more than it does from any other agency. As noted above, in testimony before the SVAC in 2006 (Perlin, 2006), VA revealed that it was just beginning to focus a portion of its research dollars on the wounded of the current war. Yet, in 2007 alone, the Defense Appropriations Committee provided $50 million to the brand new Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. And by 2009, the amount had grown to over $210 million. Congress had provided nearly a quarter of a billion dollars for brain research and psychological health trials to an organization that did not exist in 2006. That's just reality.

Fourth, I recommend advocates focus attention on the updating VA benefits to allow for the provision of more services to family members of veterans. I mentioned earlier that DoD recruits service members and retains families. This forces DoD to spend ample time considering the services, programs, and benefits needed in order to retain service members and ensure that their spouses and children can have a reasonable and enjoyable life during their collective time in the military. VA sometimes sees itself as playing a role in that continuum and sometimes does not. Too often in the area of health care, members of Congress, VA, and to some degree Veterans Service Organizations see VA as an agency devoted to caring only for veterans, not their families. The challenge, as any family member of a severely wounded service member will tell you, is that it takes tremendous efforts on the part of family members to care for a veteran in need of that service. Those efforts can involve stress on family members, children, and even parents. As a system, VA needs to begin to turn its operations towards one that better recognizes that when a service member is injured, the whole family is impacted. And VA's response—with Congressional backing—must be geared towards that reality long-term.

Finally, I recommend that Congress focus some attention on delivering a benefits structure for care support that allows individual circumstances to dictate the needed response. By that, I do not mean that programs geared towards specific injuries (spinal cord injury, PTSD) are not needed. But, I do mean that the family support structure can be an evolving concept for any American (single, married, married with kids, no kids, living with parents, etc.…). That is also true for a service member. As such, when a service member is facing an injury that will require a lifetime of support, in some manner, the benefits structure needs to be flexible to allow for the changing circumstances that the Veteran will confront over a lifetime. Any structure for lifetime support should be flexible enough to recognize that a service member may be single when injured, married when discharged, divorced a few years later, and cohabitating with a significant other for an extended period of time without being re-married far into the future. Or some variation of all of those. VA will increasingly see single parents, same sex couples, and those who spend the rest of their lives living with friends and family members. The need for support won't change. Only the circumstances in which the support is required.

Congress should not attempt to design a litany of programs that take each of those circumstances into consideration. There should be a menu of services and/or benefits to which an injured service member is entitled. From among that menu, what is needed can be accessed and what is not required need not be provided.

6.5.1 Conclusion

As noted at the outset of this chapter, many of the most important improvements to programs and services that impact families in the military took place in the 1990s. The most obvious of these were changes to base housing and the health care benefit available to spouses and children (TRICARE). These changes took place in an

environment that allowed time for discussion and focus on Capitol Hill and in the agencies. That type of opportunity is once again, thankfully, upon us. Now is the time to begin raising questions about which agency has primary responsibilities for caring for the wounded and their families in a time of war and for how long. When should transitions begin to VA and what should VA have available to assist family members so that the transition is a welcome one and not a step down in service?

Advocates for family members need to approach Congress understanding how the Committee structure works and focus their efforts on the members who sit on the committees that oversee the agencies that need the attention. Concentrate on creating a framework now for the environment and structure that the next advocates, at the outset of the next conflicts, will encounter. It will be time well-spent.

References

Duckworth, T. (2005). Opening Statement: Hearing of the Senate Committee on Veterans' Affairs. May 17.

Kizer, K. W. (1996). *Prescription for change: The guiding principles and strategic objectives underlying the transformation of the veterans healthcare system*. Washington, DC: Department of Veterans Affairs. Retrieved from https://www.va.gov/healthpolicyplanning/rxweb.pdf.

Lockwood, D., & Siehl, G. (2004). *Military base closures: A historical review from 1998–1995*. Washington, DC: Congressional Research Service.

McDonough, M. (2013) *Gordon H. Mansfield, top Veterans Affairs official and advocate for disabled soldiers, dies.* Washington Post.

Perlin, J. (2006). *Opening Statement: Hearing of the Senate Committee on Veterans' Affairs: April 7, 2006*.

Priest, D., Hull, A. (2007). Soldiers face neglect, frustration at Army's Top Medical Facility. *Washington Post*.

Public Law 104-262, 110 Stat. 3177. Oct. 9, 1996.

Wilson, E. (2010). *Official Notes Health System's 'Amazing' Impact*. Armed Forces Press Service.