DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

May 14, 2010

Executive Office

The Honorable Ron Wyden
United States Senate
Washington DC 20510

Dear Senator Wyden:

Thank you for your inquiry of May 13, 2010 regarding concerns raised by Soldiers in the Oregon Army National Guard (ORARNG) related to their demobilization at Joint Base Lewis-McChord. A successful demobilization and reintegration program is critical to Army readiness and to the health and welfare of Soldiers and their Families.

I have enclosed a copy of a presentation that has raised concern among some of the redeploying Soldiers. As Commanding General of the Army Medical Command, I recognize and apologize for the insensitive and offensive depiction of Reserve Component Soldiers in this presentation. The U.S Army and the Army Medical Command are dedicated to ensuring that all service members and Families are treated with respect, compassion and outstanding clinical care.

The presentation was prepared by the Acting Chief, Family Practice Department, Madigan Army Medical Center (MAMC). The officer delivered this presentation in March 2010 to her new provider staff in preparation for the redeployment of the 41st Brigade Combat Team (BCT). She understands the seriousness of this matter and has written a letter of apology to the Soldiers and leaders of the 41st BCT. She deeply regrets her insensitive slides.

The MAMC leadership was unaware of the contents of this presentation. Once this material came to their attention, MAMC leaders made changes to the offensive slides. I have enclosed their changes. On Wednesday, May 12th, the MAMC Commander and clinical leadership met with the Commander of the 41st BCT and other key leaders in the ORARNG to discuss and review individual Soldier concerns and issues. Any Soldier who is not satisfied with his or her medical care will have the opportunity to have their case reconsidered.

Lieutenant General Jacoby, Commanding General of I Corps and Joint Base Lewis-McChord, has directed a command investigation into the demobilization of the 41st BCT. In conjunction with Major General Volpe, Commanding General of Western Regional Medical Command, he has appointed a medical officer to define the scope of the problem, look thoroughly into all issues, and provide recommendations for action to improve operations involving the Joint Mobilization Brigade, the Warrior Transition

Battalion, the Soldier Readiness Center, and demobilizations involving Reserve Component Soldiers.

Thank you for your attention to this matter and for your support of Soldiers and Families.

I am appalled by the insensitivity of one of my own officers. I deeply apologize for this depiction of our comrades in the Reserve Component. I have personally seen the many sacrifices made by our ARNG & USAR Soldiers and the Families and deeply regret this offensive presentation.

Sincerely,

Eric Schoomaker

Eric B. Schoomaker, M.D., Ph.D.
Lieutenant General, U.S. Army
The Surgeon General and Commanding
General, US Army Medical Command

Enclosures

RUSH PROCESS

A JOINT PRESENTATION BY:

Family Medicine

SRP Site

Case Management

"Never Leave a Fallen Comrade!"

ARMY STRONG

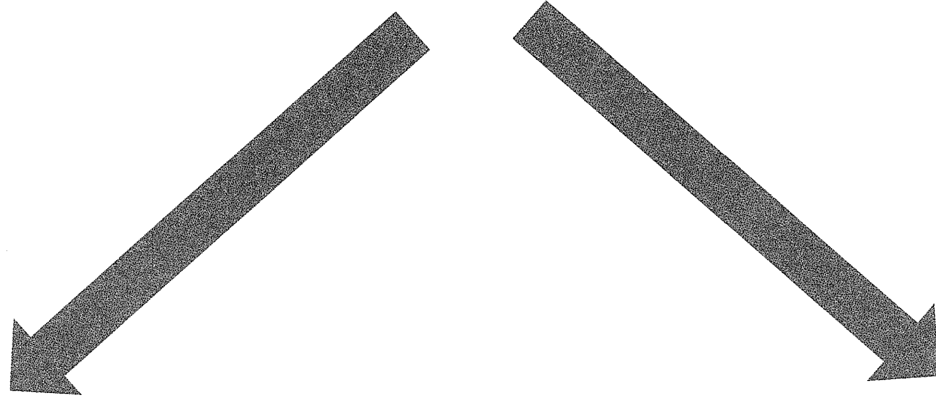
BACKGROUND

- Surge 2010
  - 3 Brigades from Ft. Lewis redeploying (up to 14,000 soldiers) – Okubo/Nisqually primary
  - ~4000 Reserve/NG mobilizing for deployment and demobilizing post-deployment – all FMC
- Critical time frame: June – Aug 2010
- Competing demands
  - Summer PCS cycle
  - Warrior Forge
  - Deployments/taskers
  - Patient care as usual

