DEPARTMENT OF VETERANS AFFAIRS COLLABORATION OPPORTUNITIES WITH AFFILIATED MEDICAL INSTITUTIONS AND THE DOD

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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DEPARTMENT OF VETERANS AFFAIRS COLLABORATION OPPORTUNITIES WITH AFFILIATED MEDICAL INSTITUTIONS AND THE DOD

Wednesday, MARCH 8, 2006

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to call, at 2:00 p.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Baker, Brown of South Carolina, Miller, Campbell, Michaud, Reyes, Brown of Florida, Udall, Berkley, and Boozman.

The Chairman. The House Committee on Veterans' Affairs, Full Committee, will come to order March 8, 2006. We are here today to learn more about the promise and progress of collaboration in the provision of healthcare.

I would like to thank all of our panelists today for their testimony, and we especially welcome the Assistant Secretary of Defense, Dr. Winkenwerder, who I believe is making his first visit to the Committee in this second session.

We appreciate your presence, and Dr. Greenberg, Mr. Moreland, and Mr. Smithburg, who are also on the next panel and who travelled to Washington, so we can learn more on a topic that grows more important by the minute and one that holds great promise for the future of VA and perhaps your own institutions.

Dr. Perlin, as always, you have become a favorite face when it comes to the topic of the healing arts, and to Mr. McClain, my respect for you continues to grow and we appreciate your presence here today. I want to thank you for your role in the Gulf Coast Planning Group and your leadership with regard to the "Charleston Model." It is kind of interesting that this is what everybody seems to be calling it, Dr. Perlin, the Charleston Model. And both of you are to be congratulated for your work with the Medical University of South Carolina.

I look forward to hearing about your experience today, especially with regard to the Gulf Coast Planning Group and the Charleston

Model.

The complexity of medicine today is unprecedented, so it is very expensive and so is the expectation among Americans that when they need medical care, it will be there for them. This has become a reasonable expectation among Americans, an expectation that in practice is usually fulfilled, and that is a profound blessing of our economic, technological and cultural progress. We cannot permit this progress to lapse.

Along with the complexity and escalating costs, the very nature of healthcare delivery has been revolutionized in the last 15 or 20 years. The rise of outpatient medicine and the fruits of preventative care have rendered much of our inpatient facilities perhaps obsolete.

As we look to expand VA's outpatient capabilities, we also look to enhance and modernize its inpatient care. Conceivably it is the more critical of the two, for it is the most acutely ill patients who are admitted to the hospital.

I believe that the idea of collaboration, whether it is the collaboration between government agencies or between the public and state entities, promises significant efficiencies as we move down this next stretch in the path of the 21st Century health system.

Of course, sharing is not a new concept. With its affiliations among the nation's teaching universities, the VA has been sharing human capital for years. Half of the doctors in America were trained at some point in VA hospitals.

In Charleston, South Carolina, some 90 percent of the doctors at the Medical University of South Carolina also practice medicine at the Ralph Johnson VA Medical Center, just a stone's throw away.

VA and DoD began sharing resources in 1982, with the passage of a law that directed them to pool resources, increase efficiencies and reduce redundancies. In a sign of progress, the 2002 agreement between the Navy and the VA to share facilities in North Chicago is much closer to being fulfilled. Collaboration with the military helps perfect the seamless transition of servicemen into the VA and back again to active duty or back to the civilian world.

Collaboration with medical universities is a logical next step from shared personnel to shared facilities. This benefits veterans in the country with better access and enhances the quality of care. It is our goal that this may be perfected.

If we can do this and at the same time, save money, increase the life cycle of these facilities and increase the quality of care, it is a win/win situation for the Federal Government and the States. And we are building from the win/win situation that we have with regard to VA and DoD facilities.

So the challenge, as we know, is not determining if this is feasible or a worthwhile concept, it is determining where an already proven concept can next be applied and how best we can apply it to achieve

greater efficiencies, better quality of care, improved access to care and still retain the identity of VA's healthcare system.

I will hazard a guess that the testimony submitted today from the veteran service organizations will urge us to ensure that in any collaborative undertaking, the VA retains managerial control and ensures the veterans are seen in a uniquely "veterans' environment." Those are appropriate concerns, and I think they are also manageable concerns.

The high expectations among those whom we serve, be they Dr. Perlin's veterans or Dr. Greenberg's patients, are established, will grow and must be met with state-of-the-art service and must be provided on a sustainable basis.

I believe that taking advantage of the leverage of local healthcare economies through strategic collaborative partnership is one powerful approach to accomplishing a mutual goal.

I ask unanimous consent that a statement by the Ranking Member Lane Evans be submitted for the record. Hearing no objections, so ordered.

[The statement of Lane Evans appears on p. 55]

THE CHAIRMAN. If any member would like to have an opening statement, I will yield. I recognize Chairman Brown for an opening statement.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. As you know, the Committee has expended a great deal of effort over several years to ensure the VA considers all alternatives when contemplating new facilities in delivery of healthcare.

I am excited about today's hearing as it will allow us a good opportunity to hear from department affiliated organizations and the Department of Defense on the progress that has been made across the country.

Mr. Chairman, I am especially pleased that Charleston is well represented here today by my friend, Dr. Ray Greenberg, President of the Medical University of South Carolina. I would like to welcome him back to our nation's capital and to this hearing today. While it is always good to see friends, I am especially interested in sharing information with our colleagues regarding the collaborative model that has been successfully developed in Charleston between the VA and the Medical University. I am equally interested in completing the model's development and exporting it to other areas of the country where similar collaborative efforts may be appropriate, not the least which may be New Orleans. While this model has already served the VA well, I expect that over time the department will find increasing utility in it. To that end, I look forward to engaging Mr. Smithburg from Louisiana State University during the second panel in order to get a clearer picture of what a collaborative facility may look like in

the Gulf Coast region. I appreciate him joining us today and I hope that the work we have done in Charleston helps to fuel his efforts in Louisiana.

In a similar vein, I am thrilled to have Dr. Winkenwerder with us here today to speak to some of the collaborative opportunities that have been undertaken by the VA and the Department of Defense. Like the Charleston Model, I'm interested in finding out what types of models may help fuel additional collaboration between the departments, whether it's North Chicago or Las Vegas or something in between.

In my mind, and I think you share this view, Mr. Chairman, collaboration is becoming increasingly essential in delivering healthcare across the nation. So long as we remain true to the distinct identity of the VA, and so long as we ensure the continuing quality associated with VA care, we should embrace opportunities to maximize local health rated economists.

Now the Charleston experience has taught us a lot. We can improve the quality of care delivered, the efficiency of the care delivered and we can accomplish it without dramatically increasing the life cycle cost of the new facility.

Again, Mr. Chairman, I appreciate your leadership in this area, and I stand ready to assist you in leveraging our work in Charleston against future collaborations around the country. And I yield back the balance of my time.

THE CHAIRMAN. Thank you. Mr. Michaud.

MR. MICHAUD. Thank you, Mr. Chairman. I also would like to thank Chairman Brown for his hospitality when he went to Charleston to look at the collaborative effort as well as Chairman Buyer. Mr. Chairman, since we have Dr. Perlin and Dr. Winkenwerder with us today, I would like to actually -- they don't need to respond -- but I would like to ask them, use my time for opening statement to request some important data that you could aid the Committee as it works to provide appropriate mental health services to returning OIF and OEF veterans which actually could help us if there might be a potential to look at other collaborative efforts as we deal with the mental health issue.

And, Dr. Perlin, if you would provide the Committee with OIF and OEF healthcare utilization data generated by your office for public health in environmental hazard, that would be helpful.

And, Dr. Winkenwerder, would you please provide the Committee with an analysis of the outcomes of DoD health reassessment surveys of OIF and OEF veterans particularly pertaining to their mental health concerns. And I do want to thank both panels, members, for -- or panelists -- for coming today. Looking forward to your testimony.

And, Mr. Chairman, as we receive the information from both doctors, particularly in light of the recent Army study which shows one in

three veterans have sought veterans mental health services, I think it is important that probably the Full Committee have a hearing on this and see if there are ways that we can look at making sure that the services for returning veterans or troops meet their needs and the two agencies are able to respond to the needs of men and women returning home. So I think it would be important if we could have a hearing on that and also to see if there are ways that we might be able to assist in collaborative effort, you know, in this particular area.

So, with that, I want to thank you, Mr. Chairman, for having this hearing and will yield back the balance of my time.

THE CHAIRMAN. I appreciate the gentleman's contribution. Chairman Miller, you are now recognized.

MR. MILLER. Thank you, Mr. Chairman. We have all seen some of the benefits of collaboration in our country. And in the time when the need for more efficient spending could not be more evident, it is refreshing to see opportunities for our nation's citizens to get the most for their tax dollars.

As we find the healthcare needs of our nation's veterans changing every day, it is imperative that we in Congress work with the Department of Veterans' Affairs to ensure delivery of the new healthcare needs. And collaboration with medical institutions as well as the Department of Defense are two of the best ways of going about this.

Equally important is providing access where veterans need it most. Our nation is a constantly changing landscape, and so VA must maintain a sense of flexibility in anticipation as demographics shift. That is certainly no easy task, but it is still an aspect of the VA's mission to serve those who bravely have served this country.

I would like to thank all who are testifying before us today as they outline ways to better accomplish this mission. But I would also like to emphasize that collaboration should not be forced. The collaborative conditions need to occur where we know the veterans are, where we know more veterans will be coming.

You all know that my district in Northwest Florida is home to one of the largest veteran populations in the nation, as well as home to five military installations. Some of these installations will become dramatically larger over the next few years as a result of the 2005 BRAC process.

Already in an area specified in CARES as an under-served market, anyone can now see that Northwest Florida is going to become even more under served. The growth rate of the veterans' population was strong long before CARES came out, and long before BRAC, and it is my hope that VA will continue to focus on an efficient delivery of needed healthcare by looking at the future as well as the present. Yield back.

THE CHAIRMAN. Mr. Reyes, you are now recognized.

MR. REYES. Thank you, Mr. Chairman. I would like to join you in

welcoming our guests here today on the three panels, but I would like to associate myself with the comments of my colleague, Mr. Miller, from Florida, because my area, my region, like his, will be seeing some substantial growth under the decisions of BRAC, and so I would hope that we are able to work as additional troops come in with both the VA and the Department of Defense to do as much as we can to facilitate both active duty and the veteran population.

My region has about between 70 and 80,000 veterans, and we have one of the projects -- in fact, we just celebrated the tenth anniversary of the partnership -- for me it is not a collaborative effort -- is it a partnership between the VA and William Beaumont Hospital. And while I will have some questions when it is appropriate, Mr. Chairman, I understand that some Committee staff during the last break went to El Paso to look at the VA Beaumont relationship, and I was wondering, Mr. Chairman, would it be possible to better coordinate that with the member from the area, because -- and the reason I ask you is because as you know I have requested a field hearing for the El Paso area for my district again because of the large population of veterans in the region. And it would have been helpful for me to know that they were coming because I would have had the opportunity to show them a little bit more than just that relationship between the VA and Beaumont, so if we can do a little better job of coordinating, I would appreciate that in the --

THE CHAIRMAN. Mr. Reyes, that is unfortunate. It was Committee travel of the O&I Subcommittee of which you are a member, and the minority was invited to participate in that trip by staff and declined.

We will improve the direct relationship with the member office and that should not occur.

MR. REYES. Okay. And I only mention it because of that pending request that I have. But I appreciate the opportunity to make those observations in terms of the expected --

THE CHAIRMAN. Mr. Reyes, please recognize, though, the O&I Subcommittee, of the years that I participated, was a very good Subcommittee and you know this is a very good Subcommittee.

MR. REYES. Yes.

THE CHAIRMAN. And that staff from both sides try to cover the waterfront, and so majority might be going this way, and the minority is going that way, and they do talk to each other. But with regard to going to a Member's district, they should let you know.

MR. REYES. Yeah.

THE CHAIRMAN. I apologize for that.

MR. REYES. Oh, no. Well, and I wasn't seeking an apology. I just hope that we can maximize those trips because it is a big country and there are a lot of issues all over the place and it is a good opportunity that we would have to show them some more --

THE CHAIRMAN. Well, it is a great facility.

MR. REYES. Yes.

THE CHAIRMAN. Even when I was on the Armed Services Committee, I --

MR. REYES. Absolutely.

THE CHAIRMAN. When I was in charge of personnel in the health delivery system, Secretary Winkenwerder, I went to that facility at El Paso. They do a great job, and they were one of the early facilities, early on. But thank you very much.

MR. REYES. We are very proud of it, and thank you, Mr. Chairman.

THE CHAIRMAN. Thank you.

MS. BROWN OF FLORIDA. Thank you very much, Mr. Chairman. I certainly want to thank the Under Secretary and the other members of the VA staff for being here today to present their testimony.

In Mr. Perlin's testimony, he touches on an issue of great importance to veterans. The need to improve access to healthcare via collaborative efforts. I am not sure -- and maybe you could elaborate on this in your testimony if this concept has been picked up any other place, and that is certainly whether it is Ms. Berkley's area or Mr. Miller's area or Mr. Reyes' area, where there is growing population and more and more veterans moving in, if any of the developers have said we will build a clinic if you will staff it.

We did that in the villages and I would just like to know if you are taking this concept anyplace else. While it is not direct collaborative healthcare -- it provides everything you need except for the equipment and the staffing and as, you know, bricks and mortar are expensive and if you can work with various developers, it seems to me as if it is a win/win situation of having the developer donate the land, put up the building and have greater access to veterans' clinic facilities.

As you know, we are not building the mass of Hospitals that we once did. Long before I was here, we went to the community-based outpatient clinic which really provides quicker, less expensive care than in a hospital setting. So I would just encourage the VA to pursue this in other growing veteran areas because it really is a win/win situation.

I thank you very much, Mr. Chairman, and I look forward to hearing their testimony.

THE CHAIRMAN. Thank you. Mr. Udall, you are recognized.

MR. UDALL. Thank you, Mr. Chairman, and rather than giving an opening statement, I would like to, Mr. Chairman, just offer my opening statement for the record, and then just a couple of comments about collaboration in the Louisiana, New Orleans context.

It seems to me that the briefings that we have received from Members of the House that have been down there on co-dels, the opportunity to talk with Members of Congress who represent this area, they are in a very dire, dire situation down there, and anything that you

can do in terms of working with other institutions and other medical centers in trying to provide the care, I think is something that is very welcome.

So I want to thank you for that, and we will also be visiting with you in the question section, and I am just introducing my statement for the record. Mr. Chairman, thank you.

THE CHAIRMAN. Hearing no objection, your written statement will be submitted for the record.

[The statement of Mr. Udall appears on p. 57]

THE CHAIRMAN. Ms. Berkley, you are now recognized.

MS. BERKLEY. Thank you, Mr. Chairman. I was at another hearing when my staff notified me that Las Vegas was mentioned in my colleague, Mr. Brown's statement, and I felt the need to come here and clarify some things.

As you know, and I have said this on the record many times, Southern Nevada has one of the fastest growing veterans populations in the country. Currently Southern Nevada is struggling, and I mean struggling, to meet the needs of the population growth which has been compounded by the evacuation of the Addeliar D III Guy Ambulatory Care Clinic, outpatient clinic, and its replacement with ten clinics scattered across the Las Vegas Valley.

My veterans also seek care at the Michael O'Callaghan Veterans Hospital at Nellis Air Force Base where the Chairman was kind enough to spend a day with me, seeing exactly what the critical situation is at the VA.

I must state for the record that while in some communities shared facilities between the DoD and the VA work well or may work well, it is not a one-size-fits-all solution for all of us. Las Vegas has had shared facilities. It does not work for communities that are growing the way Las Vegas is.

Nellis Air Force Base wants its own facility. They need their own hospital. They have got a very active Air Force base, one of the primary Air Force bases in the country. Every bed is filled all the time and we are on divert. The only problem is that every other hospital in Las Vegas is currently on divert.

So we -- while I understand that in perhaps South Carolina the shared facilities work very well, they would not work well in Las Vegas, and we are looking forward to our full-service medical complex with an exclusive VA hospital, outpatient clinic and long-term care facility, and it cannot come soon enough for the veterans that live in my community. We are in a critical situation in Las Vegas and shared facilities don't work.

THE CHAIRMAN. As well.

MS. BERKLEY. At all.

THE CHAIRMAN. At all. No, I don't believe that -- you can't say

that.

MS. BERKLEY. Well, in my community, I think it is -- I think it was demonstrated.

THE CHAIRMAN. I have been there with you, and it was great, and --

MS. BERKLEY. I think you shared our pain on that day.

THE CHAIRMAN. All right. Let me now, before we begin, extend a welcome to our new Committee member, Mr. John Campbell of California. John Campbell took over the district of the former member Chris Cox, when he went over to become the Chairman of the Securities and Exchange Commission.

John Campbell brings to the Committee a strong business background. He received a bachelor's degree in economics from UCLA and has a master's degree in public taxation from UCS. Prior to his public service, he was employed as a CPA at the firm of Ernst & Young, and he was the CEO and president of Campbell Automotive Group, which included Saturn of Orange County and Saab of Orange County.

His public service includes serving in the State House as a California State Assemblyman and as a California State Senator. Mr. Campbell resides in Orange County, California, and he has one wife and two sons.

[Laughter.]

THE CHAIRMAN. Is that what it says? That makes you a conservative in the State of California.

[Laughter.]

THE CHAIRMAN. I can't help myself. I apologize. We welcome the gentleman to the Committee.

Now we will turn to our panel, and let us see, who do we give deference to, DoD or VA; gentlemen, you decide. Dr. Perlin.

STATEMENTS OF JONATHAN B. PERLIN, M.D., Ph.D., MSHA, FACP, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TIM S. McCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; AND WILLIAM WINKENWERDER, JR., M.D., M.B.A., ASSISTANT SECRETARY OF DEFENSE OF HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; ACCOMPANIED BY JOHN L. KOKULIS, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH BUDGETS AND FINANCIAL POLICY, DEPARTMENT OF DEFENSE

STATEMENT OF JONATHAN B. PERLIN

DR. PERLIN. Well, thank you, Mr. Chairman. Members of the Committee, good afternoon. I ask for our full statement to be submitted for the record.

THE CHAIRMAN. Your statement will be received. Hearing no objection, so ordered.

DR. PERLIN. Thank you. Veterans' Health Administration understands the benefits of collaboration for VA, for veterans and for the American taxpayer. We are proud of our expanding partnership with the Department of Defense, and I would like to personally acknowledge and thank Dr. Bill Winkenwerder for his leadership in that regard.

We are in the process of creating new and fruitful partnerships with other healthcare providing as well, especially our critical and very valued medical school affiliates.

Let me begin by discussing our work with the Department of Defense. As you know, there have already been a number of successful examples of VA/DoD sharing, and perhaps the most far reaching and ambitious is Chicago, where the partnership between our North Chicago VA Medical Center and Naval Hospital of Great Lakes will result in a joint federal facility.

Six working groups are now addressing human relations, information technology, leadership, finance, budget and clinical and administrative management issue. In Alaska, the Anchorage VA Outpatient Clinic and the Elmendorf Air Force Base have a long-standing joint venture to serve veterans and DoD beneficiaries.

Anchorage and Elmendorf are also looking for new areas to collaborate and are currently the site of a budget and financial management demonstration project. In addition, the VA is opening a new outpatient clinic in 2008, next to the Elmendorf Hospital.

In El Paso, VA has an outpatient clinic, co-located the at Beaumont Army Medical center, as Mr. Reyes alluded, and that is a very successful partnership. Beaumont provides inpatient services to VA patients as well as Department of Defense beneficiaries in two facilities which really pioneers an implementation of medical record sharing between our two systems, as we work through the total joint interoperability or our electronic health records.

I would note in passing that is the site of one of the pilots in the Bidirectional Health Information Exchange, which I am proud to report won an excellence dot gov award for departmental data sharing from the American Council for Technology.

Our agencies, working together, is serving as a model for our nation to demonstrate how the President's goals and Executive Order to make electronic health records available to most Americans by 2014,

can be met. And I am honored to serve with Dr. Winkenwerder as a commissioner on the American Health Information Community, which is composed of eight private and public sector healthcare leaders.

In Charleston, VA and DoD are constructing a $40 million consolidated medical clinic at Goose Creek in Berkeley County. VA's portion is funded through our minor construction program. By joining forces, VA and DoD have removed their need for separate ancillary and support services and construction will start this fiscal year, anticipated to wrap up in the Fall of 2008.

VA is pursuing collaborations with other healthcare providers, and recently we, and the Medical University of South Carolina, conducted a joint review to identify options for collaboration and sharing in Charleston.

The structure used for that review provided useful information that enabled us to identify viable sharing opportunities. The process consisted of a steering group with representation of national and local VA leaders and USC leadership and leadership from the Department of Defense.

They reviewed data, including quality indicators of population statistics, care volumes and costs.

Mr. Chairman, let me take this opportunity to thank you and Chairman Brown, the Chair of the Health Subcommittee, for your leadership in support of this endeavor. I would also like to thank Dr. Ray Greenberg, the president of MUSC, for his exceptional work and collaborative attitude which has greatly contributed to a successful outcome.

An underlying process critical to the steering group's success was the use of the cost effectiveness analysis. This provided insight into both estimating initial capital costs and the potential savings and life cycle operational costs. The group identifies some short-term options for resource sharing that have already been initiated. I have asked Mr. Moreland to provide you with an update on the status of that activity in his remarks.

The model functioned so well in Charleston that I recently charged the group to conduct a similar review in New Orleans, where the tragedy Hurricane Katrina brought, made restoring in patient services an urgent priority. It offered us an unusual opportunity for new collaboration.

This group will study collaborative opportunities between the New Orleans VA Medical Center and Louisiana State University. I was honored to sign a memorandum of agreement with LSU two weeks ago to evaluate possibilities to realize efficiencies through partnership.

VA's strong partner in this effort, Mr. Don Smithburg, executive vice president of LSU and CEO of their healthcare services division,

provided outstanding support and leadership, and he and I look forward to sharing the group's finding with you later this year.

Mr. Chairman, VA will continue to look for opportunities to leverage our abilities to improve our ability to provide world-class care to enroll veterans. Thank you for this opportunity to describe our progress to you.

THE CHAIRMAN. Thank you. Secretary Winkenwerder.

[The statement of Jonathan Perlin appears on p. 58]

STATEMENT OF WILLIAM WINKENWERDER, JR.

DR. WINKENWERDER. Thank you, Mr. Chairman. I appreciate the chance to be here today and a chance to testify together with Dr. Perlin. Let me also thank you for your leadership and for the other members of the Committee for your interest and coaxing, persuading, cajoling, the VA and DoD to continue to work thing. I think we have established a good track record and I very much would like to see that continue.

Having submitted our VA/DoD Joint Executive Council Annual Report for Fiscal Year 2005, the accomplishments of the past year are fresh in our minds. We continuously explore new avenues of partnership with the VA through our Executive Council, the VA, DoD Executive Council, and the associated work groups.

And just for everyone's benefit, this involves a meeting of Dr. Perlin and myself and our staffs. We meet approximately every two or three months, and it really is an excellent formal structure and a great vehicle for both departments to jointly address issues, set priorities and strategic goals, as well as to monitor the implementation of these priorities and to ensure that people are accountable for executing what we're asking them to do.

As a companion to the annual report, the VA/DoD Joint Strategic Plan for 2006 through 2008, was just published. This is a roadmap that was recently reviewed and updated to incorporate lessons learned as well as to set more concrete milestones and performance measures.

Resource sharing is a vital component of both organizations' healthcare delivery systems. At the end of Fiscal Year 2005, VA and DoD had 446 sharing agreements, covering nearly 2,300 services, and 136 VA medical centers reported reimbursable earnings during the year as TRICARE Network providers. This is an increase of 59 percent over the previous year.

My written testimony provides the details on a number of joint facilities with regard to collaboration to improve access to care and John has covered those well. I will say that I am in total agreement that a great model for resource sharing is the first federal healthcare facility, with a single management structure.

In October, I joined John and Deputy Secretary Mansfield and attended a ceremony in Chicago to mark the creation of this innovative initiative. The North Chicago Veterans' Affairs Medical Center and Naval Hospital, Great Lakes, are going to integrate all clinical and administrative services under one line of authority.

This is a new venture. It is a new way of doing business, but we absolutely believe in it, and we believe that it takes constant oversight to make sure that the people on the ground get the job done.

Another example, and I agree with Dr. Perlin, is the opportunity for the Keesler Air Force Base, VA, Biloxi, campus area with the fact that our healthcare facilities in the area received damage and there's an issue there with respect to how to go forward.

DoD and VA have established a joint task force to explore the potential for a joint venture medical center. This task force has identified several options for a significant partnering. We are committed to moving forward within the next several weeks with the best design for the beneficiaries of the region and for taxpayers.

DoD and Navy are also collaborating to finish the DoD/VA Joint Ambulatory Care Center in Pensacola. This project represents one of the largest joint collaborations to date and was made possible by a land-use agreement that grew from the VA capital asset realignment for enhanced -- or services or CARES decision to expand services in the Florida panhandle.

The facility is currently under construction with a completion expected in January 2008.

Another important collaboration is planned in South Carolina. As many of you may know, the 1993 base realignment and closure BRAC action significantly decreased the work load for the 500-bed naval hospital in Charleston. Currently, this military treatment facility is a hospital in name only. Inpatient services are performed at a nearby civilian hospital.

But what we now have underway is a 35 million Fiscal Year 2006 construction project that includes approximately 164,000 gross square feet of clinical space. The 4.4 million, that VA portion was funded with, with their minor construction program, includes approximately 18,000 gross square feet. By joining forces, VA and DoD have removed the need for a separate ancillary and support spaces.

Mr. Chairman, again, thank you for the opportunity to speak with you today. DoD is committed to continued collaboration with the VA.

There are some other things that just in the interest of time, I will not touch on, but I do want to mention in the area of health information, the fact that we are now really picking up speed with respect to moving clinical information, health information, on separated service members to the VA, and we have moved 3.1 million information on 3.1 million, unique patients to the VA electronically.

We are now moving pre and post employment health assessment information and nearly half a million of those assessments have been moved electronically. And, again, I endorse John's comments and the Commission. We are really being looked upon as leaders in this whole area of developing electronic, since we both have electronic health records, as to how to share that information and to do in a seamless and interoperable way.

We have got really smart people working on this. They are up to the task, and so we are excited about that. With that, I will conclude my remarks and look forward to any questions.

[The statement of William Winkenwerder appears on p. 63]

THE CHAIRMAN. Let me pick up right where you just left off on IT. We have some ways to go. Our staff had returned from Tampa at the Polytrauma Center where they were pleased to see you have the seamless transition of the electronic medical record. That is our goal. It is going to take us some time to get that throughout the system.

Dr. Perlin, Chairman Walsh and I met with the Secretary this morning. I want to thank you for your leadership on the IT. I know you are being responsive to those in the field, are given tremendous push back, and the Secretary was very complimentary towards you and wanted me to appreciate what a difficult position those in the field are also putting you in. He also wants me to trust you to do that which is right.

I trust you to do that which is right, because I know you are coming my way. You are coming the Committee's way. And so he told me that you are all going to go off and you are going to do your two-day -- I don't want what you want to call it -- summit or whatever you are going to call this -- but the Senior Leadership Council is going to sit down and you are going to work this thing through and make the right judgments, and I believe that is going to happen.

We don't have to pound this anymore. You know the desires of this Committee, and but we have got to see it through. There is a cultural thing. We have to get through this barrier so we can begin to work on these relationships between two major departments of government.

So, I am a good listener to the Secretary, and he was very complimentary towards you, along with our CIO. And he does want to see the two of you go to dinner. Okay?

Before I yield, I want to let the members know we are to have votes around the 3:15 to 3:30. We will push that to probably about 3:40. Secretary Winkenwerder, you have to leave about when?

MR. WINKENWERDER. Approximately 3:15 to 3:20.

THE CHAIRMAN. All right. We will please try to accommodate the members as much as we can. I'll tell you what. I will reserve my questions, because I can have a pretty quick access to both you gentlemen. Let me yield to Mr. Miller.

MR. MILLER. Thank you, Mr. Chairman. I have several questions for Dr. Perlin. If I can, and I am going to focus specifically on the report to reestablish a medical center in New Orleans.

Was Baton Rouge an expansion of the Baton Rouge CBOC considered instead of, again, I am going back to the issue of the veterans that evacuated and left and nobody can tell with certainty who is coming back. There is significant discussion about accelerating CBOCs in the outer region because of the increased need for medical care, but it seems to me if you are increasing the size of the CBOCs for the veterans that the assumption would be that they are going to stay; and, therefore, if you rebuild a medical center in New Orleans, you are overbuilding.

Or if you are sure that these veterans are going to go back to New Orleans, then you are overbuilding CBOCs. And I am trying to figure out which is it. And in the same question, if you could answer for me the question of what consideration was given to Baton Rouge in regards to expanding their sea bock and making it a larger facility?

DR. PERLIN. Thank you, Mr. Miller. Those are absolutely excellent questions. Let me just start by offering the comment that the Baton Rouge Clinic is actually operating beyond its capacity in addition to the expanded new CBOC that is there. We were able to obtain a lease on our old CBOC and they are operating both.

It is clear, just as you have indicated, that some veterans from New Orleans proper, from St. Bernard's Parish, and Orleans Parish, have likely moved to the periphery of that area, and they are being supported.

I think what is so compelling about the New Orleans situation is whether or not those veterans actually returned to Orleans Parish and St. Bernard Parish, I think what the data reveal, is that there is need for a tertiary medical center in the region.

Your question of whether that should be located in New Orleans or Baton Rouge is also an excellent one as to what would have the greatest centrality to the population and where would the resources be in place to support the tertiary care needs.

I think that it is fairly evident that there are longstanding and very effective relationships with Louisiana State University and Tulane University in terms of providing this sort of specialty expertise and subspecialty care that make that aspect fairly self-evident.

In terms of the centrality, I think that there is also a good history of referral patterns and catchment that shows that New Orleans is, in fact, a good and central location. So both on the geographical test and the resource test, it would meed the need and even absent the population being fully restored in the two major parishes, it would still meet the need in terms of population.

MR. MILLER. If there was never a New Orleans Medical Center, would you be putting one there today?

DR. PERLIN. I think again I come back to the issue that --

MR. MILLER. No. The question is if there was not a New Orleans Medical Center, would you build one there today?

DR. PERLIN. Yes, sir, we would.

MR. MILLER. Why?

DR. PERLIN. Because of the ability to affiliate and deliver efficiencies --

MR. MILLER. Would Tulane and LSU be there if the VA Medical Center had not been there?

DR. PERLIN. I would have to go back and research the history. I think they predated us, though. So the answer is yes they would.

MR. MILLER. You are sure?

DR. PERLIN. Our building is 50 years old. I believe that they are extant before us. But, Mr. Smithburg would be --

MR. MILLER. So we are doing this -- I am looking through the memorandums between LSU and VA, and I am looking for, you know, where the veteran gets the best, you know, deal without having to get in a car and drive, you know, an inordinate amount of time. And I am not seeing that. I am seeing a if we build it, maybe they will come back.

And, you know, I want you to convince me that the taxpayers of the United States of America should spend $600 million, which is what I understand is coming into the emergency supplemental, to rebuild a medical facility in a declining population.

DR. PERLIN. Your question is absolutely a fair and appropriate one, and in the central, southern market area, in fact, there are 377,000 veterans in total. And while it is true that under any scenario, hurricane or not, there would be some decline.

There clearly is a population as well in that report. I am glad you have had a chance to look at it. You will see that there are a number of options, including not being actually close.

Part of the rationale for both VA, and I believe for Louisiana State University, is the ability to share capital equipment and reduce significantly the capital investments. Share infrastructure, share staff, and actually get the taxpayers the best deal on location that you fairly ask is appropriately close and accessible for veterans.

MR. MILLER. And I looked in the report, and you talked about two independent towers, one for LSU, one for VA. The parking lot would be shared and all the administrative areas, and I understand that.

But we are talking about healthcare for veterans and where the veteran population is, and I find it difficult to understand why we are forcing the issue of going back in with 600 million -- the original request was 825 million -- but we are looking for 600 million now.

Thank goodness it appears that it will require authorization from this Committee to be done. But I have a long list of questions that I would like to submit for the record in regards to proof of the numbers

that are being used to support what is being requested. And my time is out, and I yield back.

THE CHAIRMAN. Chairman Miller, you may submit those questions for the record, and please also recognize that Chairman Brown has the responsibility for holding his Subcommittee hearing, along with Mr. Michaud on the construction. So you are right. We will take up these issues in further detail, but you have your right to ask any questions you like and you may probe. Sir?

MR. MILLER. May I respond?

THE CHAIRMAN. Yes.

MR. MILLER. Given the way appropriations are done at this current time, in this Congress, it is nice to see that the appropriators recognize that we have a role as authorizers of the money to be spent. Ordinarily it would not happen that way. The appropriators would appropriate the funds without it ever coming before this Committee, and so I am saluting our Chairman for getting us back in the loop.

THE CHAIRMAN. Thank you. Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. Dr. Perlin, the CARES decision identified 156 new CBOCs by 2012. VA has not funded the bulk of these CBOCs and it is related to some of the concerns that Mr. Miller has.

How will VA keep these CBOCs a priority while pursuing a collaborative effort with limited funds? Will the new collaboration mean that the efforts to open up the needed CBOCs will be delayed?

DR. PERLIN. Thank you, Mr. Michaud, for that question. I think just the opposite is apt to be true. If we can free up resources through some effective synergies that fundamentally serve veterans, and let me be very clear that we appreciate that the collaboration doing many great things, but ultimately our first responsibility is veterans. We are glad that all these sorts of collaborations will also serve others, but those synergies will allow us to operate more efficiently and provide resources for things such as CBOCs.

The other thing that I think is important in terms of the affiliations is that as healthcare moves from the hospital to the clinic, one of the sites for expansion of residency programs, an appropriate site for training, something that improves service to veterans, but also improves efficiency all around, is the collaborative opportunities for training experience as in those outpatient clinics as well.

MR. MICHAUD. Thank you. Mr. Chairman, in essence of time, I request permission to submit the remaining questions in writing.

THE CHAIRMAN. Yes.

MR. MICHAUD. For the record. Yes, without objection. You have that right.

MR. MICHAUD. Thank you.

THE CHAIRMAN. Chairman Brown, you are now recognized.

MR. BROWN OF SOUTH CAROLINA. Mr. Chairman, thank you. Dr. Per-

lin, overall, what lessons can be learned from the VA's experiences with the joint venture proposal in Denver and in Charleston? And I know we had some differences in the collaboration there.

DR. PERLIN. Well, thank you, Chairman Brown. I know that your exceptionally familiar with the Charleston Model, and I think the fact that is now called the Charleston Model is really testament to it being both a documented process that captures the best of the experience.

It really, I think, showed us how important it is to bring together leadership at the very beginning to be able to discuss what the particular needs of each entity are and understand operational realities, capital realities, funds flow, service needs, in ways that can potentially be synergistic.

I want to commend, again, not only Dr. Greenberg for his leadership in that effort, but Mike Moreland on the next panel, who I think can elaborate on what really now is, and should be a standard for evaluation of potential collaborative opportunities.

It is a systematic ability to review finance, government, human resources, and clinical services, and provide a cost effectiveness analysis, not only to look at initial capital outlay, but how to improve efficiencies.

MR. BROWN OF SOUTH CAROLINA. Thank you. And, Mr. Chairman, one further question. What are the advantages and disadvantages for VA medical centers to enter into a sharing agreement to become TRICARE providers? Is that something that we might work into --

THE CHAIRMAN. Well, let me respond that I think there are advantages. The common denominator among veterans is that they were service members, and to the extent that we can work together, I believe that we should be working together, and I appreciate the great partnership that has been evidenced by DoD as a whole in the person of Dr. Winkenwerder, and as he noted in his testimony, a 59 percent increase over the last year alone.

