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STATEMENT BY

BRIGADIER GENERAL DONALD M. BRADSHAW
COMMANDER, SOUTHEAST REGIONAL MEDICAL COMMAND

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 Isaakson, Senator Graham, and other distinguished members of the Committee, I thank you for the opportunity to discuss the relationships that exist between the Southeast Regional Medical Command (SERMC), Dwight D. Eisenhower Army Medical Center (DDEAMC), the Veterans Integrated Service Network (VISN) 7, and Augusta Veterans Affairs Medical Center

(VAMC) and our joint mission to provide seamless, quality health care to the brave men and women of the United States Armed Forces. As a Soldier and a Family Medicine physician, I recognize the profound impact a combat environment can have on the physical, behavioral, emotional and spiritual well-being of our Warriors In Transition and their Families. As the current SERMC and DDEAMC Commander, I also recognize the importance of working cooperatively with our VA partners to ensure our Warriors, Veterans, and their Families receive the health care they need to restore themselves in body, mind, and soul.

In opening, DDEAMC and the SERMC have a long and strong history of working collaboratively with VISN 7 and the Augusta VAMC to optimize the use of Federal health care resources for the provision of health care to our nation's Warriors and Veterans. Our sharing efforts actually started in the early 1980s, then matured in 1995 with the joint provision of neurosurgical services to DoD and VA beneficiaries, and now includes cardiothoracic surgery, the exchange of intensive care beds, imaging, and hyperbaric services, to name just a few. One of the most noteworthy initiatives occurred in May 2003 when the SERMC Commander and the VISN 7 Director established a VA/DoD Tiger Team with the goals of identifying opportunities for resource sharing and standardizing business processes. This was implemented in anticipation of the need for closer collaboration between the DoD and VA in response to the impact of the Global War on Terrorism.

As direct result of this joint effort, the SERMC/VA Southeast Network Active Duty Rehabilitation Unit (ADRU) was established at the Augusta VAMC in May 2004 to ensure the health care needs of severely injured Warriors returning from Operations Iraqi and Enduring Freedom (OIF/OEF) are met. The ADRU currently consists of 30 inpatient beds and is staffed by numerous VA rehabilitation specialists including physiatrists, psychiatrists, psychologists, physical, occupational and recreational therapists, social workers, nursing, and administrative staff. Other appropriate specialties, such as respiratory therapy, are available as needed. The ADRU provides all aspects of rehabilitative medicine services for blast, traumatic brain (TBI), and spinal cord injuries and also identifies and treats Post Traumatic Stress Disorder (PTSD). Embedded within the ADRU are DDEAMC Army Nurse Corps case management staff and DDEAMC command and control personnel. This combination of clinical and command elements enables Warriors In Transition assigned to the ADRU to receive coordinated, timely health care and to maintain a sense of esprit de corps. Both Departments and facilities recognize it is critical to our success that a high degree of communication and cooperation exist between the VA and the DoD. Toward that end, in addition to the military liaisons assigned to the program, the Warriors in Transition commanders at DDEAMC attend weekly team conferences where multi-disciplinary reviews are made of each Warrior's progress and treatment plans and goals are set. Also once a week, the ADRU medical staff attends orthopedic surgery rounds at DDEAMC to report back on progress being made by Warriors assigned to the ADRU and to review patients slated for transfer to the program.

As of August 2007, a total of 1,037 active duty personnel have been treated in the ADRU, including 491 inpatients. Patients admitted to the ADRU included Warriors injured in OIF/OEF combat operations, training incidents, and other accidents. Twenty-five percent of the Warriors were treated for TBI. Most service members are discharged back to an Army MTF, while 25 percent are returned to duty and 16 percent go on to be medically boarded. If upon discharge from the ADRU, it is determined a Warrior still requires intensive outpatient therapy and is not sufficiently recovered to be self-reliant, the Warrior is assigned to the Outpatient Care Unit (OCU) at the Augusta VAMC. This program allows the Warrior to be housed at the Augusta

VAMC ensuring availability for treatment and preventing potential delays in care.

I would like to briefly address our joint efforts to ensure the seamless transition of our Wounded Warriors. As these brave men and women return from theater, often with grievous injuries, it is paramount they and their loved ones receive the best care available. It is also essential that those Warriors no longer able to serve, seamlessly transition from active duty to veteran status without a lapse in benefits. To facilitate this transition, a VA Health and Benefits Advisor is embedded within DDEAMC. This individual meets with our Wounded Warriors to ensure they have a basic understanding of their entitlements under the VA system. Both DoD and VA have rich benefit programs for the active duty soldier and the veteran but significant disparities exist between these programs and the health benefits covered by TRICARE. We must ensure that no Family member is unable to visit and support their loved one as a result of the extensive out-of-pocket expenses required by a system established on a reimbursement basis. We must ensure these costs are covered up front. A promise of reimbursement is worthless if the Family cannot afford to pay these initial expenses. The leadership and staff of the SERMC, VISN 7, DDEAMC, and the Augusta VAMC are working to make sure every Warrior and Family are taken care of, however, your support in making this policy change would make this task considerably less cumbersome and further reduce the frustrations of our Warriors and their Families.

