

S. HRG. 110-801

**FIELD HEARING: VA AND DOD COOPERATION
TO PROVIDE HEALTH CARE TO OUR WOUNDED
SOLDIERS RETURNING FROM IRAQ AND
AFGHANISTAN**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE**

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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AUGUST 28, 2007
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**FIELD HEARING: VA AND DOD COOPERATION
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TUESDAY, AUGUST 28, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in the Conference Room of the Active Duty Rehab Unit at the Augusta VA Medical Center, Augusta, Georgia. Hon. Johnny Isakson, Member of the Committee, presiding.

**WELCOME STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA**

Senator ISAKSON. I'd like to welcome everybody and to call this meeting to order of the Veterans' Affairs Committee of the U.S. Senate. I would like to thank everybody who is here today for this very important hearing on the great work that's being done here at the Augusta VA and Eisenhower Medical Center.

Before I do anything, though, I want to introduce the recently newly-elected Congressman from this district, Dr. Paul Broun, to welcome everybody to his district. Paul.

**STATEMENT OF CONGRESSMAN PAUL C. BROUN, M.D.,
U.S. REPRESENTATIVE FROM GEORGIA**

Dr. BROUN. Senator Isakson and distinguished Members of the Committee, thank you for holding today's hearings here in Augusta. Senator Isakson, as you're well aware, Augusta has a tremendous story to tell regarding the treatment our men and women who have suffered injuries in service to our country. You have been a leader in working on this issue and I greatly appreciate your efforts. Men and women who serve our country in uniform come from all over America, but as my friend Laurie Ott of the Wounded Warriors project points out: approximately 70 percent of those returning from Operation Iraqi Freedom and Operation Enduring Freedom come from the southeastern United States. Regrettably, some of these men and women return from their service with severe injuries. As a medical doctor I know patients recover more quickly when they're surrounded by family and those they love. So what can we do to treat more of our Nation's wounded warriors closer to home, especially at a time when our Nation's resources are stretched thin. Today's hearing will focus on a possible answer. As

the Committee will learn, the Veterans Administration and Department of Defense have entered into a unique partnership in Augusta which allows them to share resources to treat soldiers. It is a successful program that can serve as a model for the Nation and it is my hope that other communities around the country will be able to learn from our local example.

The program features collaboration between two assets of different Federal agencies: the Department of Defense Dwight D. Eisenhower Army Medical Center at Fort Gordon; and Augusta's Uptown VA. Each of these important medical centers deserves further description. The Army Medical Center is second only to Walter Reed, which is scheduled to close—second in the number of evacuees treated from Iraq and Afghanistan. From January 2005 to March 2007 the President's Commission on Wounded Warrior Care found that the soldiers treated near home have better care and better outcomes, so I'm happy to welcome you. I'm happy to serve as the Congressman of the 10th Congressional District and I'm excited about this project. I'm excited that Senator Isakson has brought this hearing here to the VA hospital, because I think we have a wonderful opportunity to show the Nation how well we can treat our wounded warriors and how two different departments—and maybe with the Medical College of Georgia, with its burn center—that we can even grow our facilities and grow our efforts to treat our brave men and women in the military. So, thank you, Senator Isakson, for your work. I thank you for the opportunity to be here and welcome you to Augusta and the VA hospital. Thank you.

Senator ISAKSON. Thank you very much, Congressman Broun. Congratulations on your election. [Applause.]

I want to introduce some very special people but I want it to be known, first and foremost, that the very special people that are here today are all our men and women in the U.S. Armed Services. We have a lot of folks here today and I want to tell you, on behalf of not just myself, but the people of the State of Georgia and the people of the United States of America, God bless you for your service and your sacrifice. [Applause.]

And running a close second is the first lady of Augusta, Georgia, Gloria Norwood. Where is Gloria? Stand up Gloria. [Applause.]

Don't sit down. I'm going to brag just a second. This lady is the beautiful wife of the late Charlie Norwood, Congressman for seven terms from this district. I called him Dr. Feelgood. He was never short for an opinion and he was never in doubt, and he did more for health care in the U.S. Congress while he was there than any other member of the Congress. He became a great friend of mine. Every time I was having a bad day I tried to find Charlie and I always ended up with a smile, mainly because he married so far over his head. Gloria, we're glad to have you here. [Applause.]

I want to introduce Tom Cook. Where is Tom? Tom, would you stand. Tom is the assistant to Pete Wheeler who is the Commissioner of Veterans Affairs for the State of Georgia and has been for 58 years. He is the longest-serving commissioner in the history of the United States of America in any State. I called him because I wanted him here today so I could brag about him to his face. I've been in government a long time, but I'm just a baby compared to Pete. But Pete said he had to be in Reno, I think, today because

the President had him come out there for the American Legion, so we will give him an excuse to go see the President. But thank you, Tom, for being here, very much.

Mr. COOK. Thank you, sir.

Senator ISAKSON. Thanks for what you all do. [Applause.]

This district was represented for 16 years in Congress by a truly great Georgian and a great friend of mine, Congressman Doug Barnard. Doug, would you stand up.

Mr. BARNARD. Thank you.

Senator ISAKSON. Doug got my attention, I guess, over a year ago to make sure I understood what you all were doing in Augusta and what was being done specifically at this center. And he's the reason I got to meet General Schoomaker, got to find out what was going on as a model and example to all the Veteran's and DOD officers around the county. And, Doug, I want to thank you for the leadership you've demonstrated in this community in so many ways, but in particular, in taking care of our wounded warriors and finding a new and a better way to have seamless transition from DOD to VA. Congratulations to you.

From the Committee Chairman, Danny Akaka—his staff member representing him is Ted Pusey. Where is Ted? Ted, stand up right back there. And John Towers from Senator Craig's staff is right back there. Thank you for all the work that you did in making today possible.

From the Augusta area there are two distinguished members of the Georgia House of Representatives, Representative Barbara Sims—where are you, Barbara? Stand up; you're too pretty to sit down. And the Majority Whip of the Georgia House of Representatives, Barry Fleming. Where is Barry? Welcome and thank you all for coming. [Applause.]

I am delighted to be here personally for this hearing. I am going to give an opening statement and then we're going to turn it over to the real heroes who will be testifying in three panels. The way we're going to do those three panels is we'll have each one make their testimony, and I would ask the panelists to try and keep it within 5 minutes. But the first two guys are exempt. The generals, I'm going to hold them tight. These two guys sitting at the table up here, I'm going to give them a liberal license. If the red light goes off, wherever it is—where's the red light? Back there. If you see the red light you two don't have to pay any attention to it, but the generals are going to have to pay close attention.

**OPENING STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA**

We're going to have three panels to discuss what's happened here at the Uptown Augusta Medical Center and the seamless handoff between the Department of Defense and the Department of Veterans Affairs.

This medical center operates an active duty rehab unit which is the Nation's only medical rehabilitation unit within the VA system for active duty military personnel. It is my sincere hope, General Schoomaker, in years to come the word "only" will be deleted from that statement and what's been done here can be replicated in other areas of the United States for our soldiers.

The Augusta VA Medical Center was awarded the Olin Teague award by Secretary Nicholson in 2005 for successful partnership with the military and VA in regards to the active duty rehab unit. Major General Schoomaker, who is a witness today and is doing a wonderful job at Walter Reed Hospital in Washington, DC, was instrumental in the creation of the active duty rehab unit when he was commander of the Eisenhower Medical Center at Fort Gordon. As I cited earlier, Pete Wheeler, who cannot be here today, was also instrumental in being a catalyst for what happened here to actually take place and become a reality. The active duty unit has revealed how the collaboration and coordination of this idea—a seamless transfer—can benefit wounded veterans who come back from Operations Iraqi Freedom and Enduring Freedom.

As of August 2007, 1,037 active duty personnel have been treated at this facility: more than 490 of them as inpatients; and 26 percent have returned to active duty in the U.S. Armed Forces. Since August 24, 2004, on average on any given day 25 to 30 active duty personnel will be here at this center in rehab and 24 of the 30 beds are filled with active duty personnel today. So, it is a pleasure for me to be here today and illuminate what has been done here in Augusta.

I'd like to introduce our first panel. We have Sergeant First Class Thomas Morrissey and Specialist Jason Capps. I want to tell you just a little bit about them. Sergeant First Class Morrissey has served the U.S. military for 30 years, the last 13 of them in the Illinois National Guard. In 2006, on his third combat tour in Afghanistan, he received eight direct hits from an AK-47 in all four extremities and his upper chest area. Specialist Jason Capps, who is also here to testify today, from 1990 to 1993 served in the Marines in the intelligence field, and was deployed overseas during Desert Storm. In September 2006 he joined the Army as a combat medic. In May 2007 Specialist Capps was again deployed to Iraq with the Third ID—deployed out of Georgia I might add. Specialist Capps was injured on June 10, 2007, when an Iraqi suicide bomber drove a civilian vehicle packed with explosives and detonated it under the bridge where his staff was on guard. I want to tell both of you gentleman before I introduce you, thank you for your service to your country and God bless you for all you've done for all of us in this State and this Nation. [Applause.]

Sergeant Morrissey.

**STATEMENT OF THOMAS M. MORRISSEY,
SERGEANT FIRST CLASS, U.S. ARMY**

Sergeant MORRISSEY. Good morning, Chairman Isakson and distinguished guests. As the Senator said, I've served over 30 years in the military and he's told you a little bit about my story. I'm able to speak to you here today because of the superior leadership, training, equipment and medical care that I received from the U.S. military. It starts with my team commander who insisted on extensive medical training and rehearsals ad nauseam before each of my deployments. This insured that at the time I was shot I reacted without thinking in those critical moments right after the event happened. Medical personnel from an American forward operating base had responded to my call for assistance. I was in the air on

a medical evacuation flight within 45 minutes after the shooting and into my first surgery within 2 hours. I awoke in the recovery room the next day and my first thought was of my family. They had been contacted shortly after I was shot and I was able to speak to them by phone. I owe my battalion commander many thanks for personally keeping my family advised of my status. The next day I left Afghanistan and headed for Germany where I remained for 5 days and two additional surgeries. Nine days after receiving my wounds I arrived at Eisenhower and I was reunited with my family in the ER where we were all briefed on what we could expect. The next morning I began the process of having both my arms rebuilt, literally. My right humerus had been shattered from one of the shots and they had to use a cadaver bone to implant and rebuild it. My left forearm, both bones—my ulna and radius—were fractured so there were many pins, bolts and plates that were put in there. The nerves in both arms were damaged or traumatized, luckily not severed, and so my arms were virtually useless for about 2 to 3 months. Both of my legs had extensive soft tissue damage, but no fractured bones.

Every morning a procession of doctors would start their rotation through my room at 0600 hours. I was completely dependent on the nursing staff for all activities of my daily life. This humbles a person even more than the initial realization that the simple things we take for granted I could no longer do. This went on for many months. My wife who is a social worker in a civilian hospital, was amazed at the support and care that I was receiving.

It took 2½ months of surgeries and general rehabilitation before I was ambulatory and able to exit my bed. During that time secondary complications added to the difficulty of my physical and occupational therapies. At the end of August 2006 I moved to the Veterans Affairs active duty rehabilitation unit to further my progress. Prior to leaving Eisenhower I met the head doctor and physician's assistant from the VA rehab unit. They briefed me on the facility, staff and the uniqueness of the unit I was about to become a part of. I quickly realized the unit was staffed at all levels by capable professionals filled with compassion for all injured soldiers. My inpatient status at the VA lasted 10 months. During that time I reported back to Eisenhower for regular doctor reviews and follow-up surgeries, but my day-to-day needs were very effectively taken care of by the VA.

I moved back to Fort Gordon in July 2007 and continued my rehabilitation here at the VA as an outpatient. To date, I have received 16 surgeries and have at least two more planned. I'm able to perform all basic ADLs, but I still have my limitations. Every day is a new challenge and a new opportunity.

No process or program is perfect and improvements can always be made. Some part of my personal success is the fact that I'm a senior NCO and I know my way around the military structure. The areas I believe which need to be refined and better integrated for the benefit of all injured soldiers are as follows.