PURPOSE OF 'RUSH'

- Early enhanced access to care for acute issues
  - Problem began or was exacerbated during deployment
  - Needs to be addressed prior to demob (NG/Reserve) or block leave (AD)
- Specialty care access for initial appt within 72 hours

STEP 1



ACTIVE DUTY

RESERVE / NG

ACTIVE DUTY

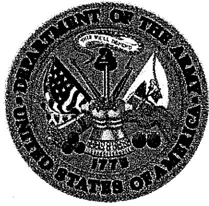
- PDHA done while deployed by Bn/Bde surgeon
- SRP upon return home
  - 1. acute issue identified → RUSH appt ideally with unit medical provider, referral as needed
  - 2. chronic issue identified → may address during or after block leave through usual medical channels

RESERVE / NG

- If demobilizing
  - Goal (most): get home ASAP
  - Goal (some): extend military paycheck indefinitely by delaying demobilization
- If mobilizing
  - Goal (most): get acute issues resolved and be eligible to deploy
  - Goal (some): maximize medical issues to avoid deployment and get medical benefits
    - Beware the 25 day window – don't buy it if it's broken

RESERVE / NG – CASE 1

- Urgent and simple – soldier needs med refill, x-ray, etc.
  - Provider resolves the issue
  - Patient is cleared to demobilize
  - Case manager sends soldier back to SRP for REFRAD (release from active duty)



RESERVE / NG – CASE 2

- Chronic and non-urgent – i.e., soldier with 2 years of shoulder pain, needs PT/rehab
  - Do NOT refer to MAMC specialty provider
  - Advise patient to f/u with civilian provider
  - TAMP and Tricare benefits up to 180 days if deployed more than 30 days
- Provider documents findings and recommendations
- Soldier returns to case management for explanation of benefits
- To SRP and REFRAD

RESERVE / NG – CASE 3

- Issue requires prolonged care but must be addressed prior to demob (i.e., ACL tear requiring surgical repair)
  - Document that soldier is medically unfit to continue demobilization process
  - Recommend consideration for WTB placement (NOT the provider's decision – do not promise this!)
- Document T3 profile in AHLTA and thorough note with recommendations
- Return soldier to case management

SOLDIERS ARE ENTITLED TO:

- Accurate profiles
  - Too restrictive and too permissive are both bad for soldier and the military
  - Review profile to make sure limitations are clear
- Quick and comprehensive care for medical issues sustained or exacerbated during deployment
- 180 days transitional medical benefits for chronic issues
- Compassionate care

SOLDIERS ARE **NOT** ENTITLED TO:

- Interrupt provider in clinic and demand same day follow up on tests
  - Case managers schedule follow up
  - Provider may make arrangements with patient
- Demand that the provider page radiology for a stat reading of their films
- Bully the provider into ordering tests or consults that are not indicated

SPECIALTY CLINIC CONSULTS

- Place consult in CHCS/AHLTA as usual
  - RUSH DEMOB (OR RUSH MOBILIZATION) should be the first words in the consult
  - Most clinics want these as 'ASAP'
- 72 hour access to care standard
- Consult to the clinic does NOT guarantee that soldier will get the surgery, procedure, etc they expect, if not indicated

QUESTIONS?

Talking Points to Accompany Slides

The following are a synopsis of the talking points the officer indicates were used during her presentation (however, this has not been validated).

SLIDE 0 RUSH PROCESS

None

SLIDE 1 BACKGROUND

As the summer months approach, the Department of Family Medicine will be heavily involved in managing the deployment and redeployment of close to 18,000 troops. Most of you know that the 3 Stryker Brigade Combat teams stationed at Ft. Lewis will all be redeploying in the June to August timeframe, and will likely have many medical needs that we will have to address. Much of this work will be done through the outlying clinics, Okubo and Nisqually, with the Family Medicine clinic assisting as needed. In addition to that, there are around 4,000 reserve and national guard soldiers who will be deploying or redeploying through Ft. Lewis this summer – these will all be seen by providers in the Family Medicine clinic. As you know, all other departmental missions must still be covered during this summer also – we have to take care of our patients, as well as the cadets and cadre of the ROTC training (Warrior Forge), and we have to do it while many of our providers are deployed or changing out. In order to be able to accomplish all of this and provide outstanding care to all our patients under these demanding conditions, I want to set down some specific guidelines on how to deal with the deploying and redeploying soldiers you will be caring for.

