Statement of
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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.