Case management: it appears to me that most injured soldiers are in their late teens or early 20's and they have not been in the military very long. Even though some may be seasoned early by their experiences, they really don't know how to get around a bu-

reaucracy. Their families are under emotional stress. The individual is both physically and emotionally traumatized. The issue is continuity. In my own case I've dealt with seven different case managers in the past year, both civilian and military.

Financial entitlements: there has been a rush to establish an upgrade in various entitlements for injured soldiers. Some are specific to veterans who have served in theater and others are applicable to all soldiers regardless of where injured. The problem is no one individual appears to be responsible for advising the soldier of the entitlements or where to find them. A simple checklist and official briefing on all potential entitlements may be a simple answer, but the responsibility to manage the ongoing change needs to be assigned somewhere.

Family visitation: when I first arrived at Eisenhower I was told that while I was in the hospital two to three family members would be covered on official Army orders. The orders were intended to cover their lodging and per diem while I was in the hospital. However, once I moved to the VA this entitlement stopped. There appears to be some inconsistency in the policy, because I did find in casual conversation that people who complained actually received more support to have their families with them. While this was really no concern to me, I'm concerned for the young soldiers who may be the sole income producers for their families and don't have other opportunities. Family participation in the recovery of the soldier is critical.

The health care I received from the U.S. Army and the Veterans Affairs has been exceptional. My family and I have been treated with respect and compassion always. I'm amazed at the capabilities I've recovered in such a short time. I will be forever grateful. In my opinion, this unique partnership should be expanded anywhere complementary facilities exist. This is to ensure the largest number of injured soldiers return to their maximum potential. Thank you.

PREPARED STATEMENT OF SERGEANT FIRST CLASS THOMAS M. MORRISSEY,
ILLINOIS NATIONAL GUARD SOLDIER

Good morning Chairman Isakson and Members of the Committee: My name is Sergeant First Class Thomas M. Morrissey. Thank you for extending me the invitation to speak before you today. I've served in uniform for over 30 years. For the last 13 years, I've been a member of the Illinois National Guard and I'm proud to be a citizen/soldier in service to his country during a time of national need.

In June 2006, I was on my 3rd combat tour in Afghanistan when I was caught in an enemy ambush. As a result, I received 8 direct hits from an AK-47 in all 4 extremities and my upper pectoral area. I'm able to speak to you today because of the superior leadership, training, equipment and medical care provided to me by the U.S. Army. It starts with my team commander who insisted on extensive medical training and rehearsals during our pre-deployment train-up. It was due to his leadership and emphasis on training that I reacted without having to think in the seconds after being shot.

Medical personnel from an American forward operating base (FOB) quickly responded to my call for assistance. I was in the air on a medical evacuation flight 45 minutes after the ambush and into my first surgery within 2 hours. I awoke in the recovery room the next day and my first thought was about my family. They had been contacted shortly after I was injured and were at home when I called to speak to them. I owe my Battalion Commander many thanks for personally keeping them advised on my status. The next day I left Afghanistan for Germany where I remained for 5 days and 2 additional surgeries.

Nine days after receiving my wounds, I arrived at Eisenhower Army Medical Center (EAMC), Fort Gordon, GA. I was reunited with my family in the emergency room where the medical staff gave us a joint briefing on what to expect. The next

morning I began the process of having both my arms rebuilt. My right humerus bone had been shattered and a cadaver bone was implanted as part of the repair. In my left forearm, both my ulna and radius bones were fractured. The nerves in both arms were traumatized so I could not use the arms to do anything. Both of my legs had extensive soft tissue damage, but no fractured bones.

Every morning, a procession of doctors would start their rotation through my room at 0600 hours. I was completely dependent on the nursing staff to assist me in all activities of daily life (ADL). This humbles a person even more than the initial realization that one cannot do the simple things we all take for granted. This went on for months. My wife, who is a social worker in a civilian hospital, was amazed at the attention and support I was receiving.

It took 2½ months of surgeries and general rehabilitation before I was ambulatory and could exit my bed. During that time, secondary complications added to the difficulty of my physical and occupational therapies. Lymphodema, heterotrophic ossification, muscle atrophy, a gangrenous gall bladder, multiple infections caused by the hospital environment and even tinnitus made it difficult to establish a regular, effective rehabilitation regimen.

At the end of August 2006, I moved to the Veterans Affairs (VA) Active Duty Rehabilitation Unit to further my progress. Prior to leaving EAMC, I met the head doctor and physician's assistant from the VA rehab unit. They briefed me on the facility, staff and the uniqueness of the unit I was about to become a part of. I quickly realized the unit is staffed at all levels by professionals filled with compassion for all injured soldiers.

My inpatient status at the VA lasted 10 months. During that time, I reported back to EAMC for regular doctor reviews and follow-on surgeries, but my day-to-day needs were very efficiently served at the VA. I moved back to Ft. Gordon in July 2007 and continue my rehabilitation as an outpatient at the VA. To date I've received 16 surgeries and have at least 2 more planned. I'm able to perform all basic ADLs, but I still have my limitations. Everyday is a new challenge and an opportunity.

No process or program is perfect and improvements can always be made. Some part of my personal success is the fact I'm a senior NCO who knows how to make his way around the structure of the military. The areas I believe which need to be refined and better integrated for the benefit of all soldiers are as follows:

1) Case Management—It appears most injured soldiers are in their late teens or early twenties and have not been in the military very long. Some may be seasoned early by their exposure to a war zone, but most do not yet know how to deal effectively with a bureaucracy. This is especially true when they and their families are under physical and emotional stress. The case manager is expected to help the people assigned to them with the everyday management of their health care program. The issue is continuity. In my own case I've dealt with 7 different case managers in the past year, both civilian and military. Based on their individual training, experience and personality their effectiveness in helping or hurting a soldier varies.

2) Financial Entitlements—There has been a rush to establish and upgrade various entitlements for injured soldiers. Some are specific to veterans injured in theater and others are applicable to all soldiers regardless of how and where injured. The problem is no one individual appears to be responsible for advising the soldier of the entitlements, or where/how to get them. A simple checklist and official briefing on all the potential entitlements maybe the simple answer, but the responsibility to deal with the on-going changes needs to be assigned somewhere.

3) Family Visitation—When I first arrived at EAMC, I was told that while I was in the hospital two family members would remain on official Army orders. The orders were intended to cover reimbursement on lodging and per diem when the family members were visiting me in Augusta, GA. Once I moved to the VA, I was told the family orders were no longer valid. This seems to be an inconsistent policy. In casual conversation with other soldiers I found those who complained received extended compensation for their family members. My concern is not for myself, but the junior enlisted who maybe the sole income producing member of a family. Family participation in the recovery of the soldier is critical and should be supported.

The health care I've received from the U.S. Army and the Veterans Affairs has been exceptional. My family has been treated with respect and compassion always. I'm amazed at the capabilities I've recovered due to the joint effort of my doctors, therapists and nurses. I will be forever grateful. In my opinion, this unique partnership should be expanded anywhere complementary facilities exist to insure the largest number of injured soldiers recover their maximum potential.

Senator ISAKSON. Thank you, Sergeant. [Applause.]

Specialist Capps.

STATEMENT OF JASON CAPPS, SPECIALIST, U.S. ARMY

Specialist CAPPS. Good morning, Senator Isakson and Members of the Committee. My name is Specialist Jason Capps. As the Chairman said, I was in the U.S. Marine Corps in the intelligence field and was deployed during Desert Storm. I rejoined the service back in September 2006 as a member of the U.S. Army as a combat medic. Never did I question whether or not I made the right decision to join the Army because I believe in the war efforts we have in Iraq. In May I was again deployed in Iraq with the 3rd Infantry Division, 269 Armor. My unit had already been deployed, so I had to play a little catch up and met with them at FOB Kalsu. I was thrilled that I'd been put with some of the best soldiers the Army had to offer.

We had three general duties that we performed. The majority of the time we were the QRF unit that was deployed if a convoy took a hit from an IED, or if another U.N. convoy needed our assistance. We also performed other daily missions as well. For 3 days of each week we rotated guard on two different posts: Checkpoint 20 and 21.

It was on Checkpoint 20 where I received life-changing injuries. On June 10, an Iraqi suicide bomber drove a civilian vehicle packed with explosives equivalent to a 4,000-pound bomb under our bridge and detonated the device. The bridge, along with our squad, fell to the ground. Fortunately, our troops that were on the other side of the bridge were not injured. Out of the ten soldiers that were on our side of the bridge, three soldiers were killed and six of the remaining soldiers were injured, including myself. Luckily for us, one of our lieutenants was on Checkpoint 21 and was outside at the time of the explosion. He saw the explosion, radioed our location and got no response, and at that time he called the QRF unit back on FOB Kalsu. He jumped into a vehicle and came to our aid within minutes; and also luckily for us, there was a U.S. convoy coming through at that time who stopped and rendered aid to us.

The U.N. personnel along with our lieutenants secured the areas and radio command our nine-line Medevac. Within 20 minutes I was on a Black Hawk helicopter headed for Baghdad. As a result of the blast I received two spinal fractures, six pelvic fractures and multiple facial lacerations, which basically confined me to a gurney for the next week while in transition back to the U.S.

The medical personnel I came in contact with from Baghdad to Landstuhl, Germany, were very compassionate and professional in all treatment needs. They also made sure that I stayed in contact with my wife and family at all times. I called my wife immediately to inform her in case she had happened to be seeing anything on the news. I didn't want it to be alarming to her. My wife relayed the information to my brother and sister as soon as I got off the phone with her at 0300 Monday morning. My mother was reading an article that morning in the paper about a bridge collapse and thought I might have been in the area and was concerned. My brother informed her that I was in the blast and that I was stable. My doctors and nurses made sure that I made contact with my

mother and family at all times for their peace of mind. I will never forget their attention to detail.

I was originally sent back to Martin Army Hospital at Fort Benning. After consulting with the physicians we determined that the active duty rehab facility would be the best place for me to rehab. My wife, Darla, actually works at a VA hospital in Oklahoma in the prosthetics department. I was asked if I would like to do my rehab in my hometown. I telephoned my wife and her immediate response was no. Her reasoning was this: the rehab I would receive in Oklahoma would be based on an older generation and not the aggressive rehab that I needed. Our decision was made to do the rehab in Augusta because of the information we received of the top notch care and resources that were available. Our decision was correct.

I never expected the care and compassion that I received from day one at the active duty department. My daily life now comprises physical and mental rehab. My in-house doctor and therapists are always asking me how I'm doing. My problems are dealt with immediately instead of later. I feel if I'm going through something they are sincerely concerned with my issue.

I have mentioned mental rehab. Our recreational therapist, Dave James, works to no end to make sure that we have recreational events every week. He does this with the help of the community and other nonprofit organizations such as the Reynolds Plantation that wanted to help in our rehabilitation. He sacrifices his own time that he could be spending with his family for the soldiers of this unit. There are no words that can express my gratitude to him.

The nursing staff is led by Jeff Beard and it's one of the most caring groups of people I've ever come in contact with. Without these professionals this unit would not be a success story. If it were up to me there would be a unit like this in every region of the country. I believe that I would still be in a wheelchair at this time—at least for another 2 or 3 months—if it wasn't for these people. To the employees of the active duty rehab unit I say thank you.

We now have a platoon sergeant and a squad leader who acts as our liaison between the VA and the Army to make our lives less stressful and help us with our individual concerns. This will, in turn, take a partial load off Master Sergeant Stewart who has been working so diligently to take care of our needs. They can now work together to achieve the goals that are set in front of us.

We do have a few issues that need to be addressed to try to maximize our mission. There are a number of entitlements that most soldiers do not know about. We could use specialists in that area who can explain them thoroughly to each soldier that comes to the unit. Soldiers, including myself, are having a hard time receiving our personal belongings from theater locations. We are being told that our belongings are in transit but cannot be traced.

Third, it would be more efficient for us to be able to receive treatment from the doctors who specialize in each individual's needs here at the VA Medical Center instead of being transported to the Eisenhower Medical Center for each appointment. We are having a tough time even being seen on base because of the number of soldiers that are walking through their doors on a daily basis. There

are other small things that are troublesome but everyone from doctors to military are trying to eradicate the situation.