SLIDE 2 PURPOSE OF RUSH

First, let me explain the reason behind the RUSH process: many of the reservists and national guard soldiers are not necessarily from this area. They may be from a different state, and only completing their mobilization or demobilization through Ft. Lewis. As you can imagine, at the end of a long deployment they are eager to get back to their families as quickly as possible. In order to help facilitate that, we have in place an enhanced access to care process that will allow them to address their issues in the most timely way possible. The issues we are most concerned about are those that were sustained by the soldier during the deployment, or that were significantly exacerbated during the deployment. Basically, we want to make sure we address those problems that need to be resolved before the soldier can safely demobilize (if NG or RC) or go on block leave (if active duty). The specialty clinics in this hospital are working hard with us to send soldiers we refer to them as quickly as possible – usually within 72 hours, but definitely within one week of the consult being placed.

SLIDE 3 STEP 1

The first step to the process is to accurately identify which component the soldier belongs to – active duty, reserve, or national guard – since this will help determine the priority of care.

SLIDE 4 ACTIVE DUTY

Most active duty soldiers will be remaining on Ft. Lewis, so it is not essential that their chronic issues are addressed immediately. They will have a post-deployment health assessment completed by their unit provider prior to leaving theater, and hopefully major medical issues will be identified at that time. Once they go through the Soldier Readiness Processing site, the provider there will make a determination whether a problem needs to be addressed acutely, in which case the patient will be referred to their unit medical provider for evaluation and possible referral; or, if it's a non-urgent, chronic issue, the soldier may address it during or after their block leave through their usual medical channels.

SLIDE 5 RESERVE/NG

As I mentioned, for Reservists and National Guard soldiers, there is a greater urgency. If they are returning from deployment, we need to work hard to get their issues addressed and get them back home as soon as possible so they can reunite with their families. If they are preparing to deploy, we need to evaluate them quickly to see if they are medically fit for deployment. This determination needs to be done within a 25 day window from being placed on active duty orders; if the process extends past the 25 days, the soldier may be stuck at Ft. Lewis having to address medical issues they could have taken care of at home.

SLIDE 6 RESERVE / NG – CASE 1

The first case you may encounter is the soldier who has an urgent but simple need – for instance, he has run out of his medication, or he needs an xray to document that an injury has resolved.

In this instance, the provider will simply comply with the soldier's request, order the appropriate medication or study, and ask the soldier to return to their case manager who will assist with getting him or her back to the SRP site to be cleared for demobilization (or mobilization).

SLIDE 7 RESERVE / NG – CASE 2

In the second scenario, you may be seeing a soldier who has a chronic problem that has been ongoing for an extended period of time, and does not require surgery at this time. Many soldiers, whose musculoskeletal problems got worse during deployment, will need a period of conservative treatment or physical therapy/rehabilitation after returning from theater.

In this case, a specialty referral is not necessary. There is a good safety net of Transitional Assistance Medical Program (TAMP) benefits; as long as a soldier has been deployed for over 30 days, they are entitled to Tricare benefits for up to 180 days after the end of the deployment. This means that they can return home and get all necessary rehabilitation care near their family instead of extending their time away.

In this case, the provider needs to document the findings of their examination and any lab or radiologic results accurately in the medical record. The soldier should then return to their case manager, who can assist with a thorough explanation of their benefits; they can then proceed to the SRP site and be released from active duty.

SLIDE 8 RESERVE / NG – CASE 3

In the final scenario, the soldier may have sustained an injury that will require prolonged care, but really needs to be addressed in a timely fashion – for example, an orthopedic injury such as an ACL tear that has been evaluated by an orthopedic surgeon who determined that it requires surgical repair. When this is the case, we need to afford the soldier the opportunity to address the medical issue here in a timely fashion. One of the options for addressing long term care is through placement in the Warrior Transition Battalion, where the soldier will be assigned for the duration of their treatment. However, a primary care provider cannot make the determination as to who gets assigned to this unit; we can only provide a recommendation. The soldier will then go before an accession board where the determination will be made regarding WTB placement. For this reason, please do not promise a soldier that he will be place in WTB or in a remote care unit (CBWTU) – we do not want to raise expectations that may not be met, if the decision of the board is to address the issue differently.

In this situation, please create a temporary profile in AHLTA, and write a thorough note documenting your findings and your recommendations. The soldier will then return to case management, who will initiate the WTB accession process.

