

STATEMENT OF VINCENT CRAWFORD
DIRECTOR, VA REGIONAL OFFICE
ST. PAUL, MINNESOTA

I have appreciated the high degree of involvement afforded to the St. Paul VA Regional Office by VISN 23 in its Capital Asset Realignment for Enhanced Services (CARES) planning process. As VARO Director, I served as a member of the VISN 23 CARES Steering Committee. Our Assistant Director, Sue Ihrke, served on the CARES Area Market Planning (CAMP) Team for the Minnesota market area.

In addition to this involvement, the VISN 23 CARES process has considered the space requirements of the Veterans Benefits Administration in support of meeting the needs of the veterans we serve. The Director of the Minneapolis VA Medical Center and the VISN 23 Network Director both have been very supportive of an Enhanced Use Lease initiative which would provide space to build a new Regional Office on the campus of the medical center. In addition to providing greater convenience for veterans seeking VA services, this would further cement the excellent working relationship we have enjoyed for years between this Regional Office and the VAMCs with which we cooperate in such areas as the Compensations & Pension program, veterans education and outreach, and staff education efforts.

I would be happy to answer questions about the Enhanced-Use Lease process or other issues the Commission may have regarding VBA impact of the proposed CARES Plan for VISN 23.

Via separate request I have been asked to staff a veterans benefits help desk during the course of the hearing. We will have a Veterans Service Representative present throughout the hearing to answer veterans' questions or do other claims-related outreach work that may arise.

Vince

Vincent Crawford, Director
St. Paul VA Regional Office

**Testimony to the Capital Asset Realignment for Enhanced Services Commission
September 3, 2003
Minneapolis Veteran's Affairs Medical Center**

Offered by Sandra R. Edwardson, PhD, RN
Professor and Dean
School of Nursing
University of Minnesota

The School of Nursing at the University of Minnesota has had a long though relatively modest affiliation arrangement with the Minneapolis Veteran's Affairs Medical Center (MVAMC). We have also occasionally placed graduate students at the VA facilities in St. Cloud and Fargo for preceptored experiences. At the MVAMC we annually have five undergraduate students who do intensive preceptored rotations in critical care and several graduate students who are in preceptor relationships with clinical nurse specialists and nurse practitioners in both inpatient and outpatient areas.

Our most significant relationship has been with the MVAMC School of Anesthesia. Since 1996, the School of Nursing and the School of Anesthesia have collaborated in offering a graduate program for nurse anesthesia students. The nurse anesthesia certificate portion of the program has been offered by the VA and the School of Nursing has offered the master's course work. Responding to a request from the School of Anesthesia, the School of Nursing has proposed to the University's Board of Regents that it assume full responsibility for the program beginning in the Fall 2004. The proposal is currently in the deliberative process and is expected to be approved.

In a year or two, we expect that this program will grow from the current eight admissions per year to ten per year and will depend on VA resources. We have agreed that the VA will provide the time of nurse anesthetists and anesthesiologists to serve as preceptors and will make available classroom and office space, library facilities, and computer services. Faculty for the program will be drawn from the regular and term faculty of the School of Nursing and the individuals currently serving as faculty for the MVAMC School of Anesthesia. The University will reimburse the MVAMC for the instructional time of three nurse anesthetists who will be regular members of the graduate faculty in nursing. The director of the program has been a member of the graduate faculty in nursing for a number of years and the other two will be reviewed for such appointments. A member of the School of Nursing faculty served on the search and selection committee for the latter two. The highly rated nurse anesthesia program has been accredited since 1971 and we have every intention of maintaining the high standards that students and employers have come to expect.

While I cannot pretend to be an expert on the implications of the proposed actions of your commission, it appears that the proposed changes will have little effect on our current education affiliation arrangements with the MVAMC. The most crucial variable for us is the volume of surgery that, according to my information, is not likely to decline significantly in the foreseeable future.

Our faculty and students have also worked with VA staff in conducting various research and demonstration projects over many years. I also see no reason to believe that those opportunities would be affected by the proposed changes.

We highly value our current affiliation arrangements with the VA and would welcome the opportunity to increase them both for education and for research. While the links between the VA facilities and nursing schools have been less substantial than those with medical school, I see no reason why that should continue to be the case.

REMARKS TO CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) COMMISSION

On behalf of the University of Minnesota Medical School, I am pleased for this opportunity to provide written input to the CARES Commission.