It should be recognized by this Committee that in 2005, VISN 7, the SERMC, and the Augusta VAMC were given the Olin Teague Award, the highest VA customer service award, in recognition of our unique and innovative operation of the ADRU in providing outstanding rehabilitation care to members of all the services.

In the remainder of my comments I would like to focus on other resource sharing achievements between SERMC, VISN 7, DDEAMC, and the Augusta VAMC. Currently DoD and VA leadership meet on a regular basis both at the local and regional levels to monitor sharing activities, proliferate best business practices, and seek opportunities to partner and create efficiencies for providing health care services to VA and DoD beneficiaries. In March 2007, a new Master Sharing Agreement (MSA) and a new Outpatient Care Unit Agreement were implemented between the SERMC and VISN 7. The MSA provides an instrument for sharing health care resources between VISN 7 and SERMC facilities in instances where the need for sharing is either immediate, short-term or of insignificant volume to warrant a separate sharing agreement. The MSA also provides a detailed process for referrals, authorizations, reimbursement rates and resolution of issues that may arise between DoD and VA facilities. Examples of sharing instituted at SERMC and the Augusta VAMC under the agreement include imaging services, OB/GYN services, the sharing of intensive care unit beds, echocardiogram reading, and laboratory services.

DDEAMC and the Augusta VAMC also cooperate in a number of joint endeavors designed to sustain the quality of health care for DoD and VA beneficiaries and maximize available resources. Let me briefly highlight three of our most significant and innovative sharing initiatives. The Coordinated Staffing and Recruitment Joint Demonstration Project began in 2004 with the purpose of exploring the use of the VA's hiring authority to recruit and retain critical medical, nursing, and ancillary staff to fill key shortages at both medical centers. The concept was to maximize the VA's ability to recruit and pay these critical staff under Title 38 authority, effectively minimizing the impact of deployments and military staffing shortages on the patient care provided by both organizations. The program has demonstrated successes in recruiting and retaining critical care nursing staff for the Augusta VAMC and DDEAMC and was essential in

maintaining the viability of our DDEAMC/Augusta VAMC Neurosurgery program. This program began in 1995 as a result of DDEAMC having two military neurosurgeons with a minimum of operating room slots available for performing neurosurgery cases. At that time, the Augusta VAMC possessed ample OR time but was paying significant dollars to contract for a part time neurosurgeon and was still referring many patients to the Atlanta VAMC. By locating DDEAMC surgeons and support staff at the Augusta VAMC and utilizing their surgical suites, support staff and inpatient wards, access to neurosurgical services was preserved for both DoD and VA beneficiaries. This enabled DoD provider readiness to be sustained at a significant reduction in cost to the taxpayer. In the fall of 2005, DDEAMC and the Augusta VAMC, in anticipation of losing their two military neurosurgeons, submitted a request for the approval of funds to support the hiring of two civilian neurosurgeons under the Coordinated Staffing and Recruitment Project. As stated previously, the approval of this proposal preserved neurosurgical services for both the Augusta VAMC and DDEAMC and identified numerous lessons learned in the sharing of joint recruitment and staffing processes. A final report is due to Congress later this year.

The DDEAMC and Augusta VAMC Cardiothoracic Resource Sharing initiative is also a premier example of using combined resources to meet the medical needs of our beneficiaries. Under this agreement, DDEAMC performs cardiothoracic surgery on DoD and VA beneficiaries at DDEAMC. This provides necessary workload for DDEAMC's Graduate Medical Education (GME) programs, sustains the skills of our active duty surgeons, and reduces VA costs by minimizing their dependence on the private sector. The VA reimburses DDEAMC at DoD/VA discount rates which at present make this a win/win for both organizations. I would strongly recommend to this committee that the Congress re-look the current DoD/VA guidance on mandated reimbursement rates for inpatient (DRG - 10%) and outpatient (TMAC -10%) sharing between DoD and VA facilities. This reimbursement methodology no longer provides incentives for DoD and VA facilities to enter into sharing initiatives as this discount can be achieved through network providers without incurring any MTF resources to support the program.

Health Care is local - and we (SERMC, DDEAMC, VISN and AVAMC) have ongoing collaborative meetings - monthly between AVAMC and DDEAMC, quarterly VISN and SERMC but more frequently at the staff level. This opens communication, ensures accountability and removes personality of leaders from the process. Request you encourage this communication through more flexible and consistent resource streams as well as consistency in recruiting and paying staff, advertising and benefits packages.

I want to assure this Committee that the Army Medical Department's highest priority is caring for our Warriors and their Families. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors that we are honored to serve.