DR. WINKENWERDER. Congressman, I will also just add that certainly from my perspective for the DoD entitled beneficiary population, retirees, as well as active duty and their family, but retirees and their family members, where there is a VA facility available, we encourage that to be used as part of TRICARE Network.

We have contracts, and we have also sometime ago, one of the first things we did was to set the payment rate so that it was equal between the VA to the DoD or DoD to VA, and in the past we have had problems with disputing, you know, who should get paid what. And we said this is crazy. Let us just have one payment amount that we agree to.

And that has, I think, helped, but we continue to encourage, from my standpoint, you know, we have got fixed assets and our charge is how to fully utilize those fixed assets. And frankly where we don't

need fixed assets, let us not build them. I mean that has been our approach.

We, of course, with the BRAC process, we are consolidating Walter Reed in Bethesda. We are consolidating Brook Army in Wilford Hall and we are closing ten other hospital inpatient facilities. And in some of those locations, we will be looking to the VA as a source for inpatient care. So that is our view of the world, and we want to just keep pushing forward with that.

MR. BROWN OF SOUTH CAROLINA. Well, thank you, Mr. Chairman. I know it is real refreshing to have both of you at the table and certainly with that cooperative effort, and thank you very much for both coming in. Mr. Chairman, in the sake of time, I will just submit the rest of my questions.

THE CHAIRMAN. Thank you, Chairman Brown.

Mr. Reyes, you are now recognized.

MR. REYES. Thank you, Mr. Chairman. And I will have just a couple of questions, and then have some questions for the record as well.

The first one is Dr. Winkenwerder, how will the Defense health program funding be allocated to respond to the population shifts due to BRAC in the armies overseas rebasing initiative? I am particularly concerned about that because we are going to see growth of between 21 to 24,000 new troops in our area.

Will funding for military construction to expand and build new medical facilities be funded out of the existing DHP military construction account, or will they be funded from the BRAC accounts?

Also have these projects such as the expansion of the Beaumont Army Medical Center in El Paso, been included in the services' BRAC military construction plans?

And then, secondly, can you please tell us how you and your staff are working with the services, from my perspective especially the Army, which will see major growth in several CONUS bases, to ensure that medical services will be available for troops and for their families when they arrive at their new duty stations?

DR. WINKENWERDER. Thank you, Congressman, for that question there. The short and quick answer to where are the funds coming from is that they are coming from the BRAC funding, the designated BRAC funding. Some will be paid for with our ongoing military construction account and some, as I understand it, John, would be through the Army Modularity, would be sources of funds as well, so all three of those.

But we clearly have a challenge in front of us, and we are thinking actively right now as we look at the whole issue of BRAC and we are, as you know, moving towards more joint operation of medical facilities.

And traditionally, these have all been funded through individual service lines, but we are giving serious thought to if we are going

to have it jointly operated and staff facility, should we think about a joint funding mechanism and oversight process to ensure that we don't get undue competition between the services and that we ensure that we expend these funds in the most efficient way. Sometimes giving somebody an authority to do that, really helps arbitrate the process. So we are doing that.

Your second question had to do with how to -- I am sorry?

MR. REYES. With working, especially with the Army, in terms of addressing the growth in the bases to ensure medical services to both the troops and their families when they actually arrive.

DR. WINKENWERDER. When they come back. Principally, we are looking to the Army and to Surgeon General Kiley, Army Surgeon General, to identify where there may be a need for more medical resources, be it people or facilities, to handle the additional workload that we do anticipate in certain places. Yours might be one of those locations and at Fort John, New York, Fort Carson, there is a handful of locations.

But we will be prepared. We are not taking this off our radar screen at all. But if there is more detail about that, that we might be able to provide for you subsequently, we would be glad to do that.

MR. REYES. And I will have some additional questions, but I appreciate the time, Mr. Chairman. I yield back. Thank you.

THE CHAIRMAN. Thank you. Mr. Campbell.

MR. CAMPBELL. I have nothing.

THE CHAIRMAN. Let me ask you a few questions here before we break for our vote. I would like to address the Charleston Model for a second, because what I am sensing is that our Collaborative Opportunity Steering Group meets we have a great investment; we have no idea where this is going to take us; we jump into these identified areas and what are possibly the no-go areas: and so we go into the darkness and define it. That is pretty exciting.

So when it is all done, you know, the three of us are standing there, General Love and Mr. McClain and Dr. Perlin, and I don't remember which one of you turns and says we have broken a paradigm. I don't remember which one of you said that.

And I have never forgotten it, because I was just as stunned, because I had sensing, but it wasn't even where I thought it was going to go, and how it got defined was pretty exciting, and I could sense that in the room, Dr. Greenberg.

My question is, though, where do we go from here? So we have this Charleston Model, we have something we are sort of excited about, and we talked about how it can be leveraged and before we can even define it and proceed with it in Charleston, it then gets leveraged into this idea with LSU, because of what has happened, and this is called an opportunity.

And my gut is telling me that what we did in Charleston is we went

through the heavy lift, but there is still work yet to be done. And so are we now getting ahead of ourselves? So where are we "on the next phase" with regard to the Charleston Model? Dr. Perlin.

DR. PERLIN. Well, thank you, Mr. Chairman. And, you know, I think if there is a completed product, initially, part is the model itself for evaluation.

THE CHAIRMAN. Yes.

DR. PERLIN. So let me put that aside and come back to Charleston specifically. I think I may have used the term that this is a new paradigm, and it really was a new lens, a new way of looking at collaboration.

I am extremely excited about what it brought us in terms of opportunity. Seven million dollars has been transferred to the Charleston Medical Center, and they will, as quickly as the federal processes allow, contract for the new services which will bring great new technologies to both veterans and the citizens of the state.

The tomotherapy, a type of radiation therapy that is available nowhere else in the state currently, will come to veterans and citizens as result of this collaboration as will two angiography suites. So I think the model of putting the capital investment there and receiving reduced rates on services in return, is absolutely fantastic. So the $7 million are already transmitted.

Now the assessment brought forward a number of different proposals. Admittedly some were permutations of the others, particularly if you remember the "A" group of models. I have concurred that the analysis is effective. I have nothing to add to it in terms of believing that I can out think the great work that the group did.

And I have submitted a forward to the Department's Capital Asset Management board for prioritization among all of the construction projects to capital investment activities in the Department that the Secretary might consider.

THE CHAIRMAN. My gut is also telling me we haven't defined criteria on how and where to use such a model. I mean, I look across the landscape out there, and say, okay, let us see. In Charleston, the Medical University has a construction project that is on a time line. Yes, we are able to provide quality services. When does the model fall into that time line? That is an unknown.

We know we are constructing a new hospital in Orlando. We have one in Las Vegas. We have one in Denver, and now we have this in New Orleans. So these are very large construction projects.

We have not been in the building business since, what, '92, '93? So it has been a while since we have been in the building business, and we are about to get into the building business in a very large way.

So when we look at this, and we go, okay, in Orlando, the State of Florida wants to build a medical university. So my gut is telling me, try to move into that in close proximity, and when they can move

together it is a good thing.

I also learned then when I am out with Ms. Berkley in Nevada, that the chancellor of UNLV wants to do a medical university. It is a good thing, you know what I mean, to do that collaboration.

We didn't do so well in Denver with regard to these initiatives, but it did give us the opportunities to progress because Dr. Greenberg hired the same firm that was used in Denver, and we had the VA working with Dr. Greenberg on matters we were able to work through in Colorado.

And now we have New Orleans. We have Mr. Miller dancing on the edge there with regard to New Orleans, and it was about right to go through the door of something very challenging. The President of the United States has said that we are committed to help rebuild New Orleans.

And so now we have this task, and I understand the sensitivities. I don't live in the Gulf region, such as Chairman Miller, but the sensitivity is to trying to service veterans there and at the same time, LSU has a challenge. They want to progress. They want to move into the future. If we can do that in collaboration with them, and define where it is going to be, I understand where we want to go.

Okay. I can embrace that, while I am also equally as sensitive to Chairman Miller's concerns.

So now let me dance -- let me try to go in with Chairman Miller for a second. Now we are going to do this with regard to New Orleans, and we are closing Gulf Port and enhancing Biloxi. What are we doing about having a joint facility with Keesler? I don't understand that.

Dr. Perlin. I am sorry. I am not sure I understand, because we are doing a joint facility with --

The Chairman. Why? That is my question. Why? I mean the close proximity of it, with only the available dollars -- I guess I don't know what you mean by joint facility with Keesler.

Dr. Winkenwerder. What we mean is this, and I don't want to get to far ahead of where the work group is, but the Air Force has a hospital base at -- hospital -- at the Keesler base. It was scheduled to become a clinic, originally with a BRAC process, rather than a hospital, because of the level of utilization and the relatively small population of people being served.

One of the thoughts is rather than to rebuild -- and it was damaged -- significantly damaged in the storm. As I understand it -- and I visited the hospital -- I didn't visit the VA right after the storm -- is that the VA facility is on higher ground, is very nearby.

Rather than our, again, trying to reconstitute and build and invest heavily in a new hospital structure, we may want to consider using the VA and partnering with the VA to use the VA for an inpatient facility.

And even -- and then I don't know about the outpatient piece yet, whether we build something alongside it or have it on the base or how all it would work, but the point is it is an opportunity to think freshly rather than both systems just going down their merry paths to recapitalize and rebuild.

THE CHAIRMAN. All right. Right before I yield to Mr. Baker of Louisiana, Dr. Winkenwerder, I would like you to know this, that when we went through the budgetary process last year, we learned in greater detail how DoD was really cost-shifting dental into the VA. And that was a great concern of mine and in the 14 years that I have been here on Capitol Hill, I have never had a general officer be non-responsive.

Twice my staff put in phone calls to the Surgeon General of the Army, General Kiley, and I have never been stiff armed before, but now once in November and once in December, and I have never heard from him. So let me tell you what that means. That means that he has invited this Committee into his business, that is what it means.

So I have assigned the O&I Subcommittee to do an investigation on the issue. So you can please take that message back to the Surgeon General of the Army that we don't appreciate that type of -- well -- conduct.

This moment, let me yield to Mr. Baker.

DR. WINKENWERDER. Thank you. Mr. Chairman, if I might just respond to that. I wasn't aware that there was a concern, and I do find it a bit unusual that General Kiley wouldn't respond to you, not a bit. It is -- I don't have an explanation for that.

THE CHAIRMAN. The invitation has already been out there.

DR. WINKENWERDER. Yeah, but we will convey the information, and we have been working together in the dental issue. To my knowledge, it has been worked and worked out. So, but we will --

THE CHAIRMAN. Well, if that in fact is true, I will find out, I have never been stiff armed before, and that is really insulting.

DR. WINKENWERDER. Okay.

THE CHAIRMAN. Mr. Baker.

MR. BAKER. Thank you, Mr. Chairman. In light of the votes pending, I shall be brief. I understand also that LSU is scheduled to appear at later time during the hearing today, and it would be appropriate for me to speak further at that time.

But I would like to point out that with regard to resolution of veterans' healthcare in the State, we are still at a very unsettled time in our State. A housing resolution is pre-imminent of importance. There have been literally hundreds of thousands of people dislocated with not the ability to return as of this date and likely for the foreseeable future.

Although I will be quick to point out that the dislocation is not permanent, nor does it mean that individuals have left the State. It is my hope that LSU and the necessary healthcare professionals and

the VA can work together cooperatively going forward, but I would not want to arbitrarily forgo a load of bricks anywhere else right at the moment.

Until appropriate professional assessment is made of the continuing need within Louisiana, our recovery effort is likely to be decades long. It looks as if the supplemental now pending is subject to some controversy, and if we are unfortunate enough not to receive additional assistance, it is going to be extremely important to have every other federal agency cooperating with us to the maximum of their legal authority.

So I wanted to just put a statement on the record that I don't have the answer. I don't know what should be done today, but I don't have access to anyone who can tell me. And I am going to await the professional judgment of those to tell me what future needs may look like and what it makes sense in the way of deployment of strategic federal resources and certainly not to put people back in harms way of a future storm. That would be the least level of responsibility that would could exhibit.

So Mr. Chairman, I appreciate the courtesy of allowing me to make this statement. I understand that LSU is to be heard later, and I may revisit the subject at that time. Thank you, sir.

THE CHAIRMAN. Thank you very much. Does anyone have any follow-up questions with this panel?

[No response.]

THE CHAIRMAN. If anyone has questions for the record, please submit them. We are going to have six votes. Is it up right now?

We are going to have six votes. So this first panel is excused, and I apologize to the second panel. Dr. Greenberg, when is your flight?

DR. GREENBERG. No problem, sir.

THE CHAIRMAN. All right. We will stand in recess, and we will return immediately after the sixth vote.

[Whereupon, at 3:15 p.m., the Committee recessed to reconvene at 4:30 p.m., the same day.]

THE CHAIRMAN. The full Committee of the House Veterans' Affairs will come to order. The second panel will please come forward, Please take your seats at the witness table.

While the second panel moves forward, let me provide a brief introduction of each of the panelists. Mr. Michael E. Moreland is the director and chief executive officer of the VA Pittsburgh Healthcare System. Mr. Moreland oversees the management of three campuses with 692 operating beds, distributed among medicine, surgery, psychiatry, immediate care, nursing home care, and domiciliary.

Dr. Ray Greenberg became the eighth president of the Medical University of South Carolina and is the professor -- I didn't know you were still teaching -- of biometry and epidemiology. I guess I

just didn't know that. I thought the whole admin kept you so busy, but you are still in the classroom. Well -- not very often? That is a nice title to have on the side. I don't mean to bust you publicly, but congratulations.

We also have with us Mr. Donald Smithburg, who currently serves as the chief executive officer of Louisiana State University, LSU, Healthcare System Division, headquartered in Baton Rouge, responsible for nine hospitals across Southern and South Central Louisiana. LSU provides the vast majority of care to the uninsured and working poor in the State of Louisiana.

Gentlemen, I want to thank you for making the trip here to Washington, D.C., to testify before the Committee. May I also extend an apology. Sometimes you get six votes in the middle of a Committee hearing, and members, get all together, and then they scatter. We had such good rhythm going, so hopefully some members will return.

What is most important is, that we are able to get this on the public record. We can have a good discussion and I am pleased that Chairman Brown is here.

Let me turn to the witnesses for the second panel and, Dr. Greenberg, you are recognized for testimony.

STATEMENTS OF RAYMOND S. GREENBERG, M.D., PH.D., PRESIDENT, MEDICAL UNIVERSITY OF SOUTH CAROLINA; ACCOMPANIED BY JOSEPH G. REVES, M.D., VICE PRESIDENT FOR MEDICAL AFFAIRS AND DEAN, COLLEGE OF MEDICINE, MEDICAL UNIVERSITY OF SOUTH CAROLINA; MICHAEL MORELAND, MSW, CHE, DIRECTOR AND CHIEF EXECUTIVE OFFICER, VA PITTSBURGH HEALTHCARE SYSTEM, DEPARTMENT OF VETERANS' AFFAIRS; AND DONALD R. SMITHBURG, EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER, LOUISIANA STATE UNIVERSITY HEALTH SCIENCE, CENTER HEALTHCARE SERVICES DIVISION

STATEMENT OF RAYMOND S. GREENBERG

DR. GREENBERG. Mr. Chairman, Chairman Brown, Members of the Committee, it is a privilege to appear before you this afternoon on behalf of the Medical University of South Carolina. The message that I wish to convey to you is that we greatly value our work in relationship with the Department of Veterans' Affairs, and we look forward to the opportunity to expand that relationship.

As we explore opportunities to build on our already existing collaboration, we are driven by one primary motivation and that is to improve the care of the veteran population that we and the Veterans'

Affairs serve.

Let me be clear here. Veterans in the Charleston area today in my opinion get absolutely excellent medical care. So why then if things are going so well would be motivated to make any changes.

To me there are really two fundamental reasons for this.

The first is that hospital care is becoming increasingly complicated, in part because today only the sickest patients are admitted to hospitals. And secondly the technology that is used to care for these patients has grown evermore complex and expensive.

Personnel shortages and expensive technology drive up the costs of healthcare, and you as legislators and we as healthcare providers have a shared mutual interest in assuring that healthcare delivery operates as efficiently as possible.

So how then can we be more cost effective?

As Mr. Moreland is going to describe in more detail in his testimony, one of the most attractive opportunities for us is to avoid redundancy in building and operating separate expensive highly specialized diagnostic and treatment equipment and facilities.

By sharing resources, we can save an avoid duplicative capital investments. This type of partnership has been undertaken successfully by the Department of Veterans' Affairs elsewhere on a somewhat limited basis. What we are proposing is to build upon those successes by expanding the level of collaboration and we are prepared to be an immediate test case.

The opportunity to take our working relationship to a higher level was created by the Medical University's decision to replace its 50-year-old teaching hospital. The site for the new hospital, presently in the first phase of construction, is immediately adjacent to the VA Medical Center.

In the 2004 CARES study, a replacement VA medical center was not proposed in Charleston, but a specific recommendation was made to explore enhanced collaborations with the Medical University.

In August of 2005, Under Secretary for Health of the Department of Veterans' Affairs, Under Secretary Perlin, cited the recommendations of the CARES report and charged representatives of the Department of Veterans' Affairs and the Medical University, and I am quoting here, to determine what if any mutually beneficial consolidation should occur between the Charleston VA Medical Center and MUSC.

A working group was formed to study that. I was privileged to co-chair it with Mr. Moreland, the director of the VA Pittsburgh Healthcare System. With your indulgence, Mr. Chairman, I would like to take this opportunity to thank Mr. Moreland and his colleagues from the Department of Veterans' Affairs for the diligence that they approached this assignment with.

By December of this past year, a final report was prepared which

summarized our findings. With your permission, I would like to submit a copy of that report which I have with me for the record today.

THE CHAIRMAN. Hearing no objections, so ordered.

DR. GREENBERG. The steering Committee focused on --

THE CHAIRMAN. Will the gentleman pause for just a moment. This is a pretty long document, right?

DR. GREENBERG. It is about 40, 50 pages.

THE CHAIRMAN. So if you would revise your request, if you would make this submitted for part of the written record of today -- no, that won't do it either.

All right. Let us do this. I would ask unanimous consent that this be made -- that your proffer be made part of the official record, but not part of the published record. Would that --

DR. GREENBERG. That would be perfect.

THE CHAIRMAN. All right. Hearing no objections, so ordered.

DR. GREENBERG. The steering group focused on collaborative efforts that would increase the quality of services, lower overall facility and operating costs an ensure optimal use of the land resources.

It was agreed that any model of integration would be essential -- it would be essential for the VA to have its own bed tower, including general medical and surgical ICU beds. This facility would be clearly identified and designated as the VA Medical Center. Veterans would be housed with other veterans and would not be intermingled with other patients.

Staffing on these wards would continue to be provided by VA personnel. All of these were issues that were expressed to us as important by the Veteran service organizations and the employees of the VA Medical Center.

The opportunities for sharing come in the various support areas and in particular the expensive technology intensive areas such as operating rooms and cardiac catheterization labs. In scheduling the use of these resources, veterans would be given the same or higher priority as non-veteran patients.

By sharing these resources, both the VA Medical Center and MUSC could lower their operating costs. In the process, we could also assure that the latest technology is available to both patient populations and in particular that local veterans would not have to travel great distances to get these same specialized services.

With agreement to this basic concept, we then explored several models of sharing, and at the risk of oversimplification, let me say that these models differed with respect to the size and contents of the facility to be built by the VA Medical Center.

A very interesting observation that came out of this was that despite initial significant differences in construction costs for the various models, if you looked over the 30-year life cycle costs, there were really very modest differences between them.

For example, if you took the most extensive model and then you compared that to not replacing the VA Medical Center at all, over 30 years of life-cycle costs, it was only about a 10 percent differential. In other words, for a premium of about 10 percent, veterans could receive care in a brand-new state-of-the-art facility as opposed to one that is today 40 years old, and by the time of that 30-year period, it would be 70 years old.

There was further good work that came out of the evaluation, in that the group focused on governance issues concluded that we could create an advisory structure for sharing opportunities without undermining any of the existing authorities of either the VA or the MUSC executive leadership teams.

And the work group on legal matters concluded that all of the necessary authorities required for both construction and contracting already are well-established so there should not be a requirement for any additional statutory changes.

In choosing between the various models, at least two important considerations surfaced. First there is the very pragmatic question of the amount of money the Federal Government can afford to invest in constructing a new VA medical center facility. This is a resource allocation question that clearly went beyond the scope of our assignment as a steering group.

The second key issue that arose during our evaluation was whether VA facilities would be required to be built to the new federal guidelines for homeland security. These guidelines while understandable and defensible for safety purposes, raise construction costs an estimated 30 percent.

Thus, it would be more expensive for the VA medical center to build shared space than for an outside entity to do so.

For the purposes of our analysis, we assumed that the safety standards would have to be met. If it turns out that those guidelines are not required, our estimates of VA medical center construction costs can be revised downwards by about 30 percent.

A related issue is the fact that the existing VA medical center is in a flood zone, and as it was designed more than four decades ago, it is vulnerable to a major hurricane. While we are about to hear about the situation in Hurricane Katrina, it seems particular prudent at this time, to make sure that similar disasters don't occur to other VA medical center facilities that are in hurricane areas.

If the Committee and the Department of Veterans' Affairs find favor in our recommendations, there clearly is further work that needs to be done. We need to move from the macro level of the initial evaluation that has been completed to the micro level of really focusing on operational issues.

Our suggestion is that we formalize an initiative as a demonstration project. We appoint a working group to develop an implementa-

tion plan and we allocate appropriate resources for that effort.

Mr. Chairman, thank you very much for your time.

[The statement of Raymond S. Greenberg appears on p. 71]

THE CHAIRMAN. Mr. Moreland, you are now recognized.

STATEMENT OF MICHAEL MORELAND

MR. MORELAND. Thank you, Mr. Chairman and Members of the Committee for this opportunity to testify on the important topic of improving veterans' access to care through collaborations.

In my experience as the director of the VA Pittsburgh Healthcare System and at other facilities, I have participated in a number of positive collaborations. I also am familiar with a variety of collaborations that have worked well for my VA colleagues.

Today I will share a few examples and provide an overview of the collaborative study that I was privileged to co-chair with Dr. Greenberg, and I, too, congratulate Dr. Greenberg for such wonderful staff and the great work we did together. But I will go ahead and talk a little bit about that and the potential sharing opportunities between the Charleston VA and the Medical University of South Carolina.

First I want to outline in general terms the process I have used to determine whether particular collaborations were likely to in the best interest of veterans. For a collaboration opportunity to be considered favorably, it should increase veterans' access, improve quality through service enhancements and provide VA with improved efficiency.

As one would expect, if two organizations can share a capital expense rather than duplicating it, they will save money on equipment and buildings. Those funds can then be used to enhance services. When deciding whether to consider sharing a given resource, we first determine the cost providing that service independently. Then costs are developed for joint delivery of that service.

For a collaboration to be considered a good sharing opportunity for VA, it must be more efficient for VA to deliver that service in collaboration with another entity, or the sharing might provide an enhancement to care that VA could not offer independently.

The quality of the service delivered has to be as good or better than what is currently provided. The best sharing opportunities improve services while saving cost. To make these comparisons, data relating to demand and capacity for particular types of care, trends in the quality of service delivery and cost information are reviewed.

A good example of a sound collaboration is the Charleston VAMC and MUSC planned sharing of high tech equipment. Veterans and patients of MUSC will have access to care enhancement and the cost of each organization will be improved by sharing the equipment and

the expense.

The type of sharing arrangement used in this case allows the VA to make a capital investment up-front that is then recouped through revenue that supports operating expenses for several years.

In Pittsburgh, VA collaborated with the Commonwealth of Pennsylvania in providing long-term care to the State's veterans. VA provided the State with land on the grounds of the Pittsburgh Healthcare System and a grant for the construction of a long-term care facility. The State, under a sharing agreement, purchased services from VA to assist in the operation of that facility. This facility offers several levels of care that are in great demand in Allegheny County with this large population of aging veterans.

The Buffalo VAMC contributed $250,000 toward the purchase of a new PET Scanner for University Nuclear Medicine, Inc. VA's purchasing power resulted in a lower price. The University Group operates the scanner and VA purchases services at a negotiated reduced rate. Again, the community and its veterans benefit from additional services and both organizations reduce cost.

I completed a similar arrangement while I was the director of the Butler VA, in which VA purchased a CT scanner that was installed in and operated by the community hospital. VA then received access to very low cost CT services for veterans and the community benefitted through the availability of high tech equipment that local facility -- that that local facility could not readily afford.

In all of these arrangements, there are numerous legal and technical details that require careful planning. In each instance, the arrangements are a good financial deal for veterans. For funds that are saved through these collaborations support other service enhancements. Savings like these assist us in maintaining and enhancing care in an era of bourgeoning demand for VA care and continually escalating healthcare cost.

On occasion, I have been presented with opportunities for collaboration that were presented as good deals for the VA. However, financial analysis revealed the proposals to either increase operating expenses over current expenses or to require up-front financial outlays without a reasonable return on investment. While this may seem obvious, it is important to note that any prospective collaboration must be considered on its own financial merit.

The Collaborative Opportunity Steering Group that developed sharing options for the VAMC in Charleston and MUSC presented an opportunity to consider taking this type of sharing to a much broader level. This Group developed options for joint construction, as Dr. Greenberg described, of new facilities that would maintain both organizations' identities and independent mission while sharing some of the enormous cost burden associated with replacing aging healthcare facilities.

The Group was able to identify viable models for such construction. By sharing some of the higher cost infrastructure, both VA and the University could reduce the investment required to build and operate new facilities.

As I mentioned earlier, this Group identified opportunities to collaborate in the purchase of high-tech equipment that will make new state-of-the-art services available to veterans and other residents of South Carolina that might not otherwise be feasible for either organization to provide independently. The successful experience VA has had in this type of sharing at other facilities enabled this Group to recognize this opportunity in Charleston.

The plan for equipment sharing in Charleston is in the process of being implemented. I believe Dr. Perlin mentioned $7 million in equipment funds have already been transferred to the VA in Charleston. Draft documents are being prepared to complete this process.

Collaborative opportunities abound as private and public sector facilities across the nation are seeking to upgrade aging infrastructure and bring state-of-the-art care to their communities. With thoughtful planning, these collaborations can be mutually advantageous and provide VA with opportunities to assure that veterans have access to the latest technology at a more efficient cost. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you very much. Mr. Smithburg, you are now recognized.

[The statement of Michael Moreland appears on p. 78]

STATEMENT OF DONALD R. SMITHBURG

MR. SMITHBURG. Thank you, Mr. Chairman. I am Don Smithburg, CEO of the LSU Hospitals and Clinic System in Louisiana. I thank you for your interest in healthcare in Louisiana after Katrina and Rita in particular.

I also thank you for the invitation to appear today and the opportunity to answer any questions you may have about Louisiana State Public Hospital System, especially as a potential partner with the Depatrtment of Veterans' Affairs in New Orleans.

I represent nine of the eleven State public hospitals and over 300 clinics that traditionally have been called the Charity Hospital System in Louisiana. I would like to briefly describe that for you.

Our hospitals and their clinics constitute the healthcare safety net for the State's uninsured and under-insured, particularly the working uninsured. Fully two-thirds of our patients are hard-working Americans.

In your States, this role is generally a local government function, but in Louisiana it is the responsibility of a State-run and Statewide hospital and clinic referral system, under the aegis of Louisiana State

University, LSU.

This system has been in place for 270 years.

The LSU hospitals also have had an integral role in supporting the education programs of our medical schools and training institutions for generations, and that includes not only LSU, but also Tulane University and the Ochsner Clinic Foundation.

Our system flagship is in New Orleans and commonly is known as Big Charity, which is actually two hospitals, Charity and University, operated under one medical center umbrella. Big Charity has been in operation since 1736, making it the second longest continuously operating hospital in the United States.

At our New Orleans facility alone, there were over 1,000 Tulane and LSU medical students and medical residents in training and many more nursing and allied health students, plus thousands of staff when Katrina struck and then her floods devastated our institution. Some of these very same students and faculty had rotations at the VA Hospital in New Orleans as well.

As a flagship of our Statewide system, Charity Hospital sits just a stone's throw from the VA Hospital. Big Charity operated the only level-one trauma center that served South Louisiana and much of the Gulf Coast.

Today these facilities sit in ruins. Charity Hospital has been deemed uninhabitable and unsalvageable for healthcare by consulting engineers. And a somewhat younger University Hospital that we operate -- it is only 35 years old -- although severely damaged and not viable in the long term, will be temporarily propped up as an interim solution toward New Orleans' critical need for health services.

And we are seeing our patient population grow steadily every day, up to 300 patients a day that we are seeing in tents; a series of ten tents currently operating in the convention center, which are about to be relocated to an abandoned department store.

Time does not allow me to go into detail about what we are seeing in terms of the population change and demographic nature of our community, but I can tell you that a replacement hospital is absolutely critical.

We see the potential collaboration with Veterans' Affairs and Louisiana State Public Hospital System as one propelled by unintended opportunity. With both systems' hospitals in New Orleans devastated by Katrina and her floods, we stand at a rare moment in time, a chance to jointly design and cooperatively operate a new facility that meets the needs of both institutions and the patients they serve while at the same time achieving significantly enhanced efficiency, cost savings, and quality healthcare.

The integrated structure and vision of the VA system has permitted it to become a leader in the development and use of electronic records. You know this. It has made tremendous progress in this and

other areas in the last decade. Electronic medical records also are a high priority for LSU, although we are not as far along as the VA. In fact, in my view, the VA is more advanced in information technology than most in the healthcare industry.

The collaboration of the VA and LSU in the narrowest view offers the opportunity to solve the immediate facility problem of the two systems in New Orleans, but it is also an enlightened and visionary step that will create a major asset for rebuilding community and a base from which to better serve the patients who depend on us.

Governor Blanco and our legislative leaders from both sides of the aisle, have recognized and embraced the benefits of collaboration with the VA. The media has extolled the virtues of this potential collaborative, despite so much coverage about what has gone wrong in dealing with the hurricane zone. Thoughtful editorials have applauded this effort as a real diamond in the rough.

We welcome involvement from other allies and together we can take advantage of an historic opportunity to improve care for those we serve and at the same time help to rebuild a major American city.

Thank you, again, for your interest for this opportunity to share LSU's perspective on this critical matter.

[The statement of Donald R. Smithburg appears on p. 81]

THE CHAIRMAN. All right. Thank you very much. I want to get this right in my mind. We, on the Committee, are moving in this sort of trend, from the collaboration with personnel and equipment, and then to facilities, with university hospitals.

So my sense here is, that this is not all really defined that well at the moment. So you have a university hospital in New Orleans, correct? You have University Hospital and you have Charity?

MR. SMITHBURG. They are both one institution with two names -- there are two buildings with distinct names, but they are one medical center that serve as an academic medical center. One happens to be called University Hospital, but they are both the primary teaching hospitals for LSU and Tulane.

THE CHAIRMAN. All right. You know, we kind of have this also in Indianapolis. We have the University Hospital next to our VA, and we have Wishard, and Wishard is sort of the safety-net hospital.

MR. SMITHBURG. Mr. Chairman, we are both.

THE CHAIRMAN. But your Charity Hospital is also run -- is owned by the State of Louisiana.

MR. SMITHBURG. The Charity Hospital and University Hospital are, for all intents and purposes, one and the same.

THE CHAIRMAN. Oh. You can't answer like that.

MR. SMITHBURG. Well --

THE CHAIRMAN. Tell me what the legal standing is.

MR. SMITHBURG. The legal standing is that they are both one Medi-

care provider number which identifies the institution. They are both entities of LSU, which is an instrumentality of State Government.

THE CHAIRMAN. All right. There we go.

MR. SMITHBURG. They are both, via contracts, teaching hospitals for LSU School of Medicine, dentistry, nursing, allied health, and their counterpart is at Tulane. All of the primary training programs of those institutions go through Charity. There is one management team. The CEO of what we call the medical center of Louisiana, New Orleans, is Charity University Hospitals. It is one medical center, has one management team that reports to me.

THE CHAIRMAN. Well, I don't want there to be confusion out there across the country in different cities either. If we are going to do collaboration and we do it with medical universities, we want to make sure that -- are you going to change the names on any of these things?

MR. SMITHBURG. We are certainly open to that, sir.

THE CHAIRMAN. You are open to it. Great. I just want to make sure that our collaboration -- I mean if we are going to do our collaborations with university hospitals, I don't want some other city to go, well, you know, I still have got my non-for-profit over here, and why can't -- I don't want to do that.

We can get away --

MR. SMITHBURG. Could I try to --

THE CHAIRMAN. Our trend line here is, is we do collaborations with agencies of Federal Government, which isn't as easy as I just said it. It amazes me. But it should be a lot easier, right? So then we say you know what? There should not be anything wrong with a relationship between the Federal Government and State Government with regard to facilities.

But I don't want to send the wrong message out there in the country that we are going to do a collaborative effort with Charity Hospital. Names are pretty doggone important. I just want to let you know. I would love to make sure that we label and title this as a collaborative effort between the VA and the University Hospital at LSU.

MR. SMITHBURG. I can tell you right now, Mr. Chairman, the MOU that the VA signed with us --

THE CHAIRMAN. Yes.

MR. SMITHBURG. -- is with LSU Healthcare Services Division. It is with LSU.

THE CHAIRMAN. All right.

MR. SMITHBURG. And that will be the arrangement going forward.

THE CHAIRMAN. Thank you. All right. You just put me at rest. I appreciate that.

MR. SMITHBURG. Sorry for the confusion.

THE CHAIRMAN. No, no, no. That is all right. And your present University Hospital you are going to utilize -- you can't go back into

Charity? That's correct?

MR. SMITHBURG. Correct. Yes, sir.

THE CHAIRMAN. And why can you utilize part of the University Hospital?

MR. SMITHBURG. Well, it was not our first choice. There are very few physical assets that can be used for healthcare purposes in the market right now. We are leasing a building from another institution that was not badly flooded to prop up a temporary trauma center. It is actually not even in the City of New Orleans.

And then we searched and searched to see if there was another building we could lease, renovate, with FEMA's help and prop up as a temporary hospital until we got a permanent replacement.

Such assets were not available to us, and so our last ditch effort was to look within our own asset base and see what it would take and FEMA has helped us figure out what it would take to temporarily use one of our buildings which is called University Hospital to provide about 200 beds.

The jury is still out as to whether we can really do it, but FEMA has approved a work order to try to make that happen, and it will take some doing, and it will probably cost tens, if not, over a hundred million dollars just to temporarily prop it up.

THE CHAIRMAN. Mr. Moreland, let me go back to this. I come to see you as one of the more forward thinkers in the Department, and I am thankful for your involvement in working with Dr. Greenberg and having spoken with Dr. Greenberg. His feelings, I think, reflect mine about you.

Given Dr. Greenberg's testimony, he says our suggestion is to formalize this initiative as a demonstration project and appoint a working group, to develop an implementation plan and allocate resources to that effort. The word "our" -- let me hit both of you here -- the word "our," Dr. Greenberg, means who? Does that mean you and Mr. Moreland or does "our" mean you at the university?

DR. GREENBERG. Mr. Moreland and I agree on many things, but I am speaking only for myself in that instance. "Our," I am speaking on behalf of the University.

THE CHAIRMAN. Okay. Now, Mr. Moreland, let me ask for your counsel with regard to Dr. Greenberg's suggestion.

MR. MORELAND. My understanding of the project and where it sits at this moment, is the report that we, Dr. Greenberg and I, submitted, has been reviewed by Dr. Perlin, and it has now been forwarded up the chain to the Secretary's Capital Asset Board. My understanding is, is that that board will then review that and they will propose further action. And so that is where I understand the process to be.