The Medical School at the University of Minnesota has enjoyed a close, lasting (more than 50 years) affiliation with our VAMC partner. Our faculty at the VAMC are integral to our mutual care, education and research missions.

The Minneapolis VAMC provides approximately 20% of our medical undergraduate clinical teaching, is an education site for 123 post graduate trainees, and is a major locus for research efforts in health outcomes, infectious diseases, neurosciences, and other translational research efforts. In addition to a rich mutual tradition of educational excellence and innovation, the programs at the Medical School are a major source for medical professionals in this state and region. Our best estimates are that over 60% of the physicians in this state have received some training at this University and its affiliates.

The Draft VISN 23 CARES plan circulated contains opportunities to increase primary care via community-based outpatient clinics. The Draft plan also calls for changes in the inpatient services in Medicine and Surgery.

The Medical School sees these proposed changes both as an opportunity for further cooperation with an important affiliate and a challenge to our educational programs.

Our challenge lies in the fact that the community-based clinics and contract hospital plan are outside any Medical School-based educational and research initiatives. The physicians are not faculty members; and these sites, while planned for efficient care delivery, are not planned with possibilities for educational or primary care research activity.

It is the goal of the Medical School to provide all our students with a stepwise educational experience in which the least experienced learn both from those proximate in their education and from seasoned professional educators. The contract physicians and their veteran patients – as now planned – will function outside this educational model. It is my belief that some aspect of the CARES planning process should include *a nationally-based group of VA and university educational professionals to seek opportunities and mechanisms to integrate at least some of these sites into the educational affiliation*. While it is difficult to provide education in a primary care setting, there are people learning to do this. Access to students (undergraduate and graduate) is an attraction for many physicians (and patients). These young people provide stimulus for continued self-learning and an opportunity for altruism. This educational model has served both partners (the VA and the Medical School) well for fifty years, and it should not be abandoned without an attempt at reconciliation between this tradition and our new care initiative. The VA has incredible resources for providing excellent health care to a large population. It is imperative for the future of our health care system that young physicians in training be educated in systems that provide effective and efficient health care. The VA community-based clinics provide a new venue for this type of training and we hope that the University will continue to be a partner in this new education and clinical effort.

REPLY TO
ATTENTION OF

DEPARTMENT OF DEFENSE
TRICARE Central Region
1681 Specker Ave., Building 1011
Fort Carson, Colorado 80913-5107

20 August 2003

TRICARE Lead Agent

Mr. Richard E. Larson
Executive Director,
CARES Commission
810 Vermont Ave, NW
Washington, D.C. 20420

Dear Mr. Larson:

As the Lead Agent for the TRICARE Central Region, I appreciate the opportunity to comment on the draft national CARES Commission report. The TRICARE Central Region is responsible for the oversight of the \$2.3B managed care support contract and comprises the Department of Defense's (DoD) largest geographical area (encompassing 16 states), and portions of 6 Air Force Intermediate Commands, 3 Army Regional Medical Commands, 1 Navy Health Service Operation and 8 Veterans Integrated Service Networks (VISN), serving approximately 1.2 million DoD beneficiaries.

Before addressing comments, I would like to provide a brief overview of this office's efforts, in partnership with TriWest Healthcare Alliance (our managed care support contractor) and a number of Department of Veterans Affairs (DVA) medical organizations within the TRICARE Central Region.

I would also like to thank Dr. Petzel, Director, VISN 23, for his inclusion of my predecessor in the CARES process for his VISN. The participation by my office in the inputs to the VISN's overall CARES assessment was invaluable in promoting stronger ties between the DoD and VA in VISN 23 and should be considered as an important facet of the overall CARES planning process.

Central Region Federal Health Care Alliance

The TRICARE Regional Health Services Operations, in collaboration with TriWest Healthcare Alliance, has undertaken an initiative referred to as the "Central Region Federal Health Care Alliance" (CRFHCA). This initiative, which is ongoing, began in earnest in an effort to establish and institutionalize federal sharing of resources between the DoD, TriWest Healthcare Alliance and the Department of Veterans Affairs (DVA). The strategic initiatives for this undertaking are:

- Development of joint leadership, governance and accountability for the collaborative health care system across the Central Region federal health care systems
- Development of shared performance measurement tools and data to support enhanced Alliance and stakeholder performance
- Evolution of the CRFHCA operating model into a Regional Health Plan

