STATEMENT OF
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Good morning Mr. Chairman and Members of the Committee.

Thank you for this opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to improve the quality of care we provide to veterans suffering from post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI). Accompanying me today is Dr. Ira R. Katz, Deputy Chief Patient Care Services Officer for Mental Health and Dr. Barbara Sigford, Director for Physical Medicine and Rehabilitation Service.

VA offers comprehensive primary and specialty health care to our enrollees, and the quality of our care is second to none. We are an acknowledged leader in providing specialty care in the treatment of such illnesses as PTSD and TBI. By leveraging and enhancing the expertise already found in our four TBI centers, which have served for over a decade as primary referral sources for Military Treatment Facilities (MTFs) seeking specialized care for brain injuries and complex multiple trauma, VA has created a Polytrauma System of Care which includes four Polytrauma Rehabilitation Centers to meet the needs of seriously injured veterans returning from operations in Iraq, Afghanistan, and elsewhere. The changing face of warfare has necessitated adaptations in our approaches to care for those brave men and women returning home from combat. We accept

the challenge of adapting VA's existing integrated system to provide this care. The focus of my testimony today will be on PTSD and TBI, emerging treatment modalities, and VA's initiatives to increase access to our veterans who use these services.

IDENTIFYING TBI AND PTSD

An important first step is identifying symptoms due to TBI or PTSD because the symptomology can be similar. The human brain is incredibly complex and each individual's thought patterns and emotions are unique. This complicates the diagnostic process; however, clinicians have devised a number of assessment methodologies for detecting even mild versions of TBI or PTSD. It is important to note the differences between these two conditions.

TBI is the result of a severe or moderate force to the head, where physical portions of the brain are damaged and functioning is impaired. PTSD is a psychological condition that affects those who have experienced a traumatizing or life-threatening event such as combat, natural disasters, serious accidents, or violent personal assaults. Therefore, while physical tests, such as brain imaging, may be able to support a diagnosis of TBI, there are currently no comparable tools for PTSD.

The two conditions also manifest themselves differently, although there is some overlap. Those who experience TBI may behave impulsively because of damage that removes many of the brain's checks on the regulation of behavior. Without the limits provided by these higher brain functions, these individuals may overreact to seemingly innocent or neutral stimuli.

The effects on individuals with TBI can vary depending on which region of the brain is injured. The manifestations of mild TBI can mimic those of mental disorders, and individuals with TBI may have associated, co-occurring mental

disorders. TBI does, however, have a unique physical origin that sets it apart from mental illness and is best addressed by a multidisciplinary approach that includes a sensitivity to the cognitive, emotional, and behavioral manifestations of brain trauma.

To effectively identify TBI, clinicians follow a general approach:

- First, clinicians evaluate the patient's medical history for previous instances of head trauma. Clinicians are looking for even the slightest changes in function because these changes may develop into something much more serious later in life.
- Second, clinicians assess for potential cognitive deficits. Executive function and memory are the two most commonly affected areas, but the exact nature of the condition will vary from individual to individual depending upon the location of the injury. There will always be individual variation in thoughts, behavior, and dispositions, and discriminating between this natural fluctuation and mild effects of head trauma is difficult.

As with TBI, individuals with PTSD may also be hyper-responsive to experiences related to the trauma. The defining symptoms of PTSD can be clustered into three groups: re-experiencing (intrusive memories, flashbacks), avoidance or emotional numbing (disinterest in hobbies, feelings of detachment), and increased arousal (difficulty sleeping, irritability or outbursts of anger).

PTSD may occur in association with other mental illnesses including substance abuse, anxiety, and depression. It may also be associated with physical illnesses including chronic pain, migraines, and sleeping disorders.

Screening procedures are in place for suspected cases of PTSD, and screening is done throughout VHA. For example, clinical reminders and prompts are included in the electronic health record to alert providers to screen veterans for behavioral health issues, such as PTSD, depression, and substance abuse.

DATA AND TRENDS

According to the August 2006 Analysis of VA Health Care Utilization among US Southwest Asian War Veterans: Operation Iraqi Freedom/Operation Enduring Freedom, 184,524 veterans have sought care from a VA Medical Center since the start of OEF in October 2001 through May 2006. During this time, 1,304 OIF/OEF veterans were identified as having been evaluated or treated for a condition possibly related to TBI. There is no medical code specific to TBI, and a patient may carry more than one diagnostic code, but the most prominent injuries included fracture of facial bones, concussions, and/or brain injury of an unspecified nature. Also, the August 2006 analysis reports 29,041 of the enrolled OIF/OEF veterans who visiting VA Medical Centers or Clinics had a probable diagnosis of PTSD.