THE CHAIRMAN. You know, we have got ourselves in this situation, Dr. Greenberg, where you and Mr. Moreland, are working on a particular project, and are you about to be overtaken. And I look at this,

as your work product is of tremendous value because you have front-loaded an ambition with regard to New Orleans.

But your work is not done, and as we take your work to a second stage, that continues to be helpful to us also in New Orleans, as we also then get judgment on what actions to take in Charleston. So, you know, someone made a comment one time saying, well, Charleston wasn't in CARES on hospital priorities. I don't think that is completely accurate at all.

You are right. Charleston was mentioned in CARES to do this collaborative effort, to do the investigation, and now this is what it is showing us to do. So when I look out there in the horizon of the hospitals that we need to build, there are five of them. And they are Las Vegas and Denver, and Charleston, Orlando and New Orleans. Those are the five that are in front of us. That is a very large dollar figure to do this, and so the Committee wants to make the best judgment in the interest of veterans.

The challenge here is how we step into the next phase, and continue your work. The question is what time line does it strike that benefits your construction time line in Charleston? That is a challenge, Dr. Greenberg.

Dr. Greenberg. Yes, it is, Mr. Chairman, and I guess I would start by saying to me the development in New Orleans with respect to LSU is both good news and bad news. I mean the good news is that already the Department of Veterans' Affairs and another academic medical center have recognized the value of the partnership that we have begun to develop.

So we have talked about this as a national model. Today was the first day I heard it really described as the Charleston Model, but we have always thought of this as a test case for replication elsewhere. And the fact that it is so quickly, the ink is hardly dry on our December report and it is already being proposed elsewhere, to me suggests the obvious value and benefit of it. I mean it is already being emulated. We don't have to wait for years for somebody to emulate it.

On the other hand, I think your point is extremely well taken that we are only the first step or two into a multi-step process, and it would be discouraging to me if we didn't take further steps down that implementation process. And that is complicated by the fact that we are in the process of building a replacement hospital right now that will be -- the first phase of which will be completed within a year.

This opportunity is really in the second phase, which we would like to undertake in about three or four years, begin the construction of that. So the longer the delay, the less likely that we could actually do a project on the time line that would make sense both for the Department and for the medical university. To me that would be an opportunity lost, because I think the ideal thing is to bring the time lines as close to mutual interest as possible.

THE CHAIRMAN. Well, Mr. Smithburg should say "thank you" to you, because actually you are designing the blueprint for what could happen in New Orleans. So what we kind of have here is that it is in your interest to continue to do the lift for which you do not receive the immediate benefit. It is kind of weird, isn't it? You know what I mean?

But what you are doing is right, because you are developing the model to be leveraged, but you don't get to be first.

DR. GREENBERG. Right.

THE CHAIRMAN. I know you would like that. But there is an immediate need right now and a national focus in New Orleans. That is the reality I think that is in front of us. I mean wouldn't you agree to that?

DR. GREENBERG. Absolutely. I think ever leader of every academic medical center in the United States would say that our colleagues in New Orleans deserve every consideration. I mean especially those of us who live in an area that has been severely hit by hurricanes in the past. And so we know what damage can result. We have tremendous empathy for our colleagues in New Orleans and if there is any part of the country that deserves special consideration right now, it certainly is New Orleans.

THE CHAIRMAN. You know, Mr. Moreland, Dr. Greenberg, what you do here is you design it. You build the model. You do the blueprint, and LSU, guess what? You get to go first. My benefit comes from any mistakes that you make.

I mean you are going to get some benefit out of this, but there are going to be some challenges. Ten thousand decisions to be made. You hope for the best, right, and there is a great learning curve that we are going to have through it. Right? Don't you agree, that is kind of where we are going here? I want to talk this through.

MR. MORELAND. Well, I can only share with you that in setting up the Collaborative Opportunity Steering Group in New Orleans, I have already in my discussions with Mr. Smithburg, we have identified some adjustments and minor modifications to the process from things that Dr. Greenberg and I learned in the first process. So I do think that, you know, some of the lessons that we learned in that process will transition to make the next review even better.

MR. SMITHBURG. I would submit to you, Mr. Chairman, that about the last thing I would want to have happen is for our potential endeavor to supplant slow or erode the progress in Charleston. Unfortunately Mother Nature kind of didn't pick her timing and so regrettably the New Orleans VA and the LSU System is out on the street.

But I think at the same time, because we are forced to be in a fast track situation, that hopefully that while we are going to take a number of pages out of Dr. Greenberg's play book, we may help write a few for him as well along the trail, and we will have --

THE CHAIRMAN. All right. So let me do it like this. So I am trying to figure this out. Mr. Moreland, you are intimately involved in both?

MR. MORELAND. Yes, Mr. Chairman, I have been provided the wonderful opportunity of being the chair of both --

THE CHAIRMAN. I am proud of you.

MR. MORELAND. -- collaborative opportunities.

THE CHAIRMAN. I am proud of you.

MR. MORELAND. Yes, sir.

THE CHAIRMAN. Now you have your work you have done in Charleston. Charleston is getting a little impatient. They want to go to the next phase. They want to proceed on. You have New Orleans going on over here. What is the best way to proceed?

Are we really going to say we take your work product that you have from the Steering Group, the Charleston Model, now you take that over to the LSU model, and the second phase we are talking about, where do we need to go next to drill it down from macro to micro? LSU perhaps could go first, is that what we need to drill it down with them as opposed to drilling it down with Dr. Greenberg? I am trying to figure out methodology here.

MR. MORELAND. Yeah.

THE CHAIRMAN. Have you thought about that?

MR. MORELAND. I am not sure I can answer that question today. I think that is an excellent question, and, you know, I am not sure --

THE CHAIRMAN. Because his is on the fast track.

MR. MORELAND. Right. And I am not sure that one necessarily has to delay consideration of the next phases in Charleston while we are doing the evaluation in Louisiana. The funding issue is outside of my purview, you know?

THE CHAIRMAN. I understand.

MR. MORELAND. My issue is to go down to New Orleans and get this first step in New Orleans started, and then I will certainly do that.

THE CHAIRMAN. So with regard to Dr. Greenberg's suggestion then, to formalize the initiative as a demonstration project, to appoint a working group that drills down into the next phase is what you are talking about, right, Dr. Greenberg?

DR. GREENBERG. Yes.

THE CHAIRMAN. Is that what you mean by this?

DR. GREENBERG. Yes, sir.

THE CHAIRMAN. To develop the implementation plan. So, Mr. Moreland, do you concur, that we can do that while you are also then drilling, because you are replicating.

MR. MORELAND. What I am suggesting is, is that the Charleston project has been sent to the Secretary's Construction Advisory Board. Depending on what happens at the end of that process, what Dr. Greenberg proposes may be very appropriate to proceed independent of New Orleans. But that depends on what happens at the Secre-

tary's CAB.

THE CHAIRMAN. Well, I want you to help us here. I mean you are in a very unique position. You are going to give counsel to this Committee. You give counsel to the Secretary. You are sitting in the hot seat between Charleston and New Orleans. New Orleans has the priority in the country and they are two of five to be built. So I am going to drill this down.

Your counsel to us would be that this Committee should embrace the suggestion of Dr. Greenberg as we continue to the focus on New Orleans. If I have missspoken, correct me.

MR. MORELAND. I would say that the Committee report that we provided to the Under Secretary has been forwarded to the Secretary --

THE CHAIRMAN. Oh, no, no, no.

MR. MORELAND. And they need to provide their -- I am not really in a position to recommend what happens with Dr. Greenberg's proposal, because that is really outside of my scope. What I am focused very much on is evaluating opportunities for collaboration and putting that discussion together so we can then move that analysis forward.

THE CHAIRMAN. All right. I know you don't want to get out of your lane. Your testimony, though, to us is that it is possible to do both of these at the same time, right?

MR. MORELAND. Yes.

THE CHAIRMAN. Okay. I have no interest of getting you in trouble. You are in a really unique position here for counsel.

MR. MORELAND. Yeah.

THE CHAIRMAN. But I can read between the lines. Okay? Let me yield to Chairman Brown, for questions he may have.

MR. BROWN OF SOUTH CAROLINA. Mr. Chairman, let me apologize first to the panel. We have a bill on the floor. This is close to my heart, and I had to go make testimony there, and I apologize for not having the complete dialogue, but I really do appreciate you coming and being a part of the first panel. You had privy to that, that dialogue, too, and, Mr. Chairman, I know that you have asked some good leading questions, and I don't want to go into part of duplicating those questions, but I know that I just would like to thank the whole group for working.

And, Dr. Greenberg, I don't know whether anybody has asked this question or not, but which model include in the final report as MUSC identified as being the most viable?

DR. GREENBERG. Chairman Brown, I think they are all viable in a sense. I think it is very difficult for someone sitting outside of the appropriation process to ask the question what is a reasonable investment to make because there clearly are resource differences.

I think when one makes that appropriation decision, I hope the focus -- inevitably I understand the political realities of having to look at how much is spent in a particular year. But the reality is what I

learned in this process, and I would not have guessed till we got into the analysis is that if you look over the long haul, the cost differential is really relatively minor between these, and so I would hate for that to be the deciding factor between them.

Personally, I think that the model, I think it is described as A-1, in which the VA builds its bed tower, plus the shared resources, and the medical university builds its separate bed tower, probably is the most logical way to proceed as long as you can coordinate the construction.

But I do think a significant open question at the moment is what security standards the VA facility will have to be built to because the estimate, and it is only an estimate at this point, because no facility has yet been built to those standards, is that it will inflate the cost about 30 percent, and so that would shift you towards having another party build that shared component and save the differential in cost.

So I think that question does need to be answered and I realize that there are other considerations involved in answering that question. But it is hard to give a final answer without knowing.

MR. BROWN OF SOUTH CAROLINA. I know this past Friday I met with the City of Charleston, concerned about just normal flooding when there is high tide and, you know, abnormal -- little abnormal -- rainfall, and I know that the VA Hospital is actually sitting in the middle of that, you know, that problem. And so I am just amazed that, you know, seems like something must be done. If in effect we had anything close to Katrina, that the, you know, the Veterans' Hospital would be really in serious trouble and I don't know whether that is being evaluated as we look at the, you know, the overall need to address, you know, some modification, and so I know it is a major -- a major problem is the drainage problem and --

DR. GREENBERG. Well, it is an important question because the GAO has studied the state of the existing facility and they said it is, you know, in adequate condition. It doesn't need immediate replacement.

But that same conclusion might have been reached in the VA facilities in New Orleans before Hurricane Katrina. I mean all it takes is one extraordinary adverse event to completely destroy the facility. We have seen that. So just as in all aspects of medicine, I think we have to focus as much on prevention as we do on treatment after the fact, after the disease has already taken place, in this case the natural disaster.

We need to do everything we can to bring the facilities up to speed in New Orleans, but we also need to make sure that we don't find ourselves in the same position in other communities that had just the same level of exposure in the future. We don't want to be dealing with the same kind of reality that Mr. Smithburg is dealing with right now.

THE CHAIRMAN. Will the gentlemen yield? Your hospital, is it at sea level or how many feet above sea level is your hospital?

DR. GREENBERG. The new hospital is raised 15 feet off the ground, plus it has gone through extensive hurricane testing. There is a facility in Florida where they shoot projectiles at it at 200 plus miles an hour. So it has been rigorously tested to withstand this kind of storm.

THE CHAIRMAN. Mr. Moreland, do you know whether, the VA Hospital in Charleston is at sea level?

MR. MORELAND. I don't recall. I know that in our evaluation, we did look at that, and I also am aware that when -- that VA is in the process of evaluating hardening of VAs in coastal areas that are in danger of hurricane and flood damage.

THE CHAIRMAN. All right. Thank you. Mr. Brown.

MR. BROWN OF SOUTH CAROLINA. You know, I don't know exactly the sea level yardstick, Mr. Chairman, but I know it is -- just visibly, it is a good bit lower than the facilities being built by the Medic University. And like I said, I met with those people on Friday. The whole region down there, and across town and Cannon and Spring Street are all impacted by this flood problem.

But, Mr. Smithburg, if I could ask you a question. I know we had the privilege to go down with the Secretary to take a look at New Orleans and Biloxi and Beaumont. But can you describe LSU's relationship with Charity Hospital in New Orleans, and how will Charity play into the collaborative project envisioned by LSU and VA? I know they are all basically all there together in the same block.

MR. SMITHBURG. First I would say by way of governance structure, the Charity Hospital System is LSU. It has been for centuries branded. The hospital system has been branded informally as the Charity Hospitals, but it is LSU, a State-run, land-grant institution.

In terms of the collaborative that we have envisioned, it is really building upon a set of relationships that have been in place for a long time as you know, having toured the area. Near the Super Dome downtown, there is a medical district that is comprised of the VA, LSU, all of its health sciences schools, Tulane University, all of its health sciences schools, and the Delgado Community College and its health sciences training programs, and I am sure I am leaving somebody out inadvertently. We are a true medical corridor if you will.

What we have preliminarily discussed, and it is still very early in this potential marriage, but what we have discussed so far is a collaborative where, since the VA needs to place itself, it has determined, we clearly determined have that there will be some real synergies in doing some things together like one common power plant, maybe one common cafeteria, other hotel-like functions that we might be able to collaborate on together, but at the same time, not necessarily having to deal with formal governance issues for the VA has a very rock solid

governance structure and we think we do on the LSU State side.

So this is the beginning of a journey where we want to explore opportunities for collaboration, and it could get much deeper, penetrate much deeper in terms of integration collaboration, or not, depending on what makes the most sense.

MR. BROWN OF SOUTH CAROLINA. And one further question. I know we have talked about this before, and I know the population base in New Orleans is you live someplace else, and it seems like to me it would be pretty difficult to track the patient demand in the near future, and I don't know whether you can project it into the distant future or not, but at this point in time, what kind of model would you develop, based on limited information?

MR. SMITHBURG. Thank you, Chairman Brown. That is an excellent question, and it is very difficult to crystal ball the future population of New Orleans proper, but there are some that would expect that the population may not be localized as it was before, kind of inside, below sea level, inside the soup bowl, but a ring of new suburbs that are above that area, yet New Orleans will continue to thrive as a cultural and industrial center. It just won't have as many bedroom communities inside the donut, if you will, but outside of it.

Who knows? But this we expect, whatever it is we design, it will need to be scalable. I also am responsible for other markets in the State and have seen a real population surge in Baton Rouge and Lafayette, and our public hospitals there have seen almost a doubling in their patient population.

What that tells us is that a lot of people are staying in State, and we know that there is a very strong desire for New Orleanians to get back home whether the levees are replaced or not. We think that people are going to come back home.

And so whatever it is we design and build, as Dr. Greenberg alluded to with his institution, it will be hurricane hardened and it will be flood proof and will have a connection to a flyover interstate that is already adjacent to our medical center. But scalability is what is top priority for us, whatever we build. Easy to say, not so easy to do, but it needs to be able to flex up or flex down, depending on what the population will bring to us.

MR. BROWN OF SOUTH CAROLINA. If you had to make this projection today, I think the population around New Orleans is what, around 600,000 --

MR. SMITHBURG. In the parish itself.

MR. BROWN OF SOUTH CAROLINA. Right. And now it is less than 200,000 I believe.

MR. SMITHBURG. Yes, sir.

MR. BROWN OF SOUTH CAROLINA. And with those numbers, you know, do you think it is going to take you three years or five years to get back to the 600 or -- I guess my question is, I am trying -- I am not

trying to lead you into some decision that I want to hear, but I guess my question is, is the location where the present hospitals are today, is that the best location for the next 10 to 20 years?

MR. SMITHBURG. It is a very good question, one that we want to study through this process. This I will tell you. There are hundreds of millions, if not billions, of dollars of investment in facilities already on the ground in the medical school, the research facilities, same with Tulane, that are okay, relatively speaking. Okay to us means we can get back in them in a year.

And so that investment is there and so to relocate our hospitals to another geographic location will have some -- that decision will have some bearing on how we look at ourselves as an academic institution. And proximity to our researchers who use our hospitals extensively and to our training programs who staff our hospitals primarily is an important factor to take into consideration. That is why hurricane hardening and flood-proofing is absolutely essential if we stay where it is we are going -- we have been traditionally.

MR. BROWN OF SOUTH CAROLINA. It appeared to me that the hospital itself was structurally sound. But I know there is probably some mold and some other problems. Do you plan to raze that hospital and start over? Is that part of the plans? Or do you plan to try to save some of the structure itself?

MR. SMITHBURG. The two buildings, primary hospital buildings, one is called Charity Hospital and one is called University Hospital. In the case of Charity Hospital, extensive engineering reports have been conducted and they show that the building is absolutely unsalvageable for healthcare use. Maybe there is some other reuse.

But the damage to the mechanical, electrical, plumbing and energy systems is pervasive. The extent of black mold and other molds which you may not be able to see in the naked eye permeates 21 stories of HVAC systems and the like, extensive damage, because we were under water for three weeks, and concerns about the stability of foundation. It is a very old building.

And so we do not necessarily intend to raze that building at this time. Frankly, it is an art deco kind of icon of architecture in the community, greatly loved, and so if there is a reuse for the facility, we are open for that.

But razing it is not necessarily on our radar screen right now. But there are other sites on the campus that we have already identified that would be ideal, we think, for a major medical center.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Smithburg, and thank you, Mr. Chairman.

THE CHAIRMAN. Thank you, Chairman Brown. Dr. Greenberg, I want you to think about this, and I am going to do a unanimous consent. I want you to think about -- I am going to ask you a question in a little bit on if I were to do this demonstration project as we move

from the macro to micro, what are the principal areas which you are considering?

So I want you to think about that for a moment, and I ask unanimous consent that minority counsel be recognized, ask questions on behalf of the minority. Hearing no objections, so ordered. The gentleman is recognized for five minutes. Counsel for the minority.

MR. TUCKER. The GAO report, or I should say the GAO testimony from September 26, 2005, offered a hypothetical. VA may decide to purchase operating room services from MUSC. If the sharing agreement were dissolved at some point in the future, it would be difficult for VA to resume independent provision of these services. Mr. Moreland how do you, working through these study groups, plan on addressing these issues? They would seem to be very difficult.

MR. MORELAND. That was one of the basic concepts that we tried to put into place in this study group was that, you know, what happens and how do you set up a situation so these sharing agreements don't end up that one party can take advantage of the other.

And so essentially what we did was build in, I think we called it mutual dependency, so that if MUSC is running the operating rooms, hypothetically, and the VA is providing laboratory services, there is a built-in incentive for MUSC to have a good working relationship with us in the operating room because they need to have a good working relationship with us in the laboratory. So that was the basic premise, that in order to set this up so that one party would be fair with the other.

MR. TUCKER. Thank you very much. Also, you state in the December report, Mr. Moreland, also Dr. Greenberg, that under Model "A" that was proposed that there was a need for legislation. Can you be more specific on what legislation you think might be needed?

MR. MORELAND. I was looking for my counsel.

MR. TUCKER. I think it is looking at 38 USC 8153, which is a sharing agreement provision, that there was just -- I noted in reading the report that it said that you recommend legislation. So I was curious as to what that legislation might look like.

MR. MORELAND. I don't think we proposed legislation. I think what we did was we proposed that there would be an issue that would require legislation, but we did not get to the point of actually developing what that legislation should look like.

MR. TUCKER. So you haven't actually got to that point of specificity yet?

MR. MORELAND. Correct.

THE CHAIRMAN. Is that what Phase 2 is about?

MR. MORELAND. That would be part of a Phase 2, yes, sir.

MR. TUCKER. Also let me ask you again, Mr. Moreland. I am sorry that you seem to be the one I keep asking questions of. You state in your testimony that previous collaborative arrangements are a "good

financial deal for veterans," how the funds saved through these collaborations support other service enhancements.

Can you really offer explicit examples of these service enhancements? It is held out as one of the promises of collaboration that money will be saved. The VA will save resources. But where do these saved resources go -- do they disappear in a hole? Is there any really specific examples of how these things have worked out in the past and as a model for the future?

MR. MORELAND. Yes. And if it is all right, I will use the one that was really the simplest, because I think that is the easiest one to provide a good answer to your question.

When I was the director of the VA in Butler, I needed a CAT scan. And in evaluating how much it would cost to purchase a CAT scan and put it in my building and hire the staff to operate that CAT scan and the cost of the service agreement for maintenance of that CAT scan, I calculated how much it would cost to do that.

Then I sat down with the CEO of the community hospital, who also wanted to upgrade and buy a new CAT scan. And I was currently purchasing from him CAT scans. And so when I sat down and did the math comparison, what would it cost if I put one in my building and ran it, what would it cost if I just keep buying them from the community, and what would it cost if I were to purchase a CAT scan, place it in his building, have him operate it and give the CAT scans with interpretation from me, one dollar each.

When you sit down and did the math, I ended up it was much cheaper to put that machine into his building. What that did then was that my operating budget was reduced. Now could I track where that dollar went? No, sir, I could not.

What I could track, though, was that I treated another veteran. I provide more medication. I then turned around and enhanced my nursing staff on my inpatient unit for my nursing home. So I could point to what did I do with that money, and it did go back into enhancement of services.

MR. TUCKER. Thank you very much. Also just a general question on the tomotherapy suite, the $7 million piece of equipment. I understand that it is not available anywhere in South or North Carolina. It sounds very interesting. What is the track on this? How is it moving forward? Have you worked out arrangements, because it is not available to make it available to other facilities and how do those arrangements work legally?

DR. GREENBERG. First, let me say that it wasn't available at any other facility at the time of this report. I can't tell you whether it is today or not. It is a new emerging therapy and it is basically radiation therapy that can give and be given very precisely so that what it does is limit the damage to normal tissue around the cancer that you are trying to irradiate. So it is much more precise targeting of the

cancer; and, therefore, it really is a huge step forward in the advancement of such treatment.

When you look at it from the VA point of view, they don't have a large enough patient population to justify purchasing this equipment for their own patients, and I am not sure if even in the vison there is available. So it is not even a question of the distance that someone would have to travel to access it.

At the Medical University, we would probably have the volume. We would probably purchase this on our own, but this is an opportunity to, it strikes me, to benefit the veterans population at the same time we would be installing this for our own use.

Of course, we see ourselves as a referral area for the entire State and so it would, of course, be a resource through our operation of it that would be available to patients throughout the State of South Carolina.

MR. TUCKER. Thank you. One more question, Mr. Chairman? Thank you for your indulgence.

Adding on to that, I think one of the problems that some have in addressing or looking at collaboration efforts is whether veterans get priority and how that priority works out, especially when you are dealing with a population that may have a more -- I don't know -- fundamental legal contractual obligation for their healthcare - they buy insurance or they have some sort of provider relationship with a university hospital.

Have you worked the details out in how that has worked out?

DR. GREENBERG. As a general principle, we have certainly said that this does not make sense to go forward in a sharing relationship if veterans are treated as anything other than first-class citizens. I mean the goal is to make sure that they have at least the access they have now.

I would actually argue this increases their access because what it does it bring specialists and special equipment that they don't otherwise have access to in the local marketplace. They might if they went to Atlanta or somewhere else.

So to me, and when we sat down and talked with local veteran service organizations, they quickly have appreciated the fact that this brings more opportunity to them rather than a limited opportunity.

Your question, I think, leads us immediately, though, to the implementation questions. How do you monitor that you are actually doing that, and I think that really is the next phase. We didn't get to that point in our initial descriptions, but I think there would have to be some accountability; and, of course, this is all becoming now automated, so it would be fairly easy on a regular basis to review waiting times for VA patients versus non-VA patients, and I personally would be dissatisfied with the outcome if we found that there was any differential between the two patient populations.

THE CHAIRMAN. Mr. Moreland, could you also respond to this question?

MR. MORELAND. Yeah. That is part of the agreement that is set up in the contract which essentially says this piece of equipment continues to be owned by the VA. It is just in your building. You are operating it. And the university gets benefit and non-veterans and the VA gets benefits and veterans.

But essentially the time line standards are part of the negotiations, so that I know that if refer a veteran into that machine -- and I use the example I gave you earlier in Butler as an example -- if I refer a veteran there, I expect them to get seen quickly. And you can identify that by the number of hours and the number of days, and you monitor that.

And I just have found that if you do that and you provide that feedback, there is no interest in that not working well, because Dr. Greenberg doesn't want that to not work well and nor do I. And so I don't think that will be really an issue.

And I agree with you. It meets all the tenets. It increases access because currently veterans don't have access to that machine in Charleston. It enhances quality because you have access to that machine, and at the end of the day, it is going to be a financial good deal. It meets all three components of what we are trying to do, so I think this is an example of a win/win for everybody.

MR. TUCKER. Thank you, Mr. Chairman.

THE CHAIRMAN. I thank the minority counsel for the questions, because you are going right to the heart of it. If the university builds a bed tower and the VA builds a bed tower, and then on the inside you share some of is medical equipment that then escalates the quality of the care, veterans are going to want to make sure that they have the access. They are treated like they would be treated in a VA hospital, and so your question went right to the heart of it. So I appreciate the gentleman's question, and I appreciate the answers you have just now given.

I think where we are, Mr. Brown, is as you develop your construction budget, we are going to need to be some very good listeners here with regard to how we handle this, meaning where are we with regard to Charleston and the Collaborative Working Group? What does Phase 2 mean? And what is this fast track now that Mr. Moreland had to do with regard to New Orleans?

So to help us in this, Dr. Greenberg, help me -- help the Committee -- sort of define what is a Phase 2? If we move to a demo, what do you have in mind, and I am also interested in your counsel to us, Mr. Moreland.

I don't mean to jump ahead of where you would go, Henry, in your own Subcommittee, but we have an opportunity here.

DR. GREENBERG. Well, Mr. Chairman, one of the things I would like

to do, and I say this as a tribute to Mr. Moreland, is sit down with Mr. Moreland and map out what a charge would be. I think the first -- the obvious thing we need to do is clone Mr. Moreland, because he clearly needs to be in two places at the same time.

THE CHAIRMAN. Can you also include a time line of expectency in your accounts you are about to give? I think it will sort of helpful to us and whatever overlay there will be with regard to actions also taken with Louisiana.

DR. GREENBERG. To me the principal issue is that we identified opportunities for sharing, and the good news on that was that there was agreement on both sides clinically about what the things -- what services -- are the targets for sharing.

But beyond doing that, in doing some costing of construction, we really haven't gotten in at all to the operational issues. And so what I think we would need to focus on, just as categorically, would be looking at moving towards implementation.

How would you actually operate this, not just build the shared facility, but on a day-to-day service of these, of the clinical service involved, how would they be operated?

To the best of my knowledge, the working group on clinical integration really just scratched the surface. They made considerable progress by identifying the category of services that might be shared, but not how they would actually be operated. And to me that really is the fundamental question.

I think six months is a reasonable period of time to do that. You always seem to have a faster time track than I do, and that probably is good, because it keeps us accountable and as productive as we can be when you set time frames for us. But I think that these are moving to fairly complicated questions about how things would operate clinically and I think six months is probably a reasonable time frame for that.

I would hope that in parallel with this, we get answers to the questions about the security standards issue and some direction about the magnitude of investment that is reasonable for us to be thinking about so that it directs us towards an appropriate model. It will clearly be a model of sharing, but as of yet, we don't really know exactly how much should be shared. And so I don't want for us to work in isolation of the thought process about what is a reasonable fiscal investment to be made.

THE CHAIRMAN. Mr. Moreland.

MR. MORELAND. I was thinking about the traditional way a project is developed to get into the process of from concept to design to construction. And, you know, what I think we provided is a basic concept. Really the next step is design and generally one looks at the estimated construction cost and then assets. That is a number of about 10 percent. And then estimated project as to what it would cost

to then go into the next phase which is called design.

And in that design process, I recently participated with an architect that has done some really interesting work called the FATHOM, and I don't remember what all that acronym means, but essentially it is sitting people in a room together and designing what that work space should be like in the future, not the way we have done work in the past.

And I hear what Dr. Greenberg describing really is that kind of process, and that generally is accomplished in the design process. So what I am suggesting is opposed to having a work group, one might think about moving it to that next step, which is more of an official step which is the design process. That is just explaining the natural progression of construction projects.

THE CHAIRMAN. Can this be, if we were to say instead of doing the demo actually, Dr. Greenberg, what Mr. Moreland has just said trumps you big time, because what he just said has just advanced this so far you ought to just hug him right now.

DR. GREENBERG. That is why I like him so much.

THE CHAIRMAN. If we were to say, if we were to scrap your idea on a demo, and actually go to plan and design -- let me just ask this, though -- in a planning phase, we would need to put in some language, I would think, we would need to put in some exact language, helping to define what that Phase 2 is, because what we want to be able to do here is replicate.

So if we are going to make this investment to examine all these clinical areas, with integration for a successful operation, you want to be able to say, okay, we have made an investment. We are proceeding to do this in Charleston, but guess what? I am able to use our investment with what I am about to do in New Orleans too, right, because -- help me out here. I am not --

DR. GREENBERG. I think you are headed in a direction that I hope the conversation would move in, which is I think it is a mistake to look at the situation in New Orleans and the situation in Charleston as being in conflict with each other.

THE CHAIRMAN. I don't see them in conflict. We just have two different time lines.

DR. GREENBERG. Right. I suspect much of the work that would be involved in the design phase would have utility in both New Orleans and Charleston. There are some things that would be specific to a particular geographic configuration. But many of the operating principles would be largely the same.

Now it gets even more complicated if you got three parties at the table, but I just think it is an opportunity for us to think about taking this to the next level, especially if it involves a significant investment as Mr. Moreland has suggested.

In thinking about those principles that span not just these two fa-

cilities, but hopefully would inform us in Las Vegas and Orlando and other places that one might be considering the same kind of thing. We don't have to reinvent the wheel uniquely in every geographic location. We should look at a model to the extent possible that can be replicated in each of these settings with the understanding that there is always going to be some element of difference between the individual settings, but the more that we can make that can be transported from one setting to another, the more efficient the whole process will be.

THE CHAIRMAN. I concur. Consider the exporting of this model, let us take Ms. Berkley's district for a second in Las Vegas. She has tremendous challenges because this is a population growth unlike anyplace in the country. And so what is plan and design today, by the time you get it built may even be obsolete. I mean her challenges are remarkable.

So she has an immediate need while at the same time, you have got this desire of a chancellor to build a medical university, but guess what? It will be on a different time line, too, right, because there is a tremendous amount of funding required to pull something like that off.

But if we know what the model is as they construct it, something can be partnered for it at some point in time. And that is what we also want to be able to be receptive to with Orlando. If Orlando or the State of Florida has an interest in putting the medical university there, then we want to be able to build a facility that is receptive to that.

So, different than LSU, you have the property, right, and as I understand, you want to be able to say to the VA, we have property. We are interested in the collaboration, and we want to be able to build this together, and work it out together, right?

MR. SMITHBURG. We have some of the property.

THE CHAIRMAN. So -- pardon?

MR. SMITHBURG. We have some of the property and designs on the rest.

THE CHAIRMAN. Okay. All right. So it is called the most flexible model ever? You know what? The Charleston Model is appropriate, because Charleston is, you know, a pretty loving city, a caring city. We are exporting your love.

Chairman Brown, we will allow you to close.

MR. BROWN OF SOUTH CAROLINA. Mr. Chairman, I just would like to thank you for your interest and innovation and energy that you have put on this project, and Mr. Moreland, Dr. Greenberg, Mr. Smithburg, we are grateful for your energy that has been expressed today, and our whole commitment is to provide better healthcare for our veterans and our population as a whole and I think this is a win/win.

And certainly I am like Dr. Greenberg. I don't see a conflict be-

tween Charleston and New Orleans. I think it is certainly a complement to each other, and I think by moving them both the same time, but certainly I think would have some numerical economic savings, too. So I thank you all three for being here and being part of this discussion. And thank you, Mr. Chairman.

THE CHAIRMAN. Thank you, Mr. Chairman. We as a Committee, want to remain sensitive right now with regard to construction time lines across the country, because they all have their own time lines, and they all get really sensitive. Oh, my gosh, you got money for this one. Are we less a priority, and that type of thing. We just want to get these things built. We want these hospitals built.

We are going to embrace the suggestion from both of you. A demonstration project, or do we really go to plan and design, or a hybrid thereof? And so we will take that to the next step. We will work with each other on how to define this properly and so when we put together our construction budget, I think that will probably be the best way to handle it. Do you agree?

Okay. Thank you very much for coming to town and really congratulations to you. This hearing is now concluded.

[Whereupon, at 5:50 p.m., the Committee was adjourned.]

APPENDIX

HONORABLE HENRY BROWN
Opening Statement
Full Committee Hearing on VA Collaborative Projects
March 8, 2006

Thank you, Mr. Chairman.

Mr. Chairman, as you well know, the committee has expended a great deal of effort over several years to ensure that VA consider ALL alternatives when contemplating new facilities and the delivery of health care. I am excited about today's hearing as it will allow us a good opportunity to hear from the department, affiliated organizations and the Department of Defense on the progress that has been made across the country.

Mr. Chairman, I am especially pleased that Charleston is well represented here today by several friends of the "low country": Doctors Ray Greenberg, President of MUSC, Jerry Reeves, Dean of MUSC's College of Medicine and Jack Fuessner (Foyz-ner), Chairman of the Department of Medicine. I would like to welcome them back to our nation's Capitol and to this hearing today.

Mr. Chairman, while it's always good to see friends, I am especially interested in sharing information with our colleagues regarding the collaborative model that has been successfully developed in Charleston between the VA and MUSC. I am equally interested in completing the model's development and exporting it to other areas of the country where similar collaborative efforts may be appropriate---not the least of which may be New Orleans. While this model has already served the VA well, I expect that over time, the department will find increasing utility in it.

To that end, I look forward to engaging Mr. Smithburg from Louisiana State University (LSU), during the second panel in order to get a clearer picture of what a collaborative facility may look like in the Gulf Coast region. I appreciate him joining us today and I hope that the work we have done in Charleston helps to fuel his efforts in Louisiana.

In a similar vain, I am thrilled to have Dr. Winkenwerder with us here today to speak to some of the collaborative opportunities that have been undertaken by the VA and the Department of Defense. Like the Charleston model, I'm interested in finding out what types of models may help fuel

additional collaboration between the departments—whether it's North Chicago, Las Vegas or something in between.

In my mind, and I think you share this view Mr. Chairman, collaboration is becoming increasingly essential in delivering health care across the nation. So long as we remain true to the distinct identity of the VA, and so long as we ensure the continued quality associated with VA care, we should embrace opportunities to maximize local health-related economies.

Our Charleston experience has taught us a lot: we can improve the quality of care delivered, the efficiency of the care delivered and we can accomplish it without dramatically increasing the lifecycle costs of the new facility.

Again, Mr. Chairman, I appreciate your leadership in this area and I stand ready to assist you in leveraging our work in Charleston against future collaborative opportunities around the country.

I yield back the balance of my time.

Statement of Honorable Lane Evans
Ranking Democratic Member
House Committee on Veterans' Affairs
March 8, 2006

I want to express my appreciation to the Chairman for scheduling this hearing on the VA's collaboration efforts – I hope this is only the first of many hearings we will have this session on health care, and how the VA will meet the needs of veterans today and in the coming years.

I am always open to exploring ways in which the VA can improve the health care it provides veterans and the manner in which it meets its obligations to our veterans, but I also want to make sure that in chasing the possible benefits of collaboration we never lose the essential nature of the VA as a provider of health care to veterans.

Although tantalizing, collaboration raises many difficult issues that need to be fully explored, and we must always be on guard that we do not visit upon veterans' consequences we do not intend.