From the time I was transferred here there have been a number of groups and organizations that have come to my aid. Operation Homefront, Operation First Response and the Reynolds Plantation are only a few of the organizations that have helped me since I've been back. Airplane tickets for my family, rental cars, clothing are only a few of the things that have helped—they have helped me with.

Two weeks ago I was invited to attend a trip to Washington, DC, to view different sights, the Pentagon, the Capitol Building, Arlington Cemetery and all the different war memorials. The part that hurt me the most was going to Arlington Cemetery and seeing the graves of the soldiers—excuse me. It made me sad knowing that many more soldiers would be buried there before it's over. Hopefully, none of these soldiers perished because of a lack of care. As for me, my government has done its very best to make sure that I have a full recovery. Every soldier deserves the right to heal with the very best resources we have to offer. Thank you. [Applause.]

PREPARED STATEMENT OF SPECIALIST JASON CAPPS, U.S. ARMY

Good morning Chairman Isakson and Members of the Committee. My name is Specialist Jason Capps. I appreciate the opportunity to share my story with you today. From 1990 to 1993, I served as a United States Marine in the Intelligence field and was deployed overseas during Desert Storm. In September 2006, I joined the U.S. Army as a Combat Medic to again serve my country in its time of need. Never did I question whether or not I made the right decision to join the Army because I believed in what we are doing for Iraq.

In May 2007, I was again deployed to Iraq with the 3rd infantry Division, 2-69 Armor. My unit had already been deployed in March so I had to catch up to them at FOB (Forward Operating Base) Kalsu. I was thrilled that I had been put with some of the best soldiers the Army has to offer. We had three (3) general duties we performed. For the majority of the time, we were the QRF unit (Quick Reaction Force) that was deployed if a convoy took a hit from an IED or any other United Nations Force that needed our assistance. We also performed other daily missions as well. For three (3) days of each week, we rotated guard on two (2) different bridges (checkpoint 20 and 21). It was on checkpoint 20 where I received life changing injuries.

On June 10, an Iraqi suicide bomber drove a civilian vehicle packed with explosives, equivalent of a 4,000 lb. bomb, under our bridge and detonated the device. The bridge along with our squad fell to the ground. Fortunately, our troops that were on the other side of the bridge escaped without any injuries. Out of the ten soldiers that were on our side of the bridge, three soldiers were killed and six of the remaining were injured, including me. Luckily for us, one of our lieutenants was on checkpoint 21 (approximately one mile away) and witnessed the explosion and immediately radioed our location and received no response. At this time, he radioed the Quick Reaction Force on FOB Kalsu and jumped into a vehicle and came to our aid within minutes. We were also blessed to have a U.N. convoy at our site within minutes. Our lieutenant along with the U.N. personnel secured the scene and radioed to command the 9-line medevac report. Within 20 minutes, I was on a Black Hawk helicopter heading for Baghdad.

As a result of the blast, I received two (2) spinal fractures, six (6) pelvic fractures and multiple facial lacerations which basically confined me to a hospital gurney for the next week while I was being transferred back to the United States. The medical personnel I came into contact with from Baghdad and Landstuhl, Germany were very compassionate and professional in all of my treatment needs. They also made sure that I stayed in contact with my wife and family everyday to reassure them of my health and well-being. As soon as I arrived in Baghdad, they insisted that I call my wife immediately to inform her in case she happened to see something in the news and become alarmed. My wife relayed the information to my brother and sister as soon I got off the phone with her at 0300 Monday morning. My mother was reading an article in the morning paper about the bridge blast and thought I

might have been in that area and was concerned. My brother informed her that I was in the blast, but I was stable. By the doctors and nurses making sure that I made contact gave my mother and family peace of mind. I will never forget their attention to detail.

I was originally sent back to Martin Army hospital at Ft. Benning. After consulting with the physicians, we determined that the active duty rehab facility would be the best place for me to rehab. My wife Darla actually works at a VA hospital in Oklahoma in the prosthetics department. I was asked if I would like to do my rehab in my home town. I telephoned my wife and her response was "NO." Her reasoning was this. The rehab I would receive in Oklahoma would be based on an older generation and not the aggressive rehab that I needed. Our decision was made to do my rehab in Augusta because of the information that we received of the top notch care and resources that were available. Our decision was correct. I never expected the care and compassion that I received from day one at the active duty department.

My daily life now is comprised of physical and mental rehab. My in-house doctor and therapist are always asking me how I'm doing. My problems are dealt with immediately instead of later. I feel that if I'm going through something, there are sincerely concerned with my issue. I had mentioned mental rehab. Our recreational therapist, Dave James, works to no end to make sure that we have recreational events every week. He does this with the help of the community and other non-profit organizations such as the Reynolds Plantation that want to help in our rehabilitation. He sacrifices his own time that he could be spending with family for the soldiers of our unit. There are no words that could express my gratitude to him. The nursing staff is lead by Jeff Beard and is the most caring group of individuals I've ever witnessed in any hospital environment. I can actually say that we are for the most part a big family including doctors, therapists, nurses and patients. Without these professionals, this unit would not be a success story. If it were up to me, there would be a unit like this in every region of the United States. As of Monday, August 20, I no longer require the use of a wheelchair. I believe that I would still be in a wheelchair for at least other two or three months if I would have gone anywhere else. To the employees of the Active Duty Rehab Unit I say "Thank you."

We now have a platoon sergeant and squad leader who act as our liaison between the VA and the Army to make our lives less stressful and help us with our individual concerns. This will in turn take partial load off Master Sergeant Stewart who has been working so diligently to take care of our needs. They can now work together to achieve the goals that are set in front of us. We do have a few issues that need to be addressed to try and maximize our mission:

- There are a number of entitlements that most soldiers do not know about. We could use a specialist in that area who can explain them thoroughly to each soldier that comes to the unit.
- Soldiers, including myself, are having a hard time receiving our personal belongings from theater locations. We are being told that our belongings are in transit but cannot be traced.
- It would be more efficient for us to be able to receive treatment from the doctors who specialize in each individual's needs here at the VA Medical Center instead of being transported to the Eisenhower Medical center for each appointment. We are having a tough time even being seen on base because of the number of soldiers that go through their doors on a daily basis.

There are other small things that are troublesome but everyone from doctors to military is trying to eradicate this situation. From the time I was transferred here, there have been a number of groups and organizations that have come to my aid. Operation Home front, Operation First Response and the Reynolds Plantation are only a few of the organizations that have helped me since I've been back. Airplane tickets for family, rental cars, hotel rooms and clothing are only a few things that they have helped me with.

Two weeks ago, I was invited to attend a trip to Washington, DC, to view different sites like the Pentagon, Capitol building, Arlington Cemetery and all of the different war memorials. The part that hurt me the most was going to the Arlington Cemetery and seeing the graves of the soldiers that were lost in Iraq. What made me sad was imagining how many more soldiers will be buried there before it's over. Hopefully, none of these soldiers perished because of lack of care. As for me, my government has done its very best to make sure that I have a full recovery. Every soldier deserves that right—to heal with the very best resources we have to offer.

Senator ISAKSON. Specialist Capps, that is exactly why we are here today, to see to it that our soldiers get the very best care possible. And as your testimony has said, what's being done here at

the Augusta VA Medical Center is the example of exactly what you want for every soldier in the military, if I understood your testimony.

Specialist CAPPS. Yes, sir. Thank you.

Senator ISAKSON. I want to take just a minute to ask both of you a couple of questions and I want to thank you very much for your testimonies.

Sergeant Morrissey, Specialist Capps repeated your second point in terms of recommendations with regard to financial entitlements. And in the Committee in Washington—I know our staff would go along with this—we have heard this a number of times. What suggestion—understanding that you’re a 30-year veteran and know your way around the military—which I appreciate that comment because sergeants always do—tell us what you would recommend the military do in terms of making those entitlements known on a timely basis to these soldiers.

Sergeant MORRISSEY. The first observation, Senator, is that the information needs to be distributed within the hierarchy of the military and explained fully before it can leak out and be disseminated down to the soldiers. I found that I had any number of family, friends, military, nurses telling me about every little thing and then as I started to push, I knew that the people I was talking to weren’t even aware of some of these things. For instance, like the combat injury pay. The TSGLI (which I didn’t know about until I awoke in the hospital and one of the nurses told me about it), at first I couldn’t even believe it was true. But then finding people—you know, you go through all the case managers and they are saying, “it’s, well, you know, that’s not me now. That’s not my responsibility.” Well, if you’re supposed to be taking care of my needs, what are you supposed to be doing? So, I really think that the information needs to be distributed through the hierarchy and understood immediately; and taught where the responsibility for dissemination of that information lies. The biggest confusion I found was people pointing at the other guy.

Senator ISAKSON. In your testimony you said you had seven case managers. Was that within your time here?

Sergeant MORRISSEY. That is correct. Both the time that I spent at Eisenhower, the VA, and then being moved back to Eisenhower, I have been through seven different case managers, which for me—I’m not saying it was a problem for me. But, I always am concerned that if the younger troops who don’t know how to make their way encounter that, they may be less willing to push ahead. So, I think we need to make it easier for younger troops.

Senator ISAKSON. I have two questions, subquestions, to that. Number 1, are the case managers facility-specific rather than soldier-specific? In other words, case managers at Eisenhower and case managers at the Augusta VA don’t cross.

Sergeant MORRISSEY. Correct. When I was at the hospital in Eisenhower I dealt with them. When I moved over here, I was told the case manager here would be my primary contact. But then once I moved back, then I was assigned to another person again. So for me it was easy to make my own way, but I use the example simply because I’m not sure if a younger person, less experienced, would be as aggressive in pushing ahead.

Senator ISAKSON. But those case managers, are they full-time case managers? I mean, is that their job?

Sergeant MORRISSEY. Yes, I believe so.

Senator ISAKSON. In terms of hierarchy, I take it that what you meant by that was, not everybody in the hierarchy knows what everybody else knows with regard to benefits, and it's kind of a patchwork; is that correct?

Sergeant MORRISSEY. That is correct, sir.

Senator ISAKSON. Your testimony is very helpful. Thank you.

Specialist Capps, your testimony was wonderful and part of it hit home with me on why it's so important what Doug and everybody down here have done. I just left 2 weeks ago touring the VA hospital in Atlanta on Clairmont Road and there were a lot of veterans who were receiving services, and they were veterans of World War II, Korea and Vietnam. What struck me, having been to Landstuhl and Walter Reed hospitals, is the dramatic change in the types of injuries in this war. In Afghanistan and Iraq the weapon of choice is an explosive IED or a suicide bomber, and the injuries are traumatic, both from a standpoint of the brain as well as the extremities. For the benefit of those who don't know that, would you talk a little bit about the time—from the time you were hit and the 20 minutes you were picked up and your process in how you got treatment due to those types of injuries.

Specialist Capps. Well, at the time I was hit I immediately went to the ground. I remember the actual explosive blew up directly below me. Everything went black. I stayed conscious the whole time, though. I remember lifting up and coming back down. The reason why I mentioned that our guys were some of the best I'd ever seen was their professionalism—no matter what their age. They immediately secured the area in which we did have some insurgent activity. It was dealt with very, very quickly. Before I knew it, I was on a helicopter. Our lieutenant had secured the area. All the personnel who needed to be treated were treated quickly by our combat lifesavers. I was the only actual medic out there on the scene until the U.N. convoy showed up, which was minutes after it happened. Some of those guys jumped in the middle of it. I was amazed to see them work. By the time I got on that Black Hawk I had nurses there, doctors already on the Black Hawk treating my wounds and making sure that—just like a little cut on my nose here. Actually, the tip of my nose was almost cut off. They had put it back into place and before I got there, they already knew my injuries; and immediately—there were six of us brought in at that time—and at that point they jumped in there. Those people were so professional in what they did. I had x-rays; talking on the cell phone to my wife I had all my lacerations fixed on my face. This was in the first—within the first 30 minutes to an hour. That was how quick and how responsive they were. And some of the other gentlemen who had facial lacerations were being dealt with too. The personnel were great there. I hope that answers your question a little bit on how the—

Senator ISAKSON. One of the points I was getting to—you went from the battlefield to immediate care within minutes. Did you then go to Landstuhl?

