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STATEMENT BY

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CENTERS OF EXCELLENCE

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Chairwoman Davis, Representative Wilson, and distinguished members of the Military Personnel Subcommittee, thank you for inviting us to discuss the five Centers of Excellence directed by Congress in the 2008 and 2009 National Defense Authorization Acts (NDAA). These Centers of Excellence offer great promise to our Warriors and patients, to the Department of Defense (DoD), and to the Nation. I foresee a day when these centers are acknowledged as the worldwide leaders in their respective disciplines. However, we are not there yet and we are moving slowly in some areas.

Nevertheless, I am confident that we will achieve the original vision of these Centers, as embodied in the following attributes:

- Collaborative – collaborating within DoD, with the Department of Veterans Affairs (VA), with institutions of higher education, with other public and private entities—including industry leaders--and with worldwide partners
- Comprehensive – addressing the full spectrum of health including prevention, mitigation, diagnosis, treatment, rehabilitation, and transition
- Creative -- fostering innovation in an open, transparent manner
- Multi-disciplinary – including all professional specialties across the range of health services to ensure a diversity of expertise and development of full-spectrum solutions
- Evidence-based – operating according to sound scientific principles while basing decisions on solid evidence and expert consensus
- Efficient – maximizing value for health services by publishing clinical practice guidelines, promoting best practices, and reducing unwarranted variation across the Military Health System
- Strategic – envisioning long-term success by seeing over the horizon and developing the plans necessary to create our future

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (TBI), known as the DCoE, are the most developed of the five Centers, largely because the Department received significant supplemental

funding for psychological health and TBI late in Fiscal Year 2007 that helped kick-start the DCoE. Although not established by Congress until the following year, the Center of Excellence for Traumatic Extremity Injuries and Amputations is also well-developed because of the extensive joint and inter-agency groundwork laid by the Armed Forces Amputee Patient Care Program and the Military Amputee Research Program, two programs that have been operating jointly and collaborating closely with the VA and academia since the start of overseas contingency operations.

The DCoE were established in the fall of 2007 with a reporting structure through the Office of the Assistant Secretary of Defense for Health Affairs to the Deputy Secretary of Defense. Recognizing that there may be advantages to different governing structures, OSD Health Affairs recently formed a tri-service work group to determine the most appropriate governance structure for the DCoE. The work group is expected to make a recommendation to the Senior Military Medical Advisory Council within the next month and I look forward to hearing its recommendations.

Having learned from the development of the DCoE, the Centers of Excellence for Hearing, Vision, and Extremity Injury have each recently been aligned with a service. I support this alignment of the Centers and believe it will provide the most effective structure to improve readiness, health, and quality of life. Once matured, the Centers will provide platforms for integrated research, clinical best practices, training and education systems, and information management systems that will stimulate innovation in patient care, enhance outreach, and support translational research.

Since Army has been designated the lead service for the Center of Excellence for Traumatic Extremity Injuries and Amputations, I would like to provide an update on the status of this Center and the exciting progress the Department has made in this area over the last nine years.

The 2009 NDAA directed the Secretary of Defense and the Secretary of Veterans Affairs to jointly establish a Center of Excellence for Traumatic Extremity Injuries and Amputations. This joint governance is unique among the

five Centers, but is consistent with the way DoD and VA have been collaborating on extremity injury over the last several years. Our collective goal from the outset has been to optimize function of individuals with extremity injuries. This goal is shared by many, and we continue to draw from the best and brightest of American medicine to make this goal a reality. Our approach continues to be multidisciplinary, focused not only on the return of physical function but the return of full psychological and emotional health. This is especially important as many wounds are combined injuries. We believe all Warriors with limb loss as well as limb threatening injuries should have the opportunity to return to their highest level of function.

Following the September 11th attacks and as the US prepared to enter Afghanistan, LTG James Peake, then the Army Surgeon General and later Secretary of the Department of Veterans Affairs, asked for an estimate on the number of amputee patients that could be expected from a war in Afghanistan. Between 1984 and 1987 the Soviets reported 30-45% of all injuries were related to land mines with a high percentage resulting in amputations. Based upon this and other information, LTG Peake asked that an effective program be developed to manage a potentially large number of patients with severe extremity trauma and amputations. He issued guidance on October 31, 2001, to develop a virtual program, where level of care was consistent across Army Medicine and centered on care at Walter Reed Army Medical Center (WRAMC), Washington DC.

We consulted experts from the civilian health care system, the military health care system, and the VA. Based upon their input, we worked to fine-tune policies and doctrine for treatment, to evaluate the physical plant at WRAMC, and to identify requirements and shortfalls within the DoD health care system as related to extremity trauma and amputation care.

In 2003, we established a civilian advisory board under the Federal Advisory Committee Act; the Board's first planning meeting was held on September 15, 2003. The Board focuses on both amputation and functional limb loss and serves in an advisory capacity to broaden the scope of vision for the

extremity trauma and amputee care program. Following the guidance of the Board, we established the Armed Forces Amputee Patient Care Program in 2003. Initially centered on WRAMC and later expanded to include Brooke Army Medical Center (BAMC) in San Antonio, Texas, Balboa Naval Medical Center, in San Diego, California, and VA facilities, this program has received national and international recognition for the outstanding care provided to our wounded warriors. Further guidance from the Board in 2005 led the Program to expand its focus from amputee care to include functional limb loss and traumatic extremity injuries undergoing limb salvage. The Board continues to be very active, meeting twice annually, and will continue to guide the Center of Excellence.