As this project has evolved, we have confronted numerous challenges and successes, many of which are addressed peripherally in your draft national plan. One of the greatest challenges we have confronted involves the management of our information systems and data interface; more specifically, issues concerning data acquisition, data access, data integrity, claims coding consistency and population common denominators. Through our efforts, we have achieved a number of significant successes, including the following:

- CRFHCA pilot projects have resulted in building market-based, collaborative infrastructures that can be replicated in other markets
- Relationships across the DoD, DVA and TriWest leadership and staff have been enhanced, leading to the informal sharing of best practices and knowledge
- Several formal sharing arrangements have been developed, or are under development, in the Northern Tier, the I-25 "Corridor", and Boise markets
- Improvements in automating the collection and reporting of demand, capability, and demographic information through the development of our web-based data warehouse
- Streamlined the development of Central Region DoD/DVA collaboration through a master sharing agreement and financial transaction guidance

With these challenges and successes, have come a number of vitally important "Lessons Learned". The most significant being:

- Governance is key
- Honest discourse and developing trusting relationships are critical
- Jointly defining the value of services is essential (vs. personality or leadership-driven process)
- Time and effort required initially by all organizations is great but decreases as infrastructure develops
- Vision with a local focus is a critical component
- Data and analysis is a defining factor of success
- Training is an opportunity across the board
- Readiness and deployment are critical factors that must be individually incorporated into collaborative planning

At this time, we are pressing forward with this initiative and have identified a number of important, valued goals and objectives that we hope to accomplish as we proceed down this exciting and challenging path. We envision this initiative eventually creating a paradigm shift towards a regional health planning model, utilizing the tools developed to collaboratively forge plans and operations collectively between our agencies and institutionalize this model as the way we do business. We believe the process and structure developed creates value and can be applied both regionally and nationally through the establishment of market-level governing boards and "Boards of Commanders/Directors" to

provide leadership and oversight, and the creation of institutional-level steering groups for local strategic direction and guidance that will lead to a collaborative, market-based healthcare delivery model. Eventually, the evolution of this initiative is the development of an ongoing, collaborative partnership between the DoD and DVA, with the support of the managed care contractor, in the development of a comprehensive, exhaustive strategic plan, whose performance will be reviewed quarterly and whose strategy will be revised annually. This annual plan will utilize the military health system and the veterans health system's strategic plan as its cornerstone and become the foundation for joint market plans and service area plans resulting in the maximization of health care to both agencies' beneficiaries, while optimizing federal resources and enhancing the readiness posture of the MHS.

CARES Commission National Plan (Final Draft)

I would like to begin by commending the CARES Commission, their supporting staff, the VISN's staffs, the VISN medical facility staffs and the numerous veteran organizations, for their arduous efforts in producing an extremely well researched, thoroughly documented planning assessment. As stated in the "Introduction", its value lies in its comprehensive, data-driven intensive, objective and systematic approach.

I also wish to commend the CARES Commission for their enhanced CARES model, consisting of a nine-step planning process. Likewise, the CRFHCA has developed a process for ensuring consistency in approach when examining DoD/DVA market opportunities for potential federal sharing. In addition to consistency, this process was designed to enhance institutionalization of federal sharing at the respective level. The CRFHCA planning process consists of the following steps:

- Identify the geographic area for the market and sub-markets
- Establish CRFHCA governing board for the market
- Establish a market strategy team consisting of representatives from the Lead Agent, MTFs, VISN (and VAMCs as appropriate) and TriWest
- Conduct initial demographic and capability analysis
- Conduct a market-wide design/development workgroup planning session to develop overall market strategies and design the implementation planning approach
- Conduct site visits to MTFs and VA facilities
- Conduct sub-market (i.e., service area) steering group operational planning sessions at each MTF, or appropriate facility, to identify opportunities for sub-market
- For each opportunity, the steering group will identify participants for a workgroup, including a lead person for the workgroup that will develop an action plan for the implementation of the proposed opportunity
- Conduct draft plan presentation sessions at each MTF to allow sub-market workgroups to present plans
- Establish a sub-market (service area) steering group for each sub-market to oversee day-to-day operations of the sub-market as well as monitor and manage micro-level metrics associated with plan objectives

