

STATEMENT OF
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BEFORE
THE DEPARTMENT OF VETERANS AFFAIRS'
CARES COMMISSION
HEARING ON CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
WITHIN VISN 9
SEPTEMBER 8, 2003 / LEXINGTON, KENTUCKY
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Mr. Chairman, members of the Commission, distinguished veterans and guests - good morning. I am pleased to be here today to address the CARES Commission regarding the Mid South Healthcare Network's actions relative to the national CARES process.

Working with the national Cares Program Office the VISN reviewed population projections as well as historic utilization patterns at the county - and in some instances zip code levels. Based on information provided from the NCPO and our own validation of historic and projected utilization VISN 9 identified four primary markets within our network: North, Central, East, and West.

In defining market areas there were a number of national planning parameters we worked within, such as areas defined as urban, rural or highly rural. Specific distance and travel time factors, as well as terrain and topography, were considerations within each of these definitions by types of services i.e. primary care, inpatient hospital care and tertiary hospital care.

VISN 9 also completed a very specific and detailed reporting of inventory of current clinical services provided either at - or - through each Medical Center and Outpatient Clinic within the network. This inventory was more extensive than just a listing of services. It included identification of where the service was provided, if the services were provided directly by VA staff or through a contract or fee for service arrangement, as well as services that were provided by another VA medical care center. This inventory served as the basis for looking at the gaps in service delivery based on demand and projected utilization of service analysis that was provided by the NCPO.

While the overall veteran population is anticipated to experience a decline, forecasts for each market within VISN 9 identified growth in veteran's use of our medical facilities. Common among the four market areas is an anticipated increase in demand for primary care and subspecialty care.

The Central and West market forecasts indicate an increased demand for inpatient medicine beds; the East and North market forecasts indicate there will be an increased demand for outpatient mental health services. In our network, there is projected increased demand for services through FY 2012, and FY 2022 demand is projected to be lower than that of 2012, but greater than our current demand.

Given the national scope of CARES, our network chose to manage the process with an executive-based command and control structure. In August of 2002 we established a VISN 9 CARES Committee that developed individual market workgroups, stakeholder involvement mechanisms, a communication process, and a process for data development and analysis. The CARES committee and workgroups were lead by senior managers, and the VISN 9 Executive Leadership Council carried out final selection and approval of the service delivery options.

A great deal of effort and attention was paid to the development of the market workgroups since these individuals would be responsible for analysis of the CARES data, aligning the data with national and network augmented criteria, and eventually develop alternative solutions and final recommendations. Over 50 individuals representing each medical center within the network were involved in the market workgroups. Workgroup membership was weighted towards clinical staff and included at least one labor partner representative on each of the four market workgroups.

Given equal priority, was development of a stakeholder process, which resulted in a multiple focus group strategy within each defined market. Focus group leaders were provided formal training. Focus groups were held twice at each medical center during the CARES process. The initial focus group sessions centered on questions of how to meet projected increasing service demands. The second round of focus group meetings were held after the initial CARES options were identified. These meetings centered on the alternatives. Information gleaned from these sessions was provided to our market workgroups and utilized in the development and finalization of the service delivery options.

The result of this process was the identification of a number of options for each of the CARES areas being addressed within a market. The initial review by the Executive Leadership Council of the market workgroups alternatives resulted in development of additional network criteria that were applied to the alternative service delivery options. A second presentation to the Executive Leadership Council was given, which included the additional network criteria and resulted in clarifying the proposed recommended solutions where the recommendation would be the best alternative but fell outside of the network defined criteria. The refined service delivery options were accepted in April of 2003 and entered into VA CARES portal.

The underlying foundation of the VISN 9 assessment process was the determination of what the service delivery option impact would be on access, quality, and the cost of providing healthcare. It also encompassed an assessment of any potential negative impacts on stakeholders and the consideration of strategies to mitigate the negative effect. One of our expectations of the CARES process was that it would serve also as an enhancement to ongoing network strategic planning efforts. The VISN 9 objective was not only to complete the CARES project, but also provide us with a meaningful strategic planning document.

A need for further analysis was identified when projected in-house costs exceeded projected contract costs by more than 115% for a given alternative. The value of 115% was deemed a flag for investigation rather than a lesser figure since VHA would continue to have some administrative costs associated with contract ventures.

A strong consideration was placed on enhancing access rather than expanding existing medical centers for planning initiatives necessitating additional capacity. If expansion was necessary, contracting was considered as a preferable alternative.

Preference was placed on Service Delivery Options that considered the consolidation or complementary mission reorganization of existing VA-owned infrastructure where practical.

VISN 9 internal criteria also placed a preference on reducing VHA owned infrastructure. This approach was deemed prudent in order to (1) enhance patient access, (2) reduce recurring capital expenditures to build and/or maintain infrastructure, and (3) to reduce recurring capital expenditures for high-tech equipment. It was recognized that by the time major construction projects were designed, approved, and constructed; the peak patient demand would have passed and the additional capacity would no longer be required. It was also acknowledged that if demand declines over time as projected, it would be easier to discontinue contracts and leases than dispose of buildings and reduce staffing levels.