Today, the amputee and extremity trauma program provides state-of-the-art treatment as a "virtual," multi-site, coordinated complex of facilities that includes: Landstuhl Army Medical Center in Germany; BAMC; WRAMC; Balboa; the VA Amputation System of Care (ASC); and other military and civilian treatment facilities. The presence of the VA's ASC as well as the DoD's Center for the Intrepid (CFI) at BAMC; the Military Advanced Training Center (MATC) at WRAMC (and the plans for like capabilities within the new Walter Reed National Military Medical Center); and the Comprehensive Combat and Complex Casualty Care (C5) Balboa Naval Medical Center, provide the backbone for a nationwide virtual Center of Excellence for Traumatic Extremity Injuries and Amputations.

The VA's ASC assures consistency of amputation rehabilitation across the VA and enhances the environment of care for the new generation of veterans. The ASC incorporates seven Regional Amputation Centers (RACs), twenty-one Polytrauma/Amputation Network Sites (PANs), networking thorough Amputation Clinic Teams (ACT), and Amputation Point of Contact (APOC). The ASC was developed to provide state-of-the-art amputation rehabilitation by incorporating the latest practice in medical rehabilitation management, rehabilitation therapies and technological advances in prosthetic componentry.

Further, within our existing healthcare systems, the DoD and VA have disseminated the most current standards of care and evidence-based advances

to the individual provider level. To date the DOD and VA have published and distributed the VA/DOD Clinical Practice Guideline for the Rehabilitation of Lower Limb Amputation as well as the Patient Education Handbook that accompanies this guideline.

The second mandate from the 2009 NDAA was to conduct basic, translational, and clinical research to develop scientific information aimed at saving injured extremities, avoiding amputations, and preserving the function of injured extremities. Again, we have already accomplished much in this area, but the NDAA provides us the impetus to enhance these ongoing efforts. In November 2003, the US Army and the VA held an Orthopaedic and Prosthetic Workshop to develop interagency research efforts to address the growing need for innovative and functional prostheses. There have been a number of joint and interagency meetings since then, including a very recent VA/DoD Prosthetics and Orthotics State of the Arts conference held in March 2010.

The CFI, the MATC, and the C5 each have established human performance laboratories that support the Military Amputee Research Program (MARP). The MARP was established in 2004 to identify research gaps and coordinate amputee care research efforts within the DoD. This program has led to significant advances in the care of our Wounded, Ill, and Injured service members. Our research efforts have since broadened beyond amputee care to include all traumatic extremity injury. In 2006, Congress established the Orthopaedic Extremity Trauma Research Program (OETRP), a Congressionally directed, peer reviewed research program. The OETRP funded 26 proposals (7 clinical and 19 preclinical studies) during the first two years.

The emphasis on extremity research is significant because the majority of battlefield wounds occur to the extremities. In fact, 82% of battlefield injured Warriors have at least one extremity injury--penetrating soft tissue wounds and open fractures account for most of these wounds. Infection, non-union, heterotopic ossification, and impaired/loss of muscle function are common outcomes. These extremity injuries account for approximately two-thirds of inpatient hospital costs and resulting disability payments. They are the primary

burden of disease and source of morbidity from this war. In addition to the OETRP, Congress recently created the Peer Reviewed Orthopaedic Research Program (PRORP). This program will fund over $110M of orthopaedic research from its FY09 budget. A new call for proposals is expected this summer or early fall with $20M appropriated for 2010.

The Joint Center of Excellence for Battlefield Health and Trauma Research (BHT) is currently under construction and expected to open in Summer 2010 in San Antonio, Texas. The BHT will be the home of trauma research programs for the Army, Navy, and Air Force, with extensive capabilities for conducting both pre-clinical and clinical research. Research capabilities include over 200,000 square feet of laboratory space, over 300 scientists, physicians, engineers and technical staff, extensive research facilities, animal surgery and ICU capability, state of the art imaging technology, and world class IT infrastructure including the Joint Theater Trauma Registry. The units that will comprise the BHT have a distinguished record of advancing extremity trauma research, with significant advances in acute extremity trauma care as well as in regenerative medicine. The BHT will collaborate with the VA's Office of Research and Development which also has a long history of leading research in the rehabilitation of wounded warriors.

As this discussion of accomplishments demonstrates, the formalized establishment of a Center of Excellence for Amputations and Extremity Injury is the culmination of joint efforts in research and direct patient care dating back to 2001. The new Center of Excellence will lead to a stronger organizational structure and provide a single point of contact for DoD and VA issues related to amputation and extremity injury. While there has been terrific collaboration among the three services, DoD, and VA over the past nine years, the focus has been on immediate needs and solving local issues without having a true long-range corporate strategy for both Departments. The Center of Excellence is planning to have a small central staff with the time and resources to provide leadership, policy recommendations, and long term strategies to make the best

use of existing resources, prevent unwarranted variation, and enhance the care provided to our warriors.

In summary, despite the growing pains we experienced establishing the five congressionally-directed Centers of Excellence, I am confident that the Department is now moving in the right direction to provide the Centers with the governance and support to allow them to flourish. I remain concerned about unnecessary duplication of programs and unnecessary competition among the Services and Federal agencies conducting research and providing care. Alignment of these programs under a single overarching construct which reduces the number of oversight groups and administrative overhead, while ensuring agile and responsive translational research and medical programs is ideal. We are establishing favorable conditions to produce models of healthcare excellence that ultimately improve readiness, health, and quality of life for our service members, veterans, and family members.

Thank you for holding this hearing and for your unwavering support of Army Medicine and the Military Health System.