I concur wholeheartedly with the strategy for assessing outpatient access. The proposed system-wide consideration of potential new access points (e.g., CBOCs) and a selective process for identifying markets with new prioritized CBOC access sites, is in my

opinion, exactly where health care must be addressed – locally. Identifying markets in order of priority (1st, 2nd, 3rd), based upon a gap analysis between demand for care and access to care, is prerequisite to accurate health care planning. Without knowing the intricacies of the marketing tool utilized in this undertaking, a similar approach has been undertaken by the participants in the CRFHCA. Marketing analysis involving current and projected population demographics, resource (manpower) allocations and service capabilities, married to ambulatory and inpatient utilization from both the direct MHS system, purchased care (civilian-delivered care) system and the respective VA medical facilities, has produced a similar gap analysis for future planning purposes. Therefore, it is especially noteworthy that attention was given to consideration of DoD collaborations when the highest priority groups of CBOCs were addressed. The ability to examine fully the opportunities that may exist between DoD and DVA in these areas can realize tremendous benefits for both agencies' beneficiaries and should be strongly encouraged by both agencies' leadership. This point is especially important in light of the recent Presidential-appointed task force findings examining enhancements to the delivery of health care to veterans, and in light of the identified need by this body to renovate/expand existing CBOCs, establish 161 new CBOCs (in markets where "Access Planning Initiatives" existed) and 73 new CBOCs (in markets where "Access Planning Initiatives" did not exist).

I would also concur with the comprehensive assessment performed in validating the acute inpatient infrastructure requirements. As in the MHS, determining the magnitude of the funding required to fully prepare for the future is staggering. I would stress the criticality and importance of viewing the National CARES Plan as a strategic guide to the future investment of capital, primarily focusing upon the need to realign service capabilities and availability where it serves the greatest number of beneficiaries in the most efficacious manner. As has been accomplished through the implementation of the MHS's TRICARE Benefit Program and the partnership with civilian health care organizations, I applaud the VISN Market Plans' conclusions that proposes using contract care to improve hospital access. It has been instrumental in the success of the MHS and a solution that has definitely provided the flexibility necessary in meeting the health care needs of our beneficiaries, while resulting in more cost effective health care delivery.

I am especially pleased that the CARES Commission identified partnering with DoD as one of its important initiatives. This is not only in keeping with the President's direction to improve coordination of benefits, services, information and infrastructure to ensure the highest quality of care and efficient use of resources, but provides the impetus for both agencies to move forward in an unprecedented manner towards further collaboration, cooperation and sharing. Prioritization of sharing opportunities, particularly for those initiatives identified under "High Priority" and "Near Term", illustrates a systematic approach that emphasizes a willingness and desire to find avenues for sharing between our agencies. The individual draft VISN Market Plans are a testimony, not only to ongoing efforts by both agencies, but show tremendous promise for future sharing through enhanced collaboration. I commend the efforts of all involved in this process and strongly encourage further collaborations within the DVA and DoD so opportunities can be fully investigated to the mutual benefit of both agencies and our beneficiaries.

Closing Comments

Today, administering and delivering high quality, cost efficient care to DoD and DVA beneficiaries is becoming increasingly complex. With ongoing resource constraints affecting both entities, along with the apparent gaps and overlaps in the Department of Defense (DoD) TRICARE program and the Department of Veterans Affairs (DVA) healthcare systems, there has never been a greater need for collaboration between the two government agencies. Finding creative ways to maximize DoD/DVA capabilities and resources through collaboration and sharing will result in improved access, cost efficiencies, and quality of care.

The intent of the Central Region Federal Health Care Alliance (CRFHCA) is to maximize the use of federal resources, thereby improving the delivery of care to the DoD beneficiaries and the DVA veterans, to the benefit of all parties involved, including the American taxpayers. This model will ensure, above all else, the maximization of federal systems and personnel in meeting the health care needs of the beneficiaries and veterans in the TRICARE Central Region. This includes maximizing the use of existing MTFs and VA facilities.

This concept, used in conjunction with the CARES Commission, will further our common goal of maximizing the use of federal resources while providing world class care to our deserving beneficiaries. It is my opinion that this can only result in more efficient use of capital resources, reduction in duplication of services and expenditures and the more effective delivery of health services to our beneficiaries.

Thank you for the opportunity to provide comments to this report. Such communication is a sign that collaboration is not only thriving but is being integrated into the overall CARES planning process. My office relishes the opportunity to continue to cultivate this relationship. As the new TRICARE contracts are awarded and the responsibilities of this office are transitioned to the new Regional Office in San Diego, I trust that the groundwork laid here will foster improved communication and enhance the productivity of the relationship.

Respectfully,



LAIRIE O. STABLER
COL, USA, MC
Lead Agent