NATIONAL HEALTH CARE REFORM

FIELD HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JUNE 3, 1993
Dublin, GA

JUNE 4, 1993
Atlanta, GA

Printed for the use of the Committee on Veterans' Affairs

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June 4, 1993

NATIONAL HEALTH CARE REFORM

THURSDAY, JUNE 3, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Dublin, GA.

The subcommittee met, pursuant to call, at 8:06 a.m. in the Auditorium, VA Medical Center, Dublin, GA, Hon. J. Roy Rowland (chairman of the subcommittee) presiding. Present: Representatives Rowland, Collins and Linder.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Dr. ROWLAND. We are going to go ahead and get started. John Linder has not come yet, but I am sure he will be here shortly.

I want to thank all the witnesses here this morning for coming and also thank the veterans who are here and the representatives of veterans' organizations as well.

With all the debate in Washington regarding the current VA health care system and potential changes that may occur under national health care reform, I believe it is imperative that Members of Congress hear from individuals who would be directly impacted by any actions that might be taken. There is no better place than here at home to hear from you. It is critical that your voices be heard and that is why we are having this hearing here this morning.

I want to thank my good friend Mac Collins for being here as well, and I am going to hear from him in just a few moments. As I said, John Linder will be here a little later I am sure.

At this morning's hearing, we will receive testimony regarding the current operations at the Department of Veterans' Medical Centers in the State of Georgia, and particularly those facilities located here in Dublin and in Augusta. It is my hope that this hearing will provide a valuable look at such issues as access to care and availability of services to Georgia veterans. In addition, we will focus on the issue of impending national health care reform and what impact such reforms might have on the operation of the VA health care system. If you saw the headlines in this morning's *Macon Telegraph*, you will know that the President has indicated that it will be even later in the year than we originally thought that national health care reform will be considered, that the Administration is going to present a plan. So this gives us an opportunity—a window of opportunity, I believe—to do more to get our thoughts and our actions together insofar as the VA is concerned.

As the debate on this national health care progresses, it is critical that we focus on the VA as an integral part of any reforms. It is also necessary that we understand the current state of the VA health care system, both its strengths and its weaknesses. As the country's largest health care system, the VA should provide a model for the health care reformers to consider.

However, all of us know the current reality facing many veterans who seek their care from the VA. While most Category A veterans seeking inpatient care are treated on a timely basis, long waiting lines for many outpatient care services have become commonplace. In some areas, VA has been forced to cut back on outpatient services to many veterans who previously received their care from the VA, because VA simply does not have the resources to continue to provide them care. Are these veterans being treated in some other setting? Do they have access to alternative forms of health care? I do not know, but more importantly, the VA does not know.

I do not want to unfairly criticize the VA, after all it is not the Department that ultimately determines the size of its own budget. My reason for raising what many of us already know is that it is time all of us acknowledged the current realities facing the system. For too long now, VA has been asked to provide more services and programs with less overall funding. Years of funding shortfalls have taken their toll. And this cannot continue.

This morning, we will hear testimony from the Directors of the Dublin and Augusta VA Medical Centers as well as the Director of the Southern Region. I look forward to the insights that they will provide regarding the current operations at their facilities in terms of their ability to meet the demand for health care of Georgia veterans.

With regard to the larger issue of national health care reform, VA officials have been deeply involved with the President's National Health Care Reform Task Force. From all indications that involvement is not mere token representation. VA has been on many of the task force working groups, and Secretary Brown's credentials as an advocate help assure us that veterans are getting a fair hearing in this planning effort. There is much that the Secretary and his team can bring to the table from the VA's own experience.

However, the point must be made that under national health care reform, veterans like other Americans will be given the opportunity to access one of several health care options. Given a range of choices, some veterans currently using the VA may decide to seek their health care someplace else. It is imperative that we recognize this fact and work to ensure that VA remains an attractive, high-quality health care option for our Nation's veterans.

As many of you know, the immediate challenge ahead is the budget and the annual effort to secure adequate levels of funding for the VA health care system. We have a lot of work ahead of us and I look forward to working with all of you to help this committee and the Congress achieve its goals.

I look forward to hearing the testimony from our distinguished witnesses this morning.

I want to now recognize my good friend and colleague Mac Collins, who represents the 3rd District of Georgia. He serves on the

Public Works and Transportation Committee and the Small Business Committee. Thank you very much for coming down this morning, Mac.

OPENING STATEMENT OF HON. MICHAEL A. "MAC" COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. COLLINS. Thank you, Congressman Rowland. It's a special privilege and honor for me to be able to be here and I appreciate the invitation. As a freshman Member of Congress, this gives me an excellent opportunity to meet with people from the VA and also an excellent opportunity to learn—and that is very important.

