

TESTIMONY
IN SUPPORT OF FUNDING
BRAIN INJURY PROGRAMS AND INITIATIVES
IN THE
DEPARTMENT OF DEFENSE

SUBMITTED TO
THE SENATE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON DEFENSE
BY

George A. Zitnay, PhD

Co-founder of the Defense and Veterans Brain Injury Center
and former advisor to the Department of Defense (retired)

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Dear Chairman Inouye, Ranking Member Cochran and Members of the Senate Appropriations Subcommittee on Defense:

Thank you for this opportunity to submit testimony in support of funding brain injury programs and initiatives in the Department of Defense. I am George A. Zitnay, PhD, a neuropsychologist and co-founder of the Defense and Veterans Brain Injury Center (DVBIC).

I have over 40 years of experience in the fields of brain injury, psychology and disability, including serving as the Executive Director of the Kennedy Foundation, Assistant Commissioner of Mental Retardation in Massachusetts, Commissioner of Mental Health, Mental Retardation and Corrections for the State of Maine, and a founder and Chair of the International Brain Injury Association and the National Brain Injury Research, Treatment and Training Foundation. I have served on the Advisory Committees to the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), was an Expert Advisor on Trauma to the Director General of the World Health Organization (WHO) and served as Chair of the WHO Neurotrauma Committee.

In 1992, as President of the national Brain Injury Association, I worked with Congress and the Administration to establish what was then called the Defense and Veterans Head Injury Program (DVHIP) after the Gulf War as there was no brain injury program at the time. I have since worn many hats, and helped build the civilian partners to DVBIC: Virginia NeuroCare, Laurel Highlands, and DVBIC-Johnstown. Last year I retired as an advisor to the Department of Defense (DoD) regarding policies to improve the care and rehabilitation of wounded warriors sustaining brain injury.

I am pleased that DVBIC continues to be the primary leader in DoD for all brain injury issues. DVBIC has come to define optimal care for military personnel and veterans with brain injuries. Their motto is “to learn as we treat.”

The DVBIC has been proactive since its inception, and what began as a small research program, the DVBIC now has 19 sites,¹ and serves as the key operational component for brain injury of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) under DoD Health Affairs.

I am here today to ask for your support for \$40 million for the DVBIC and \$45 million for the National Intrepid Center of Excellence (NICoE) in the Defense Appropriations bill for Fiscal Year 2011. This level of funding is consistent with the request made by

¹ Walter Reed Army Medical Center, Washington, DC; Landstuhl Regional Medical Center, Germany; National Naval Medical Center, Bethesda, MD; James A. Haley Veterans Hospital, Tampa, FL; Naval Medical Center San Diego, San Diego, CA; Camp Pendleton, San Diego, CA; Minneapolis Veterans Affairs Medical Center, Minneapolis, MN; Veterans Affairs Palo Alto Health Care System, Palo Alto, CA; Fort Bragg, NC; Fort Carson, CO; Fort Hood, TX; Camp Lejeune, NC; Fort Campbell, Kentucky; Boston VA, Massachusetts; Virginia Neurocare, Inc., Charlottesville, VA; Hunter McGuire Veterans Affairs Medical Center, Richmond, VA; Wilford Hall Medical Center, Lackland Air Force Base, TX; Brooks Army Medical Center, San Antonio, TX; Laurel Highlands, Johnstown, PA; DVBIC-Johnstown, PA.

30 Members of the Congressional Brain Injury Task Force to the House Appropriations Committee as well as with the President's budget request. The Administration requested a total of \$920 million: \$670 million for treatment and \$250 million for research. Since DVBC and NICOE provide both treatment and research, line items are requested for these individual agencies.

As you know, traumatic brain injury (TBI) remains the "signature injury" of the conflicts in Iraq and Afghanistan, affecting over 10% of all deployed service personnel. Blast-related injuries from improvised explosive devices and extended deployments are contributing to an unprecedented number of TBIs (ranging from mild, as in concussion, to severe, as in unresponsive states of consciousness) and psychological conditions such as anxiety, depression, post traumatic stress disorder (PTSD) and suicide. TBI-related health issues cost billions of dollars, not including lost productivity or diminished quality of life.

For a myriad of reasons, it is in everyone's best interest – our wounded warriors, their families and loved ones, our national security and military readiness and the nation's taxpayers -- to assure that service members with TBI are given the appropriate treatment and rehabilitation as soon as possible. Our country cannot afford to allow service members to fall through the cracks and suffer from the deleterious effects, sometimes life long, of TBI.

After sustaining an initial TBI, a service member is at twice the risk of sustaining another TBI and compounding the injury. This can be particularly devastating in a combat zone especially if not removed from action. A 2009 Consensus group of brain injury specialists (50 civilian and military experts), suggested that troops with mild TBI receive cognitive rehabilitation as soon as possible. (Neurorehabilitation. 2010 Jan 1; 26 (3): 239-55.

On June 7, 2010, National Public Radio and ProPublica published the results of an independent investigation which showed that despite the DoD's efforts to detect and treat TBI, a huge number remain undiagnosed. NPR reports that "the nation's most senior medical officers are attempting to downplay the seriousness of so-called mild TBI. As a result, soldiers haven't been getting treatment." (<http://www.propublica.org/feature/brain-injuries-remain-undiagnosed-in-thousands-of-soldiers>). The report states that "tens of thousands of troops with TBI have gone uncounted.