SLIDE 9 SOLDIERS ARE ENTITLED TO:

Here are some things that all are soldiers are entitled to:

One of the most important things you can do for the soldier is to provide an accurate physical profile. It's important that it spells out in detail what a soldier can and cannot do. It is very frustrating to both soldiers and commanders to get profiles that are either too restrictive, making the soldier unable to be used in any capacity, or too permissive, putting them at risk of worsening their injury. Please review the profile with the soldier and make sure they clearly understand the limitation of their profile; it is helpful to put your contact information on the profile in case the chain of command has a question about specific activities.

All soldiers are entitled to have medical issues that were sustained or exacerbated in combat addressed in a quick and comprehensive manner. For those injuries that are chronic, soldiers are entitled to access their transitional benefits and address them close to their home and family.

Finally, don't forget that all soldiers are entitled to compassionate care at every encounter.

SLIDE 10 SOLDIERS ARE NOT ENTITLED TO:

Here are some things that soldiers are not entitled to:

Soldiers may not interrupt a provider in clinic and demand same-day follow up on their tests. Providers usually have full schedules, and it is not fair to other patients to have their medical care interrupted. A soldier who needs follow up on their result should schedule this through their case manager, who can get them in expeditiously. Alternately, in certain circumstances, a provider may opt to make individual arrangements with a patient such as obtaining contact information and contacting the patient with the results when they are available.

A patient may not demand that radiology be paged for an immediate reading of a study that was just done. Radiology is well aware that RUSH studies have priority, and they will make results available to the provider as soon as humanly possible.

Finally, a soldier may ask for tests or consults that are not medically warranted, in the provider's opinion. You are not required to order unnecessary tests or studies even if a soldier demands this. Please do your best to explain to the soldier in detail why certain tests are indicated while others may not be; sometimes understanding the reasoning behind the refusal can go a long way.

If a soldier continues to disagree with you regarding the care they want, please refer them to the case manager. Case management has a way to request higher level review of individual soldiers' cases on a case-by-case basis. They will generally contact me first to review the treating provider's decision and make changes to the recommendations if appropriate. If the issue is still not resolved, it can go to the DCCS for final determination.

SLIDE 11 SPECIALTY CLINIC CONSULTS

A final word on placing consults to specialty clinics: these should be placed in CHCS or AHLTA as usual; the first words in the consult should state RUSH DEMOB (OR RUSH MOBILIZATION) to emphasize the priority of case. Most clinics want these entered under the 'ASAP' option. Please clarify to the soldier that this is a consult for specialty evaluation; do not promise that the soldier will get the surgery or procedure that they request, since the specialty provider may determine that the soldier is not a good candidate for a particular course of treatment.

*** NOTE: this process has changed somewhat since this presentation – we now enter specialty consults under the EATC code which standardizes the process, with the access to care metric of no more than 1 week for initial specialty evaluation ***

Slide 12 Questions

I will now entertain any questions you may have – thanks for all you do!

STEP 1

PROPOSED

ACTIVE DUTY

RESERVE / NG

ARMY STRONG

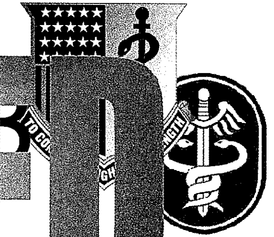
"Never Leave a Fallen Comrade!"

RESERVE / NG

PROPOSED

- If demobilizing
  - Goal (most): facilitate return to their families
  - Goal (some): extend military service to treat deployment-related injury/illness
- If mobilizing
  - Goal (most): get acute issues resolved and be eligible to deploy
  - Goal (some): revalidate medical issues that may affect deployment
    - Note: a 25-day window is in place

RESERVE [obscured] PROPOSED



- Issue requires prolonged care but must be addressed prior to demob (i.e., ACL tear requiring surgical repair)
  - Document that soldier is medically unfit to continue demobilization process
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- Document T3 profile in AHLTA and thorough note with recommendations
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SOLDI
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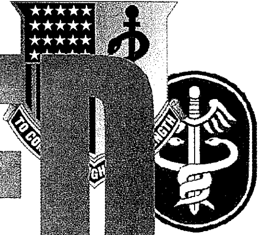
PROPOSED



- Interrupt provider in clinic and demand same day follow up on tests
  - Case managers schedule follow up
  - Provider may make arrangements with patient
- Demand that the provider page radiology for a stat reading of their films
- Demand the provider order tests or consults that are not indicated