Specialist Capps. Yes, sir.

Senator ISAKSON. How did you—did you go by C-17?

Specialist CAPPS. Yes, sir. Yes, sir.

Senator ISAKSON. Which is this phenomenal piece of equipment, if you've ever seen the Medevac C-17 configuration. I appreciate your paying tribute to those people at Landstuhl because they do a miraculous job as well. The point I was getting to is because of those miraculous jobs—both because of the equipment that our soldiers now have on the torso and the blast glasses and all those protective things, the preponderance of injuries are to the extremities and you have a lot more amputations. You have a lot more prostheses and you have a longer type of medical service need. It's not—it's not just like your nose. You can sew it up and it looks just fine and it's not going to cause you a problem. But there are other injuries where—not only while you're on active duty but as a veteran retired or off-duty you're going to continue to need those services. That's why what they've done here is so important, because it's a seamless transfer and those injuries are really timeless. Many of them will be with you the rest of your life. So, your story was very important to illustrate to everybody the nature of the injuries that are received in Afghanistan and Iraq and the need for that seamless transfer from DOD to VA and the long-term care that our veterans deserve and should get.

Specialist CAPPS. Yes, sir. It was very, very seamless; and it was very caring all the way—all the way—even on the transport, sir. The medical personnel there were attending to every need of every soldier who was wounded.

Senator ISAKSON. It's a flying hospital, isn't it?

Specialist CAPPS. Yes, sir.

Senator ISAKSON. And your recommendation, which echoed Sergeant Morrissey's recommendation on entitlements, you said precisely the same thing he did in a different way. We will take that back to the Committee and work with the Department of Defense and see what we can do to make that better so that particularly the young soldiers who don't know their way around have a one-stop shop where they can go and get the information they need on the entitlements that they have earned and deserve. Thank you very much for your testimony today. [Applause.]

As our next panel is coming forward and our two veterans are making room for them, I'm going to break with the agenda, which since I'm the only person from the Committee here I guess I've got the authority to do. I want to introduce Laurie Ott. Laurie, could you come up here a second. Would you come right over here.

I'm introducing Laurie because she is, as I told Doug Barnard, she's easy on the eyes. But also, she's got a great story to tell about what has been done here in Augusta and about how this idea started. And just like these two brave, courageous veterans who have just testified—talk about a veteran that really was the catalyst to make this happen.

Laurie, would you take a minute or two to just fill us in.

**STATEMENT OF LAURIE OTT, EXECUTIVE DIRECTOR, CSRA
WOUNDED WARRIOR CARE PROJECT, AUGUSTA'S VA MEDICAL
CENTER AND THE ACTIVE DUTY REHAB UNIT**

Ms. OTT. Thank you, Senator. It is a delight and an honor to be here with you. Thank you so much for coming to Augusta. We really appreciate your efforts, all that you have been doing and all that we hope you do.

I had the pleasure and honor, really, of interviewing Specialist Crystal Davis in early March of this year. She is a 22-year-old young woman from Camden, South Carolina. She was in Ramadi, Iraq, in November 2005. She's a track mechanic. She was supposed to fix the tracks on tanks and when she arrived in Iraq she realized there weren't any tanks and she would be doing something else.

She was driving an 18-wheeler truck to go retrieve our exploded vehicles from the road and they were also on a convoy to discover and find IEDs. She found one. Her vehicle suffered an IED blast directly under her vehicle on the driver's side and she ended up losing her leg in that blast. She said she saw it happening; she could feel it happening. And she told me when it was happening she thought, well, I guess I'm going to lose that leg.

She ended up being transferred very quickly from Iraq to Landstuhl; from Landstuhl to Walter Reed. She was at Walter Reed and had dozens of surgeries—more than she could count. She said she received excellent medical care at Walter Reed; however, when it came time for her physical therapy and occupational therapy, there was a delay. She said she could get one appointment a day at Walter Reed, but she said she felt she needed more. And she also felt that conditions were very crowded and that she wasn't being pushed. When she would come home to Camden from Walter Reed and visit her family, she would notice she would get better and then when she returned to Walter Reed she felt she would deteriorate. She ended up being transferred to the active duty rehab unit here at the VA and she reported to me that she arrived on a walker and within 3 weeks was on her prosthetic full time.

I thought this was a very dramatic story and I thought it should be told, so, we featured her on the news. Additionally, Specialist Davis told me something else. She said it was the best thing that had ever happened to her, that she felt it had given her a purpose in life; and now she wants to go to physical therapy tech school in Texas to become a physical therapy technician. She wants to turn around and help those like herself. And I hope that one day she gets transferred back to Augusta. I hope she ends up working in our active duty rehab unit. I think she's a wonderful example of the service the men and women of our military give to our country, and we can never thank them enough. She's a source of inspiration for all of us. Thank you for letting me tell her story.

Senator ISAKSON. Thank you, Laurie. Crystal's story is a very important testimony to what's been done here—how much quicker she got service and how much better she got in time because it was close in proximity and easy to access. Thank you, Laurie.

I'd now like to introduce our second panel. First is Dr. Dennis Hollins. Dr. Hollins is a Ph.D. and he's the medical director of the Augusta VA Medical Center active duty rehabilitation unit at the

Augusta VA Medical Center. Welcome, Doctor. We're glad to have you.

Next is the guy I brag about all the time, General Schoomaker, who right now is on duty at Walter Reed Army Hospital in Washington, DC, where I spend about 1 day every couple of months when there's a Georgia soldier there, going to see firsthand the services that they receive. And I can tell you that they are just phenomenal, General, and I appreciate what you're doing. I also appreciate your attention to address those problems that we have experienced to see to it that it gets even better.

And last but not least, Brigadier General Bradshaw. Welcome, sir. We're glad to have you at this hearing today and glad to have you at this Vet Center. Your service to your country has been wonderful and outstanding. Your service here at Eisenhower is phenomenal and we're very appreciative.

If each of you would take about 5 minutes—we have your written testimony, which will be submitted for the record, I might add. We'll start with you, Dr. Hollins, and then we'll go along and then I'll have a few questions for each of you.

Dr. HOLLINS. Thank you. Good morning, Senator Isakson.

Senator ISAKSON. Good morning.

**STATEMENT OF DENNIS HOLLINS, M.D., MEDICAL DIRECTOR,
ACTIVE DUTY REHAB UNIT, AUGUSTA VA MEDICAL CENTER**

Dr. HOLLINS. Congressman Broun and other distinguished guests, on behalf of the staff of the Augusta VA Medical Center I would like to welcome you to our fair city and our facility; and to thank you for your dedication and service to our Nation's veterans and servicemembers. Thank you also for allowing me to represent the U.S. Army Southeast Regional Medical Command and the VA Southeast Network (VISN7).

It is my pleasure and honor to share with you how the Department of Veterans Affairs and the Department of Defense work together on the active duty rehabilitation unit at the Augusta VA to provide health care to wounded soldiers returning from Iraq and Afghanistan. I would like to request my written statement be submitted for the record.

Senator ISAKSON. Without objection.

Dr. HOLLINS. The active duty rehabilitation unit at the Augusta VA meets the unique intensive medical rehabilitation needs of active duty servicemembers injured in combat or who sustain serious non-combat injuries during service. Since the program was created 3 years ago the active duty unit has provided care to more than 1,037 servicemembers—more than 491 of whom were treated as inpatients. Approximately 32 percent of all patients were injured in combat in Operation Enduring Freedom or Operation Iraqi Freedom, and about 25 percent of our admissions are for brain injuries. Roughly 16 percent of our admissions will be considered for medical retirement through the medical board process and, as you noted, 26 percent of our inpatients are returned to their units fit for duty.

Even before OEF and OIF began, the military knew providing care to wounded servicemembers would demand the highest priority. Then-Brigadier General Eric B. Schoomaker, the com-

manding general of Eisenhower Army Medical Center, approached Augusta VA officials in August 2003 to determine if a team of medical specialists capable of providing therapeutic support could treat patients at Eisenhower. Augusta VA's leadership proposed a new active duty inpatient unit in the Augusta VA Medical Center and this unit would provide clinically managed and medically rehabilitative care to active duty servicemembers. The active duty unit received its first inpatients in February 2004. Leadership obtained necessary rehab equipment, assembled a rehabilitation care team and oversaw the creation of a 3400-square-foot gym—a therapy gymnasium. Representatives from the Southeast Regional Medical Command and VISN7 signed a memorandum of understanding defining roles for the support and growth of the program.

As Committee members know, most combat injuries from OEF/OIF are the result of explosive blasts. Orthopedic injuries, wound management and Traumatic Brain Injuries are the most frequently seen medical problems at our unit. The active duty unit also contains a very strong PTSD or Post Traumatic Stress Disorder treatment program designed to help patients process their combat experiences. We screen all patients with combat exposure during the admissions process for both PTSD and TBIs.

The active duty unit maintains a warrior ethos for the sailors, soldiers, Marines and airmen we treat in a variety of ways, from addressing our patients by rank to using military terminology on the unit. A dedicated military liaison case manager handles administrative and command and control issues for our patients, which helps them and their families feel at home, helping to reduce their stress. This project has been a success because VA and DOD staff communicate openly and directly. Warrior and transition commanders at Eisenhower attend our weekly team conference meeting here in the VA and once a week the unit's medical staff attends the orthopedic surgery rounds at Eisenhower Army Medical Center. This cooperation and integration demonstrates what VA and DOD can do for our wounded servicemembers and veterans when we work together. The pride this Nation takes in those who serve is evident in the tremendous attention and accolades this unit has received.

This concludes my prepared statement. I'll be happy to take any questions you have.

[The prepared statement of Dr. Hollins follows:]

PREPARED STATEMENT OF DENNIS HOLLINS, M.D., MEDICAL DIRECTOR, ACTIVE DUTY REHABILITATION UNIT, U.S. ARMY SOUTHEAST REGIONAL MEDICAL COMMAND (SERMC) AND AUGUSTA VA MEDICAL CENTER AND VA SOUTHEAST NETWORK (VISN 7)

Good Morning, Senator Isakson. On behalf of the staff of the Augusta VA Medical Center, I would like to welcome you to our fair city and our facility, and to thank you for your dedication and service to our Nation's veterans and servicemembers. Thank you also for allowing me to represent the U.S. Army Southeast Regional Medical Command (SERMC) and VA Southeast Network (VISN 7). It is my pleasure and honor to share with you how the Department of Veterans Affairs (VA) and the Department of Defense (DOD) work together on the Active Duty Rehabilitation Unit at the Augusta VA Medical Center to provide health care to wounded soldiers returning from Iraq and Afghanistan. I would like to request my written statement be submitted for the record.

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members injured in combat or who sustained serious, non-combat injuries during service. Since the program was created 3 years ago, the Active Duty Unit has provided care to 1,037 servicemembers, 491 of whom were treated as inpatients. Approximately 32 percent of all patients were injured in combat in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF), and about 25 percent of our admissions are for brain injuries. Roughly 16 percent of our admissions will be considered for medical retirement.

Even before OEF and OIF began, the military knew providing care to wounded servicemembers would demand the highest priority. Brigadier General Eric B. Schoomaker, then Commanding General of Eisenhower Army Medical Center, approached Augusta VA officials in August 2003 to determine if a team of medical specialists capable of providing therapeutic support could treat patients at Eisenhower. Augusta VA's leadership proposed a new, active duty inpatient unit in the Augusta VA Medical Center. This unit would provide clinically managed and medically rehabilitative care to active duty servicemembers.

The Active Duty Unit received its first inpatients in February 2004. Leadership obtained necessary rehabilitation equipment, assembled a rehabilitation care team, and oversaw the creation of a 3,400 square foot therapy gymnasium. Representatives from the Southeast Regional Medical Command and VISN 7 signed a Memorandum of Understanding defining roles for the support and growth of the program.

As the Committee members know, most combat injuries from OEF/OIF are the result of explosive blasts. Orthopedic injuries, wound management, and Traumatic Brain Injuries (TBI) are the most frequent medical problems managed at the Augusta VA Medical Center. The Active Duty Unit also contains a strong Post Traumatic Stress Disorder (PTSD) treatment program, designed to help patients process their combat experiences. We screen all patients with combat exposure during the admissions process for PTSD and TBI.

