



September 8, 2003

Statement to the Capital Asset Realignment for Enhanced Services (CARES)
Commission Hearing
September 12, 2003
Durham Marriott, Civic Center
201 Foster Street
Durham, North Carolina 27701

The Department of Veterans Affairs (VA) W.G. (Bill) Hefner Medical Center in Salisbury, North Carolina and its accompanying clinic in Winston-Salem, North Carolina has been a strong affiliate of the Wake Forest University School of Medicine (WFUSM) for over a decade. In recent times we have increased our collaboration and clinical care and education in the areas of mental health, ophthalmology, otolaryngology, and some cardiovascular services.

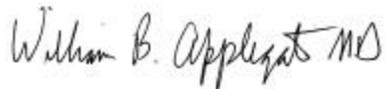
Although this partnership has been very healthy for both the VA and WFUSM, as the new dean of our medical school, I am committing my personal time, energy and institutional resources to take our collaboration with the Salisbury VA Medical Center to a much higher level. I have recently met with Mr. Daniel Hoffmann, Network Director, and Dr. Mark Shelhorse, Chief Medical Officer, with the Veterans Integrated Services Network (VISN 6) and have had a number of productive meetings and visits with Dr. Sidney Steinberg, Interim Chief of Staff of the Salisbury VA Medical Center. It is our combined agreement that we are proceeding to make our VA relationship a full VA/DEAN'S Hospital affiliation.

We have agreed that staff at the VA Medical Center in Salisbury and its satellite clinics will receive faculty appointments at the WFUSM. We are currently planning or contracting with the Salisbury VA Medical Center with particular emphasis in the following clinical areas: primary care, gastroenterology, mental health, general surgery, cardiac care, radiology, radiation oncology, and possibly several other subspecialty areas of medicine. The CARES plan will allow the Salisbury VA and our school of medicine to more firmly partner to meet the health care needs of the veterans in our geographic area. It is estimated that there are approximately 250,000 eligible veterans in our area, many of whom have not managed to access the VA system. We realize that the Salisbury VA Medical Center and its satellite clinics in Winston-Salem and Charlotte are in a very strong growth phase and we would like to partner with them to assist in this continued growth and comprehensive health services provision.

In addition to the clinical areas above, we have proposed to the Salisbury VA Medical Center that WFUSM work with them to help provide ambulatory primary care medicine for veterans at a proposed site in Hickory, Greensboro, and an expanded site in Charlotte, North Carolina. The CARES program would allow us to accomplish this in partnership with the Salisbury VA Medical Center in a way that would benefit the health care and health status of veterans in our region without acquiring a large capital investment on the part of the Department of Veterans Affairs.

In addition, through the CARES initiative this partnership would greatly enhance both our teaching and clinical missions in our geographic area. WFUSM, like the Salisbury VA Medical Center, is committed to the mission of providing world-class health care. Through the CARES process, we look forward to strengthening a partnership that will further benefit America's veterans.

Sincerely,

A handwritten signature in black ink that reads "William B. Applegate MD". The signature is written in a cursive style with a clear, legible font.

William B. Applegate, M.D., M.P.H.
Senior Vice President, Wake Forest University Health Sciences
Dean, Wake Forest University School of Medicine

CARES Commission Hearing
12 September 2003 – Durham, NC
VISN 6/TRICARE Region 2

Hampton VA/1 MDG Hospital Collaboration

CARES is focused on getting the best value/best care through optimal management of DoD-VA resources. Expansion of the current robust cooperation with Langley AFB Hospital (hereinafter referred to as the 1st MDG) and Hampton Veterans Administration Medical Center (HVAMC) is a golden opportunity!

Current/future collaboration opportunities are being evaluated and rank ordered with HIGH PRIORITY projects at the top of the list for early implementation. The Sharing Initiative between HVAMC and 1 MDG meets all criteria for a HIGH PRIORITY opportunity. However, VISN 6 is not on the current list of HIGH PRIORITY DoD collaborations. It definitely should be for the reasons outlined in this testimony.