I can assure you that Congressman Rowland has his sights, as many of us do, set on the home folks. He is right on target when he said there is no place to be like home to learn from people and to get advice. I have watched him in my first few months in Congress and he is an excellent example to follow and pay attention to because he pays attention to people from his District.

I see we have an excellent list of witnesses. I look forward to hearing your testimony because, as I say, it gives me an opportunity to learn and get some insight. So with that, I will just move forward with you, sir.

Dr. ROWLAND. Thank you very much, Mac. And thank all of you again. And I would like to go to Mr. Miller first. I would ask that you limit your formal presentation to 5 minutes, if you will. And your entire statement can be submitted for inclusion in the record. Thank you so very much. Mr. Miller, if you will proceed now.

STATEMENTS OF RICHARD P. MILLER, DIRECTOR, SOUTHERN REGION, VETERANS HEALTH ADMINISTRATION accompanied DR. JOHN HIGGINS, SOUTHERN REGION CHIEF OF STAFF; WILLIAM EDGAR, DIRECTOR, CARL VINSON VA MEDICAL CENTER, DUBLIN, GA; THOMAS AYRES, DIRECTOR, VA MEDICAL CENTER, AUGUSTA, GA; W. DOUGLAS SKELTON, M.D., DEAN, MERCER UNIVERSITY SCHOOL OF MEDICINE

STATEMENT OF RICHARD P. MILLER

Mr. MILLER. Thank you, Mr. Chairman, Mr. Collins. I have my formal comments that I presented to the committee and I will just make a few brief opening comments. I am delighted to be here and participate in this activity this morning. I would like to introduce—on my left, I have Dr. John Higgins, the Southern Regional Chief of Staff.

I would like to start by giving you a little perspective and overview of what the Southern Region is.

Dr. ROWLAND. Let me state that I did not state that you were Director of the Southern Region of the Veterans Health Administration. Let me include that.

Mr. MILLER. Thank you, sir.

The Southern Region is one of four geographic regions in the Veterans Health Administration. In the Southern Region, we encompass 11 States and Puerto Rico and the Virgin Islands. Our boundaries run from the west of Oklahoma and Texas, on the north of Arkansas, Tennessee, North Carolina, down the east cast to Florida

and our southern boundary is the Gulf of Mexico and as I stated before, we also include Puerto Rico and the Virgin Islands. As such, this fiscal year, we anticipate treating over 6.6 million outpatient visits and some 309,000 inpatient visits. And I would like to put that in perspective.

That reflects on a daily basis over 20,000 outpatient episodes and 1,200 inpatient episodes, and when you multiply that by the number of encounters that we have with those patients each and every day, I think it is remarkable to recognize the services we deliver at a budget of approximately $3.9 billion with 58,000 employees. And in fact, the hospitals in the State of Georgia, the fine hospitals in the State of Georgia, support that effort in the Southern Region with a budget of over $320 million and 4,700 employees.

The region has responsibility for supporting and monitoring operational activities in resource planning and management, strategic planning, human relations, equal employment opportunity, public affairs, construction and facilities, in nursing, in pharmacy, in our fire and safety program, our industrial hygiene program, as well as our radiation safety and women's veterans' programs and our Quality Assurance programs.

We have many strengths in our health care system and we have long histories of accomplishing delivery of health care and providing a continuum of care. We have very significant and favorable networks among our medical centers where hospitals relate to one another to provide efficient, effective high-quality care. We are leaders in delivering certain types of care and also in delivering non-institutional care modalities. We provide very effective utilization of services. I know we have many challenges in areas for improvement within the delivering of our services. However, I am confident that, as we have in the past, we will continue to meet those challenges and to prove our worth in the health care delivery system, whatever form that may take.

In closing, I would like to say that I am very proud to be a part of the Veterans Health Administration system in the Southern Region and we are part of what I consider a very noble cause in providing quality, effective and efficient health care to those people that defended our country. And with that in closing, I look forward to contributing to the panel and thank you for inviting me.

[The prepared statement of Mr. Miller appears on p. 69.]

Dr. ROWLAND. Thank you very much, Mr. Miller.

Next is Bill Edgar, who is Director of the hospital here in Dublin and a good friend of mine who I talk fairly often with. Bill, thank you for providing this facility for us to have this hearing this morning and we are pleased to hear from you now.