A whole host of issues arise out of collaboration, issues relating to VA's statutory authority to entertain collaboration possibilities, governance issues, issues relating to VA's caregivers, legal issues relating to control and ownership, how possible collaboration efforts fit into the CARES process and VA's 5-Year Capital Plan, how scarce construction dollars should be prioritized and allocated, how collaboration may work with public entities, and whether or not it is advisable with private entities. These are all difficult questions, and questions that must be fully addressed as this Committee, and the VA, moves forward.

I hope that after all is said and done that collaboration may indeed live up to the promises made by its proponents, but I also want to make sure that the VA is not merely looked upon as a cash cow for non-federal entities, and that the needs and interests of veterans are never sacrificed for promises of benefits and possibilities of income streams down the road.

Taking care of veterans is a federal responsibility, a responsibility that we may look to improve and augment, but never abrogate.

Rep. Corrine Brown
HOUSE COMMITTEE ON VETERANS' AFFAIRS
Department of Veterans Affairs Collaboration Opportunities with Affiliated Medical Institutions and the Department of Defense
Wednesday, March 8, 2006, 2:00 p.m.
334 Cannon House Office Building

I want to thank the Chairman for calling this hearing.

I also would like to thank all the witnesses for being here today.

It is important for the VA to set guidelines and have guidelines for working with outside organizations.

Whether the organization is a private company, state university or another branch of the government, do we know enough about the different regulations overseeing each of these entities and will they be able to work together and will there be proper oversight to secure the safety of the patients?

The patients are and always will be the first priority and decisions need to come from that assumption.

I look forward to listening to your testimony.

Congressman Tom Udall (NM-3)
House Veterans Affairs Committee
Oversight hearing on Improving Access to Quality Care through Collaboration with Affiliated Medical Institutions and the Department of Defense and the Operation of Integrated Medical Facilities
March 8, 2006

Mr. Chairman,

I would like to welcome today's witnesses and thank them for their testimony. Enhanced collaboration efforts by the Department of Veterans Affairs (VA) are complex in nature, as all of you have testified. Both of the experiences in New Orleans and Charleston offer snapshots that we should examine and take into consideration when trying to understand how this can and should work.

While VA collaboration efforts with the DoD or another entity can result in improved access of services for veterans, cost savings, and increased efficiency, collaboration will result in numerous, complex questions that must be answered. Put another way, it often raises more questions than it answers. Issues of ownership, legality, planning, and healthcare are simply a few of the broader questions. More specifically are questions of how collaboration will affect a single state or a single district or a single facility – and most importantly, a single veteran. Entering into complex collaborative efforts must be undertaken with caution, with foresight, and only after all questions have been addressed. Without taking due time to explore this issue, the VA will enter into situations fraught with ill-advised and unwanted consequences.

I do believe that many of these questions can be addressed, but we must ensure that collaboration by the VA fundamentally protects our veterans, and ensures that their needs are being met along each step of the way. Thank you again to today's witnesses.

Thank you, Mr. Chairman.

Statement of
Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health
Department of Veterans Affairs
Before the
House Committee on Veterans' Affairs

March 8, 2006
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Good afternoon, Mr. Chairman and members of the Committee.

I would like to begin my testimony by expressing my appreciation for your continued interest in and support of the Department of Veterans Affairs' (VA) opportunities to improve access to care, quality of services, and the facilities in which we deliver health care to America's veterans. As you are aware, VA invests hundreds of millions of dollars each year to maintain and improve our facilities. Like most public and private health care facilities across the country, which were largely constructed shortly after World War II, our facilities are aging and keeping them current is becoming increasingly costly.

The Department of Veterans Affairs has a long history of working closely with the Department of Defense (DoD) and with affiliated medical institutions in the delivery of health care. These working relationships are evolving. Since President Bush identified this activity as one of the 14 key management priorities for his Administration, opportunities for greater levels of sharing and different kinds of collaborations have been developed and still others are being explored.

We have several examples of successful VA/DoD sharing, including assuring a seamless transition from active duty to civilian life, as well as collaborations between North Chicago and Naval Hospital Great Lakes; Alaska VA Health Care System and the 3rd Medical Group in Anchorage, Alaska; Charleston, South Carolina; and El Paso, TX. At each of these sites VA or DoD serves as the inpatient facility for both Departments.

DoD and VA have been working closely to ensure that returning servicemembers transition from active duty to civilian status in a seamless manner. VA outreach programs are ensuring that returning combat veterans of Operation Iraqi Freedom and Operation Enduring Freedom are receiving medical care, prosthetics, and other services from VA quickly and with minimal paperwork. VA and DoD are also identifying departing servicemembers who may be at risk for Post Traumatic Stress Disorder (PTSD), and have implemented an aggressive plan to determine the appropriate care best suited to each veteran.

VA and DoD are working towards the two-way electronic transfer of health records between the two Departments. This sharing of electronic health information is necessary to ensure that when patients are seen at one facility,

their information will be available to doctors and nurses at other facilities where they may seek care in the future. Because the information is available more rapidly, patients can receive needed care without extensive waits and unnecessary duplication of tests.

Plans are underway for even greater collaboration between the North Chicago VA Medical Center and the Naval Hospital Great Lakes. The effort at this location will provide increased capabilities and access to the veteran and DoD populations. Extensive work has already begun by six work groups to address Human Resources, Information Technology, Leadership, Finance/Budget, Clinical, and Administrative management issues.

In Anchorage, VA and the Air Force's 3rd Medical Group (Elmendorf) have a long standing joint venture which serves veterans and DoD beneficiaries in Alaska. They are continually looking for opportunities to collaborate on more administrative activities, such as a library, warehousing, and food services. They are currently one of the VA/DoD budget and financial management demonstration projects. They are addressing better billing practices and capturing workload sent to the other system. VA is also building a new outpatient clinic on the grounds of the Elmendorf Air Force Base next to the existing Federal Hospital. It is currently under design and expected to open in 2008.

In Charleston, SC, VA has joined with DoD to construct a new Consolidated Medical Clinic at the Naval Weapons Station, which is located approximately 15 miles north of Charleston near the city of Goose Creek, in Berkeley County. The FY06 project includes approximately 164,000 gross square feet of clinic space. The $4.4 million VA portion is funded via our minor construction program and includes approximately 18,000 gross square feet. Combined, the project is nearly $40 million with 182,000 gross square feet. It is important to note, that by joining forces, VA and DoD have removed the need for separate ancillary and support spaces. Construction will start this fiscal year, and is anticipated to wrap up by the fall of 2008.

In El Paso, VA has a collaborative venture with William Beaumont Army Medical Center (WBAMC). The VA Outpatient Clinic is collocated with WBAMC. WBAMC provides inpatient services to both VA and DoD beneficiaries. This joint venture is also one of our information management/information technology demonstration projects. They are doing significant work to implement medical record sharing between the two systems. The Bidirectional Health Information Exchange (BHIE) is operational there, which enables real time sharing of allergy, outpatient pharmacy, demographic, laboratory, and radiology data between DoD BHIE sites and all VA health care facilities for patients treated in both VA and DoD. It should be noted that inter-departmental data sharing accomplishments of BHIE were just recognized by the American Council for Technology with an "excellence.gov" intergovernmental award. They are also implementing the

Laboratory Data Sharing Initiative, which allows VA and DoD providers to order and receive results of chemistry labs electronically where either DoD or VA serves as a reference lab for the other.

A new approach was undertaken when VA and the Medical University of South Carolina (MUSC) conducted a joint review to identify options for collaboration and sharing in Charleston. This project is known as the Collaborative Opportunities Study Group (COSG). The structure used for that review provided useful information that enabled us to identify viable sharing opportunities. The model used in Charleston can serve as a template for the structure of future reviews of potential collaborations between VHA, affiliates and DoD.

The study undertaken in Charleston used a newly defined structure that enhanced and supplemented existing VA and VHA processes for capital planning and construction decisions. The process consisted of a VHA chartered steering group made up of senior level national and local subject matter experts with a matching set of participants from the other interested parties, in this case primarily the affiliated medical university, with some input from DoD. The Collaborative Opportunities Steering Group, as it was called, served as the oversight body for four workgroups – Governance, Legal, Finance, and Shared Clinical Services. These focused groups reviewed relevant data and policy and presented options to the Steering Group. The workgroup chairs served on the steering group and the workgroups were populated with additional subject matter experts from both parties. Their efforts assured that at a minimum certain key areas assigned to them were reviewed and considered. Data reviewed included quality indicators, population statistics, care volumes, and costs.

In addition to directing and coordinating the workgroups, the Steering Group completed a higher-level review of the combined information from the workgroups to develop specific options for sharing and evaluated the viability of those options. With representation of all potential collaborators, the group also addressed stakeholder communications, including interactions with the media, veterans, Veterans Service Organizations, employees, and the community. This coordinated communication effort assured that stakeholders received consistent, timely and accurate information.

An underlying process critical to the Steering Group's success was the use of a cost effectiveness analysis, a tool also used by the VHA and VA level Capital Asset Board to evaluate every major construction project. This provided insight into both initial capital cost as well as potential savings in life-cycle operational costs from synergies of sharing. Application of this tool to the review of options for collaboration provided a smooth transition from the collaboration study directly into existing VA capital processes and procedures. The group identified some short-term options for resource sharing that were initiated.

Broadly, the goal of a study group in using the outlined business case analysis methodology is to assure that options developed for further consideration are mutually beneficial. Evaluation of the merits of a local collaboration or sharing arrangement must consider service, quality, access, practicality, and efficiency of potentially shared services. Additionally, there must be consideration of managing the cost distribution of shared services, sharing of components of facilities such as operating rooms or imaging equipment, impact to VA information management systems, and logistics. The group must also determine the impact of not moving forward with collaborations and sharing opportunities. The summary of the analysis describes the advantages and disadvantages of alternatives and estimates the associated costs. My office will review the options outlined by such study groups and look to VHA's Capital Asset Board for a recommendation.

The model functioned well in Charleston and I have recently charged a group to conduct a similar review in New Orleans. This group will study the collaborative opportunities between the New Orleans VAMC and Louisiana State University and explore options to reestablish a mutually beneficial health care presence in New Orleans. The template that was developed for the Charleston study will serve as a framework for the evaluation of sharing opportunities in New Orleans. While using a similar structure, the group will continue to develop and refine the process described. I look forward to sharing the findings of the New Orleans collaborative opportunities group with you later this year.

Charleston and New Orleans present unique options in some respects. In Charleston, MUSC is in the midst of replacing their facilities, presenting a time limited opportunity for collaboration. In New Orleans, both the VA and the affiliate facilities experienced dramatic devastation and a potential collaboration is timely. In other locations the processes used to review collaborative opportunities will depend on the specific circumstances. However, the tools used by the steering groups are available for use by other VA facilities in their reviews if they are appropriate.

Sharing and collaboration have existed in the VA throughout its history. VA and DoD have enjoyed successes in joint facility utilization and capital asset ventures which have strengthened the capability of both Departments to enhance services to our beneficiaries; however, the potential exists for even greater future collaboration specifically in the area of leveraged purchasing power. By leveraging resources and joint buying power, VA and DoD can achieve even greater healthcare value and efficiency in a combined or linked network of healthcare delivery, healthcare management, and a sharing of resources both nationally and locally.

Clearly we have new opportunities to build on VA's strengths to forge successful relationships with medical affiliates and the Department of Defense. Where

these opportunities can provide cost-effective enhancements to the quality and availability of veterans' care, VA will pursue them diligently.

Thank you again for this opportunity to share these comments. We appreciate the interest and support of you and the Committee and we would be pleased to answer any questions that you or the Committee may have.

THE HONORABLE WILLIAM WINKENWERDER, JR, MD, MBA
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

BEFORE THE
VETERANS AFFAIRS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

COLLABORATION WITH THE DEPARTMENT OF VETERANS AFFAIRS
MARCH 8, 2006

NOT FOR PUBLIC RELEASE
UNTIL
2:00 PM ON MARCH 8, 2006

Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS) and our collaborative efforts with the Department of Veterans Affairs (VA) to improve access to quality health care. Having just submitted our VA/DoD Joint Executive Council Annual Report for Fiscal Year 2005, the accomplishments of the past year are fresh in our minds.

We continuously explore new avenues of partnership with the VA through our Executive Council and associated sub-councils and work groups. This formal structure provides the setting in which the Departments jointly address issues, set priorities and strategic goals, as well as monitor the implementation of these priorities and ensure that accountability is incorporated into all joint initiatives.

As a companion to the Annual Report, the VA/DoD Joint Strategic Plan (JSP) for 2006-2008 was published. The VA/DoD JSP, initially approved in April 2003, was a way to articulate a shared vision for collaboration. This roadmap was recently reviewed and updated, in order to accommodate additional focus on the collection of lessons learned as well as to set more concrete milestones and performance measures. Progress on the JSP objectives, strategies, key milestones, and performance measures are reported to the Joint Executive Council and higher on a regularly scheduled basis.

Resource Sharing

Sharing of resources is a vital component of both organizations' healthcare delivery systems. At the conclusion of Fiscal Year 2005, VA and DoD had 446 sharing agreements covering 2,298 health services, and 136 VA Medical Centers reported reimbursable earnings during the year as TRICARE Network providers. This is an increase of 59 percent over the previous year. Every day we collaborate to further improve the healthcare system for our service members; we have substantially increased joint procurement, and we are working to publish jointly used evidence-based clinical practice guidelines for disease management to improve patient outcomes.

VA and DoD are working toward the establishment of the first Federal healthcare facility with a single management structure in North Chicago. In October, I attended a ceremony in Chicago to mark the start of this innovative initiative. More specifically,

North Chicago Veterans Affairs Medical Center (NCVAMC) and Naval Hospital Great Lakes (NHGL) will provide increased access to the veteran and DoD populations. Extensive work has begun by six work groups to address Human Resource, Information Technology, Leadership, Financial/Budget, Clinical, and Administrative management issues. The lessons learned from this initiative will have a significant impact on the future of DoD/VA sharing and collaboration. Additionally, in response to the devastation at the federal health care facilities in the Keesler AFB/VA Biloxi campus area caused by Hurricane Katrina, DoD and VA established a joint task force to explore the potential for a joint venture medical center. This task force has identified several options for significant partnering, and we are committed to moving forward within the next several weeks with the best design for the beneficiaries of the region and for the taxpayers.

DoD and the Navy are also working expeditiously to finish the DoD/VA Joint Ambulatory Care Center in Pensacola near Corry Station. The project was made possible by a land-use agreement that grew from the VA CARES decision to expand services in the Florida panhandle by Secretary Principi in May 2004. The $55 million project, entirely funded by the VA, constructs a 204,000 gross square foot clinic on land donated by DoD. Sharing agreements include inpatient, emergency, ancillary, audiology, and orthopedics services. The ground breaking was held in May, and the facility is currently under construction with completion anticipated in January 2008.

Another important collaboration is planned in South Carolina. The 1993 BRAC action significantly decreased the workload for the 500 bed Naval Hospital in Charleston. Currently, this military treatment facility is a hospital in name only, as inpatient services are performed at a nearby civilian hospital (Trident Regional Medical Center) through a sharing agreement. DoD has an FY06 military construction (MILCON) project that the VA has joined to construct a new Consolidated Medical Clinic at the Naval Weapons Station, which is located approximately 15 miles north of Charleston near the city of Goose Creek, in Berkeley County. The $35 million FY06 MILCON project includes approximately 164,000 gross square feet of clinic space. The $4.4 million VA portion is funded via their minor construction program and includes approximately 18,000 gross square feet. Combined, the project is nearly $40 million with 182,000 gross square feet. It is important to note, that by joining forces, VA and DoD have removed the need for

separate ancillary and support spaces. Construction will start this fiscal year, and is anticipated to wrap up by the fall of 2008.

There are many joint activities underway all over the country designed to improve access, satisfaction, and timeliness of services for VA and DoD beneficiaries. Let me highlight a few of them. Under the authority provided in the National Defense Authorization Act for Fiscal Year 2003, VA and DoD have established an annual account in the Federal Treasury, and in 2005, the VA/DoD Health Executive Council approved 17 projects, many of which will have a direct impact on improving veterans' access to health care. One of the projects involves the expansion of the Sleep Diagnostic and Treatment Lab at the Harry S. Truman Memorial Veterans Hospital in Columbia, Missouri in conjunction with the 509th Medical Group, Whiteman Air Force Base. This project will enable VA to reduce its backlog for these services. Another project underway between Madigan Army Medical Center and the Puget Sound VA Health Care System entails the joint recruitment of scarce medical specialties including neurosurgeons to provide coverage for more beneficiaries of both VA and DoD. As a final example of the positive work being done to improve access, two other joint projects at Cheyenne VA Medical Center/F.E. Warren Air Force Base and at VA Medical Center Boise/Mountain Home Air Force Base will provide much needed mobile Magnetic Resonance Imaging (MRI) services to VA and DoD beneficiaries in rural areas.

Information Technology and Management

DoD has a long history of transforming healthcare delivery through the use of information technology. For more than a decade, DoD has been a national leader in using one of the world's first and largest computerized physician order entry systems. We continue to lead the way with our new electronic health record AHLTA, which has greatly enhanced capabilities and the ability to move medical information with patients around the world 24 hours a day, seven days a week.

DoD recognizes the value of secure and on-demand accessible computerized patient information as a substantive way to enhance patient safety and the quality of healthcare delivery, and we are committed to working with VA and other organizations to exchange this important health data.

Over the past year, DoD, VA and Health and Human Services (HHS) have launched a new era of Departmental information technology collaboration, with unprecedented strides toward a new federal partnership through a number of initiatives. I would like to address a few of these today.

As a member of the American Health Information Community, I work with both public and private medical partners to help develop recommendations that will assist with the implementation of the President's agenda – that every American will have an electronic medical record within ten years. HHS chartered this group made up of eight private sector and nine public sector leaders to discuss and guide the formation of an operable electronic health record. Secretary Leavitt has identified DoD and VA as key leaders and participants in the overall public-private electronic health record effort. I am honored to be on this committee.

DoD and VA are lead partners in establishing federal health information interoperability standards as the basis for electronic health data transfer in federal health activities and projects through the Consolidated Health Informatics initiative. These adopted standards will be used in new acquisitions and systems development initiatives. DoD and VA are also leading partners in many national standards development efforts, and both Departments participate in multiple standards boards to collaborate and share expertise. In addition, DoD and VA are co-leads for the Federal Health Architecture initiative managed by HHS, and we co-lead the Health Care Delivery – Electronic Health Record Work Group formed in May 2004. DoD is also active in the HHS initiatives to build partnerships throughout the nation's healthcare environment in developing an integrated health information exchange network.

DoD and VA are making great strides every day in secure sharing of health data with initiatives such as Federal Health Information Exchange (FHIE) and Bidirectional Health Information Exchange (BHIE). FHIE enables the secure electronic transfer of appropriate electronic health information from DoD to the VA. We have transferred health information on over 3.27 million unique patients to the VA, and permitted the rapid electronic transfer of data for our separated service members.

Building from the FHIE technical and personnel advancements, BHIE is another important capability that enables real-time sharing of allergy, outpatient pharmacy,

laboratory and radiology results and demographic data between DoD and VA for patients being treated in both systems using existing automated systems. This capability is operational at all VA healthcare facilities and at Madigan, William Beaumont, Eisenhower and Walter Reed Army Medical Centers and at the Naval Hospital Great Lakes and the Naval Medical Centers in San Diego and Bethesda, and also at the Michael O'Callaghan Federal Hospital at Nellis Air Force Base. Deployment to additional sites in 2006 is being coordinated with the Services and local DoD/VA sites. Site selection is based primarily on support to returning service members of Operations Enduring Freedom and Iraqi Freedom, number of visits for VA beneficiaries treated in DoD facilities, current FHIE usage, local sharing agreements, and retiree population. We anticipate implementation at Bassett Army Community Hospital, Fairbanks, AK; Brooke Army Medical Center, San Antonio, TX; Landstuhl Regional Medical Center in Germany; David Grant Medical Center, Travis AFB, CA; Elmendorf AFB Medical Facility, Anchorage, AK; Wilford Hall Medical Center, San Antonio, TX; Tripler Army Medical Center, HI; and Womack Army Medical Center, Ft. Bragg, NC. The electronic health information from each DoD facility that implements this functionality is available to all VA facilities.

Seamless Transition

DoD and VA have been working closely to ensure that returning service members transition from active duty to civilian status in a seamless manner. VA outreach programs are ensuring that returning combat veterans of Operation Iraqi Freedom and Operation Enduring Freedom are receiving medical care, prosthetics, and other services from VA quickly and with minimal paperwork. VA and DoD are also identifying departing service members who may be at risk for Post Traumatic Stress Disorder (PTSD), and have implemented an aggressive plan to determine the appropriate care best suited to each veteran.

VA and DoD are expediting the two-way transfer of medical records between the two Departments, largely using their state-of-the-art new electronic medical records systems. This sharing of electronic health information is necessary to ensure that when

patients are seen at one facility, their information will be available to doctors and nurses at other facilities where they may seek care in the future. Because the information is available more rapidly, patients can receive needed care without extensive waits and unnecessary duplication of tests.

The Departments have been working together for a number of years to increase their joint purchasing of drugs, medical supplies and equipment. This has been accomplished, in part, through the development of joint standards, allowing for purchase of larger quantities by both agencies. VA and DoD expect that this collaboration will continue to grow -- resulting in significant savings to the government.

Another information sharing initiative used to help service members transition from DoD to VA care are the pre- and post- deployment health assessments. DoD now sends electronic pre- and post-deployment health assessment information from the Defense Medical Surveillance System (DMSS) to VA for separated service members. This information contributes to the ongoing care and wellbeing of troops who have deployed. The information supports monitoring, maintaining, and improving their overall health condition, and informing them of any potential health risks. Transmission of electronic pre- and post-deployment health assessment data to the data repository began in July 2005 with a transfer of over 400,000 assessments. Monthly data transmissions began in September 2005. As of the end of February 2006, DoD had successfully transmitted over 515,000 assessments on more than 266,000 individuals. DoD will work with VA to add the new post-deployment health reassessment to the information VA receives.

We are especially pleased with our work with VA towards seamless, responsive and sensitive support to service members as they transition from active duty to veteran status. Both the VA and DoD are committed to providing our service members a seamless transition from the MHS to the VA. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides guidance on the collection and transmission of critical data elements for service members involved in a medical or physical evaluation board. DoD began transmitting

pertinent data to VA in September 2005, and has since provided five lists with a total of 5,177 service members while they are still on active duty. Receiving this data directly from DoD before these service members separate eliminates potential delays in developing a claim for benefits by ensuring that VA has all the necessary information to award all appropriate benefits and services at the earliest possible time.

Conclusion

These are just a portion of the successes the MHS has experienced this year. We have launched our electronic health record AHLTA, we have a brand new initiative to create a new federal healthcare facility, we have shared electronic health data with VA facilities, and we have implemented new programs that will benefit our service members every day. It is important to note that we always seek areas of improvement, new opportunities to expand the benefits and improve access to care. We have worked with our VA partners to support the goals and meet the milestones outlined in the Joint Strategic Plan. DoD is, as always, committed to continued collaboration with the VA, continued support to our service members who keep this nation safe and secure, and continued care for their families. Thank you again for this opportunity to speak with you.

Testimony Before the House Committee on Veteran's Affairs

March 8, 2006

Raymond S. Greenberg, MD, PhD
President, Medical University of South Carolina

Mr. Chairman and Members of the Committee, it is a privilege to appear before you this afternoon on behalf of the Medical University of South Carolina (MUSC). The message that I wish to convey is that we greatly value our working relationship with the Department of Veterans Affairs and we look forward to the opportunity to expand that relationship. Our partnership with the VA spans all of our missions, from education, to clinical care, to research. All of the physicians-in-training at the Ralph H. Johnson Veterans Affairs Medical Center (VAMC) in Charleston are in MUSC residencies. The vast majority of attending physicians at the VAMC are also MUSC faculty members. Some of our best scientists are VA investigators, and the two institutions share a major laboratory facility – The Strom Thurmond Research Building. Without question, the presence of the VAMC as a neighbor enhances the capabilities of our institution, and we believe that we are a vital contributor to the success of the VAMC as well.

As we explore opportunities to build upon this strong collaboration, we are driven by one central motivation – to improve the care for the veteran population that we both serve. Let me be clear here – veterans in the Charleston service area get excellent medical care today. Talking with representatives of veterans service organizations, it is clear that they agree that the current services are excellent. This raises an interesting

question: If things are going so well, why would we be motivated to make any changes at all?

To me, there are two answers to that question. The first is that hospital care is becoming increasingly complicated, in part because only the sickest patients are admitted to hospitals now. In addition, the technology used to care for these patients has grown ever more complex and expensive. State-of-the-art hospital care requires a full range of specialist physicians, many of whom are in short supply, as well as a large investment in technology. Personnel shortages and expensive technology drive up the costs of care and you as legislators and we as health care providers have a mutual interest in assuring that the health care delivery system operates more efficiently.

How can we can be more cost effective? One of the most attractive opportunities is to avoid redundancy in building and operating separate expensive, highly specialized diagnostic and treatment equipment and facilities. By sharing these resources, we can save duplicative capital investments. For example, the VAMC could purchase equipment and/or build a facility, leasing resources to MUSC in order to provide services to both veteran and non-veteran populations. In so doing, the VAMC could negotiate discounted fees for services to veterans and also receive an income stream from the lease agreement. The rental income could be used to expand other services to the veteran population. Such a collaborative arrangement is a win-win-win: MUSC has access to new equipment and facilities without a capital outlay, the VAMC gets discounts on contracted services, and veterans get expanded services. All of this can be accomplished today simply by being more creative in our purchasing and contracting relationships. This type of partnership has been undertaken successfully by the Department of Veterans Affairs elsewhere on a

limited basis. What we are proposing is to build upon those successes by expanding the level of collaborations and we are prepared to be an immediate test case.

The opportunity to take our working relationship to a higher level was created by the Medical University's decision to replace its 50-year-old teaching hospital. The site for the new hospital, presently in the first phase of construction, is immediately adjacent to the VAMC. In the 2004 CARES study, a replacement VAMC was not proposed in Charleston, but a specific recommendation was made to explore enhanced collaborations with MUSC.

In August of 2005, the Under Secretary for Health of the Department of Veterans Affairs, citing the recommendations of the CARES report, charged representatives of the Department of Veterans Affairs and the Medical University "to determine what, if any, mutually beneficial consolidation should occur between the Charleston VAMC and MUSC." A Collaborative Opportunities Steering Group (COSG) was formed with six members each from the VA and MUSC. I was privileged to co-chair this oversight group with Mr. Michael Moreland, the Director of the VA Pittsburgh Healthcare System. With your indulgence, Mr. Chairman, I would like to take the opportunity to thank Mr. Moreland and his colleagues from the Department of Veterans Affairs for the diligence with which they approached this assignment.

Much of the analysis was performed by four working groups related to, respectively: (1) targets for shared clinical services, (2) finances, (3) legal matters, and (4) governance. By December of 2005, a final report was prepared which summarized our findings. With your permission, I would like to submit a copy of that report for the record.

The COSG focused on collaborative efforts that would increase the quality of services, lower overall facility and operational costs, and ensure optimal use of land resources. It was agreed that in any model of integration, it would be essential for the VA to have its own bed tower, including general medical and surgical ICU beds. This facility would be clearly identified and designated as the VAMC. Veterans would be housed with other veterans and would not be intermingled with other non-veteran patients. Staffing on these wards would continue to be provided by VA personnel.

The opportunities for sharing come in the various support areas, and in particular, the expensive, technology-intensive areas, such as operating rooms, and facilities for cardiac diagnostics, hemodialysis, endoscopy, cardiac catheterization, interventional radiology, and bronchoscopy. In scheduling the use of these resources, veterans would be given the same priority as non-veteran patients. By sharing these resources, both the VAMC and MUSC can lower their operating costs. In the process, we also can assure that the latest technology is available to both patient populations, and that local veterans do not have to travel great distances to get specialized services.

With agreement to this basic concept, we then explored several models of sharing. At the risk of oversimplification, these models differed with respect to the size and contents of the facility to be built by the VAMC. At one extreme, the VAMC would build its own bed capacity, all of the shared infrastructure, as well as bed capacity for MUSC. While this model would entail the largest initial capital outlay for the VA, it assures a significant revenue stream over time from the leasing of equipment and facilities to MUSC. That revenue stream can be used by the VAMC to assure and expand services to veterans.

The various other models that we explored involved progressively less initial construction by the VAMC, and accordingly, less lease revenue back to the VAMC over time. An interesting observation was that despite initial differences in construction costs for the various models, there were only modest differences in 30 year life cycle costs of building and operating the VAMC. For example, if one compared the most extensive model described above to a model of not replacing the VAMC facility at all, the difference in 30 year life cycle cost was only about 10%. In other words, for a premium of only 10%, veterans can receive care in a brand new facility as opposed to one that is 40 years old today and would be 70 years old by the end of the evaluation period.

There was further good work that came out of our evaluation. The group that focused on governance issues concluded that we could create an advisory structure for the sharing opportunities without undermining the existing authorities of either the VAMC or MUSC executive leadership teams. The workgroup on legal matters concluded that the authorities required for both construction and contracting already are well established.

In choosing between the various models, at least two important considerations surfaced. First, there is the pragmatic question of the amount of money the federal government can afford to invest in constructing a new VAMC facility. That is a resource allocation question which the COSG was neither charged nor equipped to address. It is appropriate to note, however, that MUSC is not here to advocate the most expensive model. Our preference is a model in which the VAMC and MUSC each build their own respective bed towers and share common infrastructure to be built by the VAMC. We believe that this model, built at a third less expense than the most expensive version,

would serve both the needs of the VAMC and MUSC, while still providing a significant revenue stream over time to the VA to expand care to veterans.

The second key issue that arose during our evaluation was whether VA facilities would be required to be built to the new federal guidelines for homeland security. These guidelines, while understandable for safety purposes, would raise construction costs an estimated 30%. Thus, it would be more expensive for the VAMC to build shared space than for an outside entity that did not have to adhere to these security standards to do so. For the purposes of our analysis, we assumed that the security guidelines would have to be met. If it turns out that those guidelines are not required, then our estimates of VAMC construction costs may be revised downward.

A related issue is the fact that the existing VAMC is in a flood zone, and as it was designed more than four decades ago, it is vulnerable to a major hurricane. While the Department of Veterans Affairs prepares to rebuild the facilities destroyed by Hurricane Katrina, it seems prudent to assure that similar disasters do not happen in other hurricane-prone cities. New construction in Charleston must allow the VAMC to withstand a hurricane the size and intensity of Katrina.

While the focus of the COSG appropriately has been on the situation in Charleston, it is important to note that much of the work that we completed has relevance elsewhere. There are many other academic medical centers that enjoy as close a working relationship with the VA as we have in Charleston. A number of these centers are either building or planning to build new hospitals. Although the geographic proximity between the VAMC and the new university hospital is particularly close in Charleston, it is not unique in that regard. As Representative Brown knows all too well, Charlestonians take

great pride in our history and the role that the military has played there since the Revolutionary War. At the same time, we believe that Charlestonians can lead the way to future innovation. As we look to ways to control the growth of health care costs, the Charleston model could be expanded to better serve veterans throughout the country.

If the Committee and the Department of Veterans Affairs find favor in our recommendation, there is further work to be done. We need to move from the macro level of the initial evaluation to the micro level of operational issues. Our suggestion is to formalize this initiative as a demonstration project, to appoint a working group to develop an implementation plan, and to allocate appropriate resources for that effort.

We are very conscious of the fact that in the wake of Hurricane Katrina, there are many construction priorities that could not have been anticipated when the CARES evaluation was performed. CARES recommended a study of collaboration in Charleston, but the message of Katrina is that we need to move beyond study to action. It makes sense to replace older facilities in areas prone to hurricanes, and to do so with the greatest efficiency by sharing resources. Charleston is prepared to be the test case and we hope that you will give us the opportunity to demonstrate the value of this model.

Again, I would like to thank our colleagues in the Department of Veterans Affairs for their hard work on our initial evaluation. I would like to thank the Chairman and the members of this Committee for your support of our nation's veterans. And, most importantly, I would like to thank the brave men and women who have served our country in time of conflict and who deserve the best medical care that together we can provide for them.

Statement of
Michael Moreland
Director, VA Pittsburgh Healthcare System
Department of Veterans Affairs
Before the
House Committee on Veterans' Affairs

March 8, 2006

*

Good afternoon, Mr. Chairman and members of the Committee and thank you for this opportunity to testify on the important topic of improving veterans' access to care through collaborations. In my experience as Director of the VA Pittsburgh Healthcare System and at other VA facilities, I have participated in a number of positive collaborations. I also am familiar with a variety of collaborations that have worked well for my VA colleagues. Today I will share a few examples and provide an overview of the collaborative study that I was privileged to co-chair with Dr. Greenberg to develop potential sharing opportunities between the Charleston VAMC and the Medical University of South Carolina.

First, I want to outline in general terms how I have determined whether particular collaborations were likely to be in the best interest of veterans. For a collaborative opportunity to be considered favorably it should increase veterans' access, improve quality through service enhancements, and provide VA with improved efficiency. As one would expect, if two organizations can share a capital expense, rather than duplicating it, they will save money on equipment and buildings. Those funds can then be used to enhance services. When deciding whether to consider sharing a given resource, we first determine the cost of providing that service independently. Then costs are developed for joint delivery of that service. For a collaboration to be considered a good sharing opportunity for VA, it must be more efficient for VA to deliver that service in collaboration with another entity; or the sharing might provide an enhancement to care that VA could not offer independently. The quality of the service delivered has to be as good or better than what is currently provided. The best sharing opportunities improve services while saving costs. To make these comparisons, data relating to demand and capacity for particular types of care, trends in the quality of service delivery, and cost information are reviewed. A good example of a sound collaboration is the Charleston VAMC and MUSC planned sharing of high tech equipment. Veterans and patients of MUSC will have access to care enhancements and the cost to each organization will be improved dramatically by sharing the equipment and expense. The type of sharing arrangement used in this case allows the VA to make a capital investment up front that is then recouped through revenue that supports operating expenses for several years.

In Pittsburgh, VA collaborated with the Commonwealth of Pennsylvania in providing long term care to the state's veterans. VA provided the state with land on the grounds of the Pittsburgh Healthcare System, and a grant for the

construction of a long term care facility. The state, under a sharing agreement, purchases services from VA to assist in the operation of the facility. This facility offers several levels of care that are in great demand in Allegheny County with its large population of aging veterans.

The Buffalo VAMC contributed $250,000 toward the purchase of a new PET scanner for University Nuclear Medicine, Inc. VA's purchasing power resulted in a lower price. The university group operates the scanner and VA purchases services at a negotiated reduced rate. Again, the community and its veterans benefit from additional services and both organizations reduce costs.

I completed a similar arrangement while I was the Director of the Butler VAMC in which VA purchased a CT scanner that was installed in and operated by the community hospital. VA then received access to very low cost CT services for veterans and the community benefited through the availability of high tech equipment that the local facility could not readily afford independently.

In all of these arrangements, there are numerous legal and technical details that require careful planning. In each instance, the arrangements are a good financial deal for veterans. Funds saved through these collaborations support other service enhancements. Savings like these assist us in maintaining and enhancing care in an era of burgeoning demand for VA care and continually escalating health care costs.

On occasion, I have been presented with opportunities for collaborations that were presented as "good deals" for VA. However, financial analysis revealed the proposals either to increase operating expenses over current expenses or to require up front financial outlays without a reasonable return on investment. While this may seem obvious, it is important to note that any prospective collaboration must be considered on its own financial merit.