To be HIGH PRIORITY, a project must meet 4 criteria. There must be:

- an acute demand for access to services or facilities on the part of DoD or VA.
- substantial mutual advantages to collaboration.
- DoD must have proposed a major construction facilities project at the collaboration site. The project must be currently in planning or design, and immediate coordination is needed to determine the scope, cost, and operational implication of collaboration.
- The project should have high visibility to Congress and senior leadership of DoD &/or VA. As you will see, the HVAMC/1 MDG collaboration fully satisfies all of these criteria.

There is an **acute demand for access to services on the part of both HVAMC and 1 MDG**. There is a history of collaboration and mutual support between these institutions extending over the past several years. We have a rather robust and growing sharing agreement which is set up to be cost neutral over the long haul. Two past and current examples are orthopedics and pathology. VA has an unmet need for orthopedic surgery. 1 MDG has a need for pathology services. For a period of 3 years, 1 MDG orthopedic surgeons and technicians did outpatient clinic and inpatient surgeries (mostly joint replacements) on VA patients weekly. The benefits to VA were improved access to care, customer convenience at not having to travel to Richmond VA for care, and cost avoidance by not requiring the purchase of care from the civilian community. The benefit to

1 MDG staff was the ability to do more complex cases than Langley Hospital could support. This expanded scope of care was possible because HVAMC had an anesthesiologist and an ICU; Langley had only nurse anesthetists and no ICU. When HVAMC closed their inpatient surgical unit in summer 02, the arrangement was halted. However, the program will resume as soon as HVAMC has hired surgical unit staff and reopened their inpatient surgery unit. In May of 03, 1 MDG lost their pathologist. A new annex to the Sharing Agreement was written, and since 1 June 03, HVAMC has provided all cytopathology services for 1 MDG. 1 MDG equipment is on loan to the VA, and 1 MDG histopathology technician supports the VA. This is working extremely well for all parties and continuation of this workload makes maintenance of current VA pathologist staffing levels cost effective. In both of these examples, professional staff hold dual credentials at both hospitals. Additional near-term sharing opportunities exist in a number of areas: ENT, general surgery, dermatology, radiology (MRI), psych testing, critical care nursing/technician, cardiology, and gynecology. All of these can begin with current staffing and financial resources.

There must be **substantial mutual advantages to collaboration**. All of the past, current, and future sharing initiatives provide mutual benefit, as is exemplified by orthopedic surgery and pathology. 1 MDG is standing up an ENT service. One ENT physician and two ENT technicians are already in place; however, 1 MDG has no office space, clinic, or operating room (OR) equipment. HVAMC has an ENT clinic and some OR equipment and an anesthesiologist, but has an acute and ongoing need for ENT services. There are some inherent limitations in that Air Force ENT practice has a substantial pediatric component and pediatrics will never be within the VA's scope of care. Despite that limitation, mutual benefits exist. HVAMC is critically short of surgeons; 1 MDG has 4 general surgeons but only 3 offices and insufficient OR time. As with all of the surgical sharing initiatives, once HVAMC reopens their surgical inpatient unit, 1 MDG surgeons and technicians will be able to perform more complex cases on sicker patients, thereby maintaining peacetime and wartime skills. Full scope of practice is important to enhance retention of our AF physicians and professional staff. 1 MDG has 2 dermatologists and some excess capacity--VA has unmet needs for dermatology care. HVAMC has a new MRI scanner which will be operational this fall. The nearest DoD facility with MRI capability is Portsmouth Naval Medical Center (PNMC), and they have insufficient capacity. 1 MDG beneficiaries who need urgent or semi-urgent MRIs must be referred to the civilian network at considerable expense to 1 MDG. (TRICARE Region 2 is under Revised Financing--the MTF pays directly for any care referred to the civilian network.) 1 MDG has radiologists who are MRI trained and who need to read MRIs in order to maintain their skills. HVAMC has a small but important need for psychology testing, and civilian services in the area are not of high quality. 1 MDG has excellent psych testing capabilities, and has sufficient capacity to handle HVAMC's relatively small workload. 1 MDG has a number of critical care nurses, all of whom occupy mobility positions that require currency. HVAMC has an ICU. HVAMC has non-interventional cardiology services