STATEMENT OF WILLIAM EDGAR

Mr. EDGAR. Thank you, Congressman Rowland. I would like to say good morning and I want to thank you for allowing me the opportunity to offer testimony regarding the current and planned provision of care provided at our Carl Vinson VA Medical Center here in Dublin. And I would like to start by saying that for me personally, it is a pleasure to appear before you and the subcommittee today as a representative of the Carl Vinson VA Medical Center

and certainly it is an honor for our medical center to host this important hearing.

Simply stated, our mission at the Carl Vinson VA Medical Center is to provide continuous quality health care to our veterans in a compassionate and efficient manner. And I think we do an excellent job of that.

Our hospital is a 366-authorized bed primary and secondary care facility. We provide medical, psychiatric, surgical and rehabilitation care. We have extended and geriatric care that is an important component of our primary bed programs. In addition to that, we also have an 86-bed nursing home care unit and a 344-bed domiciliary program here and we also provide what I think is very comprehensive outpatient care.

Our patients treated at our hospital have averaged about 4,900 the previous 3 years and during the decade of the 1980s, we averaged treating about 5,100 veterans on an inpatient basis. And to minimize the need for inpatient care, we have increasingly used outpatient alternatives for the care of our veterans. Our outpatient visits in 1980 were a little over 21,000. That has now risen in 1992 to about 67,000 and we anticipate about the same number of veterans treated on an outpatient basis this year.

One of the things I am especially pleased to tell you this morning is that in September, we were surveyed by the Joint Commission and I am delighted to tell you that we received the maximum 3-year accreditation that they provide and we also got a hospital accreditation score of 90 and our long-term care score was 94. And as you know, the maximum score that you can get is 100. So we are extremely proud of that and I think that is indicative of the type of care that we provide at our hospital here in Dublin.

As you know, we have just recently completed a brand new outpatient clinical addition. That has had a tremendous impact on our ability to provide care here and that is extremely good news for all of us and also our veterans in our 52-county area that we provide care for.

Our nursing home care unit here consistently has a 90-plus percent occupancy rate.

We have a number of sharing agreements. Among those is a sharing agreement with the Warner Robins Air Force Base. They provide mammograms for us and we provide CAT scans for them and that is advantageous for both the VA, DOD and also taxpayers, I might add.

I should say that we have outstanding support from our 19 service organizations. They are very active at our hospital and they contribute almost 30,000 hours of their time and there are over 500 regular and occasional volunteers at our hospital.

I am glad to say that we have one of nine cooperative health manpower education programs in the VA system—there are only nine and we have one of those. It is an educational partnership between the Carl Vinson VA Medical Center and various community health care organization agencies that are located in 39 counties in south central Georgia. Last year, we provided over 250 educational programs and trained in excess of 9,000 health care employees.

As you know, Congressman Rowland, the Dublin VA Medical Center now has an active medical school affiliation with the Mercer

University School of Medicine in Macon. As you know, presently that affiliation involves only surgical residents. However, we have plans in the near future to expand that into psychiatry and medicine. Currently we have a surgical resident from Mercer that rotates through our hospital every 2 months and I believe we are on our seventh resident now. I just cannot say enough about that affiliation and I am glad to see Dean Skelton with us this morning. He has worked and Mercer has worked very hard with us and I think we will have one of the best affiliations as it grows stronger each year.

We have other affiliations. Our social work service is affiliated with the University of Georgia and Florida State.

Our nursing service is affiliated with four nursing schools in south central Georgia. And as a result of our affiliation with Mercer, I think we now have a rather active research and development program at our hospital and we're working very closely with Mercer in that area.

One of the things I am delighted to tell you—just recently we were informed that we have been funded for a domiciliary homeless veteran treatment and assistance program. We submitted a project for that. We were one of 43 medical centers out of 130 that applied for that and I have recently been funded five additional staff and we are now in the process of filling those positions and very soon we will be into the treatment of homeless veterans in south central Georgia and we can probably draw from the entire State of Georgia. This is a service we have desperately needed, we are delighted to have that.

We have also recently established a respite and a hospice program in our hospital and we are delighted to be active on those two fronts.

We have an active construction program. We are right now completing the renovation of some space to add 30 additional nursing home beds to our facility and the key aspect about that is that we will have an option on that ward to provide oxygen for our nursing home patients, which we do not have now.

We have also been fortunate to receive funding to start design on what we call a wandering ward. This will be a new bed program for us. It will establish 40 beds for the demented, Alzheimer type patient and we have been funded preliminary design funds and we expect to complete design this year and we will move on into construction next year.

So with that, I will close and tell you that at the end of the panel, I will be delighted to respond to any questions that you might have.