PTSD. VA's approach to PTSD is to promote early recognition of this condition for those who meet formal criteria for diagnosis and those with partial symptoms. The goal is to make evidence-based treatments available early to prevent chronicity and lasting impairment.

Available treatments such as certain antidepressant medications and specific forms of cognitive and behavioral therapy are demonstrably effective. Ongoing pharmacological research is evaluating the utility of other approved medications that can block the actions of the stress hormones. Findings from a recently completed study of a behavioral treatment are currently being analyzed. Ongoing research is also evaluating the most effective ways to make specific psychotherapies available to those requiring care. Preliminary research suggests that certain medications can facilitate emotional learning and that they may accelerate and amplify the effects of behavioral therapy, and a large majority of patients respond to these available treatments; however, some patients continue

to have residual symptoms, and rehabilitation to support the veteran's functioning in the family, work or school, and the community may be required.

TBI. Imaging of both the structural and functional aspects of the brain is an emerging diagnostic tool for TBI; however, it is too early to assess whether population based imaging is practical versus its use on an individual basis.

The newly implemented Polytrauma System of Care is integral to not only initial rehabilitation processes but to assure the mitigation of long-term outcomes of patients. This system of care includes the already established four primary Polytrauma Rehabilitation Centers and the 17 new Polytrauma Network sites that are moving toward full implementation this fall. These locations will enhance access, ensure lifelong coordination of care including specialized clinical care and case management, and serve as resources to other facilities.

CLINICIAN SUPPORT

In 2004, VHA developed an independent study guide for health care providers entitled "Traumatic Brain Injury." VA has taken steps to raise awareness of TBI issues by requiring training of primary care, mental health, spinal cord injury, and rehabilitation care providers via this web-based independent study course. The course advises practitioners that brain trauma causes both acute and delayed symptoms and that prompt identification and multidisciplinary evaluation and treatment are essential to a successful recovery.

Supplementary information is under development. For example, in January 2006, an Under Secretary for Health Information Letter about the screening and clinical management of TBI was released to the field to address cognitive, behavioral, and affective disorders following TBI. A group is now working to identify data-driven and appropriate screening questions to improve assessments for TBI.

VHA has also sponsored or supported national conferences on TBI and PTSD that offer training and guidelines for health care professionals. Since July 2005, VHA has produced five satellite broadcasts and materials for returning veterans and their families.

Families are an essential component of the recovery process for both PTSD and TBI. To assist family members, VA has:

- Required all Network Sites to develop an inventory of TBI specific services;
- Established a 24-hour, seven-day a week Polytrauma Helpline Service for patients and families that can answer questions regarding health care problems, including emergencies and administrative or benefits issues;
- Prepared a satellite broadcast titled, “Serving our Newest Generation of Veterans,” that addresses the unique needs of patients with TBI or PTSD, the needs of families, and the rehabilitation environment;
- Helped establish Fisher Houses at each of the Polytrauma Rehabilitation Centers; and
- Assigned a designated case manager for each family of a polytrauma patient.

COORDINATION WITH THE DEPARTMENT OF DEFENSE

The VA/DoD Deployment Health Working Group (DHWG), with representatives from VHA, Veterans Benefits Administration (VBA), Department of Defense (DoD), Health Affairs, Centers for Disease Control (CDC), and others, has met and will continue to meet on a monthly basis to explore how we can enhance our responses to military and veteran health issues, including TBI. The DHWG is a source of outreach and education to veterans and military populations as well as to their VA and DoD healthcare providers on health issues such as diagnosing and treating TBI , and will continue to serve in that capacity.