available and is able/willing to provide some oversight of 1 MDG cardiopulmonary technician services (Holter monitors, echocardiograms). In exchange, 1 MDG cardiopulmonary technicians can provide some of these procedures to VA patients. HVAMC has Women's Health Practitioner, but could benefit from OB-Gyn physician oversight. 1 MDG has 6 OB-Gyn physicians, but their primary workload is OB; they need/want to maintain a component of gynecologic care in their practice, including gyn medical and surgical care in menopausal and post-menopausal women.

Both HVAMC and 1 MDG have a strong interest in graduate medical education (GME). HVAMC has a training affiliation agreement (TAA) with Eastern Virginia Medical School (EVMS) and has residents doing clinical rotations at HVAMC. 1 MDG has a very robust GME mission. 1 MDG provides clinical rotations for residents in family practice, advanced basic obstetrical nursing, laboratory students, family nurse practitioners, women's health practitioners, nurse midwives, PhD psychology students at Regent University, and physician assistant (PA) students. 1 MDG is one of only 3 DoD training sites for PA students from all three branches (AF, Army, Navy). The HVAMC/1 MDG sharing initiatives discussed benefit the students, staffs, and programs at both sites. The ability to teach is an important job satisfaction and retention tool for many of the professional staff at both facilities. Appointment as an affiliate faculty member is a great perk.

DoD has proposed a major construction facilities project at the collaboration site. 1 MDG's \$50.4M project is 35% designed. Construction is scheduled to be complete in 08. A primary consideration in justification of this MILCON project is the military readiness mission. Over the past 10 years, many military treatment facilities (MTFs) have been downsized or closed. In many locations, the needs of the patient populations can be met by purchasing care in the civilian sector. As a result of this trend, the Air Force does not have many locations to base readiness-essential staff. Langley AFB hosts one of our larger beneficiary populations and is a primary delivery platform to keep readiness-required providers trained and ready to deploy. In fact, 222 troops currently assigned to 1 MDG fill primary UTC deployment roles (A unit tasking code designates specific equipment/personnel to fulfill a deployment tasking; for example, a critical team, a surgical team, a surgical augmentation package). An alternate is also aligned against each of these positions whenever possible. Even with the upgrade of 1 MDG facilities to include an ICU and expanded surgical capability, VA patients remain critical to skills maintenance. 1 MDG services primarily a young and healthy population (average age <30); VA patients greatly expand the scope of both medical and surgical skills maintenance for military staff. Continued emphasis on supporting the Graduate Medical Education (GME) programs will remain very important to both HVAMC and 1 MDG in the future. The table below lists the officer UTC personnel (both primary and alternate).

Position	#
Orthopedic Surgeons	4
General Surgeons	4
Nurses	42
Nurse Anesthetists	12
Flight Surgeons	8
Internists	4
Family Practice Physicians	18
Emergency Room Physicians	4
Dentists	4
Public Health Officers	4
Laboratory Officers	6
Pharmacists	2
Radiologists	2

In a nut shell, the military's unique mission drives the scope of care, which in turn drives the facility capability. A significant secondary benefit is recapture of expensive medical care from the civilian sector. An additional significant benefit is maintenance of strong GME programs, with enhancement of staff satisfaction and recruitment/retention. The VA patient population provides medical and surgical scope of care much broader than seen in the traditional DoD patient population. VA patients benefit from the enhanced array of medical services made available to them through effective VA/DoD collaboration.

