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STATEMENT BY

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WALTER REED ARMY MEDICAL CENTER

COMMITTEE ON VETERANS AFFAIRS

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# COLLABORATIVE WORKING RELATIONSHIP BETWEEN SOUTHEAST REGIONAL MEDICAL COMMAND AND AUGUSTA VA MEDICAL CENTER

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Senator Isakson, thank you for the opportunity to participate in this hearing on the cooperative efforts between the Department of Defense (DoD), Department of the Army (DA), and the Department of Veterans Affairs (VA) to provide the most comprehensive care and rehabilitation for our service men and women. I am Major General Eric Schoomaker, currently serving as the Commanding General of the North Atlantic Regional Medical Command (NARMC) for the Army Medical Department and the Commanding General of the Walter Reed Army Medical Center (WRAMC) in Washington, DC.

I feel especially privileged to be included in these hearings today, having spent three very professionally and personally rewarding years as Commanding General of my counterpart regional medical command and medical center-the Southeast Regional Medical Command (SERMC) and Dwight David Eisenhower Army Medical Center (DDEAMC)-here at Ft. Gordon in Augusta, GA-a command currently held by my good friend and trusted colleague, Brigadier General Don Bradshaw. It was during my years in Augusta, at the outset of the current phase of the Global War on Terrorism-Operations Enduring and Iraqi Freedom-that this unique medical and rehabilitation unit--The Active Duty Medical Rehabilitation Unit in the Augusta VA Medical Center (Augusta VAMC)--was created. To gain a better understanding of the genesis of this unit, it is necessary to outline the history of the relationship between these two Federal medical facilities.

Prior to 1993, Augusta VAMC and DDEAMC shared resources on a limited basis via a traditional VA/DoD sharing agreement. This included laboratory and other ancillary services. In October 1993, a decade before the war began, the Augusta VAMC and DDEAMC began sharing operations under a Joint Venture for Shared Services Agreement (JVSS) approved at the highest levels of both VA and DoD. This allowed sharing of services without the restrictions placed by sharing agreement regulations. The bartering of services was central to this agreement. This also allowed for the quick establishment of local agreements to meet the urgent needs of both facilities. Under this authority, a joint neurosurgery program was established at the Augusta VAMC. As a result, today all neurosurgery services for VA and DoD beneficiaries are provided at Augusta VAMC utilizing Department of the Army neurosurgeons.

Under JVSS authority, numerous business agreements were put into place, including open heart surgery which is provided to both VA and DoD beneficiaries at DDEAMC utilizing Department of the Army surgeons. Other agreements under the JVSS authority included:

? Sleep Lab Studies
? Imaging services (including Mammography)
? Gynecological/Obstetric Services
? Separation Physical Examinations
? Speech Pathology Support
? Laboratory Services
? Physical & Occupational Therapy
? Hyperbaric Oxygen Therapy
? Intensive Care Unit beds when needed
? Laboratory Space for Animals

? Echocardiogram Readings
? Lodging for DDEAMC Inpatient Substance Abuse Programs

The FY 2003 National Defense Authorization Act required a number of health care resource sharing and coordination projects. These included coordinated management systems in Budget & Financial Management System; Coordinated Personnel Staffing; and Medical Information/IT Systems. Augusta VAMC and DDEAMC successfully competed for funding for a project in Coordinated Personnel Staffing. The proposal focused on hiring of Registered Nurses for critical care. It was subsequently expanded to neurosurgery when both Army neurosurgeons at DDEAMC retired from active duty and those positions were not backfilled by the Department of the Army. Funds from the demonstration project were approved for the use of paying salaries of two neurosurgeons to continue the joint Augusta VAMC/DDEAMC neurosurgery program. The demonstration project expires at the end of FY 2007. Augusta VAMC and DDEAMC officials are in discussions on how the neurosurgery program will continue.