CONSISTENT SCREENING IS NEEDED

Four years ago, DVBC began a comparative study on the efficacy of 6 diagnostic screening tools but for various reasons there has been delay in publishing the results. Since May 2008, a pre-deployment cognitive test is used based on DVBC's ANAM, but post deployment has been inconsistent. It is my understanding that top DoD officials fear that greater screening may produce false positives and follow up assessments and treatment will be expensive. This is unacceptable. In cases of positive screenings or

when there is suspicion of TBI, a neuropsychological battery should be performed. Pending the results of DVbic's study, DoD should convene a panel of outside experts to reach a consensus on the best post deployment screening tool which has demonstrated efficacy and use it consistently across the board. Amendments have been offered to the DoD Authorization bill currently under consideration that would help achieve this. Brigadier General Loree Sutton, head of the Defense Centers of Excellence for Psychological Health and TBI has repeatedly stated that her goal is to have "consistent standards of excellence across the board." This is an area that desperately needs consistency.

LONG TERM EFFECTS OF BLAST INJURY REMAIN UNKNOWN

The Institute of Medicine's (IOM) Preliminary Assessment on the Readjustment Needs of Veterans, Service Members and Their Families (March 31, 2010) notes that there is a paucity of information on the lifetime needs of persons with TBI in the military and civilian sectors and recommends funding for additional research into protocols to manage the lifetime effects of TBI.

This issue is compounded by the fact that blast injuries from IEDs are quite different from TBIs sustained in the civilian sector, from sports and car crashes. There is even less information on the long term effects of blasts.

The National Defense Authorization Act for FY2008 specifically directed DVbic to conduct a 15 year study. Assuring funding of some \$40 million specifically for DVbic would further this goal.

COMORBID CONDITIONS

As I testified last year, the distinction between TBI and PTSD remains a problem. Some senior DoD medical officers continue to argue that symptoms can be treated without regard to the underlying problem. This is wrong. Treatments for PTSD are often contraindicated for TBI and vice versa. A service member with PTSD may be prescribed a beta blocker to address memory of the trauma, but it unknown how these treatments may affect recovery from TBI. Similarly, a stimulant may be prescribed for TBI to enhance certain brain activity, but stimulants may exacerbate certain symptoms of PTSD.

More research must be done to develop evidence-based guidelines for TBI and PTSD, as well as guidelines to address the complexities of comorbid conditions.

EDUCATION

The need continues for greater education and training for TBI specialists, particularly neurologists, physiatrists, neuropsychologists, cognitive rehabilitation specialists and physician assistants, occupational therapists, and physical therapists. For the past 3 years, DVbic has held annual training sessions for some 800 military medics.

Continued funding is also needed for multi-media initiatives, development and dissemination of educational materials for providers, as well as informational tools for injured service members and their families and loved ones.

OUTREACH

Congress should continue funding the DVBIC to improve outreach to service members in remote and underserved areas and follow up. Funding is needed to increase the number of case managers as well as expand DVBIC's TBI Care Coordination program to monitor the continuum of TBI services and connect service members with local and regional TBI-related resources, clinical services, as well as family and patient support services.

The IOM recommended that DoD and the Veterans Administration improve coordination and communication among the multitude of programs that have been created to meet the needs of returning service members and veterans. DVBIC coordination with civilian, private and public, resources and services could help fill the gaps in information and referral and service delivery.

Greater effort needs to be made to create a safety net so that undiagnosed or misdiagnosed service members do not fall through the cracks. National Guard and Reserves are at particular risk as they often return to their civilian lives. In cases where TBI has been indicated, there have been reports of resistance from military treatment facilities in addressing their needs.

A total of \$40 million is requested for DVBIC to continue its work and expand and improve as necessary.

NICoE

Scheduled to open this month, the National Intrepid Center of Excellence is expected to "use an innovative holistic approach to the referral, assessment, diagnosis and treatment of those with complex psychological health and TBI disorders" and serve as "a global leader in generating, improving, and harnessing the latest advances in science, therapy, telehealth, education, research and technology while also providing compassionate family-centered care for service members and their loved ones throughout the recovery and community reintegration process." (Testimony of Charles L. Rice, MD, Acting Assistant Secretary of Defense for Health Affairs before HASC hearing April 13, 2010).

NICoE is to provide neurological and psychological treatment to some 500 service members per year, for whom standard treatment is not successful. NICoE holds much promise, as clinical research can be done like never before. What's needed is to push the envelope and develop cutting edge rehabilitation efforts for various levels of TBI and then track long term outcomes. As a Center of Excellence, NICoE should lead the way in redefining the standard of care.

It is envisioned that NICoE would develop specific treatment plan and then seek out community resources in an injured personnel's own community. However, funding is needed not only to encourage innovation but to assure that such treatments will be paid for when service members return to their communities, as new treatments will not likely yet be covered by Tricare.

In order to provide intensive and innovative rehabilitation, research and coordination with consortia of public and private partners will be necessary. \$30 million is needed for pilot projects to treat service members with various levels of TBI, including severe TBI and disorders of consciousness.

A total of \$45 million for NICoE is requested to be included in the DoD Appropriations bill for FY2011 for these purposes.

In conclusion, DoD has made some significant strides in addressing the needs of service members with TBI, but more research and innovative treatment is needed. Your leadership and continued support for our wounded warriors is very much appreciated.

Thank you for your consideration of this request to help improve the lives of our wounded warriors.