The Collaborative Opportunities Steering Group that developed sharing options for the Charleston VAMC and MUSC presented an opportunity to consider taking this type of sharing to a broader level. This group developed options for joint construction of new facilities that would maintain both organizations' identities and independent missions, while sharing some of the enormous cost burden associated with replacing aging health care facilities. The group was able to identify viable models for such construction. By sharing some of the higher cost infrastructure, both VA and the University could reduce the investment required to build and operate new facilities. As I mentioned earlier, this group identified opportunities to collaborate in the purchase of high tech equipment that will make new, state-of-the-art services available to veterans and other residents of South Carolina that might not otherwise be feasible for either organization to provide independently. The successful experiences VA has had in this type of sharing at other facilities enabled this group to recognize this opportunity in Charleston.

The plan for equipment sharing in Charleston is in the process of being implemented. Nearly 7 million dollars in equipment funds have been received in Charleston. Draft documents are being prepared.

Collaborative opportunities abound as private and public sector facilities across the nation are seeking to upgrade aging infrastructure and bring state-of-the-art care to their communities. With thoughtful planning, these collaborations can be mutually advantageous and provide VA with opportunities to assure that veterans have access to the latest technology at a more efficient cost.

TESTIMONY OF

DONALD R. SMITHBURG
EXECUTIVE VICE PRESIDENT – LOUISIANA STATE UNIVERSITY SYSTEM
CEO – HEALTH CARE SERVICES DIVISION

BEFORE

THE

COMMITTEE ON
VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

March 8, 2006

TESTIMONY OF DONALD R. SMITHBURG

Mr. Chairman and members of the committee, I am Don Smithburg, CEO of the Louisiana State University (LSU) Hospital and Clinic System in Louisiana. I thank you for your interest in health care in Louisiana after Katrina and Rita. I also thank you for your invitation to appear today and the opportunity to answer any questions you may have about Louisiana's state public hospital system, especially as a potential partner with the Veterans Administration (VA) in New Orleans.

I represent 9 of the 11 state public hospitals and over 350 clinics that traditionally have been called the "charity hospital system" in Louisiana. I would like to describe this system briefly.

Our hospitals and their clinics constitute the health care safety net for the state's uninsured and underinsured, particularly the working uninsured – 2/3 of our patients are hard-working Americans. In your states, this role is generally a local government function, but in Louisiana it is the responsibility of a state-run and statewide hospital and clinic system under the aegis of LSU. We have one of the highest rates of uninsurance in the nation – over 20 percent of the population, estimated to include more than 900,000 individuals. Another 21 percent of the citizenry is on Medicaid. So, 41 percent of Louisiana's population is without private health insurance. That was before Katrina and Rita. Blue Cross of Louisiana has recently projected a 200,000-person increase in the ranks of the uninsured as businesses fail because of the storms' destruction. Other state government reports estimate 275,000 are newly unemployed since

Katrina & Rita.

The LSU hospitals also have had an integral role in supporting the education programs of our medical schools and training institutions, and that includes not only LSU but also Tulane and the Ochsner Clinic Foundation. Our system flagship is in New Orleans and is commonly known as Big Charity. Big Charity actually consists of two hospitals - Charity and University operated under one medical center umbrella. At our New Orleans facility alone, there were over 1,000 Tulane and LSU medical students and residents in training, and many more nursing and allied health students, when Katrina struck and then devastated our institution. Some of these same students had rotations at the VA hospital in New Orleans as well.

As the flagship of our statewide system, Charity Hospital sits a stone's throw from the VA Hospital. Big Charity operated the only Level 1 Trauma Center that serves South Louisiana and much of the Gulf Coast. Today, these facilities sit in ruins. Charity Hospital has been deemed "uninhabitable and unsalvageable" for health care by consulting engineers, and the somewhat younger University Hospital (35 years old), although severely damaged and not viable in the long term, will be temporarily propped up by the end of the year as an interim solution to New Orleans' critical need for health services.

The potential collaboration between the Veterans Administration and Louisiana's state public hospital system is one propelled by unintended opportunity. With both systems' hospitals in New Orleans devastated by Katrina and the floods, we stand at a moment that may not occur again: A chance to jointly design and cooperatively operate a new facility that meets the needs of

both institutions and the patients they serve while at the same time achieving significantly enhanced efficiency, cost savings and quality health care.

But even more fundamentally, the collaboration rests on a natural and logical partnership between two similar health care systems. The new partnership may be historic, but it represents the historic joining of two ***public*** health systems – systems with similarities of structure and constraints. Both the VA and the LSU Hospitals and Clinics provide ***more extensive outpatient than inpatient care***. Both are ***integrated systems*** incorporating a full range of medical specialties serving a relatively fixed population, a structure that opens opportunities for effective disease management and other programs that improve care while they conserve resources. Both systems live with ***appropriated budgets that have risen far less than the cost of care elsewhere***. And yet, both of us have targeted and achieved substantial improvements in the operation of our systems.

The integrated structure and vision of the VA system has permitted it to become a leader in the development and use of electronic medical records. It has made tremendous progress in this and other areas in the last decade. Electronic medical records also are a high priority for LSU, although we are not as far along as the VA. In fact, the VA is more advanced in the electronic arena than most in health care. We feel that automated records management is a key to cost-effective, high quality care in the years ahead.

There are differences between the two systems, of course, and both should maintain levels of independence. LSU is distinguished by its mission to provide training for Louisiana's

future health professionals, but even that can only be enhanced by a constructive relationship with the VA. And there is every reason to think that care at the VA will be enhanced through our partnership. At the same time, its limited resources can be maximized.

The collaboration of the VA and LSU in the narrowest view offers the opportunity to solve the immediate facility problem of the two systems in New Orleans. But it also is an enlightened and visionary step that will create a major asset for a rebuilding community and a base from which to better serve the patients who depend upon us.

Some say the devil is in the details, but that does not give due credit to the need to secure financing. I am confident that with the VA we can develop a clear path to collaboration, but LSU and the State of Louisiana face the task of funding the capital costs of their share of the project. Funding capital for projects in the state is not easy, and the demands on the budget in the aftermath of the storms are far beyond our available resources.

Governor Blanco, and legislative leaders, have recognized and embraced the benefits of collaboration with the VA. The media has extolled the virtues of this potential collaborative. Despite so much coverage about what has gone wrong in dealing with the hurricane zone, thoughtful editorials have applauded this effort as a real diamond-in-the-rough. We welcome involvement from other allies. Together we can take advantage of an historic opportunity to improve care for those we serve and help rebuild a major American city.

Thank you again for your interest and for this opportunity to share LSU's perspective on this critical matter.

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

TO THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

IMPROVING ACCESS TO QUALITY CARE FOR VETERANS

MARCH 8, 2006

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
IMPROVING ACCESS TO QUALITY CARE FOR VETERANS

MARCH 8, 2006

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to submit The American Legion's views on improving access to quality care for this nation's veterans through collaboration with affiliated medical institutions and other venues.

The Department of Veterans Affairs (VA) has been recognized on numerous occasions as a leader in providing safe, high-quality health care to the nation's veterans. In addition to setting the public and private sector benchmark for health care satisfaction for the sixth consecutive year, VA has also received accolades on patient safety and quality of care and is considered by many to be the health care model others in the health care field should look to.

While VA has made great strides over the last few decades in improving the quality of care provided to America's veterans, the problem now is timely access to that care. Not only are veterans experiencing long waiting times again, but new Priority Group 8 veterans have not been allowed to enroll since January 2003. Priority Group 8 veterans of all conflicts, who have served their country proudly, are being denied access to the very health care system created to treat their unique needs even if they have the ability to reimburse VA for the care and treatment received.

Veterans serving in Iraq, Afghanistan and all corners of the globe are returning home with severely debilitating injuries and are now faced with new challenges they never considered before. Loss of limb(s), traumatic brain injury, mental conditions, stress reactions, post-traumatic stress disorder, spinal cord injury and blindness are now realities to these young heroes. VA must be there, leading the way, to help heal them and rehabilitate them. VA must be capable of providing the programs and services needed to help all qualified veterans lead the most productive and healthy lives possible.

Medical School Affiliations

The Veterans Health Administration (VHA) and its medical school affiliates have enjoyed a long-standing and exemplary relationship for nearly 60 years that continues to thrive and evolve to the present day. Currently, there are 126 accredited medical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than

thrive and evolve to the present day. Currently, there are 126 accredited medical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than 30,000 medical residents and 22,000 medical students receive a portion of their medical training in VA facilities annually. VA estimates that 70 percent of its physician workforce has university appointments.

VHA conducts the largest coordinated education and training program for health care professions in the nation and medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the nation. Medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology and cutting edge research; VHA research has made countless contributions to improve the quality of life for veterans and the general population.

Collaborations with Affiliated Medical Institutions

For several years VA has used many different types of arrangements to enhance services provided to veterans. These include Outleases, Enhanced Use (EU) leases, Sharing Agreements, which include "selling" space or buying space and sharing of VA and the Department of Defense (DoD) health-care resources.

On December 7, 2005, the Ralph H. Johnson Veterans Affairs Medical Center (VAMC) and the Medical University of South Carolina released the *Collaborative Opportunities Steering Group Final Report.* The group's charge was to conduct a preliminary analysis of potential mutually beneficial sharing options and to consider sharing of health care services between the VAMC and DoD.

The group was formed in August 2005 and met throughout the latter part of 2005 on a regular basis. Veterans' service organization (VSO) representation was notably absent from these meetings. In fact, VSOs had no voice at the table throughout the process. Instead, stakeholders were "updated" through brief presentations over the ensuing months.

In Fiscal Year (FY) 2005, the VAMC paid Medical University of South Carolina (MUSC) over $13 million for services rendered. The two organizations are currently working on contracts to buy costly equipment to share. The report specifically mentions the tomotherapy equipment and two angiography suites for installation in the MUSC facilities. The plan is that once this is negotiated, these items will be purchased this fiscal year and owned by VA, installed in MUSC space in 2007, operated by MUSC, and VA will receive services or billing credit through a sharing agreement in return for the purchase of the equipment. Additionally, the equipment will make state of the art cardiac and cancer care available to veterans, as well as other South Carolinians, treated through MUSC. The American Legion questions the actual benefit this agreement will provide to veterans seeking care. VA foots the bill and MUSC benefits from the state-of-the-art equipment and veterans get to wait their "turn" to use VA health care equipment.

While there haven't been any decisions made as to which model out of the six proposed is going to be selected, Model A got most of the attention. As stated in the report *Model A represents building a new VA facility as the next phase of local construction. In addition to replacing all clinical services in the existing VA facility, inpatient capacity constructed would accommodate additional beds needed by MUSC that had been planned for inclusion in later phases of MUSC's construction. The beds in excess to current VA need would then be leased to MUSC under a long-term agreement. The model also assumed that some VAMC specialty care would be delivered at MUSC through contracts and that MUSC would purchase some services from VAMC.*

The two bed towers would be connected by a shared support services building. This connected space would contain support services like radiology and surgery. The report does not define who would operate the support services. The organization that does not operate it receives their services for their patrons through a contractual arrangement. The thinking is that the sharing would avoid redundant construction of the same space for VA and MUSC in separate locations. So far the price tag is estimated at $546 million plus activation costs.

The American Legion supports sharing agreements, EU's and leasing. However, this "model" goes a step further in that the distinction between the VAMC and MUSC becomes blurred. The American Legion's concerns include:

- Veterans were shut out of the process. They must have a voice in any discussion involving the delivery of their health care.
- VA must maintain control of the facility and veterans must be given priority when seeking services.
- VA has a unique identity and in this model, is in danger of being swallowed up becoming a mere shadow of the bigger facility. The personal touch afforded the veteran through VA will be lost.
- Thousands of soldiers are returning from Iraq, Afghanistan and other places. VA was established to treat the very unique health needs of the veteran population. The private sector cannot even come close to providing needed mental health services to combat veterans. VA must maintain their visibility and expertise in all areas of health care concerning veterans.
- Specialty services such as blind rehabilitation, domiciliary, substance abuse and homelessness are practically nonexistent in the private sector.
- Private sector health care does not have the interdisciplinary teams it takes to handle poly-trauma cases.
- The private sector is far behind VA in terms of electronic health care recordkeeping.
- VA represents a familiarity to veterans who seek care at the VAMC. They are comfortable and enjoy being around fellow veterans.
- Services will be reduced and healthcare needs will go unmet for veterans.

VA and the Department of Defense

Recently, DoD and VA signed an agreement fully integrating the North Chicago VAMC (NCVAMC) and Naval Hospital Great Lakes (NHGL), the first such agreement of its kind. The American Legion is concerned that this is just another step toward making it tougher to distinguish the VA health care system from any other health care system. The lines are blurring rapidly and soon there will not be a VA in North Chicago, rather it will be a "Federal facility" located in North Chicago.

Ostensibly, the planning for the operation of this facility is ongoing. Six national VA/DoD joint work groups will develop working plans and contingencies for the facility through the coming years. They will focus on Human Resources, Information Management and Technology, Leadership, Clinical, Finance and Budget, and Administration functions.

Leadership will be fully integrated. There will be an interagency Board of Directors, Advisory Board, a VA Medical Center Director and a Navy Deputy Director. Their task will be to improve access, patient satisfaction, and timely delivery of services for both VA and DoD patrons. The expected outcomes are improved efficiencies and reducing costs. VA and DoD estimate that this new Federal health care system will be fully integrated by 2010.

Lessons learned over the past 20 plus years about VA and DoD sharing seem to have fallen on deaf ears. There has been minimal success with this type of arrangement. DoD and VA serve very different populations. Force readiness is the number one priority for DoD while VA treats a much older, sicker and poorer population. Concerns about long-term care, mental health capacity and domiciliary are hardly on DoD's radar screen. Similar to the collaboration efforts between the affiliates and VA, The American Legion is concerned that veterans will be the losers in this type of proposition.

Mr. Chairman, while we support the relationship that VA enjoys with both the affiliates and DoD, the American Legion believes, above all else, that VA must remain a separate and distinct health care system.

Thank you again for this opportunity to present the views of The American Legion on the quality of care provided to America's veterans. I look forward to working with you and all of the members of the committee to ensure VA is capable of providing quality health care in a timely manner.

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

March 8, 2006

Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the March 8th hearing, concerning Improving Access to Quality Care for Veterans.

Sincerely,

Cathleen Wiblemo, Deputy Director
Veterans Affairs & Rehabilitation Commission

BIOGRAPHY
CATHLEEN C. WIBLEMO
DEPUTY DIRECTOR, HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION

Ms. Wiblemo has been with The American Legion National headquarters since November 1999. She is currently the Deputy Director for Health Care. Prior to serving in her current position, she was the Assistant Director for Resource Development and before that she served as an Appeals Representative with the Special Claims Unit.

Ms. Wiblemo is a graduate of Black Hills State University in South Dakota, where she received her B.S. degree in History. She was the recipient of a ROTC scholarship and the George C. Marshall award. Upon graduation in December 1984, she was commissioned a 2nd Lieutenant in the United States Army. During her 10 years in the military she served in various positions both in country and overseas. She is currently a Major in the reserves.

During her military service, Ms. Wiblemo received many awards, most notably the Meritorious Service Medal. In August 1999 she received her Masters of Health Administration from Chapman University.

Ms. Wiblemo is a member of Post 176 in Alexandria, Virginia. Originally from Mitchell, South Dakota, she and her son, Zachary, currently reside in Alexandria, Virginia.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 8, 2006

Mr. Chairman and Members of the Committee:

Thank you for inviting the testimony of the Disabled American Veterans (DAV) at this oversight hearing on improving access to quality care for our nation's veterans through collaboration with affiliated medical institutions, the Department of Defense (DoD) and the operation of integrated medical facilities.

You have called a hearing on a very important and timely subject, one that demands a careful level of attention by the Committee, by the Department of Veterans Affairs (VA), DoD and by our community of national veterans service organizations. Initially, we believe it is important to explore and understand the current status of collaboration between VA facilities and their partners in academic medicine, and to further examine questions on the role of integration and cooperation of existing collaborations with the health care facilities and resources of the DoD. We appreciate your including the DAV in this discussion.

As you know, the Veterans Health Administration (VHA) is the largest direct provider of health care services in the United States. The VHA offers specialized care that is world-renowned to veterans with amputations, spinal cord injury, blindness, post-traumatic stress disorder (PTSD) and other mental challenges, as well as traumatic brain injuries. The VA system has been lauded numerous times, and again as recently as the past month, with accolades on its quality, maintenance of safety for enrolled patients and for the comprehensive nature of its approaches to providing health services for America's sick and disabled veterans. Access to high quality, timely health care services is essential for DAV members. Many have suffered severe or catastrophic disabilities as a direct result of their military service. Therefore, preservation of VA's specialized treatment capacities and programs as well as its quality are of the utmost importance to DAV and to our 1.3 million members.

The position of the DAV on the questions of academic affiliations and VA-DoD collaborations are well established and, we believe, well founded. In 2002, the VA was considering its options regarding how to maintain its relationship with the University of Colorado Health Sciences Center in Denver in the face of a significant realignment. The Health Sciences Center, including the medical school and its academic health center, had made a decision to relocate entirely to the site of the old Fitzsimons Army Hospital in Aurora, approximately eight miles from the existing complex, which included the affiliated VA Medical Center next door in downtown Denver. Pending this relocation, VA was examining five options, from remaining in downtown Denver in the existing but renovated physical plant, to a total

integration with the relocated Health Sciences Center in a joint venture at the new Fitzsimons campus. We supported "option four" among the various models under discussion. Option four would build an independent and freestanding VA medical center with services, including some clinical, sub-specialty, support and administrative services being shared with the Health Sciences Center.

Under option four, the VA Medical Center would retain its physical integrity but would be able both to provide and receive efficiencies associated with the co-location with the University Health Sciences Center. We understand the outline of that model is still the primary model under consideration in VA's current planning for Denver, although the site for the new VA medical center has shifted farther from the Health Sciences Center than originally envisioned due to space and land considerations beyond the University's control. We also understand that DoD has made a determination for Buckley Air Force Base near the University/VA site to renovate and improve its own aero-medical clinical facility rather than continue in joint planning with the University and VA. While unfortunate, we defer to the judgment of Air Force officials in having made their decision on caring for future Air Force and military retiree beneficiaries. It is hoped that VA's existing status as a TRICARE provider may become a basis for future sharing of VA clinical capabilities (especially inpatient care) for beneficiaries who use the Air Force clinic.

We understand that VA and the Louisiana State University (LSU) health system are also in discussions concerning collaboration that will likely lead to an examination of some of the same kinds of questions that were explored in the Denver example given. We intend to closely monitor that development to ensure consistency with our position that VA's future facilities in New Orleans be independent and continue to exhibit a recognizable VA presence and physical integrity if built on any joint campus with LSU.

Mr. Chairman, we are also aware of your and Mr. Brown's strong personal interest in pursuing collaboration between VA and the Medical University of South Carolina (MUSC) in a current development opportunity in Charleston, South Carolina. In your press release of December 13, 2005, you announced your receipt of a report from MUSC and VA that would chart a course for a "joint-use hospital [] in Charleston, SC. This facility could provide a model for the federal government to consider when replacing aging VA hospitals." It is our understanding that VA is still considering options for sharing opportunities with MUSC, but that it has not made a final decision related to the proposal of establishing a new facility, which may involve additional shared or integrated services.

While we thank you for your strong interest in this project as a precedent for future VA major construction projects, we at DAV are firm that whatever plan emerges from this work, VA must remain an independent, federally-funded institution with a recognizable presence on any consolidated campus at MUSC. We support sharing and coordination of certain support services such as laundry, janitorial, dietary and joint purchasing of medical supplies and equipment, even joint pharmacy and research initiatives. However, we remain opposed to any proposal that suggests integration of management, staff and medical services. We would not support a collection of VA clinical programs that were "buried" within the academic health center of a State university. In our judgment VA must maintain its distinct identity in Charleston and

elsewhere. We believe that in any joint initiative, VA should maintain a direct line of authority in all areas involving care of veteran patients, including authority to implement necessary safety initiatives, respond to and carry out all congressional mandates, and most importantly the ability to meet the unique health care needs of the veteran patient population it serves.

VA has a vital obligation to protect the VA health care system and safeguard its assets and the specialized programs and services it is required to provide. Any plan that would result in eroding or disrupting VA's specialized programs in geriatrics, blind rehabilitation, mental health, spinal cord dysfunction, amputation and prosthetics and sensory aids, PTSD, and other specialized programs designed for war-injured veterans, we would oppose. Also, DAV would not support a future design that subjugates the identity of the VA facility to that of a university, medical college, university academic health center, or military medical treatment facility. As a general principle, veterans have earned and still deserve to have their own health care system with a discernable identity, facilities, federally appointed personnel, distinct VA policies and governance, and a budget that is independent from that of any collaborator or sharing partner.

One issue we would like to address related to collaborative efforts is VA's Capital Asset Realignment for Enhanced Services (CARES) initiative. We strongly believe the proper and prudent realignment of capital assets is critical to the long-term viability of the entire VA system. At the urging of Congress VA invested a considerable amount of resources in developing its CARES initiative. VA is in the implementation phase of this process and has set priorities for capital asset projects. Given the considerable amount of resources invested in this plan, it seems prudent for VA to carry out its plan in a methodical data-driven manner. With proposed joint ventures, we must also take into consideration the long-standing relationship between VA medical centers and medical schools. There is abundant evidence of the advantages these partnerships provide. The VA's ability to recruit and retain high-quality physicians and the access of veterans to the most advanced medical technology, treatments and cutting edge research are just a few of the unique benefits derived from these relationships. Because of the direct advantages to the veteran patient these affiliations must always be considered in any collaborative initiative VA enters into.

We also support VA/DoD sharing of certain health resources. It is our desire that VA and DoD work toward better collaboration to best utilize scarce medical services resources and improve programs important to all constituencies. At the same time we must remain mindful of the very different missions of the two agencies. The reinvigorated Joint Executive Committee seems to be working well, although in its initial stages, its work was hampered by administrative and fiscal complications that prevented promising sharing projects from moving forward. It appears many of those issues have been resolved and we support joint efforts by both Departments to promote innovative proposals from VA health care facilities and nearby DoD facilities to share resources for better outcomes for sick and disabled veterans and for military beneficiaries as well. We are particularly supportive of information technology initiatives that hold promise for finally eliminating the chronic bureaucratic and technical barriers that prevent a smooth flow of information from DoD to VA in cases of injured active duty personnel who transition from DoD provided care into the VA health care system.

Mr. Chairman, two weeks ago, a new study was released that illustrates how critical VA/DoD collaboration is for our newest generation of combat veterans. Some of the findings in the study raise real concerns for DAV about the ability of government to ensure the mental health needs of veterans returning from Iraq and Afghanistan are fully met. The study was initially reported in the *Journal of the American Medical Association*. Commissioned by the Army, the study reported that more than a third of U.S. Army soldiers received psychological counseling soon after returning from Iraq. The study was based on recently implemented screening protocols that are being used by the Army as debriefing tools to evaluate the physical and mental health of soldiers returning to the United States from their deployments. Army Colonel Charles W. Hoge, M.D. the principal investigator on this project, as quoted in the press, said "[t]here are psychological consequences of war and we want to address those up front. The hope is we won't have as high rates of mental health consequences as we've seen in prior wars." Colonel Hoge also stated "[i]n prior wars, mental health issues weren't studied until years, sometimes decades, after the soldiers came back. For this war, we're doing it differently. Research is influencing policy and we're adjusting policies as the data come in."

The study indicated that 35 percent of Iraq veterans received mental health care during their first year home and 12 percent of the more than 222,000 returning Army soldiers and Marines in the study were diagnosed with a mental health problem. The study showed that nineteen percent of those back from Iraq reported mental health concerns, compared with 11 percent of those back from Afghanistan and 8.5 percent of those returning from other places, such as Bosnia. This study clearly indicates the need for strong collaborative efforts between DoD and VA to ensure the mental health needs of these veterans resulting from military service are expeditiously addressed.

The DAV wants to see collaboration between VA and DoD focus on obvious problems like this one. The DoD report has shown a clear-cut need for close VA-DoD coordination of services to meet this particular veteran cohort's needs for care for the mental and emotional challenges emanating from their unique combat experience in Iraq and Afghanistan. The Federal government must address and embrace its responsibilities to care for veterans of combat. DAV primarily relies on VA for this response, and we and other veterans service organizations hold VA accountable for their work with these special populations of veterans.

The question before this Committee, VA and DoD is: what is the remedy for this kind of challenge? Clearly, in its present state of very tight fiscal circumstances and a full workload, VA could not absorb new demands from tens of thousands of new veteran enrollees in need of acute mental health care services. As a historical footnote, the Committee should be aware that DoD has not generally continued to care for seriously injured soldiers, sailors, airmen and marines beyond their acute care phase. During this phase, DoD generally processed badly injured personnel (including those with serious mental health issues) to medically retired or discharge

status. In other words, DoD generally transitioned these cases along to the VA for completion or continuation of care, physical and vocational rehabilitation, disability compensation, and other VA benefits.

We appreciate Colonel Hoge's views on early intervention and course corrections based on current data from deployed soldiers, but we learned from Vietnam that for some, there is chronicity to PTSD that is not easily recognized or treated, and the scars from the triggering events that set PTSD in motion can remain tender for decades. Clearly, there needs to be a joint effort to reach out to these newly returning veterans early on as well as close oversight to ensure both Departments carry out their appropriate responsibilities. What lies ahead is resolution of the question of dealing with thousands of acutely traumatized and emotionally wounded "new" veterans and the role and responsibilities of the VA and DoD systems of care to collaborate to meet their needs. We do not see a well-formed plan today to address this problem, while an ever-growing number of service personnel and veterans come back from these overseas conflicts. We at DAV see this as a growing urgency for both health care systems and for the Congress.

Again, we thank the Committee for holding this hearing today and providing DAV the opportunity to express our views on these important issues. We hope you will consider our views as you develop policy on collaboration among VA, its university affiliates and the Department of Defense.

DAV DISABLED AMERICAN VETERANS
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FACT SHEET

BIOGRAPHICAL INFORMATION

JOY J. ILEM
Assistant National Legislative Director
Disabled American Veterans

Joy J. Ilem, a U.S. Army service-connected disabled veteran, was appointed Assistant National Legislative Director of the million-member-plus Disabled American Veterans (DAV) on August 24, 2000.

Ms. Ilem is employed at DAV National Service and Legislative Headquarters in Washington, D.C. As a member of the DAV's legislative team, she works to promote and defend reasonable and responsible legislation to assist disabled veterans and their families.

Ms. Ilem began her DAV career as a member of Class III at National Service Officer Training Academy in Denver. Following graduation from the academy in 1996, she was assigned as a NSO Trainee at the National Service Office in Phoenix, Ariz. In 1997, she was assigned as a National Appeals Officer with the DAV staff at the Board of Veterans Appeals in Washington, D.C., where she served until her appointment, as Associate National Legislative Director in April 1999.

A native of Shakopee, Minn., Ms. Ilem was raised in the greater Minneapolis area, and is a 1977 graduate of Totino Grace High School in Fridley, Minn. She earned her bachelor's degree from the University of Arizona at Tucson in 1994, where she majored in archaeology, with a minor in religious studies.

Ms. Ilem enlisted in the U.S. Army in 1982. Following basic training at Ft. Jackson, S.C., and advanced medical training at Ft. Sam Houston, Texas, she was assigned as a combat medic to the 67th Evacuation Hospital in Wurzburg, Germany, where she underwent additional certification as an emergency medical technician (EMT). Ms. Ilem's military duties included emergency room assignments and non-commissioned officer in charge (NCOIC) of recovery room operations. She was honorably discharged from the Army in 1985.

A life member of DAV Chapter 10, Arlington-Fairfax, VA., Ms. Ilem resides in Alexandria, VA.

08/05

DISABLED AMERICAN VETERANS
Building Better Lives for America's Disabled Veterans

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

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STATEMENT FOR THE RECORD OF

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

COLLABORATION BETWEEN

THE DEPARTMENT OF VETERANS' AFFAIRS

AND AFFILIATED MEDICAL INSTITUTIONS

AND THE DEPARTMENT OF DEFENSE

MARCH 8, 2006

Mr. Chairman and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on collaboration between the Department of Veterans Affairs (VA) health care system and affiliated medical institutions and the Department of Defense (DOD). We recognize the importance of such relationships in providing a broad range of services to veterans.

Chartered by the Congress of the United States

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PVA stands committed to finding workable solutions for the delivery of veterans' health care in the areas where there are significant access challenges. We understand that in many locations, collaboration between VA, DOD, and other institutions is essential to providing high quality health care services.

The relationship that VA medical facilities have developed with local medical schools and colleges and universities is essential to the training of professional medical staff. In fact, VA is currently partnered with more than 100 medical schools and more than 1,000 colleges and universities. Each year, about 83,000 health professionals are trained in VA medical centers. More than half of the physicians practicing in the United States had some of their professional education in the VA health care system. Through this collaboration veterans get excellent care, society gets well-trained doctors and nurses, and the American taxpayer pays a fraction of the market value for the expertise that academic affiliates bring to the VA.

However, we still have some concerns about any collaborative efforts that the VA undertakes with non-VA entities. We are adamantly opposed to any agreement that would essentially integrate VA medical center patients into the patient population of facilities that it has established agreements with. We are open to the many collaborative opportunities between VA and other entities, but integrating veteran patients in this manner would fundamentally change the way VA provides care. Since its inception, VA has functioned as a self-contained system providing all aspects of care within its own facilities and with its own employees. Integration could ultimately lead to VA becoming a payer rather than a provider of health care. To this end,

the VA facility should have dedicated space specifically for the veteran population it serves and there should be an open VA presence in any joint facility.

With regards to governance, we believe that VA leadership should have direct line authority and accountability for veterans' health care. The leadership at a VA medical center engaging in a collaborative effort with an outside entity should not be placed in a minority position as a part of this venture. If such an instance occurred, the interests of veterans receiving care through the facility could be marginalized by the other provider. Furthermore, there needs to be a clear understanding of how an integrated system will deal with system-wide directives, handbooks, manuals, and other documents specific to the VA facility. At no time should the activities or information provided through these forms be overlooked by the private or DOD facility.

Similar to this issue is direct management of the system. Currently, line authority exists from the Secretary of Veterans Affairs, through the Under Secretary for Health, to Veterans Integrated Service Network (VISN) directors, and finally down to individual medical center directors. This authority should not be usurped by placing management of a VA medical facility under the control of the affiliated partner.

Likewise, collaborative agreements should ensure that VA facility staff remain federal (VA) medical center employees. If staff were removed from this role, their ability to provide direct inpatient care to veterans would be threatened. They could be transferred to some other assignment within the joint venture.

In any collaborative relationship, the VA must maintain current procedures and policies for the provision of appropriate pharmaceuticals, supplies and prosthetics. Although we do not think this will be a major problem in the relationship between VA and DOD medical facilities, it could be much more challenging with private entities. Because VA and DOD serve very similar patient populations, they already maintain similar policies and procedures in this area. However, private sector policies run the gamut of possibilities.

We have always maintained concerns about joint ventures between VA and DOD facilities. This is not to say that we disagree with the concept because we recognize the value in the departments sharing services and resources. However, although they serve the same basic population, their missions are distinctly different. In any collaborative effort between VA and DOD, the VA must have a fully independent operating status to avoid the problems that develop when a military medical facility finds itself deploying large numbers of its staff to war.

VA also has a responsibility to serve as the backup to the DOD health care system in times of war or national emergencies declared by the President or Congress. The fourth mission also authorizes the VA to serve as support for local communities during emergencies. It is important that any integration between VA and DOD or a private facility address this role to ensure that the VA is able to fulfill its requirements when called to do so.

PVA also has concerns about how veterans could be impacted if they receive services in an integrated facility. Currently, veterans treated in a VA facility have certain recourse and access to benefits if they experience an adverse outcome due to VA treatment. Specifically, 38 U.S.C. §

1151 authorizes monetary benefits to veterans injured during treatment. Additionally, these veterans have legal access through the Federal Torts Claim Act. In an integrated system, there is no guarantee that a veteran receiving treatment from one of the collaborative services provided by the private entity would have these same benefits or rights. He or she would be forced to rely upon the local courts or insurance settlements. This could potentially work to the detriment of the veteran and create a situation where they are precluded from accessing intended benefits.

It is also important that any collaborative agreement establish the role that non-VA physicians and staff will play in performing compensation and pension (C&P) evaluations. The preponderance of C&P exams are conducted in VA medical facilities. Furthermore, the relationship between an integrated system and the Veterans Benefits Administration must be clearly spelled out.

Collaborative activities should also take into consideration plans developed through the Capital Asset Realignment for Enhanced Services (CARES) process. We believe it would be a great waste of valuable resources for the VA to engage in a joint venture contrary to what the CARES plan may already have spelled out for a given area.

Finally, PVA believes that veterans service organizations should be given a role when the VA seeks to establish a relationship with another entity. We have representatives on the ground that see the true effects that decisions made by the VA have on veterans seeking care. We also always keep the interests of the veteran in mind first. Furthermore, the VA and veterans service organizations have traditionally maintained relationships that include office space, site visits and

access for our service officers. We would hate to see this relationship deteriorate or vanish altogether as a result of a joint venture.

Mr. Chairman, we would like to thank you again for the opportunity to submit a statement for the record. We look forward to working with the Committee to ensure that the best services are available to all veterans seeking care. We would be happy to answer any questions that you might have. Thank you.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2006

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $252,000 (estimated).

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $245,350.

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense – $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,000.

DEPARTMENT OF
VETERANS AFFAIRS

Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans

R. James Nicholson
Secretary

February 28, 2006

DEPARTMENT OF VETERANS AFFAIRS

Plan for Re-establishing a VA Medical Center in New Orleans

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DEPARTMENT OF VETERANS AFFAIRS

Plan for Re-establishing a VA Medical Center in New Orleans

1. Introduction

This report presents an analysis of options and a summary level long-term plan for re-establishing a VA Medical Center in the City of New Orleans. It is submitted to Congress in compliance with P.L. 109-148 which includes the following directive: ***"The Department is directed to report to the Committees on Appropriations of both houses of Congress by February 28, 2006 on the long-term plans for the construction of a replacement hospital in New Orleans, Louisiana."*** Although the Congressional directive refers to a

and future VA planned presence in New Orleans.

ran population and funding support and cooperation from state and local officials are all of particular importance - as is the restoration of

proposed Option.

e response to hurricanes Katrina and Rita was highly commendable. However, a great amount of work remains throughout the affected region. While this particular report deals with infrastructure, VA continues to focus on the human element as well - assisting veterans and VA employees with a variety of support programs to hasten their return to a normal life. Their individual problems are indeed formidable.

The principal VA ob ectives regarding the New Orleans area are not only to restore complete service to veterans in the most cost effective manner, but also to aWdM In the CIty'VUeVRUtIRn In the aUeaVRI heaOh care and medical education. Prior to the hurricaneV 9 V0 IF O U URYL UP U V FR U and tertiary care to veterans throughout southeast Louisiana, eastern Texas and western Mississippi. It also supported an extensive program of on-going medical research and training in con unction with L U and the Tulane University chool of Medicine. The VA facility was in fact the primary teaching hospital training over 450 residents and specialists as well as over 900 associate health trainees annually. As such VA had an important role in the medical commun
aspect and the synergy of operating in close pr

The report begins with a summary of VA capabilities in the affected region and the impact of hurricanes an appreciation for VA related hurricane damage rence for the later discussion of the New Orleans Medical Center. Options for re-establishing the fa
concludes that ***new construction of a facility shared with LSU***

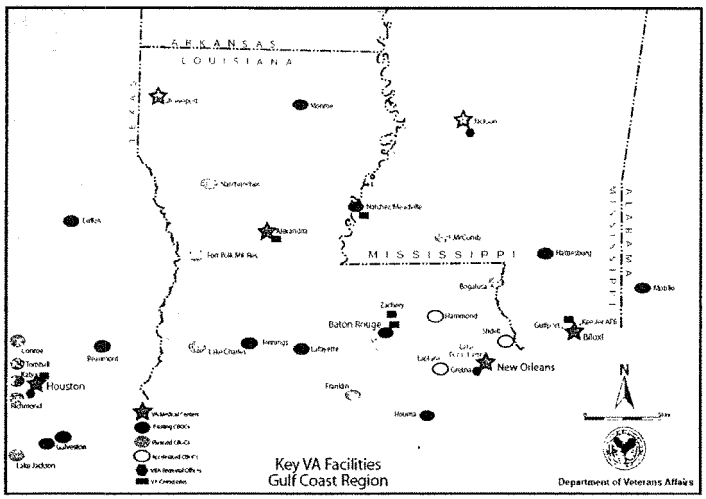
_____ is a summary of a contractor led together with costing summaries of various re-

_____

_____ is a Memorandum of Understanding vision wherein the Parties agree to ointly study state-of-the-art health care delivery options for New Orleans.

cemeteries of the National Cemetery Administration are also illustrated on the graphic.