The Active Duty Unit maintains the Warrior Ethos for the Sailors, Soldiers, Marines, and Airmen we treat in a variety of ways, from addressing patients by rank to using military terminology. A dedicated military liaison/case manager handles administrative and command and control issues for our patients. This helps our patients and their families feel at home, reducing their stress.

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Senator Isakson, this concludes my prepared statement. At this time I would be happy to respond to any questions you may have.

Senator ISAKSON. Thank you, Dr. Hollins.
General Schoomaker.

**STATEMENT OF ERIC B. SCHOOMAKER, MAJOR GENERAL,
M.D., COMMANDER, NORTH ATLANTIC REGIONAL MEDICAL
COMMAND AND WALTER REED ARMY MEDICAL CENTER**

General SCHOOMAKER. Good morning, sir. Greetings to you and to Congressman Broun and all the distinguished guests and leaders that are here today. Senator Isakson, thank you so much for the opportunity to participate in these hearings on these cooperative efforts between the Department of Defense, Department of the Army and the Department of Veterans Affairs in providing comprehensive and rehabilitative care to our service men and women. I'm Major General Eric Schoomaker. As you pointed out earlier, I currently serve as the commanding general of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center. I am Don Bradshaw's counterpart in the North Atlantic now.

The relationship between the Augusta VA and the Dwight David Eisenhower Medical Center has grown under a joint venture for shared services at JVSS since 1993. Under the JVSS we have

shared open heart surgery and other services such as physical therapy, hyperbaric therapy, gynecologic and obstetric services, just to name a few of the collaborative efforts that were here to enhance health care services for beneficiaries in the southeast U.S. and, really, throughout the services. I think it's important to note that two key conditions were present that have lent to the success of this collaborative effort that we see here in Augusta. The first is an essential pre-condition for a large cooperative team of health care leaders in the VISN7 and the integrated network for the VA that's comparable to our Army regional commands, especially the then-VISN director, Ms. Linda Watson and her chief medical officer, Dr. Carter Mecher; leaders in the Augusta VA Medical Center, notably the then-director, Mr. Jim Trusley, and his chief of staff Dr. Tom Tiernan who's here in the audience today; and leaders on my own Southeast Regional Medical Command staff at the time, our chief of staff Colonel, now retired, Sam Franko and our chief regional physician, Colonel Dr. Mike Stapleton, who's now retired and has fallen into the position that Carter Mecher had in the VA. Working closely with clinicians and administrators at both hospitals, especially Dr. Rose Trenser and now Dr. Dennis Hollins here at the Augusta VA Medical Center—you know, sir, I'm a little embarrassed that I'm often credited with being the creator of this and point out it's illustrative of that principle that when people like you they remember what you do well; when they don't like you they remember everything you didn't do well. And I guess this is just a sign people like me and that as a leader, things were working well, because this team was what really put this together, and I think that you know this as well as I do. I'm just privileged simply to be the talking head for that team.

This unique and very successful partnership is principally about a very visionary and industrious team working together with one goal in mind. And you heard Dennis describe that providing the best care for soldiers, sailors, airmen and Marines at a site that was closest to their home.

The second precondition that led to this success was the complementary plan for organizing services and patient referral on a regional basis. On a regional basis. Just as critical as the team I outlined above was the notion of overlapping the VA and Army regional health care delivery. In truth, this Augusta VA active duty rehab unit was just one of many successful programs that were subcomponents of a larger SERMC—that is Southeast Regional Medical Command—and VISN7 joint venture for shared services. Both the SERMC and the VISN committed to this overarching plan and this extends to other army medical and VA facilities in the regions that I believe the VISN director, Mr. Biro, will be talking about. Many of the first major active component units in support of OEF and OIF were deployed from Army posts within the SERMC area of responsibility—and you've heard about the 3rd Infantry Division. Quite frankly, early in OIF and OEF the 3rd Infantry Division out of Fort Stewart, Georgia; the 101st Airborne Division out of Fort Campbell, Kentucky; and many of the earliest National Guard and Reserve units that were deployed in support of the war came out of the southeastern U.S.. And it was apparent that we in Army medicine needed a regional response plan for the

injured soldiers that were discovered either during mobilization and training or for returning casualties, and that's when we turned to the Augusta VA Medical Center and the VISN7, and developed the active duty rehab unit. We leaned very heavily on their pre-existing expertise in Post Traumatic Stress Disorder, spinal cord injury, blind and deaf treatment, and the like.

I believe it's important to point out that these sharing arrangements between the DOD and the VA can aid in the success of the Army medical action plan. That's what the Army calls a larger operational and strategic plan which is standardizing many of the processes that you heard these two soldiers complain about—standardized approaches to benefit counseling, for example. We are centering much of that in our active duty large hospitals in soldier and family assistance centers, SFACs, so that we get our counselors, we get our finance people, we get our personnelists, VA benefits counselors, we get our VA health advisors all in one place working off of a single plan. It's very hard to coordinate the many, many diverse programs of—generous programs from charitable contributions to government programs that are intended to provide for the needs of these soldiers, sailors, airmen and families and that that, again, needs to be done in a standardized process that the Army medical action plan is working and very, very instrumental in that. I'll conclude my comments by pointing out how these shared arrangements between the DOD and the VA can aid in the success of this Army medical action plan which is being engineered by—the architect and engineer for that, the bureaucracy buster as we call him in the Army—is my deputy commander of the NARMC, Brigadier General Mike Tucker, who you may have met.

It's facilitating a seamless transition for these brave warriors—soldiers like Sergeant First Class Morrissey and Specialist Capps, and their families—who have borne really the heat of the battle. A seamless transition, either back to duty, because often lost in this is how many of these soldiers, sailors and airmen are returning to duty. The vast majority of them are going back to duty. We have retained 20 percent of our amputees in uniform with prosthetic devices. This is an unprecedented accomplishment, just as you pointed out the survival of battlefield wounds is unprecedented.

As a sidebar, I spoke on Saturday evening to the veterans—61st annual reunion of the 83rd Infantry Division, mobilized in 1942, trained in Camp Atterbury, Indiana. They landed in Normandy and saw 270 days of continuous combat from Normandy through the hedgerows, through Brittany into Luxembourg, the Hürtgen Forest. They were trapped at Bastogne; and crossed the Elbe river—the only military unit to cross the Elbe—and charged on Berlin before being called back. In 270 days, sir, they lost 1,500 casualties, 2,800 of whom died. I talked to the veterans of that conflict in that division. Many of the soldiers, like the two soldiers you saw today, in prior conflicts would not have survived. One soldier talked about seeing his first loss in combat, a man who had lost his arm and his leg simultaneously, and those soldiers could only stand by and watch that man bleed to death. Today we're seeing those soldiers back through the evacuation system and are taking care of them and many of them, thankfully, are returning to duty

or to productive civilian lives. And that's our goal and that's the goal of the Army medical action plan. In this regard the VA has been extraordinarily instrumental, providing us with VA counselors from a time no later than 30 days before the soldier is discharged from the hospital so that that handoff is smooth; and we have a warm handshake between the VA and the Army, or the services, to make that happen.

Sir, it's been a privilege to participate in today's hearings and I look forward to your questions.

[The prepared statement of MG Schoomaker follows:]

PREPARED STATEMENT OF MAJOR GENERAL ERIC B. SCHOOMAKER, COMMANDER,
NORTH ATLANTIC REGIONAL MEDICAL COMMAND AND WALTER REED ARMY MEDICAL CENTER

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 man-

agement 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 health care 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 health care 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 health care 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) Second, the notion of marrying the Army’s regional medical commands and VHA’s regional health care 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 U.S.C. 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 health care and rehabilitation initiatives.

Senator ISAKSON. Thank you, General.
General Bradshaw.

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

General BRADSHAW. Senator Isakson and other distinguished guests, thank you for the opportunity to discuss the relationship between the Southeast Regional Medical Command, Eisenhower Army Medical Center, Veterans Integrated Service Network 7 and the Augusta Veterans Affairs Medical Center pertaining to our joint mission to provide seamless quality health care to the brave men and women of the U.S. Armed Forces.

As a soldier, commander and 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 and their families. As the current commander of Southeast Regional Medical Command and Eisenhower Army Medical Center I recognize the importance of working cooperatively with our Veterans Affairs partners to ensure these warriors, veterans and their families receive the health care they need and deserve to restore themselves in body, soul and spirit.

As you have heard, Eisenhower and the Southeast have a long history of working with VISN7 and Augusta Medical Center to optimize the Federal health care resources for the provision of care. This collaborative relationship led to the establishment of the active duty rehab unit in 2004 and you've heard about that. Embedded in the active duty rehab unit, as Dr. Hollins mentioned, are our Eisenhower Army nurse corps case management staff and Eisenhower warrior in transition battalion command and control personnel. This combination of clinical and command elements enables the warriors in transition assigned to the active duty rehab unit to receive coordinated timely health care and to maintain the sense of military esprit de corps. In addition to these military liaisons, we have combined multi-disciplinary meetings where my staff comes down and meets with his and then his staff comes out and meets with my staff, not only on the clinical but screening potential patients, taking care of the emotional, spiritual, as well as the physical. Furthermore, a Department of Veterans Affairs health and benefits advisor is embedded in Eisenhower. This individual meets with our wounded warriors to ensure they have a basic understanding of their entitlements under the DVA system.

The remainder of my comments I'd like to focus on the resource-sharing achievements between Southeast Region, the VISN, Eisenhower and the Augusta Medical Center. Currently, our joint leadership meets on a regular basis to monitor the sharing activities, proliferate best practices and seek opportunities to partner and create efficiencies for providing health care services to the DVA and DOD beneficiaries. Examples of this sharing have already been mentioned and include imaging services, obstetrical and gynecological services, the sharing of intensive care unit beds and laboratory services. Eisenhower and the Augusta VA Medical Center also co-

operate in a number of joint endeavors to sustain the quality health care for our DOD and DVA beneficiaries and to maximize the available resources. Three significant ones are the neurosurgical program that was begun in 1995 and smoothly transitioned last summer from military positions to civilian positions. Second, the coordinated staffing and recruitment joint demonstration project which began in 2004 to recruit and train nurses for both our systems. And last, our cardiovascular—sorry, cardiothoracic resource sharing initiative.

I want to assure the 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 this opportunity.

[The prepared statement of BG Bradshaw follows:]

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

Senator Isakson, 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 1980's, 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 War-

riors 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 servicemembers 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.

Senator ISAKSON. Thank you, General, for your testimony.

Dr. Hollins, we just passed in the Senate the wounded warriors legislation. A part of that dealt with the subject you talked about, PTSD, and particularly with the referral of PTSD because PTSD is kind of one of those things, as I understand it, that can lay undiagnosed and then all of a sudden appear some time years later. Is that correct?

Dr. HOLLINS. Yes, it is, Senator.

Senator ISAKSON. Isn't it also correct that any number of specialists in the private sector, say an ophthalmologist, actually have the capability of detecting that and may be the first people to detect it after a soldier is in fact out of the military?

Dr. HOLLINS. Yes, that is true.

Senator ISAKSON. And my question is, if a soldier has gone to the ophthalmologist after he's out of the military—he fought in Desert Storm and he's been out a couple years—the ophthalmologist diagnoses that. Is there a referral back to VA for treatment on that, or how does that work?

Dr. HOLLINS. For PTSD treatment?

Senator ISAKSON. Yes.

Dr. HOLLINS. Yes. Well, any veteran who comes to the VA could be referred to a PTSD program in the VA. This is something that the VA has done for many years.

Senator ISAKSON. And you take those referrals out of the private sector if they in fact are already out of the military when it's diagnosed?

Dr. HOLLINS. Certainly, yes.

Senator ISAKSON. General Schoomaker, thank you for your humility. And I still give you a lot of credit, but I do realize what you said is true: that there's a terrific team here in Augusta. And you used the word visionary. Do you think what's happened here requires the visionary leadership at the local level up or is there a way we can maybe look to inspire some of that down? Because I know there have to be other cities and areas like Augusta where you have a major military installation and a major VA facility. Is there a way we could do that?

