

Karen L. Bohlinger

Testimony of Karen L. Bohlinger before the Senate Committee on Veterans' Affairs
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Senator Daniel K. Akaka, Chairman
And Members of the
Committee on Veterans Affairs
Washington, DC 20510

Mr. Chairman and Members of the Committee, I appreciate the opportunity to speak with you today about TBI from a very personal view. My son, a former Special Forces officer with nearly 12 years of service, has one severe and one moderate head injury. He is classified as 100% disabled.

We are 4 ½ years into active and ongoing treatment with moderate results. However, this is primarily due to my personal commitment of time and money invested in my son's care, as opposed to the services he has received through the Veteran Administration Healthcare System.

I continue to fly to Seattle every 10 days and stay as long as necessary to assist in and monitor his care. He is determined to live independently and has surpassed all predictions for functional independence. I cannot bring him home as Montana does not provide the follow up TBI care he needs.

Since 2007, I have tried to be an advocate for other veterans and their families, with the hope of their receiving more timely, effective and state of the art care. I have personally visited several VA Medical Centers throughout the United States to observe and learn.

Our Montana Congressional Delegation and Secretary Shinseki, of the Veteran's Administration, have been accessible and responsive. They have shown extraordinary leadership for our veterans and their families.

Changes in the delivery of care since 2008 are unprecedented in an institutional setting. Inclusion of family members in case management, caregiver status for reimbursement, care coordination and outreach efforts are necessary components of treatment, and while mandated are not implemented in all VA Centers. While we are grateful for the many devoted and competent VA employees, consistent standards of care should be available to all veterans.

I cannot stress enough the importance of family involvement, as TBI self assessment can often be very different than the family member assessment. It requires a team effort for best outcomes.

The VA Medical System in Baltimore, Maryland for TBI/PTSD is a model that preserves the dignity, and respect for the veteran, while including and training family members in how to best transition to their new life together.

I have met and worked with, on a volunteer basis, hundreds of soldiers, veterans and their family members, especially young wives, who have not the life experience or training to understand their new reality.

I feel I have learned some important insights to pass on to you:

1. Neuroimaging is a critical component in TBI assessment, treatment planning and disability rating.

Technology is available which demonstrates brain function and activity. It is not a guessing game. My son was given many medications, which ultimately caused more damage than his original injuries. We have been through hell, unnecessarily.

I had to private pay for a brain scan to determine what course of care was scientifically needed. Latest and best technology must be made available for all TBI veterans. News correspondent Bob Woodruff was given the best medical treatment money can buy. His family was with him every step of the way and he had a spirit that would not quit, and look at his remarkable recovery. Our wounded warriors also have the spirit, but lack the same level of medical care.

When neuroimaging is integrated with neuropsychological and neurocognitive evaluations, biometrics and social functioning, a more effective treatment plan can be developed.

2. Pre/Post Assessments for cognitive and neural functioning Current technology allows for bio-marker testing. This would provide a scientific baseline. This is a statement that cannot be changed. It ensures accuracy. Self and counselor assessments are not always accurate.

3. Follow-up treatment:

A. Functional independence is a realistic goal for many. Re-learning their own abilities and developing strategies to make up for injury related deficiencies/losses works.

B. Treatment must be personal, bring about patient engagement, positive response and include performance based outcome measures.

C. Services should be veteran driven not for the staff's convenience. Scheduling a TBI group during peak traffic hours is a disincentive for participation, because it creates more stress than benefits.

4. There are many active duty soldiers and Marines who would ask for help if they could do so, without consequences to their career. Last fall, I was part of a meeting on a military base with over 400 soldiers in attendance; many had served over 3 tours of duty in Iraq. When asked through a confidential questionnaire how many felt they had symptoms of either TBI or PTSD, over 40% responded yes and would like help, but did not feel they could ask for it, without negative consequences.

Additional treatment is not always about more money. Effective use of current dollars, with measurable outcomes that includes feedback from the veterans and family members, would provide accurate information about what is working and what is not.

Create incentives that benefit the veteran. For example, current community mental health providers for the VA are reimbursed per the number of DSM III diagnosis. In a training session of over 250 VA providers, I overheard providers discussing how to "tag" the veteran with

multiple diagnoses so they could make more money. Clearly this does not benefit the veteran, or the tax paying public.

I admire the continuing commitment and the bi-partisan effort to make the necessary changes that will provide the best possible services for our veterans. They have fought for and protected our freedom; it is our duty to protect them. They deserve respect, dignity and self worth.

What does my son miss most? Working! He is after all a Montanan, and we work! He loves his country and would go active military if he could. Thank you for listening!