In this coastal region the two Medical Center complexes that sustained hurricane damage are the Gulf Coast Veterans Health Care System (GCVHCS) in the Biloxi/Gulfport area and VA Medical Center in New Orleans. The most extensive damage occurred at Gulfport followed by severe flood damage at New Orleans. The following provides a short summary of hurricane damage to VA facilities in this area.



2.1. Summary of Damage to VA Facilities in the Region

On Monday August 29, 2005 hurricane Katrina made landfall along the Gulf Coast with hurricane Rita following less than four weeks later on September 23. Damage to VA facilities in the Mississippi and Louisiana coastal areas was extensive and is summarized as follows:

- Biloxi – Medical Center at Biloxi this complex weathered the hurricane well and remained fully operational. All building systems, with the exception of emergency communications, continued to function normally during and after the hurricane. Damage at Biloxi included the asphalt shingle roofs on several buildings, window panes, seals and gaskets, doors and interior finishes, and some damage to electrical and

  pines on the campus as well as to facility signage.
- Gulfport – *only 8 miles from the Biloxi Medical Center*
  destroyed or made irreparable most buildings on the campus. Only the boiler plant and laundry

  complex housed inpatient and outpatient mental health programs, substance abuse treatment programs, long-term care, primary care and specialt
  housed engineering and facilities management functions, billing and fee operations, long-term sition activities. Prior to

  Gulfport complex was a significant disaster. Patients were relocated to other VA facilities in the region and throughout the country.
- New Orleans – At tKe Cltry Rf New 2 U@DnV. DtUnD hit land at 6:10 AM as a Category 4 hurricane with recorded sustained winds as high as 175 mph. The previous evening, 28 August, the New Orleans Levee Authority lost power to most pump operations. At about mid day on 29 August, the New Orleans levee system, that normally holds back storm flow from Lake Pontchartrain, incurred multiple breaches of several sections as a result of rising storm surge @YeQ TKDt eYenlng, tKe 'eye' was directly over the VA Medical Center with reported 100 mph winds. The flood that followed crippled VA Medical Center, the entire City of New Orleans, and VuURunCing SDUNKeV 6eYeUt f@RCing FDuVeG extenVYe CDP Dge tR 9A 0 eGFDOCenteU– P RUt detail on damage to this specific facility is presented in Section 3 below. The other key VA facility in New Orleans that sustained damage was the Veterans Benefits Regional Office. This office was located in GSA leased space in the New Orleans Postal Office Tower building. Severe flooding caused the office to be vacated.
- Cemeteries – 6 Y UDO9 P UL VD@ K FRDVal area also sustained damage to grave markers, trees and shrubbery and were also littered with debris.

2.2. Summary of Reco ery Ste s in the Region

Clearly many of the patients that had been using VA facilities in the region are now among the evacuees that have been relocated to other parts of the region and the country. n anticipation of their return, and to continue support for those who remained, VA has taken several actions to restore service in the area refer to Figure for specific locations :

- Biloxi – K FR VUF lR R D KRVSLDO KD was already planned as part of the CARES program is being accelerated. his project also includes a potential partnership with the USAF at Keesler AFB - at least with respect to continuation of Graduate Medical Education GME - a key concern of the Air Force. From a medical education standpoint the University of Mississippi is also very interested in VA recovery activity in Biloxi.

DEPARTMENT OF VETERANS AFFAIRS

Plan for Re-establishing a VA Medical Center in New Orleans

- Gulfport –

  ing established on the Gulfport
  trailers has already been establi\heG\theU\e – the\s t\bi@\V\o\U\e Furrently being used to house VA employees and patients.
- Baton Rouge - Capacity has been increased at the CBOC in Baton Rouge with the lease of the former clinic space to accommodate administrative operations for New Orleans.
- North and west of Lake Ponchartrain CBOCs are being established at Laplace (in leased space temporarily pending donation of land for a modular building), Hammond (also a modular building), and Slidell (in leased space). The modular buildings VA will be using are pre-

  electrical wiring co ponents circuit breakers and heating and cooling outlets
- Gretna LA - A te porar Regional Benefits facilit has been established in Gretna Louisiana (60 000 S Ft and 125 parking spaces) about ten iles to the west of downtown New Orleans
- In the existing New Orleans VA co plex a pri ar care clinic has been opened in space available above the adjacent parking structure - li ited specialt care will be available shortl
- Clean-up work at VA ce eteries also continues

Fro the standpoint of outpatient edical care the above actions will acco odate the anticipated patient workload in the near ter owe er inpatient care will not be a ailable in the i ediate

This is the principal issue regarding full VA recovery in the New Orleans area

3. VA Medical Center, New Orleans

The New Orleans VA Medical Center (NOVAMC) is located in Orleans Parish about six miles South of Lake Ponchartrain and a mile west of the Mississippi River as indicated by the star in the upper section of Figure 2. Part of a four-hospital complex, as shown in the lower portion of the figure, it is the major VA

This medical center has a critically important role in caring for patients throughout Southern

Currently about two thirds of the patients previously being cared for in this facility have been seen at other VA Medical Centers. Those remaining in the area are being served by the

positions were allocated to the medical center.

and other allied health students were trained at the medical center. There were also nursing and D

of South Alabama, University of Phoenix, University of Mobile, University of Louisiana at Lafayette, University of Southern Mississippi,

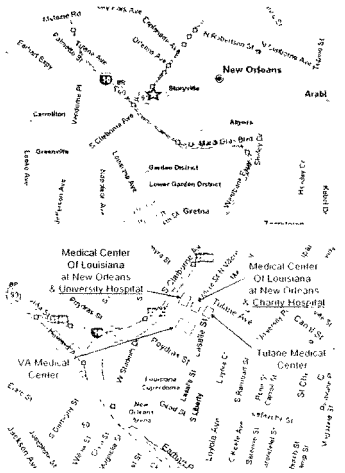


Figure 2. NOVAMC - Location

The medical center also had affiliations for physical therapy with Bishop State Community College, and
and University of Louisiana at
SUNY at Buffalo, Emory University, Texas Tech
rk with Florida State University, LSU at Baton Rouge,

and Southern University of New Orleans.

Affiliations with Tulane University were in place for audiology/speech pathology with LSU at Baton Rouge and New Orleans and University of Florida; for recreational therapy with Grambling State University; for ophthalmology, respiratory care, radiology, and nutrition/food with Delgado Community College; for dental hygiene, cardiopulmonary science, medical technology and physician assistant with LSU; for medical technology and respiratory care with Nicholls State University; and for nutrition/food with Southern University in Baton Rouge. Through sharing agreements there was collaboration in the areas of Radiation Therapy and Professional Radiology Services.

The medical center also had a well funded research and development program, including studies in such diverse areas as hypertension, heart disease, kidney disease, prostate cancer, schizophrenia, PTSD, Alzheimer's Disease, and more. All of which enhanced the ability to provide state-of-the-art medical techniques and treatments to veteran patients. The medical center was also the home of the Mental Illness Research, Education and Clinical Center (MIRECC) for VISN 16. A facility of significant importance to veterans, as well as to the extensive network of medical affiliates mentioned above, VA medical C is supported by the demographic analysis presented later in this paper.

_____) occupies approximately 10-acres which is bounded by Perdido Street on the south (the main visitor entrance), Gravier Street on the north, and Freret Street to the east. Across Gravier Street to _____). This was another facility severely damaged by flooding. The western campus property line is shared w of Administrators. Elevation of these facilities is

The NOVAMC medical center includes

- ***Building 1*** – vintage construction consisting of 11-stories above grade, plus a basement level, a sub-basement level, and two above-roof equipment penthouse levels. This building originally included Quadrants A, B, C, and D (Figure 3), and has undergone numerous renovations to include the addition of Quadrant E - a 6-level plus basement infill connecting building 1 to Quadrant F (the Clinical/Research addition). The hospital is currently licensed (pre-Katrina) as a 450 bed acute care facility.
- ***Building 2*** – ThtV IVD 6-VRUy SQVSDUIDCEDVeP ent IDFIQy, originally constructed in 1949 as a facility manager and VDII nuUeV TuDUeUX ,t IVGetDFheG IURP the P DIn hRVItDO and recently served as administrative space.
- ***Clinical Addition (Quadrant F)*** – ThtV 9-VRUy SQVeTutSP ent penthouse facility was constructed in 1982, along with the connecting link to the original main hospital. This portion of the facility supports major research functions.

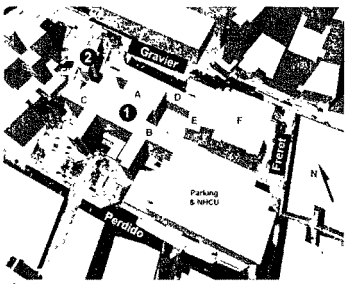


Figure 3 NOVAMC - Buildings

- ***NHCU and Parking Garage*** – ThtV 11-VRUy 1990-YlntDge IDFIQy InFQCeVD P uQL-VRUy SDUNng VUiFtuUe DtRS RI which is a two-story 120 bed Nursing Home Care Unit (NHCU).
- ***Boiler Plant*** - A 1950-vintage two-story central boiler plant is located on the northeast portion of the campus along Frerer Street.

As stated earlier, severe flooding associated with hurricane Katrina began in this area late in the morning of August 29, 2005, when portions of the New Orleans levy system collapsed. Buildings in the complex sustained extensive damage which worsened over time when the flood waters failed to recede (N/ introduction illustrates the se

area around the medical center, including the basement and sub-basement of the main building - th

complex for a long period of time the mildew and mold continued to spread creating unacceptable conditio
damaged delicate medical instrumentation throughout the facility - similar conditions were experienced in the neighboring hospitals illustrated in Figure 2.
2005 when a primary care clinic was established in the tenth floor of the former Nursing Home (NHCU) building where the parking garage also exists. In March of 2006 a specialty clinic will open in the 9th floor NHCU.

3.1. The Need for a VA Medical Center in the Vicinity of New Orleans

he demand from the initial CARE process culminatin K 6 FU Uy
pro ected gaps in inpatient and outpatient care. hese pro ections are still valid despite evacuations of _____ of
this report provides more detail on this very important issue and concludes that over the long term, a significant percentage of veteran evacuees will return to the catchment area resulting in very little

increasing - the data in the table below compares cumulative uni ue patients seen in New Orleans and its associated clinics this year and the last two years. hile the numbers were down significantly in October the rate of increase has been accelerating such that by anuary the numbers were approaching U V R OV y new clinics are ust starting up, and housing is still limited, this is a clear indication that wor load is gradually returning to previous levels.

New Orleans Unique Patients FY 2005 Compared to FY 2006 by Month				
Months	*October*	*November*	*December*	*January*
FY0	2 ,2	26,906	29, 6	0, 6
FY05 Pre Katrina	2 ,259	29, 98	,65	, 8
FY06 Post Katrina	6, 8	0,602	,52	2 , 26

Based on the demographic analysis in Attachment B, and observation of actual workload in the last few months, a basic assumption in this report is that there will be somewhat fewer but sufficient numbers of veterans with a reasonably high "utilization rate" to justify the re-establishment of a hospital either in, or close to, the City of New Orleans.

3.2. Options Considered

Four options for re-establishing a VA Medical Center in the vicinity of New Orleans were considered:

Option 1	Restore and Hurricane Harden the Existing Medical Center
Option 2	Renovate and Remodel the Existing Medical Center
Option 3	Construction of a New Medical Ce
same	general area
_____	C
	higher ground on a site yet to be determined

Common assumptions or considerations that will affect all of these options in varying ways are provided
tion are included in the discussion below for each

- _____

  Attachment B

  ssumptions of increased demand - to include some evacuees from the city resettling in surro
- _____
- _____
- Relationship with Affiliates: Affiliates are committed to VA (and vice versa); relationships will be established in the region with priority tR a "VhaUHd VHUYiFH' P RdHOn thH City.
- Availability of Qualified Workers: Although there has been some concern that the medical professional/service workforce may choose to permanently relocate outside the metropolitan area recent indications are more positive. Given the continued improvements, it is assumed that by the time a Medical Center is re-est

  employees during and after the hurricane as well as the commitment to return a full range of
- _____
- Other VA Activities ill be made for both the Veterans Benefit and the National Cemetery Admi

Estimated costs are included for each of the options but these continue to be re

ons described below are the most recent reported by
on these is provided in Attachment A

3.2.1. Option 1: Restore and Hurricane-Harden the Existing Medical Center

General Description

In this option VA would re-establish the existing Medical Center by restoring it to a condition similar to that before the hurricanes. Steps would also be taken to better protect the facility from severe flooding. For example, all critical and sensitive equipment would be moved to higher floors and lower floors would be used for less critical activity (parking, non critical storage, etc.). All damage to equipment and interior finishes from the effects of very high humidity over a long period of time (mold, etc.) would be repaired to the extent possible. More detail regarding this option is included in Attachment A under Option A.

Critical Assumptions Specific to this Option

- Hazardous conditions for a medical facility (like mold and difficult to detect contamination) can be effectively removed.

VA Potential Cost

- Approximately $225M

Pros

- Option 1 has the lowest initial cost.
- No site selection required; potentially the quickest way to re-establish a VA Medical Center in New Orleans (24 months to 3 years)

Cons

- Although the facility would be better protected from flood damage, it would still be located in the flood plain where accessibility could be difficult if flooding occurred again.
-
- Since the repair would not involve any extensive modernization, recurring operating costs would be similar to that prior to Katrina.

Issue

- Successful cleansing and disinfecting the hospital complex is the principal issue for this option.

3.2.2. Option 2: Renovate and Remodel the Existing Medical Center

General Description

VA would re-establish a medical center by renovating and remodeling the current facility. The complex would be restored as per Option 1,

es from the effects of very high humidity over a long

remodeled to accommodate a different modus operandi. For example as in Option 1 all critical and sensitive oors and lower floors would be used for

eering and food service infrastructure would be placed

the first floor level as well as the construction of

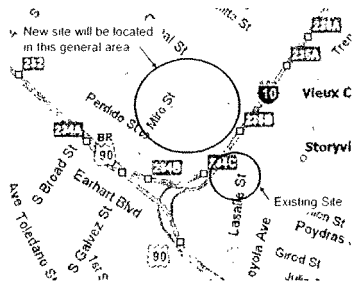
_____ could also include the addition of two more floors - this would depend on a more detailed engineering assessment. More detail regarding this option is included in Attachment A under Option B.

- effetely removed.
- Although more time consuming than Option 1 also lead to re-establishing the Medical Center

Cons

- Although the facility would be better protected from flood damage it would still be located in the flood plain where accessibility could be difficult if flooding occurred again.
- complex is the principal issue for this option.

3.2.3. Option 3: Construction of a New Medica



-
-
-

VA Potential Cost

-
-
-
-

Cons

-
-
-
-
-

3.2.4. Option 4: Construction of a New "Stand Alone" Medical Center Hospital on Higher Ground

General Description

regarding this option is _____ _____.

Critical Assumptions Specific to this Option

- Congressional support for a sufficiently large VA supplemental is obtained.

Potential Cost

- Construction estimate is approximately $645M

Pros

- This facility would be secure and fully accessible regardless of flooding.
- Since it would be based on a modern design, operating costs would be lower than with the current building.

Cons

- Initial cost would be high.
- An exclusive site for VA would have to be purchased.
- 6epatUtiRn fURP affiGateVwRuGd tend tR FRP pGate any "VaUng/VppRU" aUUngeP entV
- Would send a mixed signal to those trying to re-vitalize the City of New Orleans.

Issues

- Adequate funding and "appURYaOtR Ue-GFate Rut of the City proper are the principal issues.

3.3. Evaluation of Options

Key consideration in evaluating the above options are the condition of the existing hospital, the initial investment and 20 year operating costs, and the synergy gained from affiliation with other medical facilities.

3.3.1.

Both ***Options 1 and 2*** focus on repairing, or completely renovating/modernizing, the existing facility. These courses of action rest heavily on the ability to completely remove all mold and contaminants in the hospital building. ***A key observation from the engineering assessment (summary at Attachment A) was that the greatest perceived enemy to complete recovery to full-functionality is the post-flood high humidity conditions and resultant spread of mold, mildew and other bacteria.*** The basement floor structure was submerged temporarily in a saturated condition for approximately 2-1/2 weeks before the water was pumped out. The sub-basement was submerged somewhat longer. Water contact by submersion for such a time period would not affect structural integrity. However, the pollutants within the floodwater could have an undesirable effect on the long-term durability, appearance and smell of the concrete surfaces. Concrete masonry walls and clay tile in these levels that were submerged would require complete removal due to the probability that contaminated sewage laden floodwater penetrated into the cores through mortar joints as a result of hydrostatic water pressure. This trapped polluted water would be nearly impossible to ever completely remove, and its retention and on-going leaching through the wall systems would be untenable. Another major area of concern lies with the air conditioning ductwork throughout the facility. All air-handling equipment and most ductwork located in the basement and sub-basement levels was completely submerged in the polluted floodwater. All such equipment and ductwork would have to be removed from the site. A related problem with the damaged air-handling equipment and ductwork is that several of these submerged systems were dedicated to serving first floor clinical and other functional areas. As such, not only are these first floor areas currently without air-conditioning, their associated ductwork, which traverse between these two levels, continue to be subjected to mold/mildew and other bacterial contamination. This is due to the fact that the contaminated ductwork originating from VAH

flourish. The extensive evidence of lingering mold and contamination is a major concern. VA officials do not have a high degree of confidence that complete elimination of this contamination is possible.

Reuse of the existing complex may be acceptable for a non medical facility but not for a hospital with patients susceptible to infection. ***he options addressing the e isting facility are deemed too risky for future patient care and are unacceptable the epartment.***

3.3.2.
Both ***Options 3 and 4*** require new construction that would result in modern, highly efficient facilities. The long term cost of each option (consisting of the initial investment and anticipated operations and maintenance costs over a 20 year period) would likely be more favorable. The table below provides a summary of data from the Engineering Assessment (Attachment A). This information continues to be refined but in general supports new construction Options (3 and 4) as being more economical over the long term.

($ M)	Construction	Utilities (20 Year)	Maintenance (20 Year)	Operations (20 Year)	Totals
Option 1	$288	$133	$443	$4,074	$4,938
Option 2	$622	$35	$130	$4,074	$4,861
Option 3	$636	$42*	$155*	$3,666*	$4,499*
Option 4	$645	$42	$156	$3,666	$4,509

* **Note:**

Option 4 calls for new construction on higher ground, but it does not appear likely the other hospitals

e federal government.
Recently there have been clear signals from state and federal authorities that New Orleans will be

arrangements can be coordinated and a more effective medical environment established. This
is likely to be the
most of the new construction options because it will be a facility providing the added
benefit of co-location. The of this course of action is attractive to VA (as well as to

VA is a leader in patient safety, disease management, health promotion, customer satisfaction, and

and clinical delivery of services in areas such as cancer care, cardiovascular diseases, epilepsy and
ared campus model will leverage these strengths,
providing quality, cutting-edge health care for all beneficiaries, VA and non-VA. As an employer of

VA believes that a new facility can, and should, be built within the City proper. This approach will provide added emphasis to the commitment of bringing New Orleans back to full functionality and it can be hurricane hardened to preclude a reoccu
sk associated with removal of mold and other
tion is believed necessary. The new construction
option with the most attractive cost effectiveness is ***Option 3***

4. VA Approved Plan

Option 3, the construction of a new Medical Center as a shared facility, will re-invigorate the medical care environment in and around New Orleans. The general geographical area for this new facility was illustrated in Figure 4. A summary description of the planned complex is provided in the paragraphs below.

4.1. Key parameters of new facility

The single campus would include separate, autonomous bed towers and outpatient clinical space for both VA and the Medical Center of Louisiana/New Orleans (MCOL/NO). An illustration of the envisioned complex is provided in Figure 5. All critical electrical, mechanical, and sensitive systems will be located in the upper floors to reduce the risk of flooding damage.

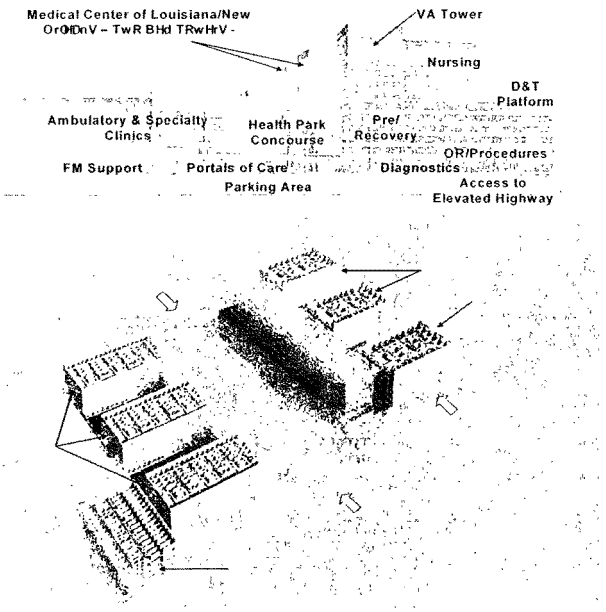


Figure 5: Notional Schematic of Option 3 – "Shared Facility"

Common areas would provide space for shared non-clinical support services such as parking, food services, laundry, energy and utility management, and helipad. Separate, though contiguous, diagnostic, major therapeutic and interventional areas such as laboratory, radiology, catherization labs, and operating suites, would be built for both VA and the MCOL/NO.

an elevated highway would also be part of the

Additional key parameters/capabilities to be

-
  -
  - 12,000 SF Central Plant Building
-
-
  - to serve both VA and MCOL/NO sections of the complex. For VA 30% of the total shared system cost is included in VA cost estimate for Option 3.
  - sized to accommodate the fire sprinkler system.
  -
  - Protection of Sensitive E uipment he following co recorded atrina flood plain
    - Chillers
    - Air andling E uipment
    - Boilers
    - elipad
    - Elevated Roads
    - ater and Sewage Storage Facilities
  - Boat ock A boat dock will be provided in the vicinity of the loading dock.
  - Foundation integrity eep pile foundations per geotechnical recommendations will be used.
- Numbers of inpatient beds Appro imately 200 per VA 200 CARES program, or as determined by
- Numbers of nursing home beds Appro imately 60 Beds
- Special Facilities/Programs
  - Rehabilitation Medicine
  - Medical Surgery
  - ialysis
  - Cardiac Surgery
  - RP V 76
  - P S
  - Mental ealth
- Parking facilities
  - 00 Elevated
  - 2000 Surface
- Administrative Space n accordance with the 200 CARES program, as ad

4.1.1. Estimated Timeline

An estimated macro timeline, based on experience with similar construction, is provided at Figure 6 below:

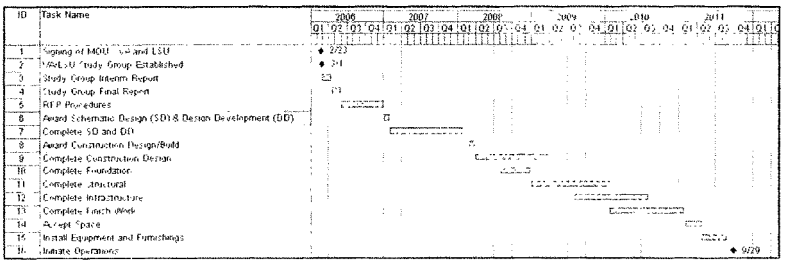


Figure 6: Estimated Macro Timeline.

4.1.2. Cooperative Arrangements with Others

Key to the success of a shared complex are the details concerning the day-to-day working arrangements and legal documents associated with a meaningful partnership. In this regard discussions have been on-going for several months but reached a critical point on February 16, 2006, when VA hosted a meeting in New Orleans. The purpose of this important meeting was to discuss ways in which VA and LSU (also other affiliates) could collaborate in providing quality, efficient healthcare in a mutually beneficial way to their individual constituencies.

In addition to VA representatives, the meeting was attended by representatives from the State of Louisiana, the Louisiana Recovery Authority, LSU, Tulane, Department of Health and Human Services, FEMA, and Congressional Staff (Sen. Landrieu and Rep. Baker). The office of Federal Support for the Recovery and Rebuilding of the Gulf Coast Region also was informed and provided with a complete brief.

VA and LSU both agreed to draft and sign a Memorandum of Understanding (MOU) that would create a ***"Collaborative Opportunities Study Group"***
wDV included as Attachment C to this report. As indicated in the above schedule, this MOU initiates the important work to define the scope of the new facility. This information will be used for more extensive schematic and construction designs.

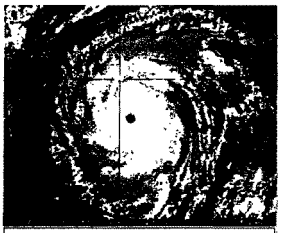
achieve a mutually beneficial outcome. If for any reason a permanent, collaborative solution cannot be attained, the results of the study will be invaluable to VA in reaching an independent determination on KRw

if an independent determination is ultimately required.

5. Conclusion

The Department of Veterans Affairs, together with the Louisiana State University Health Care Services Division, is committed to creating a modern, 21st century medical complex in the City of New Orleans. The need for a continued VA presence is supported by the latest demographic projections and the most favorable option for re-establishing this presence is the one which provides the maximum potential for sharing and leveraging a variety of medical capabilities. In the months ahead the plans for this modern complex will continue to be defined with the objective of initiating schematic design in early 2007.

VA values its affiliations with medical universities, medical schools and public and private healthcare facilities and views this initiative as a unique opportunity to re-establish world class care to veterans in the region, redefine the relationship with important affiliates, and assist in re-invigorating the healthcare environment in the City of New Orleans.



Hurricane Katrina – 29 Aug 2005

Executive Summary

LEO A DALY was commissioned by Facilities Management on 24 September 2005 to both provide an initial (expeditionary level) assessment of the New Orleans VAMC hurricane and related flood damage attributable to Hurricane Katrina, and to develop ROM cost estimates for various build-back options. Our assessment team conducted on-site observations between 26 through 29 September 2005, led by Randall S. (Randy) Braley, COTR (Facilities Management), and facilitated by Phil Boogaerts, a New Orleans VAMC facility engineer.

To accomplish the above task, this Executive Summary has been built with a three part structure:

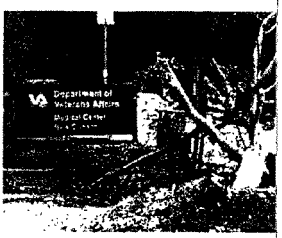
Part 1: Contains a Damage Assessment Report documenting the physical impact of Hurricane Katrina to the existing VA Medical Center in New Orleans.

Part 2: Contains Recommendations in the form of an Architectural Narrative which outlines four design options for providing VA Services to the New Orleans Region. The four Design Options provide progressive improvements as follows: A: recapture and harden the existing facility, B: provide full renovation to the existing campus, C1: build a new stand alone replacement facility on a new site and C2: build a new facility which will potentially be shared by the VA and the Medical Center of Louisiana on a site donated to the VA by the State of Louisiana.

Part 3: Contains Rough Order of Magnitude (ROM) Estimates quantifying Construction, Development and Basic Operational Costs for each of the four design options.

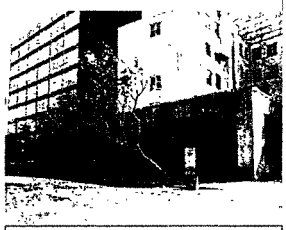
Part 1: DAMAGE ASSESSMENT REPORT:

The following was observed and is recommended.

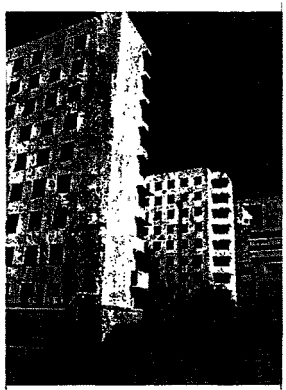


a) General Condition Status: Aside from a single VAMC staff engineer, and a contract electrician, the only VA presence on-site was a rotating shift of armed VA elite police officers charged with protecting the campus assets against theft, break-in and vandalism. The building was virtually uninhabitable due to complete lack of air-conditioning with indoor temperatures variously approaching the low 90's (degrees F) and pervasive post-flood stench. Extensive mold propagation had already occurred in the flooded Basement and Sub-Basement Levels of the VAMC and Level 1 of Building 2, and was suspected as migrating up the unprotected elevator hoistways and utility shafts of these buildings due to stack effect. Floodwaters had been mostly pumped down with the exception of the Basement Level of Bldg. 2, approximately 4 to 6 inches in the VAMC Basement, and approximately 1-foot of water in the Sub-Basement. No apparent structural damage was observed.

b) Building Exterior (General): Floodwater detritus and filming stains have occurred around the entire facility perimeter at the lowest exposed level. Miraculously, approximately only a dozen windows in various locations, an entrance canopy, and some building signage were destroyed. The various roof levels appeared to have weathered the hurricane without notable damage; however, the tar and gravel built-up membrane is aged such that it may not survive another major storm. Extensive power washing, and various limited refinishing/replacement work are required to restore the perimeter wall systems and grade-level architectural components.



North Exposure – Generator Bldg.



Building 1 – West to East View

c) Landscaping: All exterior landscaping at street level including lawn, shrubs and plants were either dead, or in the process of dying due to effects of toxic floodwater immersion. All vegetation and the underlying soil beds require complete replacement.

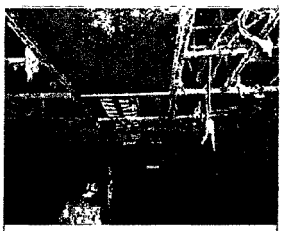
d) Building Interior (General): Aside from a general deplorable state of sanitation on all VAMC levels due the temporary housing of post-hurricane refugees, there was no immediate observable physical damage to the VAMC interior (sans the Basement/Sub-Basement) due to the hurricane itself. However, the complete lack of cooling and dehumidification precipitated elevated interior space temperature and relative humidity conditions conducive to mold/mildew growth, as well as create an environment that facilitated latent damage to architectural materials and finishes, especially wood, drywall, ceiling and floor finishes. Minor rainwater damage had occurred in a few selected perimeter rooms wherein either exterior window breakage or roof leakage had occurred. The entire Ground (entry) and partial Basement levels of Building 2 were completely destroyed by flooding, as were the entire Basement and Sub-Basement levels throughout the VAMC.

e) Emergency Generators: The emergency diesel generators and their associated underground fuel storage tanks and switchgear were not affected by water intrusion, however, flood water levels were dangerously close to entering these spaces. If this critical equipment is to remain in this location, then effective means to prevent flooding need to be implemented.

f) Lighting & Power: Limited power and lighting services have been continuously available throughout most areas of the VAMC due to operation of the emergency generators and temporary connections to selected critical basement level equipment. One of the two utility service entrance feeders was restored immediately prior to our team's arrival on-site. Normal power to Quadrant D is currently not available due to the loss of a Basement Level substation due to flooding. All power to Basement and Sub-Basement Levels had either tripped and/or had been subsequently locked-out for safety reasons due to the continued presence of floodwaters in the lower levels. Building 2 power was not capable of being re-established. Permanent power restoration to Quadrant D and Basement/Sub-Basement Levels will entail long-lead restoration design and implementation work.

g) Elevators: All elevators were locked-out of service for safety reasons. Although elevator machinery, located in VAMC roof penthouses, was not damaged; the hoistways, including a few cars, remained partially submerged in the lower levels. These cars will require replacement. Hoistway landing doors were in the process of being boarded/taped-off in an attempt to minimize mold/mildew and contaminated air propagation throughout the VAMC due to stack effect. All submerged hoistway equipment requires cleaning or replacement. Associated masonry walls require replacement due to the inability to mitigate the long-term effects of the contaminated floodwater submergence.

h) Steam Boiler Plant: Floodwaters had partially submerged boiler control panels, rendering the plant inoperable. Aside from other superficial damage, the boiler plant generally survived Katrina. Nonetheless, once restored to service, should it remain in its current at-grade level location, exterior hardening is required, as is a general replacement of its failed and aging equipment.



Typ Basement Corridor (Bldg. 1)

East Basement Areaway (Quad F)

i) Food Services: The entire food services department, including kitchen equipment and walk-in refrigerated cooler and freezer cases, were totally destroyed by contaminated floodwaters. This service area should not be replaced in the Basement. Food service restoration is recommended.

j) Medical Gas Systems: All medical air compressor and vacuum pump stations and their associated piping systems located in the VAMC Basement and Sub-Basement levels were destroyed by flooding. Only one air/vacuum station, servicing Building G (Nursing Home Care Unit) and the bulk oxygen storage and vaporizer station, survived Katrina. All flooded equipment and piping requires replacement and the entire medical air and oxygen systems require re-certification testing for NFPA and JCAHO compliance assurance prior to permitting reactivation of any in-patient beds.

k) Plumbing Systems: Floodwaters submerged all domestic water booster pumps, sewage lift stations and sump pumps in the Basement and Sub-Basement Levels, rendering them inoperable. Consequently, no potable water or toilet flushing was possible. All submerged pumps of a non-submersible design, including their controls, require replacement. As an interim stop-gap measure, certain Basement and Sub-Basement submersible sump pumps were in the process of having their motors replaced to permit temporary 'jerry-rigged' manual operation.

l) Chiller Plant: The entire VAMC 3200 Ton Basement-located multi-chiller plant, with its associated pumps, treatment and controls is deemed a complete loss due to extended submergence in the post-hurricane floodwaters. The associated roof-mounted cooling towers appeared to be unscathed by the hurricane, but were nonetheless inoperable due to the loss of the remainder of the chiller plant. As this engineering plant infrastructure is critical to facilitate VAMC operations, and is both cost intensive and carries a long-lead replacement time, its in-kind replacement in the Basement is not recommended due to the future potential for a recurrence of flooding. Temporary restoration of chilled water service was being investigated with ENTERGY, a local district chilled water service provider, having an undamaged plant located directly north of the VAMC campus. *(Subsequent to our assessment, the VA contracted with ENTERGY to provide the necessary Basement piping infrastructure tie-ins, and a temporary (or potentially long-term) service for chilled water had been established in mid-December, permitting VAMC air-conditioning to be restored.)* Should the chiller plant be replaced, it should be located in a new hardened and elevated facility on the VAMC campus to preclude its future loss should another flood event occur.

m) Fire Detection and Alarm System: The central equipment for this system was lost to Basement flooding. As key replacement components for this currently outdated system are no longer available, the fire detection and alarm system will require complete (long lead) replacement throughout the VAMC. Until this critical life safety system can be replaced, the facility is not deemed safe to permit reactivation for in-patient bed use.

n) Fire Sprinkler Protection System: The building fire pumps and controllers were completely submerged in floodwaters. A subsequent temporary (non-code compliant) power feed, 'jerry-rigged' controls, and motor replacement have afforded the main fire pump to function. However, this equipment requires complete replacement and restoration of permanent code-compliant power feeder service at the soonest opportunity.