General SCHOOMAKER. Well, sir, I mean I'm going to be the ultimate compromiser and say it works both ways, I think. As you know, health care is a local event. Ironically, Don was the commander at Fort Benning where Specialist Capps was first returned to or deployed out of and where it was decided that he should be regionally managed by the Augusta VA Medical Center and Eisenhower.

So, the first thing I would say is that on a local and regional basis I think we have to attend to what the demands are on local commanders and to include the local units that these soldiers come out of to best serve their needs and serve the needs of their families. And that really is best done as close, as we've heard, to where they live, where their home bases are, where their families have settled and where that soldier wants to go back into his or her unit.

At the same time, I think that higher leadership needs to be in a position to allocate the resources and direct standardization and you've already attended to that with some of the questions directed to these soldiers. Local communities and even regional—regions can't be in a position of just open entrepreneurship of the program. There needs to be some standardization and allocation of resource to those places that do it well. And I think this notion that on a regional basis both for the VA and in this case the Army medical department—for our regional medical commanders to allow us the latitude to build these relationships close to where we have our large Army medical centers is the best way. And I've spoken to my counterparts and Don's counterparts at the Great Plains Regional Medical Command in San Antonio and the Western Regional Medical Command centered in Fort Lewis and the Pacific at Tripler and my own up at Walter Reed. We all feel the same way, that building these relationships one-on-one with the VA close to our major hub medical centers and large community hospitals is certainly the way to go.

Senator ISAKSON. Thank you, General.

General Bradshaw, you used the term shared services. General Schoomaker used the term shared services. Dr. Hollins used the term shared services. In the testimony of Sergeant Morrissey, I think at one point he referred to being directed back and forth between Eisenhower and VA, depending on the specialty. And I think what he was referring to, he had multiple injuries and multiple specialties; and with the seamless handoff that you've had down

here you're utilizing your assets at both facilities depending on what has the need. Is that correct?

General BRADSHAW. Yes, sir. We balance it, obviously focused on the patient—the soldier, sailor, airmen, Marines' needs—but also what our capacities are, because that changes day to day. How many ORs we have open, exactly what kind of specialists we have. I have a great hand surgeon but he deployed for 90 days so that we were dependent on other expertise, and we balance that back and forth, and that's the ongoing discussion that we have. That's the benefit of the close relationship and the ongoing interactions, routine meetings, and the comfort of our staffs to handle that. And it's not directed at high levels, but they do it on a daily basis. It's part of the reason we've put the case manager down here. It's part of the reason the C2 is down here and it's part of the reason that we have the joint meetings. Because patients don't go just from DOD to DVA; they go back and forth repeatedly, sometimes very close like this. Sometimes it's months in an active duty poly—I mean, VA polytrauma unit—and then they'll come back to our facility. So I think the relationship has got to be back and forth, not unidirectional; and that's key.

Senator ISAKSON. General Schoomaker, one last question. Both you and General Bradshaw addressed the concern that Sergeant Morrissey raised with regard to entitlements and receiving information. You referred to the medical action plan. I think that's what you referred to where you were working on that. How old is that medical action plan? Is that something that's been recently done?

General SCHOOMAKER. Yes, sir. The Army medical action plan, sir, was launched in early March, not long after the initial *Washington Post* stories that addressed the problems at Walter Reed.

I arrived at Walter Reed on March 3. My deputy, Mike Tucker, was—I selected him with the help of Vice Chief of Staff of the Army, General Cody, who has taken a personal and directive interest in this along with Secretary Geren. And that plan started on or about March 19.

It is now 6 months or so into the plan. It's been very aggressively pursued. The Army as a whole has very aggressively embraced this because it involves multiple major commands of the Army, not just the Army medical department but the installation management command that builds barracks and supports ADA compliance for those barracks. It impacts the personnel community because of assignment of cadres to warrior transition units, which is what we now call the units that are clustered around. You heard one of the soldiers talk about his now having a squad leader and platoon leader. Those are warrior transition unit cadre that are assigned by the Army.

So across the board, sir, this has been a very aggressive plan engaging the Congress at every step, so that they're aware through the House Armed Services and Senate Armed Services and the HAC and SAC to ensure that we are complying with their requirements that we fix the problems that we identified at Walter Reed; that it spreads across the Army as a whole and into the DOD; and it interfaces with our VA colleagues. Does that answer the question?

Senator ISAKSON. Well, it does. And the reason I asked the question was for you to be able to say that, because I want to commend you and the Army and the entire team spreading the credit as it is deserved for responding to that need and have done so in a remarkable way. And just as these soldiers—their injuries were a while back when that was not in place. I think what you've done and what's been done with the medical action plan addresses probably the single most repeated concern that we've got, which you've heard today. And I appreciate very much your timeliness in getting that. And I think also some of that came from recommendations from the Dole-Shalala Commission Report, if I remember correctly.

General SCHOOMAKER. Yes, sir.

Senator ISAKSON. So your responsiveness to that is appreciated and I thank you very much.

General SCHOOMAKER. Sure.

Senator ISAKSON. I thank all our panelists.

General SCHOOMAKER. Yes, sir. I wonder if I might make one last pitch—

Senator ISAKSON. Absolutely.

General SCHOOMAKER [continuing]. To follow on with one of the things that both Dr. Hollins and Dr. Bradshaw just discussed. And that has to do with this sharing of personnel but also the importance, as you heard Don describe, of maintaining a vibrant direct health care system within the military to maintain the readiness skills of our physicians, nurses, medics and the like. Now, you heard the fact that one of our most talented hand surgeons, Paul Cutting, was deployed in the middle of the treatment of one of these soldiers who had an upper extremity injury. It's not by chance, sir, that we are having the survival of battlefield wounds that you see today. Those surgeons and those critical care nurses that are in the air with the Air Force or on the ground in combat support hospitals, support surgical teams, sir, they maintain their medical readiness skills by working in Eisenhower and Walter Reed with folks every day on soldiers and sailors and airmen and Marines, their retiree population and their families. If we don't have that, sir, we're not going to continue to achieve the achievements that we have in combat.

Senator ISAKSON. Well, since you said that, I'll close with a comment from one of my constituents. You had a young man, Specialist Pearson, who was in Walter Reed about 3 months ago who I went to visit. He's from Cobb County, Georgia, which is my hometown. When I go to Walter Reed I usually—I don't usually, I always—give the soldier my home number and ask him to be sure and call—in Washington and ask him to be sure and call me if he needs anything. And I get the number of his parents and I call his parents just to let them know I went to see him and if they need anything, since I'm in Washington and they're in Georgia, just to let me know. So I called Specialist Pearson's father that night and got him on the phone and said, "Listen, I went to see your son today. It looks like he's doing good." He had some very serious injuries and had been in the hospital 10 days at Reed from coming from Landstuhl. I said, "He looks like he's doing good but I just wanted to let you know if there's anything I can do for you, just let me know." He said, well, there is something you can do for me. He

said, please tell everybody that my wife and I have been up there the last 10 days and our son has never received better care than he's received at Walter Reed. So that's a testimony from a father of a wounded warrior in Cobb County who I happened to shake hands with about 3 months ago at Walter Reed. That's the best testimony of all of what you do. Thank you. [Applause.]

While we're waiting on our last panel to come forward—for the record, for the staff—I want to, by unanimous consent, enter into the record the testimony of Dr. Rahn, President of the Medical College of Georgia. He could not be here today. And Mayor Copenhaver from Augusta, who, in his testimony, said Augusta used to be known for one week out of the year when the Masters was played, but now it's known for two things: the Masters; and for this great facility here that the VA and DOD have made together. So, I wanted you all to hear that. That's from the mayor's words himself.

Our final two panelists, welcome to both of you for being here. Mr. Lawrence Biro—is that correct, Biro?

Mr. BIRO. Yes, sir.

Senator ISAKSON. Network Director of the VA Southeast Network. And you are the VISN7 that everybody kept referring to in the previous testimony?

Mr. BIRO. That's right.

Senator ISAKSON. And Dr. Michael Kilpatrick, Deputy Director of Force Health Protection and Readiness Programs, U.S. Department of Defense. Welcome to both of you. Mr. Biro, you'll be first.

**STATEMENT OF LAWRENCE A. BIRO, NETWORK DIRECTOR,
VA SOUTHEAST NETWORK**

Mr. BIRO. OK. Good morning, Senator Isakson and Congressman Broun and distinguished guests. Thank you for this opportunity to participate in this hearing on cooperative efforts between the Department of Defense and the Department of Veterans Affairs.

I've submitted my written testimony and ask that it be included in the official record.

Senator ISAKSON. Without objection.

Mr. BIRO. Network 7 consists of the States of Georgia, South Carolina, and Alabama through its eight medical centers and 27 community-based outpatient clinics. The network serves a veteran population of over 1.5 million in this area, of which 300,000 are users of our health care system. Previous testimony has clearly presented the cooperative efforts between Augusta VA and the Eisenhower Army Medical Center. The active duty rehabilitation unit is our largest endeavor here in Augusta. These cooperative efforts in Augusta are the largest efforts within our network and account for approximately 75 percent of the cooperative arrangements in the network in terms of services purchased by the Department of Defense.

In that these projects have been fully discussed in previous testimony, I will not discuss them again. Instead I'll elaborate and outline some other cooperative arrangements we have in VISN7. Second, I'd like to just briefly talk about our efforts we have underway to ensure that there is seamless transition for active duty—from active duty to veteran status for our newest veterans. Our other co-

operative arrangements—the authority for these cooperative arrangements are 38 U.S.C. 8111 and we have several just up the road in Charleston, South Carolina. We're in the process of building a clinic in cooperation with the U.S. Navy, the Naval Weapons Station at Goose Creek. It's a \$41 million project. We will be sharing staff there and obviously physical facilities and there will also be equipment sharing.

There is the—it's been mentioned a couple of times—the joint incentive fund. This is a fund set up between the Department of Defense and the Department of Veterans Affairs to fund projects, and our Network has done very well. We've just been funded in Charleston for an MRI that will go into that clinic at Goose Creek. So that is one project. Just up the road is Columbia, South Carolina, where again there has been a longstanding relationship between Fort Jackson and the Dorn VA. Mr. Heckert, the director, is here today and he'd be glad to tell you more. We've just, again, been funded through that joint incentive fund to expand mental health services in a cooperative arrangement with the Moncrief Army Community Hospital and the Shaw Air Force Base clinic. And these will be the provision of mental health services, non-standard hours, at Fort Jackson.

In southeast Alabama, again, another joint incentive fund project where we are working with and will be locating our community-based outpatient clinic at Fort Rucker to expand our outpatient services and to complement the Army efforts there. We have additional arrangements at the Maxwell Air Force Base in Montgomery, Alabama, and several other military facilities. It's our policy to be constantly seeking cooperative arrangements with the military that will improve the quality and access for both active duty military and their families and veterans.

Second, I just wanted to briefly talk to you on our seamless transition efforts. It's been mentioned that seamless transition requires flawless handoffs between the military and the Department of Veterans Affairs and I can assure you that every day we work on this in VISN7. To date 19,000 warriors from OEF/OIF and the global war on terror have enrolled in our Network; 16,000 are using our services.

To these veterans and all the veterans in Network 7 we make three promises. The first is that the care that they receive in our network will be second to none and that's non-negotiable. It will be the best care and stand up to any comparison any place, any time. It's already been proven over and over again that the VA does provide the best care. It's been written up in the *Washington Post*, *Newsweek*, *Business Week* and through other research. So we make that promise. The care that you get from VISN7 will be second to none and it's non-negotiable.

Second, that we will maintain and expand services. We've discussed this morning the services that are to be provided and we will provide them and we will continue to provide them to veterans here in this network. At least as long as I'm here, we'll never hear from me that we cannot provide what we need to provide. And we will continue to expand services where we need to.

And third—and the most important—is that every veteran in this network who receives care from us will be personally satisfied

on the care that they receive, based on the outcome. And I do mean personally satisfied.

Senator, you might want to ask me, well, how can you say that? You just said you've got 1.5 million veterans and 300,000 users. Let's just say I said it and I will stand behind it: that each and every veteran will be personally satisfied.