The VISN 9 CARES recommendations are predicated on and supported by the analysis of CARES data and common sense. It is an approach that suggests a realignment and reorganization of certain market areas within the network. The strategy moves beyond the “quick-fix”. It offers solutions that are long-term in nature, and proactively addresses the challenges before VISN 9.

The VISN 9 Executive Leadership Council and I reviewed and discussed at length the service delivery options developed by the market workgroups. VISN and Network Executive Leadership Council support and endorse the options provided the Commission, which I will briefly outline:

The Central Market consists mainly of counties in Tennessee with some counties along the Tennessee/Kentucky border and a small part of Georgia. The Central market is a mix of a few urban areas and a majority of rural areas. Movement towards the Sunbelt is supporting migration into most of our areas. VA facilities in the Central Market are well situated to provide acute and tertiary level services. Expansion of some sites will be needed to provide access to specialty care services. The geography in which the Central Market functions has limited mental health services and is becoming saturated in the availability of primary care services to the general public.

Availability of inpatient mental health services are extremity limited at the state level and not much better at the private sector level. Access to long-term care rehabilitation exists in the three major urban areas and to a lesser degree in the rural county hospitals but access to nursing home care is adequate at this time. However, discussions with the Tennessee Hospital Association as well as community hospital managers indicate that there is little planning for additional beds even though they recognize the increased future demand for these services.

In the Central Market the FY 2012 veteran population is projected to be 300,000 with an enrollment of 106,525.

Our proposed service delivery options for the Central Market include the following:

- Addressing realignment of services between the Alvin C. York and Nashville campuses to configure complementary missions and eliminate duplication of services.
- Consideration of inpatient acute surgical bed viability at the York campus and realignment of service to the Nashville campus.
- Enhancement of services offered in the Chattanooga, TN area including selected specialty and inpatient services.

The East Market area has 36 counties in three states with the greatest number of counties in Tennessee, but also counties in Kentucky and Virginia. There is one defined urban area, Knoxville Tennessee. There are three counties in North Carolina and one additional county in Virginia that were considered as part of the East Market rather than as part of VISN 6. The FY 2012 veteran population is projected to be 160,000 with and enrollment of 65,250. The primary service delivery facilities in this market are the James H. Quillen VA Medical Center in Johnson City and the Knoxville Outpatient Clinic.

Service Delivery Options for the East Market include:

- **Enhancement of services offered in the Knoxville, TN area including selected specialty and inpatient services.**
- **Collaborative opportunity exists with the National Cemetery by expanding capacity on the campus of the Mountain Home VA Medical Center.**

The West Market consists mainly of 53 counties in Tennessee with border areas of Mississippi and Arkansas. This area has traditionally been served by the Memphis VAMC and there are some natural boundaries including the Mississippi and Tennessee rivers and central interstate I-55 and I-40 that serve as the central defining aspects of this area.

Service Delivery Options for the West Market include:

- **Establishment of new access points throughout the market area including a major sub market in Jackson, TN.**
- **Addressing projected Special Disability demand for 20 long-term care spinal cord injury beds through internal realignment at the Memphis VA Medical Center.**

The North Market consists of 78 counties in Kentucky, 12 counties in Indiana, 10 counties in West Virginia and 2 counties in Ohio. The primary VISN 9 VA Medical Centers that serve this area are Louisville, Lexington and Huntington. Medical Centers from other VISN's that have some overlapping areas are mainly the Cincinnati, Ohio and Beckley West Virginia VAs.

The major interstates are I-65 and I-64, but a large segment of the eastern portion of this area is highly rural with no interstate access.

This geographically large market area was defined based on the high concentration of veterans in and around the urban Louisville area and secondarily around the Ft. Knox DoD facility. The FY 2012 veteran population in this market is projected to be 307,000 with an enrollment of 145,000. A large segment of the eastern portion of this area is highly rural with no interstate access.

The options for consideration in the North Market include:

- Consideration of a replacement facility for the Louisville VAMC.
- Consideration of a collaborative opportunity between VBA and the Louisville VAMC were identified and conceptual agreement on the desire for a jointly located facility was reached and considerations will depend on potential for development of a new Louisville facility.

*This is medium
Priority on
VBA List*

- **Consolidation of Lexington VAMC operations to one campus and exploring enhanced-use lease opportunities for the other campus.**
- **Addressing a tertiary level proximity issue within the market between the Lexington and Louisville VA Medical Centers and potential realignment of the Lexington and Louisville medical centers resulting in consolidation of the tertiary requirements within the northern market.**
- **Potential enhanced-use arrangement with Eastern State to establish long-term psychiatry services on the Leestown campus. Eastern State is Kentucky's acute and long-term psychiatric institution.**

IN CONCLUSION Mr. Chairman, I am proud of the efforts among employees and stakeholder groups in VISN 9 to address the difficult issues raised within the CARES process. Independent of the final outcomes of the Secretary's decision on CARES recommendations, this process has been fruitful in identifying not only the significant demand for patient care services that VISN 9 will face in the future. Additionally, it brought to light significant capital, infrastructure and organizational issues which we must begin addressing now in order to meet the needs of our veterans.

This concludes my formal remarks. My staff and I would be pleased to answer any questions the commission may have.