Kitchen Stove / Steam Kettle Lineup

o) Heating, Ventilating & Air-Conditioning, Heating (including Automation Controls): With the complete loss of the building automation and control system hub, due to Basement flooding, all surviving HVAC equipment was/is non-functional in an automatic mode. There was no functioning air-conditioning during our survey, save some portable jerry-rigged window air-conditioners in a few select spaces. All air-handling equipment, ductwork, piping insulation, and various components in the Basement and Sub-Basement levels is a complete loss. As a portion of the flood-damaged systems previously served VAMC Level 1, this level additionally will be without air-conditioning service for a considerable time, until replacement can be afforded, preferably in a reconfigured Level 1 (or higher) location. Mold/mildew and bacteria sampling by an industrial hygienist has revealed that all Level 1 (and lower) ductwork requires replacement, as well as all ductwork on Levels 2 and higher requires cleaning by an NADCA certified commercial duct cleaning contractor *(cleaning subsequently contracted and in-progress as of this writing)*. The building automation and controls systems requires an in-kind replacement of all flood-damaged infrastructure, again preferably in a new (higher)VAMC location (TBD) not prone to future flooding.

Part 2: ARCHITECTURAL NARRATIVE:

This Narrative outlines the effort required to return the V. A. in New Orleans to a Healthcare capacity equal to or exceeding Pre Katrina capacities. The four Design Options provide progressive improvements as follows:

1. Option A, Space Recapture/Hardening;
2. Option B, Existing Campus Renovation;
3. Option C1, Stand Alone Replacement Facility on New Campus
4. Option C2, Potentially Shared Campus Facility

The four Options, described below, will benefit from the following common improvements:

- All Engineering Services for Power, Water, Sewer and HVAC will be contained in a Central Plant Facility hardened and elevated to protect against future Cat 5 hurricane damage.
- Back up Power, Water, Sewer and HVAC systems will be enhanced or replaced in Options A & B and built new in Options C1 and C2. All Options will provide 8 days of service after disruption of the City's infrastructure during a storm event.
- A helipad will be provided in all options to accommodate emergency access by air.
- All exterior glazing will be designed to withstand code defined wind and debris damage from future hurricane events.

Utility, Operation and Maintenance Costs for all estimates were based on the following criteria:

- Staffing cost model derived form historical salary information from similar size and type of government medical facility. The costs have been escalated at 3% per annum for 30 years.
- Utility Costs projected to be 30% of of Maintenance Costs and escalated at 3% per annum for 30 years.
- Maintenance Costs projected to be 2% of Direct Construction Costs and escalated at 3% per annum for 30 years.

- The Utility, Operation and Maintenance Costs for Option C2 will continue to be refined to capture additional savings possible from a more comprehensive strategy for sharing of departments, staff and services. Option C2 currently does not take into account these potential savings, other than some minimal efficiencies for the site utilities gained by sharing. A Task Force consisting of VA and Medical Center of Louisiana representatives will soon be formed and will have a key role in outlining the specific details of operating and maintaining a truly "shared" facility. The Task Force recommendations will have a direct affect on the estimated utilities, maintenance, and operations costs.

OPTION A NARRATIVE - Post Katrina Recapture and Hardening $287,817,509:

Option A is estimated at a 45% market factor since it is anticipated that the project will bid within 12 months of Katrina.

1. Option A renovates the existing New Orleans VAMC to reactivate the Pre Katrina Program of services and harden all Central Engineering Services which were damaged due to Katrina induced wind, flood and mold damage. All substandard construction (including the Emergency Department) will be rebuilt in place to conform to current Codes and Safety Standards.
2. Post Katrina repair includes significant repair or replacement of existing partitions, finishes HVAC and Engineering systems. In this Option, the targeted renovations are limited to reactivating a Pre-Katrina Program of services in a safe and clean acute care environment.
3. Area 9G and 10G will retain it's recent Primary and Specialty Care Clinic Renovations for Option A with minor cosmetic clean-up.
4. Flood Protection will include waterproofing the exterior walls and elevating the areaway curbs to achieve significant protection against Post Katrina Flood levels.

OPTION B NARRATIVE – Existing Campus Renovation $622,165,961:

Option B is estimated at a 45% market factor since it is anticipated that the project will bid within 12 months of Katrina.

1. Option B will fully demolish all interior walls, finishes, electrical, HVAC and plumbing systems on all floors to achieve a full renovation in partial conformance with the CARES Program. This renovation will accommodate the new CARES program to the limit of the existing square footage. Thus approximately 80% of the CARES program requirements will be satisfied in option B.
2. All substandard construction (including the Emergency Department) will be rebuilt in place to conform to current Codes and Safety Standards.
3. Area 9G will be converted back to Nursing Home use and 10G will retain it's recent Specialty Care Clinic Renovations with minor cosmetic clean-up.

4. Flood Protection will include waterproofing the exterior walls and elevating the areaway curbs to achieve significant protection against Post Katrina Flood levels.

OPTION C1 NARRATIVE - Stand Alone Replacement Facility on New Campus $645,107,584:

Option C1 is estimated at a 25% market factor since it is anticipated that the project will bid within 24 months of Katrina.

1. Option C1 will be built from entirely new construction on a new site within the New Orleans Region. The site is assumed to be significantly higher than post Katrina flood levels.
2. While the new facility gross square footage (GSF) is less than the existing campus GSF, the new VA campus will have more square feet dedicated to healthcare services than the existing. Thus, C1 will fully accommodate the CARES program. Approximately 208 beds will be provided of which 60 beds will be dedicated to Nursing Home care. The new site would include sufficient parking spaces to meet the projected CARES program requirement. This facility will provide diagnostic, major therapeutic and interventional areas such as laboratory, radiology, catheterization labs, operating suites and recovery services. Outpatient Clinic, Mental Health and Pharmacy services are also provided. The facility will conform to all new construction and healthcare standards of practice.
3. Under Option C1, further studies will be required to determine the best use for the existing VAMC Campus. The costs incurred for the re-disposition of the existing campus should be carried as a contingency outside of the C1 estimate.

OPTION C2 NARRATIVE - Campus Facility Potentially Shared with the Medical Center of Louisiana (MCL costs not included) $635,789,879:

Option C2 is estimated at a 25% market factor since it is anticipated that the project will bid within 24 months of Katrina.

1. The new site for Option C2 will be provided by the State of Louisiana at a site yet to be determined and will be in proximity to the existing Medical Center of Louisiana campuses. The co-located campus plan will include separate but autonomous bed towers and outpatient clinical space for the VA and Medical Center of Louisiana Hospitals. Common areas would provide space for shared non-clinical support services such as parking, food services, laundry, energy and utility management, helipad, etc. and may be located between the twin bed towers. Separate, though contiguous, diagnostic, major therapeutic and interventional areas such as laboratory, radiology, catheterization labs, operating suites, etc., would be built for the VA and Medical Center of Louisiana Hospitals.
2. While the VA component the new facility gross square footage (GSF) is less than the existing campus GSF, the new VA campus will have more square feet dedicated to healthcare services than the existing. Thus, C2 will fully accommodate the CARES program. Approximately 208 beds will be provided of which 60 beds will be

dedicated to Nursing Home care. The new shared site would include sufficient parking spaces to meet the projected CARES program requirement. This facility will provide diagnostic, major therapeutic and interventional areas such as laboratory, radiology, catheterization labs, operating suites and recovery services. Outpatient Clinic, Mental Health and Pharmacy services are also provided. The facility will conform to all new construction and healthcare standards of practice.

3. The construction costs for the Medical Center of Louisiana program (including approximately 400 beds) have not been included in the construction number listed for Option C2.
4. Option C2 will be built on a donated site capable of accommodating the co-located requirements of the VA and Medical Center of Louisiana programs. The site will be hardened against flooding by elevating the perimeter of the site to repel post Katrina flood levels. The site perimeter will terrace up to the 1st floor of the new building which will be located significantly higher than post Katrina flood levels.
5. New Vehicular Ingress and Egress ramps for emergency access during a storm event will be provided. These ramps will be elevated to overcome a 100 year flood event and will connect the shared site to a State Highway or Federal Interstate system in conformance with the following standards: CD-54 VA design standards and the Pilot Study of ... Natural Disasters dated August 23, 2005. The cost for these emergency access ramps should be carried as an off-site contingency and is outside of the estimate amount listed above.
6. Under Option C2, further studies will be required to determine the best use for the existing VAMC Campus. The costs incurred for the re-disposition of the existing campus should be carried as a contingency outside of the C2 estimate.

Part 3: ROUGH ORDER OF MAGNITUDE ESTIMATES:

The following pages contain ROM Estimates, which capture the anticipated costs of retuning the V. A. in New Orleans to a Healthcare capacity equal to or exceeding Pre Katrina capacities. The Architectural Narrative above describe the performance targets for each of the ROM estimates below :

1. Option A, Space Recapture/Hardening;
2. Option B, Existing Campus Renovation;
3. Option C1, Stand Alone Replacement Facility on New Campus
4. Option C2, Potentially Shared Campus Facility

Executive Summary

VAMC New Orleans - Option A ; Space Recapture/Hardening
Cost Summary

Parametric Cost Summary
Date 2/21/06

	Items	Gross SF	Estimated Cost: Cost	Estimated Cost: Square Foot Cost
01	**VAMC New Orleans Hospital Clean-up**	1 134 261	$ 103,089,951	$ 90 89
	Including			
	Existing Building 1	633 148		
	Total Renovation of 1st Floor	Included		
	Mental Health Clinic Renovation - 6,500 sf	Included		
	Demolition of Basement & Sub Basement	92,818		
	New Central Plant	12,000		
	New Connector Bridge	10,000		
	Primary Care Clean-up - 9th Fl	37 765		
	Primary Care Clean-up - 10th Fl	30 699		
	Building 6 Parking Area	287 831		
	New Emergency Room	30,000		
	Kitchen Relocation	Included		
	Relocation of Mechanical Room	Included		
	Cleaning & Sanitizing Existing Building	Included		
	(6) New Elevators	Included		
	Replace Existing Roof	Included		
	Heli-Pad Area	Included		
02	**Site Work**		$ 9,600,000	$ 8 46
	Replace Sewer Line			
	Repalce Domestic Waterline			
	Demolition of Building 2	18,189		
03	**Additional Items**		$ 2,268,522	$ 2
	Re-Commissioning of Equipment - Medical Equip Only			
	Subtotal		$ 114,958,473	101.35
	Advanced Planning Fund at 5%		$ 5,747,924	$ 5 07
	Physical Security Fund at 5%		$ 5 747 924	$ 5 07
	Conversion to achieve a 45% Post Katrina Market Factor		$ 25,290,864	$ 22 30
	Design Contingency at 10%		$ 15 174,518	$ 13 38
	GC's OH Profit & Bond at 17%		$ 28 376,350	$ 25
	A/E Fees at 10%		$ 19 529 605	$ 17
	Construction Phase Services at 3%		$ 6 444 770	$ 5 68
	Construction Contingency at 7 5%		$ 16 595 282	$ 15
	Escalation @ 10% Per Annum 1 21%		$ 49 951 799	$ 44
	Total Project Estimate		$ 287,617,509	$ 253.75

Year	Utility Costs	Maintenance Costs	Operation Costs
20	$ 133,031,588	$ 443,438,628	$ 4,073,612,371
30	$ 231,964,815	$ 773,216,050	$ 7,103,085,446

Utility Operation and Maintonance Costs for all estimates were based on the following criteria
Staffing cost model derived form historical salary information from similar size and type of government medical facility The costs have been escalated at 3% per annum for 30 years
Utility Costs projected to be 30% of of Maintenance Costs and escalated at 3% per annum for 30 years
Maintenance Costs projected to be 2% of Direct Construction Costs and escalated at 3% per annum for 30 years
The Utility Operation and Maintenance Costs for Option C2 will continue to be refined to capture additional savings possible from a more comprehensive strategy for sharing of departments, staff and services Option C2 currently does not take into account these potential savings, other than some minimal efficiencies for the site utilities gained by sharing A Task Force consisting of VA and Louisiana Medical Center representatives will soon be formed and will have a key role in outlining the specific details of operating and maintaining a truly "shared" facility This group s recommendations will have a direct affect on the estimated utilities maintenance and operations costs

VAMC New Orleans - Option B; Existing Campus Renovations
Cost Summary

Parametric Cost Summary
Date 2/21/06

	Items	Gross SF	Estimated Cost: Cost	Estimated Cost: Square Foot Cost
01	**VAMC New Orleans Campus Renovation**	1,134,261	$ 210,974,422	$ 186 00
	Including:			
	Building 1 Renovation	633,148		
	Demolition of Basement & Sub Basement	92,818		
	New Emergency Department	30 000		
	Power Washing of Ext 1st Fl & Parking Area	287,831		
	New Central Plant Equipment & Building	12 000		
	Mental Health Clinic Renovation - Included in Bldg 1	Included		
	Convert Primary Care to Nursing Suite - 9th Fl	37 765		
	Primary Care Clinic Clean-up - 10th Fl	30 699		
	New Connector Bridge	10,000		
	New Heli-Pad Area - Included in Bldg 1	Included		
	New Kitchen Area - Included in Bldg 1	Included		
02	**Site Work**		$ 9,625,782	$ 8 49
	Site Utilities			
	Demolition of Building 2	18 189		
	Misc Site Work			
03	**Additional Items**		$ 5,310,776	$ 5
	Commissioning of Equipment			
	Subtotal		$ 225,910,980	199 17
	Advanced Planning Fund at 5%		$ 11,295 549	$ 9 96
	Physical Security Fund at 5%		$ 11,295 549	$ 9 96
	Conversion to achieve a 45% Post Katrina Market Factor		$ 49 700 416	$ 43 82
	Design Contingency at 10%		$ 29 820 249	$ 26
	General Conditions at 17%		$ 55 763 866	$ 49
	GC's OH Profit & Bond at 10%		$ 38,378 661	$ 34
	A/E Fees at 10%		$ 42,216,527	$ 37
	Construction Phase Services at 3%		$ 13,931,454	$ 12
	Construction Contingency at 7 5%		$ 35 873,494	$ 32
	Escalation @ 10% Per Annum - 1 21%		$ 107,979,216	$ 95
	Total Project Estimate		**$ 622,165,961**	**$ 548.52**

Year	Utility Costs	Maintenance Costs	Operation Costs
20	$ 34,948,407	$ 129,566,660	$ 4,073,612,371
30	$ 57,443,886	$ 225,923,080	$ 7,103,085,446

Utility, Operation and Maintenance Costs for all estimates were based on the following criteria
Staffing cost model derived form historical salary information from similar size and type of government medical facility The costs have been escalated at 3% per annum for 30 years
Utility Costs projected to be 30% of of Maintenance Costs and escalated at 3% per annum for 30 years
Maintenance Costs projected to be 2% of Direct Construction Costs and escalated at 3% per annum for 30 years
The Utility Operation and Maintenance Costs for Option C2 will continue to be refined to capture additional savings possible from a more comprehensive strategy for sharing of departments staff and services Option C2 currently does not take into account these potential savings other than some minimal efficiencies for the site utilities gained by sharing A Task Force consisting of VA and Louisiana Medical Center representatives will soon be formed and will have a key role in outlining the specific details of operating and maintaining a truly "shared" facility This group s recommendations will have a direct affect on the estimated utilities maintenance and operations costs

VAMC New Orleans - Option C1; Replacement Facility As Stand Alone
Cost Summary - 100% Patient Census

Parametric Cost Summary
Date 2/21/06

	Items	Gross SF	Estimated Cost: Cost	Estimated Cost: Square Foot Cost
01	**VAMC New Orleans - Replacement Facility**	948,583	$ 249,876,843	$ 263 42
	Including			
	CARES Program	870,583		
	300 Car Parking Structure	66,000		
	New Central Plant	12 000		
	Back-up Power Generation			
	Heli-Pad Area			
02	**Site Work**		$ 16,600,203	$ 17 50
	Site Utilities			
	2000 Parking Spaces on Grade			
	Misc Site Work			
03	**Additional Items**		$ 4,742,915	$ 5
	Commissining of Equipment			
	Subtotal		$ 271,219,961	285 92
	Advanced Planning Fund at 5%		$ 13 560,998	$ 14 30
	Physical Security Fund at 5%		$ 13,560,998	$ 14 30
	Design Contingency at 10%		$ 29 834,196	$ 31
	General Conditions at 12%		$ 39,381,138	$ 42
	GC's OH, Profit & Bond at 6%		$ 22,053,437	$ 23
	A/E Fees at 10%		$ 38,961 073	$ 41
	Construction Phase Services at 3%		$ 12,857,154	$ 14
	Construction Contingency at 7 5%		$ 33,107,172	$ 35
	Escalation @ 10% Per Annum 1 33%		$ 157,071 458	$ 166
	Subtotal		$ 631,607,584	665.84
	Land Acquisition		$ 13 500,000	
	Total Project Estimate - 100% Census		$ 645,107,584	

Year	Utility Costs	Maintenance Costs	Operating Costs
20	$ 41,957,702	$ 155,552,707	$ 3,666,251,134
30	$ 68,954,902	$ 271,234,488	$ 6,392,776,901

Utility Operation and Maintenance Costs for all estimates were based on the following criteria
Staffing cost model derived form historical salary information from similar size and type of government medical facility The costs have been escalated at 3% per annum for 30 years
Utility Costs projected to be 30% of of Maintenance Costs and escalated at 3% per annum for 30 years
Maintenance Costs projected to be 2% of Direct Construction Costs and escalated at 3% per annum for 30 years
The Utility Operation and Maintenance Costs for Option C2 will continue to be refined to capture additional savings possible from a more comprehensive strategy for sharing of departments staff and services Option C2 currently does not take into account these potential savings, other than some minimal efficiencies for the site utilities gained by sharing A Task Force consisting of VA and Louisiana Medical Center representatives will soon be formed and will have a key role in outlining the specific details of operating and maintaining a truly "shared" facility This group's recommendations will have a direct affect on the estimated utilities maintenance and operations costs

VAMC New Orleans - Option C2; Shared Campus
Cost Summary - 100% Patient Census

Parametric Cost Summary
Date 2/21/06

	Items	Gross SF	Estimated Cost: Cost	Estimated Cost: Square Foot Cost
01	**VAMC New Orleans - Replacement Facility**	948 583	$ 239,205,284	$ 252 17
	Including			
	CARES Program	870,583		
	300 Car Parking Structure	66,000		
	New Central Plant	12,000		
	Back-up Power Generation			
	Heli-Pad Area			
02	**Site Work**		$ 26,651,620	$ 28 10
	Site Utilities			
	2000 Parking Spaces on Grade			
	Misc Site Work			
03	**Additional Items**		$ 4,742,915	$ 5
	Commissioning of Equipment			
	Subtotal		$ 270,599,819	285 27
	Advanced Planning Fund at 5%		$ 13,529,991	$ 14 26
	Physical Security Fund at 5%		$ 13,529,991	$ 14 26
	Design Contingency at 10%		$ 29,765,980	$ 31
	General Conditions at 13%		$ 42,565,351	$ 45
	GC s OH, Profit & Bond at 6%		$ 22,199,468	$ 23
	A/E Fees at 10%		$ 39,219,060	$ 41
	Construction Phase Services at 3%		$ 12,942,290	$ 14
	Construction Contingency at 7 5%		$ 33,326,396	$ 35
	Escalation @ 10% Per Annum 1 33%		$ 158,111,533	$ 167
	Subtotal		$ 635,789,879	670 25
	Land Acquisition		$	
	Total Project Estimate - 100% Census		$ 635,789,879	

Year	Utility Costs	Maintenance Costs	Operating Costs
20	$ 41,861,766	$ 155,197,037	$ 3,666,251,134
30	$ 68,807,214	$ 270,614,313	$ 6,392,776,901

Utility Operation and Maintenance Costs for all estimates were based on the following criteria
- Staffing cost model derived form historical salary information from similar size and type of government medical facility. The costs have been escalated at 3% per annum for 30 years
- Utility Costs projected to be 30% of of Maintenance Costs and escalated at 3% per annum for 30 years
- Maintenance Costs projected to be 2% of Direct Construction Costs and escalated at 3% per annum for 30 years.
- The Utility Operation and Maintenance Costs for Option C2 will continue to be refined to capture additional savings possible from a more comprehensive strategy for sharing of departments, staff and services Option C2 currently does not take into account these potential savings other than some minimal efficiencies for the site utilities gained by sharing A Task Force consisting of VA and Louisiana Medical Center representatives will soon be formed and will have a key role in outlining the specific details of operating and maintaining a truly "shared" facility This group's recommendations will have a direct affect on the estimated utilities maintenance and operations costs

Estimating the Impact of Hurricane Katrina on EHCPM Projections for FYs 2006 to 2023

Background

Hurricane Katrina hit the Gulf Coast on August 29, 2005, severely impacting the lives of residents in the New Orleans, Louisiana and Biloxi/Gulfport, Mississippi areas. The hurricane impacted the populations of the Gulf Coast in different ways. Due to the difficult nature of tracking individuals, estimates of the number of people impacted by Hurricane Katrina vary widely. These estimates range from 700,000 to 2.4 million. Regardless of the ranges of these estimates, it is undisputed that the majority of the population in New Orleans was displaced. In addition, due to the number of houses and businesses that were completely destroyed by the hurricane, it is clear that a significant number of residents in the Biloxi/Gulfport area were displaced. The question facing VA is: how many veterans and veteran enrollees were impacted and/or displaced by Hurricane Katrina and how will future VA health care expenditures be impacted?

VA has major health care systems located in these two areas. The VA Medical Center in New Orleans (450 bed acute care facility) was impacted by severe flooding and is essentially out of commission. Temporary outpatient clinics have been established in the New Orleans area to fulfill VA's commitment to meet the health care needs of its veteran patients. The VA mental health facility in Gulfport was damaged by the hurricane and patients were transferred to the VA hospital in Biloxi, which sustained minimal damage. It is important for VA to understand the impact of Hurricane Katrina on the veteran and veteran enrollee population in order to devise a plan to meet the future needs of veterans in the New Orleans and Biloxi/Gulfport areas.

Methodology

The VA Enrollee Health Care Projection Model (EHCPM) develops enrollment, workload and expenditure projections at the sector level. This means it is possible to modify many of the model assumptions to estimate the impact of the extensive migration of veterans and enrollees away from Hurricane Katrina impacted areas to the rest of the U.S., as well as the demographic shift due to the economic hardships endured by many who lived in the Katrina impacted areas. To understand the methodology for estimating the impact Katrina had and will have on VHA enrollment, workload and expenditures, one must first understand the general model structure of the EHCPM.

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The VA Office of the Actuary produces a projection of the veteran population to 2025 and beyond. VHA tracks veterans who have enrolled in the VHA health care system. These enrollees are removed from the veteran population estimates to produce the pool of veterans who might enroll in the future. Enrollment rates are developed to project how many of the veterans in the pool will enroll each year. The demographics of the enrolled veterans (both current and future) are modeled to change over time, reflecting enrollee aging, priority level transition, geographic migration, and mortality. The size of the projected enrolled population and the demographic mix of this population are key variables in estimating future VHA workload and expenditures. The EHCPM is based on many detailed assumptions that can be modified to estimate the impact of various scenarios.

To estimate the impact of Katrina, the veteran and veteran enrollee population was modified to reflect the sudden change in geographic location of many veterans (Immediate Veteran Dispersion). These veterans, who were displaced as a result of Katrina, were then slowly migrated back to the Katrina impacted areas over the 20-year projection period (Long-term Return of Veterans). In addition, some of the displaced veteran enrollees were assumed to transition from priority levels 6, 7 and 8 to priority level 5 due to economic hardships (priority level shock) suffered as a result of the Hurricane (Immediate Economic Hardship).

It is difficult to measure how Hurricane Katrina influenced veterans' short-term behavior in its wake and even more difficult to predict how it will influence long-term behavior. There is a wide range of possible outcomes over the next twenty years. The EHCPM was used to create 20-year projections under three scenarios, each with a distinct set of model assumptions. This allows VA to understand the sensitivity of the enrollment, workload and expenditure projections to model assumptions. The three scenarios represent a middle estimate, a low estimate and a high estimate for the Katrina impacted areas. These scenarios represent three reasonable outcomes that could enfold over the next twenty years. They are within a wide range of reasonable outcomes. The Middle scenario, considered the best estimate, has the highest likelihood. Furthermore, the Low and High scenarios are believed to be reasonable outcomes, though they do not necessarily represent the extremes of the reasonable range of outcomes.

A summary of the various assumptions (in general terms) reflected in each of the scenarios is included in Table 1. In general, the Middle scenario represents an immediate geographic dispersion and economic hardship, followed by a steep and then gradual return of veterans, and a gradual shift in the priority level distribution of the affected areas toward average U.S. urban

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economic conditions, rather than pre-Katrina New Orleans economic conditions. In the Low scenario, the return of displaced veterans to and the shift in priority distribution of the affected areas is assumed to occur more gradually. In the High scenario, veterans are assumed to return more quickly to the affected areas, and long-term enrollment rates and enrollee reliance on VA health care are assumed to increase. The Base scenario reflects EHCPM projections using pre-Katrina data and assumptions.

Table 1
Summary of General Model Assumptions by Scenario

Assumption	Base	Low	Middle	High
Immediate Veteran Dispersion	No	Yes	Yes	Yes
Long Term Return of Veterans	No	Slow	Medium	Fast
Immediate Economic Hardship	No	No	Moderate	High
Long-term Enrollment Rate	Historical	Historical	Historical	Accelerated
Enrollee Reliance	Historical	Historical	Historical	Elevated

Modified Assumptions

The assumptions listed in Table 1 were developed using various information and data provided by VA and obtained from the internet. Only four sectors (geographic areas that consist of a single urban county or multiple adjacent counties) were subjected to an immediate veteran dispersion in the wake of the hurricane. These sectors and the areas they represent are listed in Table 2.

Table 2
Geographic Areas with Assumed Veteran Migration (Shock)

Sector	Description	Counties / Parishes
16-c-9-B	New Orleans (metro)	Orleans Parish
16-c-9-E	New Orleans (south)	Jefferson, St. Bernard, Plaquemines Parishes
16-c-9-F	Biloxi/Gulfport	Harrison County
16-c-9-I	New Orleans (north)	St. Tammany, Tangipahoa, Washington, St. Charles, St. John the Baptist, St. James Parishes

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Two main data sources [1,2] were relied upon to estimate the percentage of veterans that were displaced in these four sectors as a direct result of Hurricane Katrina. These estimates were based on general population displacement estimates. It is estimated that approximately 70% of veterans in the New Orleans (metro) area were immediately displaced due to Katrina. The veterans in the New Orleans (south) area were also hit hard, and it is estimated that 50% were displaced. The Biloxi/Gulfport displacement estimate is quite a bit lower at 25%. Finally, the New Orleans (north) area sustained much less damage, and the displacement estimate is only 5%. These geographic shocks were phased in for both the veteran and veteran enrollee population between August and October of 2005.

The slow, medium, and fast long-term geographic migration patterns were based upon assumed rates of return among veterans due to the rejuvenation of local economies, availability of housing, the desire to return, and steps that may be taken by VA to remodel, replace, or enhance veteran healthcare facilities in the affected areas. In no scenario were the 20-year migration patterns assumed to lead to veteran populations in the affected areas that are significantly higher than in the Base scenario. For the Low scenario, the assumed migration patterns lead to 20-year population estimates that are lower than the Base scenario. The Middle scenario assumes, by the end of the 20-year projection period, that all four sectors have gradually regained veteran populations to coincide with the Base scenario. The High scenario reaches the level of the Base scenario earlier in the 20-year projection period. The New Orleans (metro) area has the slowest recovery (population migrating back) of the four impacted areas due to the nature of the damages in this area (sustained flooding, incapacitated utilities, unsanitary conditions, etc.). On the other hand, it is assumed that the Biloxi/Gulfport area will recover much more quickly. The devastation in this area is mainly due to the high winds completely destroying houses and businesses and it is assumed that they can be rebuilt within a few years. Also, the Casinos, major employers in the area, are expected to be back in full operation during FY 2008, which will draw population back to the area. The following charts depict the impacts of the immediate dispersion and long-term return on veteran population projections (Charts 1-4) and veteran enrollee projections (Charts 5-8) for the four areas under each scenario. In each graph, the population levels correspond to estimates as of the end of each fiscal year.

[1] Hurricane Katrina: Social-Demographic Characteristics of Impacted Areas, CRS Report for Congress, November 4, 2005

[2] Internet website www.gnocdc.org - Post-Disaster Population Estimates by LA DHH Bureau of Primary Care and Rural Health (Oct 2005 -Jan 2006)

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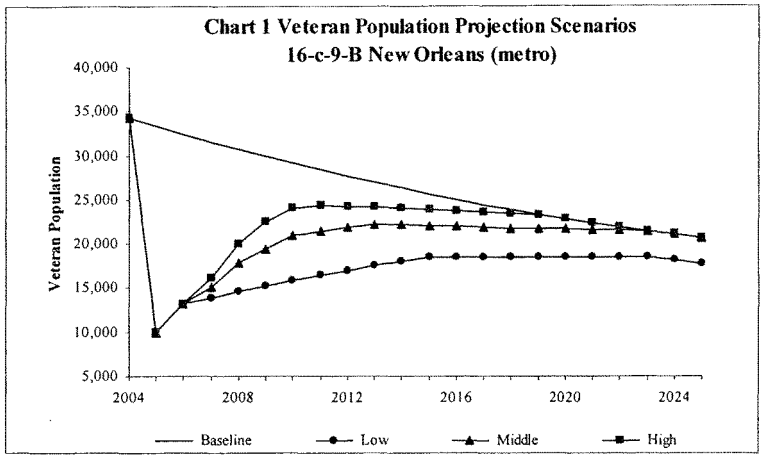

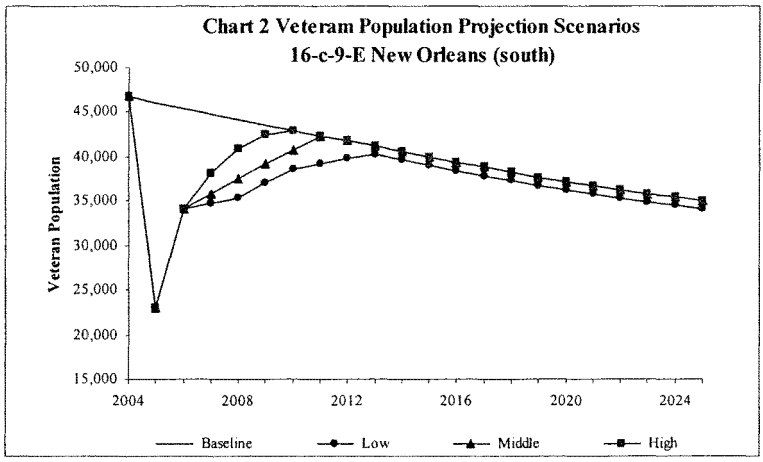

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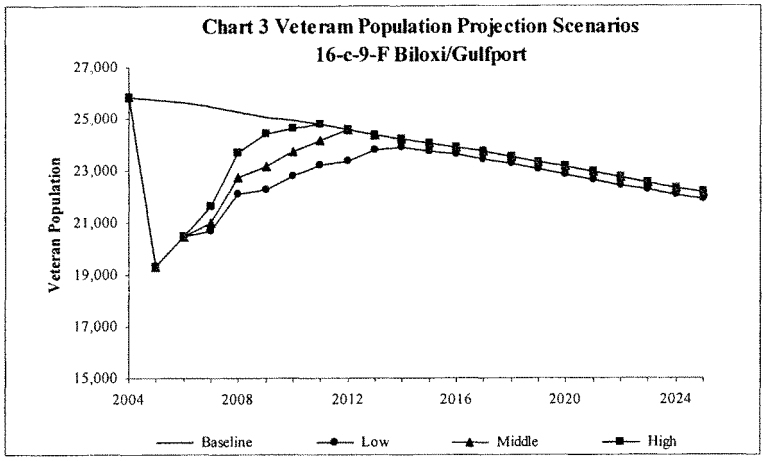

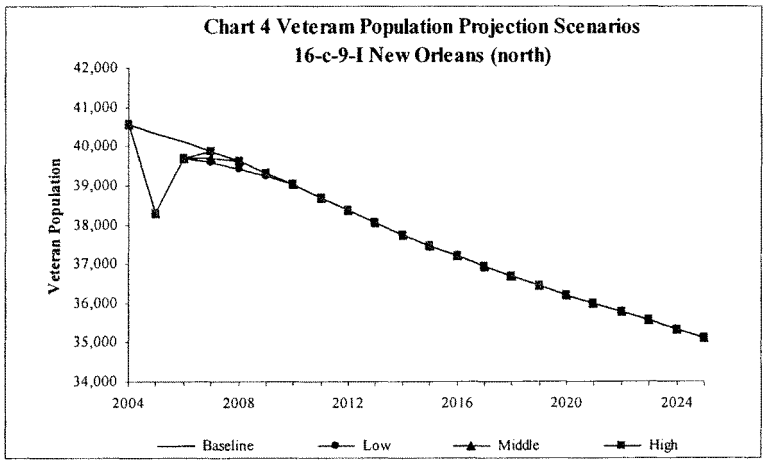

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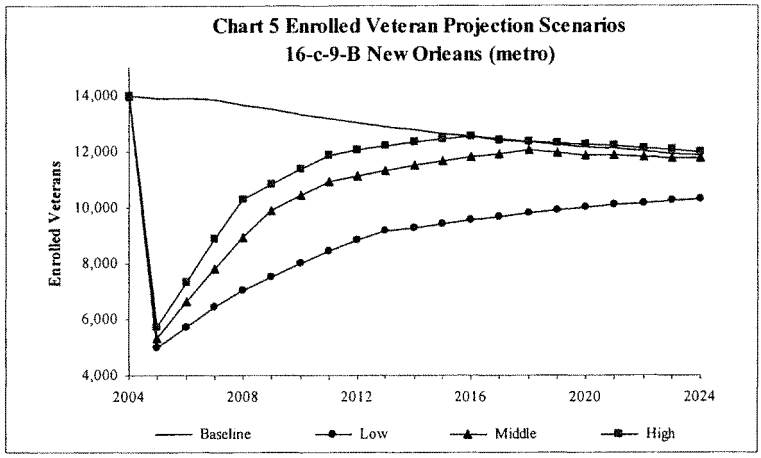

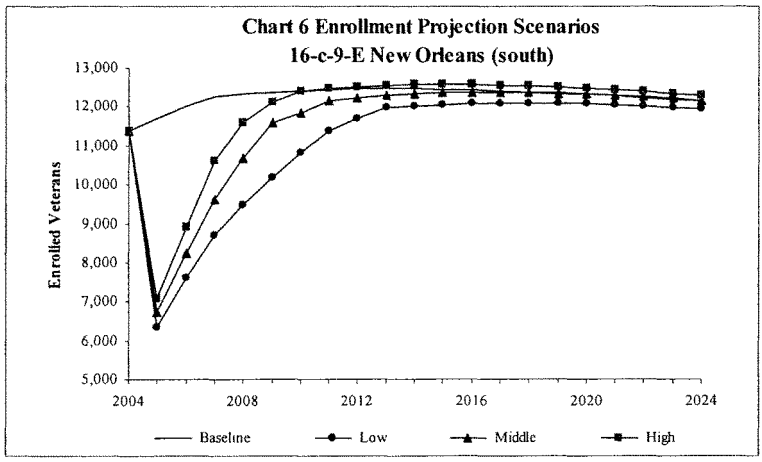

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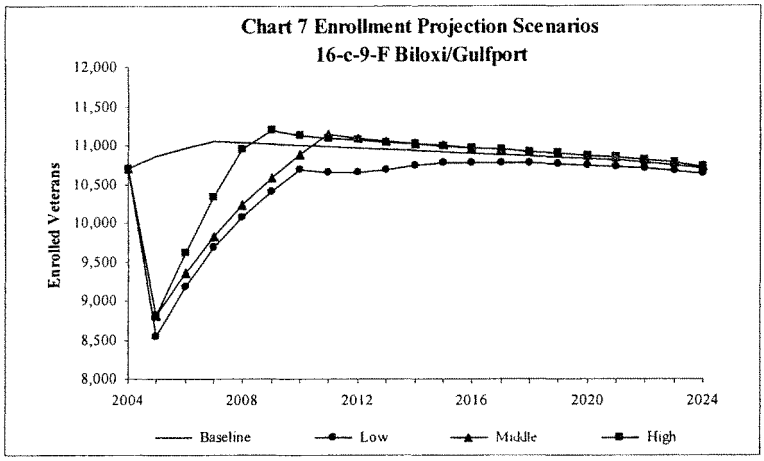

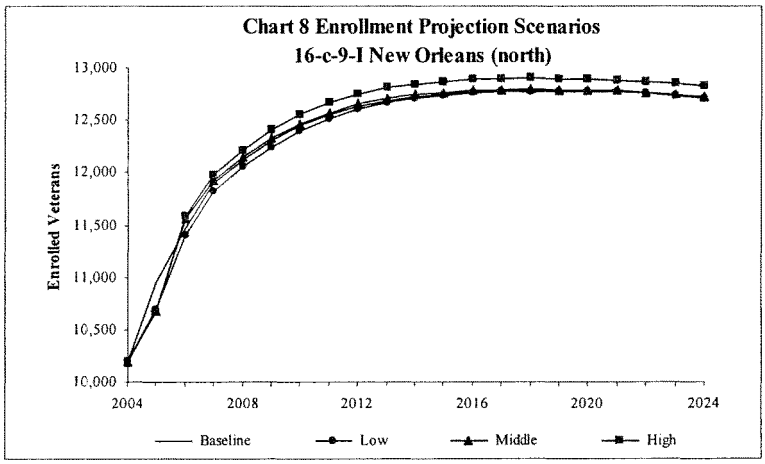

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No data was available to assist in establishing the three priority level shocks (Immediate Economic Hardships levels: none, moderate, and high). However, it is reasonable to assume that for the High scenario the majority of the displaced priority level 6, 7, and 8 enrollees lost their homes and jobs. In this case, the assumption is that 75% of the priority levels 6 through 8 enrollees now qualify as priority level 5. The Middle scenario assumes that 50% transition to priority level 5 and the Low scenario assumes that none of them transition to priority level 5.