In 2004, new guidance was given to VA and DoD health care facilities regarding the sharing of resources. Bartering of services was no longer allowed, and an agreed upon rate of CHAMPUS Maximal Allowable Charges (CMAC) minus 10 percent was established for outpatient services provided by one department to the other. In view of this a blanket sharing agreement was established between the Veterans Integrated Service Network 7 (VISN 7) and the Southeastern Regional Medical Command (SERMC). This agreement provided guidance to VISN 7 and SERMC facilities on billing of outpatient and inpatient services. Inpatient rates of exchange are based upon the interagency exchange rate or locally agreed upon rates to insure coverage of facility costs. This agreement was subsequently updated in FY 2007.

So the ground was fertile for a close working relationship between our two facilities at the outset of the GWOT. We in the Army Medical Department, in DDEAMC and in SERMC had grown confident in and respectful of what the Augusta VAMC and VISN 7 could offer our patients and our VA colleagues had grown more familiar with our culture and patient needs. It is important to note that two key conditions were present:

1) An essential precondition was a large cooperative team of healthcare leaders in VISN 7, especially the then-VISN Director, Ms. Linda Watson, and her chief medical officer, Dr. Carter Mecher; leaders at the Augusta VAMC, notably the then-Director, Mr. Jim Trusley, and the Chief of Staff, Dr. Thomas Kiernan; leaders on my SERMC staff-our Chief of Staff, Colonel (now retired) Sam Franco and our chief regional physician, Colonel (Dr.) Mike Stapleton (now retired and working for the VA); and clinicians and administrators at both hospitals, especially Dr. Rose Trincher and Dr. Dennis Hollins at the Augusta VAMC. This unique and very successful partnership is principally about a very visionary and industrious team working together with one goal in mind: to provide the best care for Soldiers, Sailors, Airmen and Marines at a site closest to their home or home unit.

2) The second condition which led to this success was a complementary plan of organizing services and patient referral on a regional basis. Just as critical as the team I outlined above was the notion of overlapping VA and Army regional healthcare delivery. In truth, the Augusta VAMC Active Duty Medical Rehabilitation Unit was one very successful sub-component of a larger SERMC and VISN 7 Joint Venture for Shared Services (JVSS) described above. Both the

SERMC and the VISN are committed to this overarching plan-which extends to other Army medical and VA facilities in the region and even extends into such areas as mutual support of disaster planning and response.

When many of the first major Active Component units in support of OEF/OIF were deployed out of Army posts within the SERMC area of responsibility-such as the 101st Airborne Division from Ft. Campbell, KY; the 3rd Infantry Division from Ft. Stewart, GA; and a large number of the first Reserve Component battalions, regiments and brigades mobilized out of this region as well, it was apparent that we in Army Medicine needed a regional response plan for ill and injured Soldiers during the mobilization and training process and for returning casualties and Soldiers and other Service Members who fell ill during deployments and returned to their home station in the Southeast.

In response to this critical need to provide rehabilitation services for military personnel injured in Iraq and Afghanistan, VISN 7 and SERMC developed the Augusta VAMC's Active Duty Medical Rehabilitation Unit. We leaned heavily on the VAMC's expertise in management of spinal cord injury, treatment of Post Traumatic Stress Disorder (PTSD), as well as rehabilitation for blind and deaf veterans. The unit, staffed by VA personnel, provides all aspects of rehabilitative medicine services, including both traumatic brain injury (TBI) and blast injuries. The first patient was admitted to the program on February 4, 2004. The unit was formally opened in May 2004. Through August 3, 2007, 1,037 active duty personnel have been treated in this unique unit.