In the context of VA/DoD collaboration, it is critical to recognize the impact of deployments. The operations tempo of the past couple of years is unprecedented in numbers of personnel and frequency and duration of deployment. This is true for both isolated MTFs in areas where the civilian network is insufficient and for MTFs in collaborative relationships with VA facilities. The Air Force is aggressively working some funding/staffing solutions. The focus is twofold; the first looks at primary care access for our TRICARE Prime MTF-empowered beneficiaries. The second looks at skill sets heavily tasked for specialty/critical care deployment taskings. Access to Care funds has been established to purchase contract provider and support personnel, such that primary access remains available in the face of deployments. Civilian contract technician, nurse, and provider staff (all non-deployable) can be hired to provide some hedge when military primary care staff deploy. Gap Analysis funding is used to purchase civilian contract (non-deployable) critical care, surgical and emergency medicine providers to maintain an adequate facility capability in the face of deployment. By way of example, 1 MDG has hired 2 primary care civilian contractors (Access to Care), and 2 civilian nurse anesthetists, and a civilian internal medicine physician Gap Analysis). At any given time, 1 internist/1 surgeon/1 orthopedic surgeon/1 ER doc/1 nurse anesthetist/1 critical care nurse is usually deployed. Military staffing has been increased from 3 to 4 general surgeons. There is increasing coordination of staffing and funding from the Air Staff level down to better coordinate staffing/resourcing with both

peacetime healthcare delivery and deployment requirements firmly in mind. This is a new phenomenon. Historically, availability of care in the civilian network and peacetime cost avoidance/best price were the primary drivers of MILCON and staffing decisions. When deployments were less common, less frequent, and more predictable in length, that approach worked relatively well. In today's environment, such a narrow focus simply doesn't work.

This project has high visibility to Congress and senior leadership of both DoD and VA. HVAMC/1 MDG have applied to become a Demonstration Site under the VA/DoD Health Care Resources Sharing and Coordination Project, as directed by the FY 03 National Defense Authorization Act (NDAA), Public Law 107-314. HVAMC and 1 MDG collaboratively developed the proposal; HVAMC took the lead in submitting the application through VA channels, while 1 MDG simultaneously provided an info copy of the proposal to Air Staff. The 1 MDG MILCON project is the Air Force's number one priority project for FY 05 AF/SG and ACC/SG directed the delay of the \$14.9M project at another ACC base by one year in order to allow the expanded Langley project to happen. The project supports AFMS Long-View financial risk reduction initiative, readiness, and provider currency needs. It facilitates maintenance of robust GME programs, and it can accommodate VA workload where is overlap with AF provider currency requirements.

June.Carraher@langley.af.mil

Work: (757) 764-6485 Cell: (757) 870-1191

Suggested Testimony to CARES Commission
Duke University Medical Center

Thank you for the opportunity to submit testimony to the CARES Commission about the draft National CARES Plan.

Duke University Medical Center is the primary academic affiliation for the VA Medical Centers in Durham and Asheville. This is a firm and mutually beneficial liaison that has been in effect since the establishment of the Durham VA Medical Center in 1953, and at Asheville since 1962. We also have a close partnership in the area of clinical research, with VA research funding and Career Development programs serving as recruitment tools for skilled clinical researchers holding joint VA and DUMC appointments.

At Durham, all VA Medical Center physicians have academic appointments at Duke University Medical Center (DUMC), and the majority of DUMC medical students, residents, and fellows spend part of their time in service and training at the Durham VAMC. Durham has over 130 medical resident positions in a wide range of specialty programs, with more than 40 resident positions in Internal Medicine alone. Division chiefs who have at least 5/8th VA appointments lead seven of the 11 divisions of the Department of Medicine at DUMC.

Asheville has a fully integrated program affiliation model with 11 funded positions in Surgery and Anesthesiology. In 2002, an additional DUMC and Asheville training affiliation began for Certified Nurse Anesthetists with one funded position.

The VA clinical and academic environment complements that of DUMC, adding to the spectrum of experience gained by trainees. The academic environment allows learners to actively participate in the care of veteran patients in primary care, acute care, Emergency Room, and inpatient ward settings, and often contributes significantly to the requirements of the Accreditation Council of Graduate Medical Education. Examples of important program contributions include:

- Procedure based health professions gain the experience required by the various accreditation boards. This is especially valuable for surgical specialties and medical specialties such as cardiology and gastroenterology.
- Primary care-based trainees have gained opportunities through programs such as the PRIME program, which is a federally funded initiative to increase trainee interaction with primary care faculty. The PRIME program has a focus on clinical and academic curriculum development in prevention, screening, evidence-based clinical practice, physician-patient communication, and palliative care.