As you visited Atlanta a couple of weeks ago we informed you of a couple of things that we're doing and I just wanted to mention here to we're reaching out to all those 19,000 OEF/OIF veterans. We have a plan and we're recontacting everybody and there's some interesting stories. I have to tell you one.

The Dublin people were calling and with this modern technology that we've been talking about, they reached a veteran that had been redeployed. He called us back from Iraq and said, you know, if you're looking for me, I'm over here in Iraq. You know, I'll remember you when I get back.

We found a veteran in Wilmington, Delaware, which is one of my former networks—my former network, and we helped reconnect that veteran to the Wilmington VA. So, first we're reaching out to find all those 19,000 veterans and make sure that we're doing what we need to do.

The second thing that I mentioned to you just recently was that Secretary Nicholson had put transitional patient advocates out. We've hired nine of them. Our philosophy is to get them out in the field and they are out. They all have cars and they're going out and finding veterans—helping with the case management of the seriously injured and seriously ill. But they're also going out to make contact with other veterans in the most nontraditional ways that we can find. So we're working on that.

So, our mantra always in this network is to help one veteran at a time and if we can help one veteran at a time, we can show that we've made a difference. We certainly are concerned—we've talked about numbers—but we're concerned with the one.

So just in summary, the Southeast Veteran—Southeast Network has many cooperative efforts underway with the Department of Defense and we'll continue to look for additional opportunities. And again, we will continue to work with the Department of Defense to ensure that there's a seamless transition from active duty to veteran status. Again, thank you for the opportunity to speak to you.

[The prepared statement of Mr. Biro follows:]

PREPARED STATEMENT OF LAWRENCE A. BIRO, DIRECTOR, VA SOUTHEAST NETWORK (VISN 7), VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, and Members of the Committee: Thank you for allowing me to appear before you today to discuss the Active Duty Rehabilitation Unit at the Augusta VA Medical Center (VAMC), operated by the Augusta VA Medical Center in partnership with the U.S. Army Southeast Regional Medical Command (SERMC). Veterans Integrated Service Network (VISN) 7 serves the broad tri-state region of Georgia, Alabama and South Carolina, home to 1.5 million veterans.

In October 2005, Secretary Nicholson presented the Augusta VAMC with the Olin "Tiger" Teague Award, the highest award recognized in VA. Secretary James Nicholson remarked that "doctors, nurses, rehabilitation specialists and support staff, came together at the Augusta VAMC in what can only be described as a blessed partnership of caring, healing, and compassionate health care professionals."

I could not agree more, and it is a privilege to testify today on their behalf. The Augusta VAMC and the Eisenhower Army Medical Center (AMC) have a long history of partnering to provide exemplary care to veterans and servicemembers. In

October 1993, the Augusta VAMC and Eisenhower AMC began sharing operations under a Joint Venture for Shared Services (JVSS) agreement approved at the highest levels of VA and DOD. This agreement allowed the facilities to share services with few restrictions. The joint venture also streamlined the process for establishing local agreements to meet the urgent needs of both facilities. VA and DOD created a joint neurosurgery program, and since that time, all neurosurgery services for veterans and servicemembers are provided at Augusta VAMC with the help of Department of the Army neurosurgeons.

Over the past 15 years, VA and DOD have relied on the JVSS for a number of other business sharing and medical care agreements, including open heart surgery, imaging services (including mammography), gynecological/obstetric services, separation physical examinations, expansion of laboratory services, physical and occupational therapy, intensive care unit (ICU) beds, echocardiogram readings, and lodging for Eisenhower inpatient substance abuse programs, among others.

The 2003 National Defense Authorization Act (NDAA) expanded VA/DOD health care resource sharing and coordination projects by including coordinated management operations in budget and financial management systems, coordinated personnel staffing, and interlinked medical information technology systems.

Pursuant to this Act, the Augusta VAMC and Eisenhower AMC received funding for a national demonstration project in coordinated personnel staffing. The project focused on hiring registered nurses (RNs) for critical care and was later expanded to include neurosurgery. VA and DOD used approved funds from this project to hire two new neurosurgeons to continue the joint program. This project is due to expire at the end of Fiscal Year 2007, and Augusta VAMC and Eisenhower AMC officials are discussing how best to continue the neurosurgery program.

In 2004, VA and DOD agreed to adopt a rate 10 percent below the CHAMPUS Maximum Allowance Charge for outpatient services provided by one Department to the other, in accordance with the 2003 NDAA. VISN 7 and the SERMC established a blanket sharing agreement, which provided guidance to VA and DOD facilities on outpatient and inpatient care billing practices. Inpatient rates of exchange were based upon the interagency exchange rate or locally agreed upon rates to ensure coverage of facility costs. VA and DOD updated this agreement in FY 2007.

While all of these accomplishments are certainly noteworthy, our cooperation on treating the critical health care needs of military service personnel injured in Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) is truly our "crown jewel." In 2003, VISN 7 and SERMC partnered to create the Augusta VAMC Active Duty Rehabilitation Unit, which provides rehabilitative care, including both Traumatic Brain Injury (TBI) and blast injuries, to Soldiers, Sailors, Airmen and Marines.

The Active Duty Rehabilitation Unit represents the best of VA and DOD medical care, and represents the fulfillment of our promise to veterans and servicemembers.

Mr. Chairman, this concludes my prepared remarks. I would like to request my written statement be submitted for the record, and I would be happy to answer any questions you may have.

Senator ISAKSON. Thank you very much.
Dr. Kilpatrick.

STATEMENT OF MICHAEL E. KILPATRICK, M.D., DEPUTY DIRECTOR, FORCE HEALTH PROTECTION AND READINESS PROGRAMS, DEPARTMENT OF DEFENSE

Dr. KILPATRICK. Senator Isakson and distinguished guests, thank you for the opportunity to speak to you on behalf of the Assistant Secretary of Defense for Health Affairs regarding DOD and VA cooperation in providing health care for returning servicemembers and new veterans.

It is fitting we are here in this active duty rehabilitation unit where soldiers, sailors, airmen and Marines and their families are receiving the quality care and support they need and deserve. The collaboration between VA and DOD that made this unit possible is just one example of the way our health care system can positively influence the lives of servicemembers and their families. The men and women being treated here and at DOD and VA facilities across this Nation have paid a substantial price protecting our way of life

and we owe them nothing less than our best. As we continue to improve our two medical communities' cooperation and processes we must keep—always keep our focus on the patient and the family.

Today I'd like to highlight some of the significant programs that DOD and VA put in place to provide world-class medical care. We have recently had many independent and internal groups evaluate DOD and VA's abilities to support and care for ill and injured servicemembers and veterans, culminating in nearly 400 recommendations. As those recommendations were being developed, the Secretary of Defense and the Secretary of Veterans Affairs chartered a senior oversight committee to systematically address treatment processes. That committee is collecting all recommendations, evaluating executability, breaking down the recommendations into actionable parts and associating those actionable parts with timelines and milestones, and establishing priorities to apply resources against them.

The global war on terrorism poses a challenge to both departments as the severity and complexity of wounds and the requirements for long-term rehabilitative care for our combat veterans increase demands on our systems. But with the last several years the DOD and VA have made significant strides in coordinating and developing common health care and support services along the entire continuum of care. Forty-eight DOD and VA joint incentive fund projects are now underway or completed, covering such diverse areas of medical care as mental health counseling; web-based training for pharmacy technicians; cardiothoracic surgery; neurosurgery; and increased physical therapy services for both DOD and VA beneficiaries.

Resource sharing is also helping us improve effectiveness and efficiency. Joint staffing is occurring at a number of Federal health facilities such as here at Eisenhower and at the Center for the Intrepid, a state-of-the-art facility in San Antonio, Texas. An Army liaison and VA polytrauma rehabilitation center collaboration program, often called Boots on the Ground, is designed to ensure the severely injured servicemembers who are transferred directly from military treatment facilities to one of the four VA polytrauma centers are met by a familiar face in a uniform. The VA has personnel at our medical facilities. There are VA social workers and counselors assigned to ten military treatment facilities, including here at Eisenhower. These social workers ensure the seamless transition of health care, including a comprehensive plan for treatment. As of June 29, 2007, the VA social worker liaisons had processed nearly 8,000 new patient transfers to the Veterans Health Administration, including 436 inpatient transfers.

Our greatest mission is to honor our servicemembers by providing the best quality care and ensuring a compassionate, fair and timely disability adjudication process to enable them to return to the fullest, most productive and complete quality-of-life possible. The satisfaction with medical care a servicemember has after becoming ill or injured in the combat theater will be the major success of cooperation between the Department of Defense and the Department of Veterans Affairs in providing facilities, treatment, rehabilitation and support for servicemembers and their families.

I thank you again for the opportunity to share the cooperative efforts of the Department of Defense and the Department of Veterans Affairs. We look forward to continuing to work with your Committee as we make progress on these very important issues. Thank you.

Senator ISAKSON. Thank you very much.

Mr. Biro, I want to first of all acknowledge we are in the eastern central part of the State, but thank you and the department for the most recent announcement on the Rome clinic. The VA is continuing to expand their services in Georgia and with the Committee I've just reauthorized the \$20.6 million, I think, for the hospital—redo of the hospital at Clairmont Road in Decatur, which I think illustrates our commitment to follow through on a request that you have made.

You mentioned Charleston, Columbia, and Fort Jackson, South Carolina; the Alabama clinics at Fort Rucker and Maxwell Air Force Base. Were those all for DOD/VA collaborations?

Mr. BIRO. Yes, they are.

Senator ISAKSON. Are they similar to what's been done here in Augusta?

Mr. BIRO. This here in Augusta is unique. It's inpatient. There—that's why there's 75 percent of the effort here. But over \$7–\$8 million that's virtually all inpatient. The other efforts are outpatient facilities.

Senator ISAKSON. The point you made about 19,000 veterans of Operations Iraqi Freedom and Enduring Freedom are both in this region. And that region is just Georgia, South Carolina and Alabama. Is that right?

Mr. BIRO. Right. And that's the number that are enrolled.

Senator ISAKSON. That's the number that are enrolled. 16,000 are being treated?

Mr. BIRO. Treated, yes.

Senator ISAKSON. You made a comment about VA health care and I want everybody to recognize your comment wasn't just home team bragging because *Time* magazine referred to VA health care as the gold standard, particularly the use of information technology in medicine, which is being done at the VA. So I commend you on what you are doing.

Dr. Kilpatrick, you're employed by the Department of Defense?

Dr. KILPATRICK. That's correct.

Senator ISAKSON. And Mr. Biro is employed by the Veterans Administration; is that correct? Well, you all are—

Mr. BIRO. That's correct.

Senator ISAKSON [continuing]. A pretty good example of seamless coordination testifying together, I'll certainly testify to that.

And the secretary—the previous Secretary of the Armed Services went through transformation—or the military was going through transformation. In fact, we were going through it when we ended up being attacked on September 11, 2001, and have been going through it while we've had our folks deployed around the world. Are the many things that you mentioned for efforts for joint sharing services. Is that a part of transformation?

Dr. KILPATRICK. I definitely think it is because we are looking at what are today's needs. We have to get the sense of looking at that

at the ground level. How do you meet those needs in the most efficient, effective manner. Being good stewards of taxpayer dollars, looking to make sure that the quality of care is not anywhere fenced because of dollars to make sure that people get the care they need when they need it. And I think that—you heard from earlier panels—that care is a local issue. The best solutions are at a local level but it has to be standardized centrally and it has to be certainly funded and supported from a central area. And I think that's what the ongoing transformation is today, particularly as DOD and VA are working closer together than they ever have in the past. Having said that, there's still opportunity for continued coordination and cooperation.

Senator ISAKSON. On that point you referred in your testimony to disability adjudication. That is, of course, of tremendous importance on issues like concurrent procedure. What the military ends up deciding as the adjudication of a disability has a tremendous impact on that veteran's life in the future. How fast or how—fast is not the right word. How timely is that adjudication taking place?

Dr. KILPATRICK. Well, I think right now today that adjudication is taking too long. I think we've heard that from servicemembers. We've heard that from veterans. The whole claims process within the VA is a very time-consuming issue. I think that people are looking at re-engineering, if you will, or transforming that process at the VA and DOD levels. At the very top level they're looking at how to start with a clean sheet of paper. What is in the best interest of the individual to make that determination.

