Testimony Before the House Committee on Veteran's Affairs

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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.