MAJ Ladda Tammy Duckworth, Director, Illinois Department of Veterans' Affairs

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Mr. Chairman, members of the committee. It is indeed a pleasure to be here to testify. I am honored to have the opportunity to follow up on my March 2005 testimony on the Seamless Transition from DOD to VA healthcare.

When I last appeared before this committee, I was newly injured and still an inpatient at Walter Reed Army Medical Center. The care that I received and continue to receive at Walter Reed is above the best. The personnel there are incredibly talented and dedicated. It is unfortunate that they are not given adequate resources to support our Wounded Warriors.

Since my last appearance, I have undergone the transition from DOD to VA healthcare and have had an overall positive experience. However, compared to the experiences of other service members, I know that my mine is not uniform across the nation. Even before I left Walter Reed, the USDVA representative had reached out to me and coordinated with the OIF/OEF coordinator at Hines VA Hospital. I had an early tour of the facility and met my future physicians. The one negative experience was the prosthetics department, which, while eager to meet my needs, was many decades behind in prosthetics technology. I now receive care at Hines but also continue to return to Walter Reed. The staff at Hines have been very helpful, and shown great initiative. For example, even though my physical therapist at Hines had not treated a high-functioning amputee like myself before, he prepared for my treatment by reaching out and coordinating with my Physical Therapist at Walter Reed. Both therapists did this of their own initiative.

I continue to return to Walter Reed for its prosthetics program. I also travel to a specialist in Florida for state-of-the-art care. Recently, Hines sent a prosthetist with me to Florida to learn about the high-tech artificial legs that I obtain from the private practitioner there. He was overwhelmed by the technology. The USDVA is absolutely not ready to treat amputee patients at the high tech levels set at Walter Reed. Much of the technology is expensive and most of the VA personnel are not trained on equipment that has been on the market for several years, let alone the state-of-the-art innovations that occur almost monthly in this field. I recommend that the VA expand its existing SHARE program that allows patients to access private prosthetic practitioners. There is simply not enough time for USDVA to catch up in the field in time to adequately serve the new amputees from OIF/OEF during these critical first two years following amputation. Perhaps after the end of the current wars in Iraq and Afghanistan, the VA will have time to advance its prosthetics program.

In addition to medical treatment, Seamless Transition is also the passing from one administrative program to another. The Seamless Transition initiative needs to be expanded to each state's VA, and more importantly, local counties and municipalities. The current model for Seamless Transition focuses on transition from the DOD to the USDVA entities within the state. It is also important to involve each state's VA agency as there are many state programs that are unique to the state. For example, in Illinois we provide Veterans' Care, a health insurance plan for

veterans. We also provide additional funds for accessibility modifications to disabled veterans' homes. New benefits are added at the state level more quickly than can be tracked by the USDVA. For example, as of January this year, Illinois gives up to a $600 rebate on employer's state taxes for each Persian Gulf War, OIF or OEF veteran that they hire.

One of the greatest difficulties for state VA agencies is the tracking of returning service members who come home from active duty status. We at the states only find out about these individuals if they self-report to our agency. It appears that a significant difficulty with the Seamless Transition between DOD and USDVA is the sharing of service member's information. The DOD and USDVA are still negotiating a Memorandum of Agreement (MOA) for this process. Recently, the USDVA announced a new program that was pilot-tested in Florida called the Florida Seamless Transition Program. This program for sharing information between USDVA and state VA agencies is just now being expanded to other states. It basically allows wounded service members at DOD medical facilities to voluntarily give permission to have their contact information forwarded to their home state's VA agency. Only seven service members chose to participate, but this is an excellent start.

A related aspect of information sharing between DOD, USDVA and state VA agencies is the technical aspect of data sharing. The USDVA and DOD each have their own excellent medical records keeping system. Unfortunately, most state agencies that operate health facilities such as long-term care facilities do not have electronic records keeping due to the prohibitive costs. At the very least, the USDVA and the DOD should be able to electronically share data so that the wounded service members' medical records can simply be transmitted electronically once they enter the USDVA healthcare system. If there are issues of patient privacy, the records could be given to the service member on a CD ROM, to be turned over at the patient's discretion once they begin seeing their USDVA healthcare provider.

Any Seamless transition program must also include comprehensive screening for Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD) and vision loss by both the DOD and the USDVA Health Care systems. I know that efforts are underway to strengthen these assessments by both the DOD and the USDVA. However, there is no standard procedure in place to insure that all war wounded are screened nation-wide.

Currently, there is an issue with TBI screenings. Some service members who are not screened for TBI, are being identified as suffering only from PTSD. However, it is possible to have both PTSD and TBI or either condition alone. My concern is that service members with TBI are not diagnosed and then return to civilian life without this medical condition noted on their records. The symptoms of TBI can result in inability to work or even aggression that results in homelessness and entry into the criminal justice system. At that time, these veterans are then often diagnosed as having PTSD and treated for PTSD even though the main injury is TBI. What is significant about this situation is that TBI and PTSD have many treatment methods that are the exact opposites.

One additional screening criteria that is critical is testing for vision loss. At the Hines USDVA Hospital, all poly-trauma patients are routinely screened for vision loss as soon as they enter the facility. The result of these screenings is that 60% of the poly-trauma patients at Hines have been found to have some form of functional vision loss. Vision loss, an acute injury on its own

terms, can also negatively affect how patients perform on tests for TBI, which are heavily reliant on vision. Hines is the only USDVA facility in the nation that conducts routine screening of patients in its poly-trauma centers. This is because it is the initiative of the excellent Blind Rehabilitation program at Hines.

I would like to close by saying that I have had a surprisingly positive transition to the VA system. I also understand that this may not be the same across the board for all returning service members. There are problems that can be resolved such as the establishment of standard screening criteria for major injuries such as TBI, PTSD and vision loss. I would also strongly urge this committee to consider eliminating the two year window for free VA care for OIF/OEF veterans. This is a new time limit that will limit veterans' ability to access care for injuries such as PTSD, which may not become evident until over two years after their service. We have more work ahead of us, but much of it can be resolved through information sharing, use of patient advocates, and a willingness to access private healthcare specialists.