Others will speak today about the specifics of what had to be done at SERMC/DDEAMC and VISN 7/Augusta VAMC to establish and maintain this unit and the partnership. I will add two perspectives with regard to challenges we experienced:

1) The first involved the transformation of the cultures of both the VA and of the DDEAMC-from clinicians to command and control elements to mutually meet the needs of the other. I have been thoroughly impressed and humbled by the efforts which our VA colleagues have made to successfully engage a younger population of Warriors and new veterans and to build their trust and confidence that "this is not your father's-or grandfather's-VA hospital". They treat our wounded warriors as we do: highly trained athletes whose new mission is to heal as completely as possible and to rejoin their comrades in uniform or to leave Active Duty and resume productive lives as citizens. We in the military health system know that the VA healthcare system is among the top systems of care in the nation and the world, focused on evidence-based medicine and outcomes of care. It has been gratifying to see them win the respect of each Wounded Warrior, one Soldier and Family at a time. We, in turn, aggressively placed liaisons and made daily contacts with our patients and the Veterans Healthcare Administration (VHA) staff to jointly manage these rehabilitating Warriors.

2) Secondly, the notion of marrying the Army's regional medical commands and VHA's regional healthcare assets has been very successful in this region. However, it was not the initial focus of the VA leadership and ran counter to their focus on the four VHA Poly-Trauma Units. Frankly, we all questioned this approach, especially since SERMC and DDEAMC as a regional asset for the entire U.S. Army Medical Command was the centerpiece of Soldier care, rehabilitation and physical disability adjudication. We also experienced first-hand the support and treatment which

the Augusta VAMC could provide literally in our own back-yard. It is gratifying to see a more dispersed system of regional and community-based care emerging from the experience of the last 4 years.

Many of the leaders and clinicians mentioned earlier were present when DDEAMC-Augusta VAMC Active Duty Medical Rehab program was awarded the Olin Teague award by VA Secretary Jim Nicholson in 2005. The pride many of us have in this achievement is second only to the pride we feel in seeing our Warriors receiving the very best care which Federal and U.S. Medicine can provide through this partnership. The unit serves as one important example of what our two systems of care can provide in defense of the Nation when we harness the vision, energy, intelligence and resources of both in support of the Service Member and his or her Family.

As I conclude my comments, I believe it important to point out how sharing arrangements between the DoD and the VA can aid in the success of the Army Medical Action Plan (AMAP), an Army-wide initiative to facilitate a seamless transition for those brave Warriors who have borne the battle and their Families to civilian life and ongoing care and assistance through the many programs and services of the VA. Key to the development and ultimate success of the AMAP is the establishment of close working relationships with the VA early in the healing process. The AMAP provides for this by assigning VA Primary Care and Case Managers to every Warrior in Transition no later than 30 days prior to discharge. By co-locating VA Liaisons with Military Treatment Facilities where Warrior Transition Units have been established, many of the preliminary interactions between the VA and Warriors in Transition can be accomplished prior to discharge. VA appointments can be arranged, Veteran benefits counseling completed, accessibility modifications made to Warrior homes and automobiles, disability determinations completed, monthly compensation arranged to begin in a timely manner immediately following discharge, and follow-on care and rehabilitation programs developed.

With the growing number of Warriors requiring care and assistance as a result of wounds, injuries, and illness received as the world continues to prosecute the Global War on Terror, the DoD Military Health System (MHS) and the Veterans Health Administration are challenged to provide the resources and care these heroes require. Through sharing resources, care can be provided across the United States of America in the most cost effective manner possible. Where the VHA has expertise but not the infrastructure to support necessary medical specialties, DoD can provide that infrastructure and conversely, where the DoD MHS has the resources the VHA requires, cooperative arrangements allow both to leverage these resources. Existing statutory vehicles such as the DoD/VA Health Care Sharing Incentive Fund established in 38 USC Section 8111 can be leveraged by visionary Congressional, DoD and VA leadership to see to it that those so deserving always have the best possible medical facilities, medical professionals, equipment, and supplies available when and where they are needed.

Thank you again for the opportunity to appear at this hearing and for your focus on our joint DoD-VA healthcare and rehabilitation initiatives.