It is not anticipated that Long-term Enrollment Rates in the New Orleans areas will change; however, once New Orleans is rebuilt, veterans may have a higher propensity to enroll. Possible reasons for this are that the VA facility in New Orleans may be extremely convenient to the returning veteran population; the health care system in New Orleans may not be replaced as quickly as the VA system; or the new VA facility may be "state-of-the-art" and attract new veterans. Only the High scenario has modified enrollment rates for the New Orleans areas. In addition, the enrollment rates in the Baton Rouge area were also slightly increased due to their dependency on certain care in New Orleans.

Finally, for the same reasons discussed above, Enrollee Reliance on VA health care is also not expected to change significantly. The High scenario includes slightly higher reliance assumptions for the geographic areas with assumed veteran migration (four sectors listed in Table 2), and for Baton Rouge (sector 16-c-9-K).

Modified Projections

The near term projections for the Katrina impacted areas under the Low, Middle, and High scenarios are lower than under the Base scenario, which is based on pre-Katrina assumptions.. Nationally, however, the projections remain unchanged as the displaced veteran enrollees are expected to continue to demand VHA health care, just in different locations. Over time, the projections under the Middle and High scenarios converge to the Base scenario, becoming the same in 20 years. Tables 3 and 4 illustrate the impacts for enrollees, patients and expenditures for FY 2006, FY 2008 and FY 2023 for selected counties. Table 3 provides some detail for the Middle scenario. Table 4 shows the impacts for the three scenarios. In addition, Table 4 includes the national impacts.

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Table 3

Middle Scenario Impacts for Selected Areas

	Enrollees		Patients		Expenditures (1,000s)	
	Estimated	Impact	Estimated	Impact	Estimated	Impact
FY 2006						
New Orleans (metro)	5,364	-62%	3,599	-62%	$28,394	-63%
New Orleans (south)	7,229	-40%	4,894	-40%	$34,513	-42%
New Orleans (north)	11,159	-2%	7,596	-2%	$50,619	-2%
Biloxi/Gulfport, MS	8,826	-19%	5,940	-19%	$43,807	-20%
Baton Rouge, LA	9,754	19%	6,581	20%	$39,075	23%
Jackson, MS	9,101	6%	6,006	6%	$38,293	7%
Houston, TX	58,867	4%	39,458	5%	$265,191	5%
FY 2008						
New Orleans (metro)	7,851	-43%	5,292	-44%	$45,701	-47%
New Orleans (south)	9,879	-21%	6,736	-22%	$54,821	-23%
New Orleans (north)	12,249	0%	8,405	0%	$63,917	0%
Biloxi/Gulfport, MS	9,846	-11%	6,649	-11%	$54,763	-12%
Baton Rouge, LA	9,808	14%	6,684	15%	$45,174	18%
Jackson, MS	9,004	5%	5,993	5%	$43,316	6%
Houston, TX	60,206	3%	40,862	3%	$310,141	4%
FY 2023						
New Orleans (metro)	11,667	-1%	8,317	-2%	$134,153	-4%
New Orleans (south)	12,219	0%	8,970	0%	$142,713	0%
New Orleans (north)	12,752	0%	9,296	0%	$140,857	0%
Biloxi/Gulfport, MS	10,694	0%	7,554	0%	$118,594	0%
Baton Rouge, LA	9,555	1%	6,855	1%	$90,955	2%
Jackson, MS	8,210	1%	5,706	1%	$78,106	1%
Houston, TX	59,563	0%	42,689	0%	$631,956	0%

Impacts are measured as the percentage change from projections with pre-Katrina assumptions.

Expenditures are defined as those necessary to provide demanded health care to veteran enrollees under normal operating conditions. They are not intended to represent any of the additional costs associated with capital and personnel recovery as a result of Hurricane Katrina.

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Table 4
Katrina Impacts for Selected Areas

	Patient Percentage Impact			Expenditure Percentage Impact		
	Low	Middle	High	Low	Middle	High
FY 2006						
New Orleans (metro)	-64%	-62%	-60%	-65%	-63%	-61%
New Orleans (south)	-43%	-40%	-38%	-45%	-42%	-40%
New Orleans (north)	-2%	-2%	-2%	-2%	-2%	-2%
Biloxi/Gulfport, MS	-21%	-19%	-19%	-22%	-20%	-20%
Baton Rouge, LA	20%	20%	20%	22%	23%	24%
Jackson, MS	6%	6%	6%	7%	7%	7%
Houston, TX	5%	5%	5%	5%	5%	6%
National	0.02%	0.02%	0.03%	-0.03%	-0.01%	0.00%
FY 2008						
New Orleans (metro)	-54%	-44%	-36%	-55%	-47%	-36%
New Orleans (south)	-28%	-22%	-13%	-29%	-23%	-8%
New Orleans (north)	-1%	0%	2%	-1%	0%	10%
Biloxi/Gulfport, MS	-13%	-11%	-6%	-13%	-12%	0%
Baton Rouge, LA	15%	15%	15%	18%	18%	22%
Jackson, MS	5%	5%	5%	6%	6%	6%
Houston, TX	4%	3%	3%	4%	4%	4%
National	0.01%	0.01%	0.03%	-0.02%	0.00%	0.08%
FY 2023						
New Orleans (metro)	-16%	-2%	2%	-18%	-4%	8%
New Orleans (south)	-2%	0%	3%	-2%	0%	11%
New Orleans (north)	0%	0%	2%	0%	0%	11%
Biloxi/Gulfport, MS	-1%	0%	2%	-1%	0%	10%
Baton Rouge, LA	3%	1%	2%	3%	2%	6%
Jackson, MS	1%	1%	0%	1%	1%	1%
Houston, TX	1%	0%	0%	1%	0%	0%
National	0.00%	0.00%	0.01%	-0.01%	0.00%	0.09%

Impacts are measured as the percentage change from projections with pre-Katrina assumptions.

Expenditures are defined as those necessary to provide demanded health care to veteran enrollees under normal operating conditions. They are not intended to represent any of the additional costs associated with capital and personnel recovery as a result of Hurricane Katrina.

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Caveats and Limitations

The analyses in this report rely in part on data and other listings provided by various personnel at VA. That data has been reviewed for reasonableness and compared to past data submissions and other information, when possible. The information has not been audited by Milliman for accuracy. If the data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete. In addition, internet searches were used to obtain supplemental information to assist in the development of the assumptions used in this modeling effort. Reports and opinions produced by government entities or presented to government entities were heavily relied upon. General impressions regarding the future of the Katrina/Rita impacted areas were gleaned from other sources.

Some of the information in this analysis is based on modeling assumptions and historic data. Other assumptions were based entirely on judgment due to the lack of any historical data that might be reflective of the restoration of a major U.S. metropolitan area and surrounding cities/towns devastated by a hurricane. Estimates presented in this report will only be accurate if future experience exactly replicates those data and assumptions used in this analysis. Given the unpredictability of how the affected areas will recover, it is almost certain that the outcome will differ from the three scenarios. In addition, many of the modeling variables are assumed to be constant over time. Therefore, emerging experience should be continually monitored to detect whether expectations based on this analysis are appropriate over time.

The results contained in this report are projections. It is impossible to determine how world events will unfold. Those events that impact the economy and the use of the nation's military may have a profound impact on enrollment and expenditure projections into the future. The analysis has not attempted to present results for events where data is not yet available to consider their impacts on enrollment and expenditures, beyond those directly related to modeling the impact of Katrina. It is important that actual enrollment and costs be monitored and the projections updated regularly based on this changing environment.

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Memorandum of Understanding

Between

United States Department of Veterans Affairs

And

Louisiana State University Health Care Services Division

1.0 INTRODUCTION

This Memorandum of Understanding (MOU) is made between the United States Department of Veterans Affairs ("VA") and Louisiana State University Health Care Services Division ("LSU") (hereinafter referred to collectively as "the Parties").

1.1 The Parties intend by this MOU to establish a mutually beneficial relationship to foster discussions regarding the future of VA and LSU medical care delivery in the New Orleans, Louisiana region.

1.2 This MOU will address the basic framework for discussions between the Parties, but leaves for later agreement the more precise terms that will constitute the substance of the future relationship.

2.0 PURPOSE

2.1 Prior to the natural disaster known as Hurricane Katrina in August 2005, each of the Parties either directly owned and operated or had an interest (financial or governmental) in various medical facilities in the City of New Orleans. The facilities involved were various and included at least the following: New Orleans VA Medical Center, University Hospital and Charity Hospital, and ancillary support facilities, (collectively "the Facilities"). Each of the facilities referred to herein sustained significant damage from Hurricane Katrina and/or the resultant flooding in numerous parts of the City.

2.2 Each of the Facilities served a segment of the population of New Orleans region and provided various levels of medical services. In many case these services were complementary among the Facilities. Many valuable and productive relationships existed between the Parties to foster cooperation and collaboration in tertiary, specialty and primary care and especially medical education and training for the medical professionals employed at the Facilities.

2.3 This MOU will provide a framework for collaboration and discussion on reestablishing a health care presence in New Orleans and how the Parties could work together to achieve that mutually beneficial goal.

3.0 AUTHORITY

3.1 Under 38 USC § 513, the Secretary of Veterans Affairs may "enter into contracts or agreements with private or public agencies or persons... for such necessary services... as the Secretary may consider practicable."

3.2 Pursuant to 38 USC § 8153, when the Secretary determines it to be in the best interest of the prevailing standards of the Department [of Veterans Affairs] medical care program, he may make arrangements, by contract or other form of agreement for the mutual use, or exchange of use, of health-care resources between Department health-care facilities and any health-care provider, or other entity or individual.

3.3 Pursuant to Article 8, Section 7 of the Louisiana *Constitution*, the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College (Board) is granted authority to supervise and manage the institutions statewide and other programs administered through its system. The LSU Health Care Service Division is a part of the LSU System.

4.0 ROLES AND RESPONSIBILITIES OF THE PARTIES

4.1 The Parties shall draft a Charter for a study group to be known as VA/LSU Collaborative Opportunities Study Group (COSG) for New Orleans (the "Group").

4.2 Subject to federal law, regulation and VA policy, the VA shall commit the appropriate resources (time, assets, personnel, etc.) to the formation and support the ongoing functioning of the Group.

4.3 Subject to law, regulation and LSU policy, LSU shall commit the appropriate resources (time, assets, personnel, etc.) to the formation and the ongoing functioning of the Group.

4.4 The Parties understand that other entities or organizations may have an interest in the goals and activities described in this MOU. In recognition of this, the Parties will invite the participation of other entities, organizations or associations as determined by the Group.

4.5 The Parties agree that the Group shall be tasked to study the following areas of mutual interest:

4.5.1 The present and future demographics of the City of New Orleans ["City"] and metropolitan New Orleans area ["Region"];

4.5.2 The present and future need for LSU and VA health care services, medical research and medical education in the City and Region;

4.5.3 An analysis of the present and future need for LSU and VA primary, tertiary, specialty and emergency health care services in the City and Region;

4.5.4 Evaluation of state-of-the art joint and collaborative health care delivery models, including the model known as the Texas Medical Center;

4.5.5 An analysis of proposed sites and locations for future LSU and VA health care facilities, research and educational facilities in the City and Region, including analysis of sites for joint and collaborative facilities;

4.5.6 An analysis of how the VA/LSU collaboration can contribute to the National and Louisiana advancement of health care services, in cooperation with medical education.

5.0 FUNDING

The Parties shall attempt to secure reasonable funding to allow for the successful accomplishment of the activities and goals of this MOU. All Parties, however, expressly acknowledge that the activities and goals under this MOU shall be subject to their limited authority and the availability of appropriated and other funds, and the assets of each Party, including the approval of alternate sources of funding. Nothing in this MOU or elsewhere shall be construed as establishing a contract (or any other binding legal commitment) obligating any Party to this MOU to provide money, goods or services of any kind to any legal or governmental entity.

6.0 AGREEMENTS

In order to foster the success of this MOU, the Parties agree to the following:

6.1 Each Party pledges in good faith to go forward with this MOU and to further the goals and purposes of this MOU, subject to the terms and conditions of this MOU. The Parties agree to resolve disputes, if any, through good faith discussions.

6.2 By mutual agreement, which may be formal or informal, the Parties may modify the list of intended activities and goals set forth in Paragraph 4.0 above, including the practical manner by which the goals, activities and purposes of this MOU will be accomplished. However, any modification to any written portion of this MOU must be made in writing and signed by all Parties, or their designees.

6.3 Nothing in this MOU shall be construed to authorize or permit any violation of Federal, State or local law, including environmental laws and regulations, and public records laws, as applicable..

6.4 All Parties agree that they do not expect, nor will they ever seek to compel in any judicial or other forum, the payment of money, services or other thing of value from any other Party based upon the terms of this MOU. The Parties agree further that this provision does not affect in any way any legal rights accruing to any Party outside of this MOU by virtue of any other law or contract, or otherwise.

6.5 The Parties agree that participation in the goals activities and purposes of this MOU does not constitute an endorsement, express or implied, by a Party of any policy advocated by any other Party.

7.0 PRIMARY CONTACTS

The Parties intend that the work under this MOU shall be carried out in the most efficient manner possible. To that end, the Parties intend to designate individuals who will serve as primary contacts among the Parties. The Parties intend that, to the maximum extent practicable and unless otherwise approved by another Party, all significant communications between the

Parties shall be made through the primary contacts. The designated primary contacts for the Parties are listed in Attachment A to this MOU.

8.0 WITHDRAWAL FROM MOU

Any Party may unilaterally withdraw from this MOU at any time by transmitting a signed writing to that effect to the Primary Contact(s) of the other Parties listed in Attachment A. The withdrawal shall be effective sixty (60) days from the date of transmittal of the written withdrawal.

9.0 EFFECTIVE DATE

This MOU shall become effective immediately upon full execution of all signatories listed below and shall remain effective until there is a withdrawal pursuant to paragraph 8.0 hereof.

The Parties hereby agree to the foregoing MOU, executed this 23rd day of February 2006.

For the United States Department of Veterans Affairs:

Date: FEB 23 2006

Jonathan B. Perlin, M.D.
Under Secretary for Health
United States Department of Veterans Affairs
Washington, DC

For Louisiana State University Health Care Services Division:

Date: FEB 23 2006

Dr. William L. Jenkins
President
Louisiana State University System

ATTACHMENT A

PRIMARY CONTACTS

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Questions for the Department of Veterans Affairs
Department of Veterans' Affairs
House Veterans Affairs Committee
Chairman Steve Buyer

March 8, 2006

Hearing on Collaboration Opportunities with Affiliated Medical Institutions and the Department of Defense

Question 1: The first Collaborative Opportunities Steering Group (COSG) process established in Charleston, SC provided a good "blueprint" for collaboration with the Medical University of South Carolina (MUSC). However, there are still outstanding issues that need to be examined in order to ensure that a collaborative initiative like the one envisioned in Charleston is viable. Is VA considering establishing a second COSG Process focusing on the issues still outstanding in Charleston?

Response: The Under Secretary for Health sent the Collaborative Opportunities Steering Group (COSG) final report to the Co-Chairs of Veterans Health Administration's Capital Asset Board (CAB) asking that the Board review the options presented and provide recommendations to him. This process should occur timely so that the decision may move forward to the Department of Veterans Affairs (VA) Capital Asset Panel with the purpose of incorporating decisions into the Department's budget development processes for the Fiscal Year 2008 President's Budget Submission.

Question 2: A new COSG process is being developed in New Orleans in collaboration with the Louisiana State University (LSU). Will this analytical process differ in scope from that of Charleston, SC? Has the Department identified the leadership structure for the collaborative process?

Response: The template that was developed from the Ralph H. Johnson VA Medical Center (VAMC) Charleston/MUSC experience included a Steering Committee with the following work groups: (1) Governance; (2) Legal; (3) Finance; and (4) Shared Clinical Services.

The VA/LSU Memorandum of Understanding (MOU), which was recently signed, included a provision for a New Orleans Collaborative Opportunity Study Group which includes the following work groups: (1) Financial; (2) Sharing; and (3) Clinical.

The Department has identified the Leadership Team to facilitate this effort and the VA/LSU steering group had its first meetings March 13 and 14. Weekly meetings are now being held. Subsequent to the meetings, it is anticipated that work groups similar to the Charleston/MUSC groups will be used.

Question 3: Please describe specific steps VA intends to take to ensure that the COSG process in Charleston is maintained and will not be left unfinished if the model is now refined in New Orleans?

Response: The process described above for Charleston VAMC/MUSC will run simultaneously to the recently chartered New Orleans COSG. VA expects to draw on Charleston/MUSC experience in order to positively impact the New Orleans analysis. VA will also continue to maintain positive relationships with Veterans Integrated Service Network (VISN) 7 representatives, Charleston VAMC leadership, and MUSC. VA will be able to profit from lessons-learned and share novel methods and solutions that may be uncovered during the New Orleans analysis to positively impact the continued work between Charleston and MUSC.

Question 4: Does VA have national criteria for evaluating collaborative opportunities, such as joint ventures with medical affiliates? If no, is VA considering developing such criteria and a model for collaboration that can be leveraged elsewhere?

Response: At this time, there are no uniform national criteria in place to evaluate collaborative opportunities, such as joint ventures with medical affiliates. The process outline from Charleston is currently being used as a starting place to provide a basic architecture plan when sharing opportunities present themselves at other sites. The process outline from Charleston's collaborative efforts has been shared and exported to New Orleans. The basic structure, along with lessons learned and modifications from different sites will be available to use in other collaborative health care opportunities.

Question 5: When considering the construction of new VA or joint facilities, will new Department of Homeland Security requirements impact the construction of these facilities? How? How much of a "premium" should be calculated to reflect the more stringent security requirements?

Response: VA is developing physical security strategies for VA facilities that will incorporate requirements of the Department of Homeland Security's Interagency Security Committee (ISC) criteria for new facilities. VA's strategies that are under development will correct the fact that the ISC criteria do not address the specific needs of a health care environment, or fully support VA's requirement for continued operation of such complex facilities after an extreme natural or man-made event occurs. These new strategies will impact facility costs and the size of the site required. VA estimates cost increases for facilities to be approximately 5 percent; however, a more accurate analysis of the cost impacts will be possible once strategies and fully detailed supporting standards are approved. In the interim, VA is providing additional funding for project development to address future approved standards.

Question 6: The Committee has heard that the land purchase funding for the new facility in Denver may be coming through reprogramming notices. Please provide a timeline as to when the Committee can expect to see those requests?

Response: The reprogramming letter which includes the request for $25 million for the Denver land purchase was signed March 14, 2006, and delivered to the Committee on March 15, 2006.

Question 7: How much does VA anticipate spending on land acquisition at Fitzsimons?

Response: An exact figure is unknown at this time. Five parcels of land which are owned by four separate entities are being proposed for the Denver facility. The largest single parcel is owned by the Fitzsimons Redevelopment Authority. The $25 million reprogramming request was made to cover the costs for this land purchase. Two of the parcels are owned by the City of Aurora, Colorado, and it is anticipated that these sites will be donated to VA for use. A fourth parcel is owned by the Fitzsimons Credit Union and the fifth parcel is owned by University Physicians, Incorporated (UPI). These latter two parcels are currently being appraised. The current fiscal year (FY) 2007 budget request for $52 million includes funding for the purchase of these two parcels. The purchase of the UPI site involves an office building, which will lessen the need for new construction.

Question 8: Please provide a detailed explanation of the new cost projections for the Las Vegas medical facility and what impact it may have on proposed construction schedules?

Response: Since the original cost estimate was made, the site has been selected, the space program refined, and the architect/engineer (A/E) has begun preparing schematic design.

The cost increase for the project is $120 million for a total project cost of $406 million, which is included in the Five Year Capital Plan submitted as part of the budget. VA is continuing to evaluate the market conditions in Las Vegas, as well as to refine the cost estimate. The results of this effort may affect the final cost estimate for the project. The primary reasons for the increase in the overall project cost are:

1. Escalation associated with construction materials in Las Vegas, is at an unprecedented double digit rate. This projected escalation rate has increased the overall project cost by approximately $35 million.

2. The original cost estimate was developed without the benefit of detailed project planning. As detailed space programming was accomplished, the resulting space plan for the facility increased approximately 18 percent. These increases were largely a result of

updating individual functional areas to be consistent with contemporary health care delivery standards which contributes an increase of approximately $50 million.

3. In addition to the approximate general 18 percent escalation rate in Las Vegas, the current saturated market conditions in Las Vegas are resulting in a premium to the project cost from 10 to 15 percent. The local market is completely saturated with projects. Labor shortages are of great concern with many owners receiving only one bid significantly higher than their budget. It is anticipated that this factor will increase the total project cost in the magnitude of $20 million.

4. Additional costs are due to the undeveloped nature and the size of the selected site, which will add approximately $9 million. These costs are associated with bringing the utility infrastructure to the site as well as the development and improvement to surrounding streets. Previous sites were located in more developed areas.

The first phase of the project (energy plant and utilities), will be awarded in FY 2006. The extra costs should not affect the timeline of the project.

Question 9: Subcommittee Chairman Brown sent a letter to Secretary Nicholson urging him to consider the Lake Nona site in Orlando for the planned new facility due to its proximity to the University of Central Florida's campus, future medical complex and research park. What progress has VA made on identifying a site for the new Orlando facility?

Response: A technical evaluation team from VA conducted a market survey in Orlando, visiting and evaluating several potential sites for the future VA Medical Center. The Lake Nona site was one of several sites visited and evaluated. The team presented its draft findings to VA's Site Selection Board (SSB). The SSB held a public hearing in Orlando on May 1, 2006 and visited the sites on May 2nd and 3rd. A report recommending the preferred site(s) will be presented to the Secretary for his selection. It is VA's goal to select a site that will best support VA's mission of providing quality health care to our veterans.

Question 10: The CARES Commission report noted that the Draft National CARES Plan contained 75 proposals for VA/DoD Collaboration and sharing. The Commission also said that for VA/DoD collaboration to be successful there has to be a clear commitment from senior leadership to such collaboration. What has top VA management done to encourage collaboration with DoD?

Response: VA's top management—from the Secretary, to the Under Secretaries, and to the chiefs of the Veterans Health Administration (VHA) program offices—continually pursue, promote, encourage and support collaboration with DoD at all levels within the organization. To further strengthen

collaboration efforts, an office of VA/DoD Liaison was established and reports directly to the Chief of Staff for the Under Secretary of Health. In September of 2005, the VA/DoD Liaison Office was merged with the VA/DoD Sharing Office. The merger of the two offices streamlined functions relevant to VA/DoD Sharing and Liaison. This office is responsible for the cooperative development and implementation of programs affecting all VHA operations in collaboration with DoD, focusing primarily in shared health care resources between the two Departments.

Also, the Deputy Secretary of VA with the Under Secretary of Defense for Personnel and Readiness, co-chair the Joint Executive Council; the VA's Under Secretary for Health with the Assistant Secretary of Defense Health Affairs, co-chair the Health Executive Council (HEC); and the VA's Under Secretary for Benefits with the Principal Deputy Under Secretary of Defense for Personnel and Readiness, co-chair the Benefits Executive Council. These top VA and DoD management officials are directly engaged in top-down collaborative efforts in a myriad of areas.

An example of the commitment of top VA officials to work with DoD can clearly be seen at the North Chicago/Great Lakes project. The $130 million DoD construction project includes a new Federal ambulatory care clinic co-located with the North Chicago VA Medical Center. Extensive work has already begun by six work groups to address human resources, information technology, leadership, finance/budget, clinical, and administrative concerns.

VA and DoD developed a Joint Strategic Plan in 2004 and have recently revised the plan in 2006. The Joint Strategic Plan is approved by the Joint Executive Council which is chaired by the Deputy Secretary of VA and the Under Secretary of Defense for Personnel and Readiness. The Joint Strategic Plan includes the following VA/DoD collaborations:

1. Seamless transition of healthcare and benefits such as Traumatic Servicemembers' Group Life Insurance (TSGLI), PL 108-375, and the cooperative separation process and benefits delivery at discharge,

2. Deployment health and the sharing of deployment health-related information,

3. Patient safety and overall shared safety practices,

4. Evidence-based clinical practice guidelines,

5. Capital asset coordination and the funding of potential joint capital initiatives related to Base Re-Alignment and Closure (BRAC),

6. Joint purchases of medical/surgical supply and equipment and the success achieved (significant cost-avoidances) as the result of leveraged joint buying power,

7. Pharmacy and the cost-avoidance achieved as the result of joint contracting,

8. Joint contingency/readiness capabilities that ensure the active participation of both Departments in federal and local incident and consequence response,

9. Information management/information technology initiatives including bidirectional health information exchange, federal health information exchange, pre- and post-deployment health assessments and post-deployment health reassessment data exchange, clinical data repository and the VA health data repository exchange, and other collaborative architecture, software applications, and data standard implementation,

10. Education and training agreements such as support for graduate medical education (GME) and non-GME shared continuing education and training, and

11. The wide-spectrum of direct sharing agreements—446 direct sharing agreements that cover 2,298 unique services, the Joint Incentive Fund projects (33) and the Demonstration Site Selection projects (7).

Question 11: What lessons can be learned from your experience with the joint venture proposal in North Chicago with DOD? Does the Department have any plans for leveraging this model at other sites?

Response: On May 27, 2005, the VA/DoD Health Executive Council signed an agreement to establish a joint venture between the North Chicago VAMC and the Great Lakes Naval Hospital.

As we move forward in implementing this joint venture, VA has learned several lessons thus far, which include the acknowledgement that:

- Working relationships between senior leaders are critical to the organization's success
- Additional administrative resources to support the demands of the joint venture
- An understanding of the cultural differences and differences in patient care environments helps facilitate better communication between the two organizations

- Establishing a close working relationship between North Chicago VAMC business office and the Great Lakes Navel Hospital business office, including the administrative staff, data analysts and systems analysts would be beneficial to collectively gather data for workload, costs, performance metrics, and Joint Incentive Fund requirements

The goal of this partnership are to improve access, satisfaction, and timeliness of services for VA and DoD beneficiaries while enhancing and expanding health care services, reducing redundancies, and more fully using existing space and capacity. Although legal and cultural issues continue to be identified and solutions sought, VA is hopeful that the project will lead to sharing on a similar scale in other locations.

Question 12: What lessons has VA learned through VA/DOD collaboration to date and how has that changed the VA/DOD joint strategic plan?

Response: With our DoD partner, we have accumulated numerous lessons over the years. First and foremost, communication is the key. Other lessons learned are:

- Leadership is essential at all levels to promote sharing goals.
- Projects/initiatives need to be jointly developed from the beginning to assure buy-in from both parties.
- The nature of local sharing has shifted from one of using untapped resources to one of partnering and gaining efficiencies by leveraging resources or buying power jointly at the regional or national level.
- Sufficient time needs to be allowed for proper coordination of joint projects in both Departments.
- Information technology projects need to be in alignment with enterprise solutions.
- While oversight mechanisms are required to assure that projects are progressing, the tools should not be too burdensome.
- Areas of collaboration need to be carefully considered to assure that they meet the needs of both Departments (i.e., sharing for sharing's sake is not necessarily in the best interest of the government).
- The Departments have recognized the need for coordinating care authorization and billing requirements.
- Certain service delivery areas result in especially good partnerships such as radiology, internal medicine, laboratory, primary care, shared staffing; and, education and training.

Disseminating "lessons learned" from the Joint Incentive Fund (JIF) and Demonstration Site Selection (DSS) projects has been incorporated into the VA/DoD Joint Strategic Plan (JSP) for fiscal years 2006-2008. The Health Executive Council is charged with conducting annual progress reviews, collecting lessons learned, and disseminating lessons learned to VA and DoD staff. Other

VA/DoD sites will be able to benefit from the experience of the JIF and DSS projects as the two Departments sharpen their evaluative techniques and the projects mature. Furthermore, the JSP includes activities to facilitate increased sharing.

Question 13: What options has the joint VA/DOD task force identified for a joint VA/DOD venture for the federal health care facilities in the Keesler AFB/VA Biloxi campus area?

Response: The Principal Deputy Assistant Secretary of Defense (Health Affairs) and the Acting Deputy Under Secretary for Health for Operations and Management formed a task force to develop possible operational models for providing care to military personnel, retired active duty, and veterans at the Keesler Air Force Base and Biloxi VA Medical Center. The models attempt to maximize the resources of both Departments, while ensuring beneficiaries receive quality care in a timely and cost-effective manner. The task force assessed the current environment and capabilities at both Keesler Air Force Base and Biloxi VA Medical Center and identified several possible options for consideration ranging from a joint VA-Air Force facility to a standalone facility with shared clinics.

Question 14: Please comment on the degree of difficulty associated with VA/DOD sharing due to the lack of a shared electronic medical record?

Response: We have made great strides in the past five years in shared electronic medical record information. While it is not fully implemented to allow real time access to all data, we are moving in the right direction.

On the local level to support returning combat veterans, we signed a MOU with DoD on June 29, 2005 to significantly improve the shared health information for combat related service members who are transiting to veteran status. VA's Polytrauma Rehabilitation Centers are establishing read-only access to electronic medical information at Walter Reed Army Medical Center and Bethesda National Naval Medical Center. VA staff has and continues to train clinicians to access and use this information.

While this is a major accomplishment, some limitations still remain as DoD works to complete the full implementation of it's overarching electronic medical record – projected to be completed later this year. In the meantime, VA's Polytrauma Rehabilitation Centers have initiated monthly video-teleconferences with the treatment teams at Walter Reed and Bethesda. This has proven to be an effective means of communicating information that is not typically documented in the medical record.

From the more global front on real-time exchange of electronic patient medical records and information, we believe that with DoD, we have made significant progress toward achieving interoperability of available electronic medical information. In 2002, VA and DoD implemented the Federal Health Information Exchange (FHIE). FHIE supports the one-way transfer of all clinically pertinent electronic data from the DoD Composite Health Care System (CHCS) to Veterans Health Administration (VHA) clinicians and to Veterans Benefit Administration (VBA) benefits workers. Upon a service member's separation or retirement from DoD, DoD sends that service member's data to a shared secure FHIE repository where the data are available for viewing by VA personnel using the VA Computerized Patient Record System (CPRS). FHIE is operational at all VA medical centers and facilities.

To date, DoD has transferred health data on approximately 3.3 million unique service members to the shared FHIE repository. Of this 3.3 million, over 2 million have registered to receive medical treatment or benefits from VA. FHIE data available for viewing by VA include outpatient pharmacy, laboratory, radiology reports, consults, admission, disposition and transfer data, and diagnostic coding data from the standard ambulatory data record.

Using FHIE, VA also has access to military pre- and post-deployment health assessment data from DoD Forms 2795 and 2796. DoD has transmitted more than 515,000 pre- and post-deployment health assessments on over 266,000 separated service members. DoD continues to send monthly transmissions of these data to VA as more members separate or retire. These assessment data provide useful information to VA clinicians including information about exposures and other stressors related to deployments. In March 2006, DoD completed an initial load of over 700,000 pre- and post-deployment health assessments for demobilized National Guard and Reservists. VA and DoD are now working together to ensure that National Guard and Reserve data also are collected and included in the monthly transmissions.

In addition to the one-way transfer of electronic medical data through FHIE, VA and DoD have developed the bidirectional capability to share some electronic medical to use in the care of shared patients. The VA/DoD bidirectional health information exchange (BHIE) automatically matches patient identities for active DoD military service members and their dependents with their electronic health records at VA facilities. It also supports the real-time bidirectional exchange of outpatient pharmacy data, allergy information, laboratory results, and radiology reports. BHIE data are available at eight DoD host sites. These DoD sites include locations that receive large numbers of Operation Enduring Freedom and Operation Iraqi Freedom combat veterans, including Walter Reed, Bethesda, and the Landstuhl Army Medical Center in Germany. DoD data from these eight host sites are available at every VA site of care, and staff at those DoD facilities has full access to this information from every VA facility.

Both FHIE and BHIE provide interoperability of data through existing health information systems for VA and DoD. VA/DoD is moving to real-time sharing of full clinical data information, as VA/DoD coordinate technologies to the to next-generation health information systems. VA/DoD is developing a coordinated implementation plan to share data between those systems.

The first release of this interface, known as "CHDR," will support interoperability between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR) and will allow VA and DoD to conduct drug-drug and drug-allergy interaction checking between VA and DoD pharmacy systems.

In January 2006, the Departments completed formalized interagency testing and conducted a successful demonstration using the production version of CHDR for VA and Military health system information technology leadership. The Departments are now working closely with an interagency staff in El Paso, Texas, to complete CHDR production testing in a patient care environment between the William Beaumont Army Medical Center and the VA El Paso Healthcare System no later than July 2006.

VA is working closely with DoD to expand the scope of clinical information that is shared. Recently, the Departments initiated a pilot to explore the feasibility of sharing scanned paper records to provide VA electronic access to clinical data that were not previously available in electronic format. VA and DoD also are closely collaborating on the development of next generation imaging technology that will facilitate the sharing of radiological images between DoD and VA.

While the lack of shared real-time exchange of patient medical information has presented challenges in the past, we have and will continue to jointly work towards a long-term solution that allows us to further leverage our joint medical systems.

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