Research collaborations are essential to assure progress for treatment VA, the National Institutes of Health (NIH) and DoD jointly issued a Request for Applications (RFA) in late 2005, to enhance and accelerate research on the identification, prevention and treatment of combat related post-traumatic psychopathology and similar adjustment problems. The goal is to encourage studies involving active-duty or recently separated National Guard and Reserve troops involved in current and recent military operations (e.g., Iraq and Afghanistan). This RFA specifically encouraged participation of clinicians and researchers who screen, assess or provide direct care to at-risk, combat exposed troops, and emphasized interventions focusing on building resilience for veterans suffering from mental health problems, including PTSD, and developing new modes of treatment that can be sustained in community-based settings. Among the approaches being considered are novel pharmacological, psychosocial and combination treatments as well as the use of new technologies (e.g., World Wide Web, DVD, Virtual Reality, Tele-health) to extend the reach of VA's health care delivery system. Fifty-five proposals were received earlier this year in response to this RFA, and those proposals deemed to have scientific merit and relevance to veterans are expected to start later this year.

VET CENTERS AND OTHER SUPPORT

VA's 206 Vet Centers, located throughout the VA system, provide counseling and readjustment services to veterans. Vet Centers also offer tele-health services to expand the reach to an even broader audience. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses, and social workers. Vet Centers address the psychological and social readjustment and rehabilitation process for veterans with TBI or PTSD and are instituting new programs to enhance outreach, counseling, treatment and rehabilitation to support ongoing enhancements under the VA Mental Health Strategic Plan.

Other support for patients with mental health diagnoses includes the development of a mental health portal for MyHealth***e***Vet to help veterans and their families understand their own behavioral health concerns and/or diagnoses and treatments and to promote active participation of veterans with mental illness in their care. The portal will include: information/education on mental illness/health and mental health problems; self-assessment screens for symptoms of mental health problems to facilitate early identification and early intervention; and self-monitoring tools to be used in conjunction with care from a mental health professional to facilitate recovery and rehabilitation. Future plans include incorporation of relevant outcomes data into the electronic health record.

FUTURE

VA continues to plan for the future. In November 2005, VA issued a program announcement to stimulate research in the area of combat casualty neurotrauma. This research initiative seeks to advance treatment and rehabilitation for veterans who suffer multiple traumas from improvised explosive devices and other blasts. Proposals for future projects are currently under review.

To assure that research such as this is translated into the clinical practice, VA has devoted its newest Quality Enhancement Research Initiative (QUERI) center to polytrauma and blast-related injuries with a focus on using the results of research to promote the successful rehabilitation, psychological readjustment, and community reintegration of these veterans.

Other VA scientific studies are currently underway to identify geographic areas where the need for rehabilitation is greatest, and to characterize these injuries and delineate their outcomes and costs. Such information is critically important in helping VA redesign its care delivery system to meet the needs of our newest veterans.

In the area of PTSD research, initial findings of a joint VA/DoD project to assess the pre- and post-deployment neurophysical status of veterans compared to non-veterans were recently published. This is an ongoing study that is expected to provide important insights about the effects of combat on mental status.

Because of women's new roles in the military and subsequent combat experiences, VA and DoD are also studying the use of psychotherapy for treatment of PTSD in women veterans and active duty personnel. A randomized clinical trial, part of VA's Cooperative Studies Program, has recently been completed and results are currently being analyzed, with a report expected in 2007. Those results will inform additional research and implementation activities across VHA. VHA has an ongoing solicitation for research about women veterans, and is working closing with clinicians to build a robust portfolio of women's health research, including combat-related topics.

CONCLUSION

VA has a long history of providing both TBI and PTSD care and has responded decisively to the increased demand for these services and care. An expanded system of care is available today providing more services and developing new, innovative approaches to addressing these potentially debilitating conditions. VA is committed to the goals of the Polytrauma System of Care to enrich the therapeutic environment to meet the needs and preferences of the combat injured veterans and their families, with specific attention to issues involving TBI and PTSD.

Further work and research are required. We can still improve the nature of our treatments for PTSD by better understanding the interactions between medications and behavioral therapies and by developing new strategies for care. We need a better understanding of the effects of stress and trauma on the brain

and how complications arising from PTSD can impact the patient's overall health. We also must devise new interventions to improve recovery for patients suffering from TBI. While VA is pursuing a more detailed and thorough identification process for mild cases of TBI, there is still more to be done.

Today our clinicians and researchers are providing state-of-the-art care and constantly evaluating their efforts to find better way to treat this patient population. I want to assure you of VA's commitment today and in the future to address the broad issues of TBI and PTSD, and especially the specific needs of veterans returning from OIF/OEF.

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