The relationship between DUMC and the Durham and Asheville VA Medical Centers has been characterized by open communication and mutual respect. We have appreciated the efforts made by VISN 6 and the Durham and Asheville VA Medical Centers to ensure that we received current information throughout the CARES process. We have received regular mailings as well as briefings at our Dean's Committee meetings, so we feel confident that our communication channels are open and working effectively. We have asked both facilities to ensure that our Department Chairs are involved in CARES planning as needed, particularly as it relates to any potential impact on the training

program in individual Departments. We have been assured that they will do so. We will be assessing the potential impact of workload increases on the quality of clinical care delivered as well as on our training programs, with a goal of ensuring that the high quality of our program is sustained.

We have reviewed the CARES Planning Initiatives for VISN 6 and noted the projected significant increase in VA enrollment (> 40%) over the next ten years. It seems that, historically, VA resources have not always kept pace with workload demand, and we know that our VA facilities have had to use waiting lists at times when demand exceeds capacity. It is our hope that the CARES process will address the resources needed to effectively meet the projected demand, and that the process is completed in sufficient time to ensure services are established and ready for activation when the patients need them.

The VISN 6 plan for Asheville calls for three additional Community Based Outpatient Clinics (CBOCs) in Franklin, Hendersonville, and Rutherfordton to improve access and meet the capacity demand for Primary Care and Mental Health, and renovation and new construction to address space needs in excess of 100,000 SF.

The VISN 6 plan for Durham calls for additional CBOCs in Burlington and Rocky Mount to improve access and meet the capacity demand for Primary Care and Mental Health; much-needed ward renovation projects to correct over-crowding in patient rooms and improve infection control; construction of a large outpatient addition at Durham to meet the need for space in many programs, particularly outpatient specialty care; and expansion of the Greenville CBOC to a full-scale satellite outpatient clinic.

For both Durham and Asheville, we strongly support these capital asset initiatives, which we view as critical for meeting the needs of veteran patients and improving their access to care. At Durham, our house staff have commented on the excellent computerized medical record system used by the VA, but also report often having only 1 exam room in which to see patients, or insufficient office space for consultation or review of cases with the attending physicians. At Asheville, adequate clinical space, increased administrative support for clinics, and timely hiring of direct care support staff such as mid-level practitioners and nurses are areas that would enhance both training and the patient care experience.

At both facilities, the additional community based outpatient clinics and new construction will improve access to care and increase the space available to meet future demand. We note that while the draft National CARES Plan includes all of the CBOCs for Asheville and the Southwest market in its list of high priority CBOCs for implementation, none of the CBOCs for Durham or the Southeast market area are included. While we understand the concern about balancing the various needs within the VA system, we recommend that each VISN be allowed to distribute the allocated number of new CBOCs across the VISN where they will have the biggest impact, rather than using an "all or none" allocation by market area.

In addition to the needed patient care space, Durham currently has a pressing need for additional clinical research space. The Durham VA Medical Center Enhanced Use project includes a plan for construction of a 34,000 SF VA Research Building. If the project progresses as planned, this building will help to off-set the space deficit for Research and will permit consolidation of research laboratories into new, modern space

that is designed for that purpose. Existing research functions are spread throughout several buildings and wings and in some cases are operating in space that was not designed for research use. If for any reason the Enhanced Use project does not provide the expected research space, we would support VA efforts to obtain needed research space through a capital asset project.

In summary, we support VA's capital planning efforts and look forward to our continued partnership in meeting our key missions of promoting excellence and innovation in the education of future health care professionals. These affiliations are critical to our core mission and we are vitally interested in, and supportive of, the ability of these VA Medical Centers to care for the veteran population in our region and ensure the normal function of the research and education programs.

We appreciate this opportunity to provide input about VA's CARES planning process.

Sincerely yours,

A handwritten signature in black ink, appearing to read "R. Sanders Williams". The signature is written in a cursive, flowing style.

R. Sanders Williams, M.D.