General Schoomaker said many of our severely injured men and women in uniform want to stay in uniform and we've made a commitment that if they're able to get back and perform in a job skill set that's required by the Department of Defense, they will be allowed to stay in uniform. And so we don't want to rush prematurely to say you have a severe injury and you're no longer part of the Department of Defense. So timing, I think, is a critical issue on that. But I think for people to know and understand what their options are, because it is an all-volunteer force and I think that if they are continuing to want to volunteer to stay, they need to know what the options are if they don't. I think that's what we heard from the two soldiers earlier; that they didn't know and they couldn't find somebody who knew. That's a process that we need to make simpler and we need to streamline and we need to make it logical and seamless.

Senator ISAKSON. And am I not correct that one of the difficulties in that assessment, again, are injuries, particularly relevant to what's going on in Iraq, in terms of Traumatic Brain Injury or mental affects? PTSD, I guess, too, in its entirety. You could actually adjudicate a disability that's physical and years later have another disability that's mental crop up; is that not correct?

Dr. KILPATRICK. That's absolutely correct. And if you adjudicate something today and somebody recovers later on, do we start to reverse issues? And I think those are some of the real problems in trying to get it right and not necessarily get it fast. So there has to be the right amount of time taken.

I think that as it occurred before, trying to associate illnesses 20-30-50 years from now to military service is always going to be dif-

difficult. Medical science is not always able to help somebody. Why you have that cancer or why you have diabetes, and to say that there's a point source or a point exposure that caused that, medical science is not able to do that for servicemembers. And I think that's one of the concerns of so many men and women in uniform—will the VA be there for that problem that I have later on in life that I believe is due to my military service. And that's a hard issue in that for the disability problem. It becomes very difficult.

Senator ISAKSON. Those are the tough calls, but those are tough calls in workers' compensation in the private sector, too, what actually is the cause of the problem. But I want to thank you for your attention and I appreciate you mentioning that. Although that wasn't necessarily a subject of this hearing, it's one of the things I hear the most about out there from the constituents that I serve.

Thanks to both of you for your testimony. Before you get up I want to close the hearing, so you all just stay put and then we can all get up together.

I want to thank any number of people. I want to first of all thank this facility for all their accommodation. They've been fantastic. I want to thank Congressman Doug Barnard for his friendship and for his advocacy on behalf of Augusta-Richmond County and in particular our wounded warriors. He's done a fantastic job and it's greatly appreciated.

For those of you in the military—General Schoomaker, I think you'd like to know what kind of a community you're in. This is a little brochure that is supplied by the American Pride Through Education Incorporated Act. This is a group of local citizens that take the month of November to teach our kids about pride in America and about our Armed Services and about the great legacy that our country has. Jane Alexander's here today and she has supplied me with a sample of each one of those for you all when you leave.

But thanks very much to the VA. Thanks to DOD. Thanks to the people of Augusta and our distinguished elected officials that are here. And as I began, I'd like to, again, say thanks to the most important people of all here today and that's the men and women who serve or have served the United States of America in harm's way. This is a great country that has been blessed by God, and because of all of you we're allowed to assemble freely today in peace. God bless you.

[Applause.]

[Hearing concludes at 11:30 a.m.]

A P P E N D I X

OFFICE OF THE MAYOR,
Augusta, GA, August 23, 2007.

Hon. JOHNNY ISAKSON,
*U.S. Senator from Georgia,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.*

SENATOR ISAKSON and other distinguished Members of the Committee: Welcome to the city of Augusta. While our community is well-known one week a year for the world's most prestigious golf tournament, year-round we are committed and dedicated to serving our Nation's men and women in uniform.

Augusta is home to a well-kept secret, though by your presence here today, I suspect it will be a secret no more. Since 2005, Augusta's Uptown VA Medical Center has been home to the Nation's only Active Duty Rehabilitation Unit within a VA facility. This collaboration between the Department of Defense and the VA is not only unique because it is the only one of its kind. It is also unique because it alone is poised to take on more missions to better serve America's wounded warriors.

To date, more than 421 wounded warriors have been treated at the ADRU, with 26 percent of them returning to Active Duty. The ADRU is not just a place where wounded troops come for healing. It is also a place where they come to be returned to their full capacities as productive members of our society. The facility was constructed with 60 beds for in-patient care, and 30 of those beds are currently staffed and funded. Our community stands at the ready to see the other 30 beds fully funded so that we might extend the gold standard of care to more wounded warriors who so richly deserve the best.

Should Tiger Woods get hurt and require rehabilitation, he'd find no finer medical care than is offered here at the Uptown VA ADRU. The success stories are numerous, but one recent example is worth citing.

Specialist Crystal Davis lost her leg in an IED blast in Ramadi Iraq in 2005. She was sent to Walter Reed AMC, and underwent dozens of surgeries. After her surgeries, she underwent physical therapy there. She noticed something when she came home for visits to her family in Camden, South Carolina. She noticed she would get better. When she went back to Walter Reed for care, she was disappointed to only receive one PT appointment a day. She reported there were delays for her getting the care she needed to learn to walk on her prosthetic. She was transferred to Augusta and the ADRU, and within 3 weeks was off her walker and on her prosthetic full time. She credits the ADRU, the level of care she received as an in-patient here, and being close to family as major factors in her recovery.

Spc. Davis is not the only success story from the ADRU, but her example shows how much better our wounded warriors heal when they are close to home. Also of importance is the fact that 70% of the returning troops from OEF and OIF are from the southeastern United States. We owe it to our wounded warriors to help them heal as close to home as we can get them. We respectfully submit Augusta, Georgia, is centrally located to help them do just that.

Augusta is also home to Fort Gordon and the Dwight D. Eisenhower Army Medical Center, the Army's southeast medical command. The DDEAMC is the number two recipient of evacuees from the war, second only to Walter Reed. Medical College of Georgia residents currently do psychiatric rounds at both Eisenhower and the VA. With the existing collaborative efforts between the Medical College of Georgia and both Eisenhower and the VA medical facilities, Augusta stands uniquely qualified and equipped with the resources necessary to provide the physical, emotional, and mental needs of wounded warriors.

In addition, Augusta has 4 major medical facilities (University, MCG, Doctors Hospital and Trinity Hospital) within 11 miles of Eisenhower and both VA facilities.

Walton Rehabilitation Hospital also specializes in returning TBI (traumatic brain injured) patients to as normal a life as possible. Walton Rehabilitation Hospital is also the recipient of numerous HUD grants providing low-cost housing for those who are becoming independent after brain injuries, something now known as the “signature injury” in the conflicts in Iraq and Afghanistan.

Also, as you may know, Augusta was recently named the number one affordable housing market in the Nation. The low cost of housing, the Fisher House on Fort Gordon (housing for seven families), and the strong employment market in Augusta all combine to offer wounded warriors and their families not just a place to heal, but a place to live and thrive while they heal.

Augusta, Georgia stands at the ready to answer the Nation’s call to better serve the wounded warrior. We are currently collaborating in a community-wide effort known as the Wounded Warrior Care Project, lead by The Honorable Doug Barnard and others to expand Augusta’s capacities to care for the wounded warrior, while mindful of the importance of transportation, housing, and vocational training, in addition to the physical and emotional aspects of healing wounded warriors.

Sincerely,

DEKE COPENHAVER,
Mayor.

PREPARED STATEMENT OF WOUNDED WARRIORS AND THE MEDICAL COLLEGE OF
GEORGIA PRESIDENT DANIEL W. RAHN’S COMMENTS ON HOW THE STATE’S HEALTH
SCIENCES UNIVERSITY CAN ENHANCE CARE FOR THE NATION’S ARMED FORCES

The Medical College of Georgia is one of more than 100 academic health centers nationwide. Academic health centers stand at the forefront of patient care, biomedical research, and health professions education and are thus uniquely equipped to serve as leaders of change—both identifying and implementing solutions to the Nation’s most vexing health care challenges.

In its recently approved Public Policy Agenda, the Association for Academic Health Centers noted that “perhaps more than ever before, academic health centers collectively must take center stage and be promoted with ideas that energize and convince all stakeholders to pursue an agenda that merges academic health center goals with those of the Nation.” Care for our Nation’s wounded warriors provides one such opportunity.

While the United States Department of Defense and Department of Veterans Affairs bear primary responsibility for the care of active duty military personnel and veterans, the complexity and volume of care needed, particularly during wartime, necessitates leveraging all available resources, including the health care services available in the civilian health care sector.

The environment for health care policy in this country is deeply rooted in the national history of the United States and our core values of entrepreneurialism, rugged individualism, and self-reliance. Innovation, productivity through competition, individual opportunity these are all national strengths borne out of our history. We must work together to ensure that the weaknesses that may be associated with those strengths—such as partisanship, decentralization, diffused, segmented, and diluted authority—don’t stand in the way of creating a true system of care for the men and women injured while serving our country.

MCG currently has strong affiliations with Eisenhower Army Medical Center and the Veterans Affairs Medical Center located in Augusta. These could be further leveraged to improve support to our Nation’s wounded warriors. For example, the MCG-VAMC Psychology Consortium is one of only 20 federally funded psychology programs in the Nation. The MCG-VAMC has an enduring track record of producing psychologists who pursue careers that are directed toward integrated approaches to health care. Expansion of this training program and utilization of these graduates could help to ensure high quality and highly integrated care throughout patients’ journeys to recovery. Additionally, MCG’s departments of neurology, neurosurgery, and psychiatry and health behavior bring significant clinical resources to the table—expertise and infrastructure that could be accessed to fill gaps in the existing system of care for America’s wounded warriors, particularly as it related to post-traumatic stress and Traumatic Brain Injuries.

The July 2007 Report of the President’s Commission on Care for America’s Returning Wounded Warriors contains six recommendations that “will produce a patient-centered system that fosters high-quality care, increases access to needed care and programs, promotes efficiency, supports families, and facilitates the work of the thousands of dedicated individuals who provide a gamut of health care and disability programs to injured servicemembers and veterans.” The perspective I share

in this document with the U.S. Senate Committee on Veterans' Affairs is viewed through the lens of patient- and family-centered care—an area for which the Medical College of Georgia and the MCG Health System have been lauded nationally. We know very well the power of involving families in the treatment and recovery of patients and would be honored to assist in a regional and cross-sector approach to care for wounded warriors returning to their homes in Georgia and across the southeast.

MCG also strongly supports the commission's recommendation regarding the development of comprehensive patient- and family-centered recovery plans. As noted in the commission's report, recovery plans should smoothly and seamlessly guide and support servicemembers through medical care, rehabilitation, and disability programs. Recovery coordinators would drive the implementation of these plans. Educational preparation, recruitment, and retention of appropriately qualified individuals to serve as coordinators will be critical to the successful implementation of this recommendation.

MCG's various health professions schools would be honored to take a leadership role in the educational preparation of recovery coordinators. For example, MCG recently launched a new graduate nursing program for the education and training of Clinical Nurse Leaders. The 10th such program developed in the Nation, MCG's CNL program prepares nurses to be clinical leaders who can thrive in the current health care system while improving patient outcomes and reducing costs. We are committed to preparing leaders who facilitate and assure individualized, evidence-based, and highly effective care to patients and families. I encourage this committee to consider the role these highly trained clinical leaders could play in ensuring continuity of care through the implementation and long-term oversight of recovery plans for wounded warriors.

My intent in this testimony is not to provide a laundry list of MCG educational, clinical, and research strengths—for they are many—but to emphasize the importance of innovative thinking, cross-sector collaboration, and bold approaches to care. MCG does indeed possess significant strength and resources that could be leveraged as the Federal Government works to implement the recommendations outlined in the commission's final report. We would very much like to be included in a consortium that inventories regional resources and works to connect them to effect better health outcomes for wounded warriors and better support for their families.

Thank you for the opportunity to provide input into your deliberations. I applaud the good work of the President's commission. The recommendations put forth in the final report, if appropriately operationalized, will significantly enhance the quality of care provided to America's wounded warriors. Please know that the Medical College of Georgia is prepared to stand shoulder to shoulder with our Federal partners to serve those injured in the line of duty, support their recovery, and simplify the complex systems through which they access their care.