[The prepared statement of Mr. Edgar appears on p. 76.]

Dr. ROWLAND. Thank you very much, Mr. Edgar.

Now I want to call on Tom Ayres, who is Director of the Augusta VA Medical Center. Tom, thank you very much for coming here this morning. I saw all of you just a week or so ago in Washington and so I appreciate you being here this morning. If you will now proceed.

STATEMENT OF THOMAS L. AYRES

Mr. AYRES. Thank you, Dr. Rowland, and I appreciate the invitation. Also it is nice to meet Mr. Collins.

VAMC Augusta is a two-division hospital with 1,033 beds. It is a Complexity Level I hospital and the Downtown Division has 380-acute medical and surgical beds, including a 60-bed spinal cord injury unit. The Uptown Division has 653 psychiatric, intermediate medicine, and rehabilitation beds, including a 60-bed nursing home. VAMC Augusta employs 2,300 employees with an annual budget of approximately $130 million.

I was appointed Director in June, 1990. Since my appointment, I have worked diligently with my staff to renew and enhance relationships between VA Medical Center, the Medical College of Georgia and Dwight David Eisenhower Army Medical Center. We established a planning and liaison group about 3 years ago. This group is dedicated to enhancing opportunities for cost effective sharing of medical resources. The concentrated efforts of this planning group have produced the following concerns, opportunities and recommendations. The specific recommendations are more clearly defined in a separate document entitled "Department of Army/Department of Veterans Affairs Joint Venture for Shared Services"

In an era of constrained Federal resources for medical care, it is critically important that co-located Federal institutions work closely together to maximize efficiency. Recognizing this, the Command of the Eisenhower Army Medical Center and the management of the VA Medical Center propose to develop innovative sharing services and consolidate, where possible, their respective resources. The objective of this consolidation will be to avoid duplication and thus achieve economies of scale and to take greater advantage of those situations in which one of the two institutions has ample resources for which the other institution has a defined need.

We jointly envision a coordinated effort to consolidate, where practical, the alignment of services and the contributions of the two institutions so that the consolidation results in an equal input of resources by each institution. Under this operational scenario, little or no actual money is exchanged. It is our joint understanding and mutual commitment that all decisions to consolidate services must make clinical good sense and this commitment is an absolute sine qua non of any past or future deliberations. We believe that these initiatives have great potential for real enhancement of the services we provide to both our beneficiary populations. We further believe that this agreement has the potential to establish a viable example of Federal cooperation in providing state-of-the-art health care, education and research opportunities for co-located VA and DOD medical care facilities nationwide.

We believe by linking these resources with other health care providers, the Department of Veterans Affairs will be improving our ability to provide quality care to the greatest number of eligible veterans. Budget constraints are a fact of life in health care, whether the care is provided at private sector or Federal facilities. Minimal growth in VA funding has caused greater constraints to be placed on the number of veterans who can be cared for at any VA medical center. During the last 6 months, the facility which I serve, VAMC Augusta, was only able to provide care for 172 veter-

ans who were non-service connected or category A non-service connected. This is a direct result of limiting of resources which has occurred over the last several years.

As we strive to care for the greatest number of veterans, in the highest categories of priority, our resources will almost entirely be devoted to long-term care, intermediate medicine, chronic psychiatry and some other very specific programs such as the care of spinal cord injury and treatment of PTSD, post traumatic stress disorder. We should be able to provide our veterans comprehensive, quality care at competitive prices. We should be opening the system to receive additional veterans and I would hope that the task force on health care reform allows the VA to serve as a model of a managed care organization, cooperating wherever possible with other health care providers.

We are confident that the VA and other health care providers, such as DOD, can constructively cooperate and assure quality care to our beneficiaries. A couple of years ago when the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) made their "Agenda for Change" public, we began the process of changing our traditional Quality Assurance program to meet a more progressive Continuous Quality Improvement (CQI) approach. We have integrated the two quality management programs and created a process where it's possible for any employee in the Medical Center to suggest an idea or point out an issue requiring a CQI analysis. The experience we have had thus far has been very positive. The CQI concept is also the basis of our coordinated efforts with Eisenhower Army Medical Center to develop future plans in sharing clinical resources.

An indicator of our success with CQI team and TQM, is our most recent JCAHO survey results. As you may recollect, about 3 years ago, the VA system was publicly criticized for its low scores on JCAHO surveys when compared to the private sector hospital scores. In this present round of surveys, the VA has surpassed the average score earned by private sector hospitals. VAMC Augusta earned a score of 89 from the Hospital Accreditation program, compared with the community hospital average score of 80. We are confident that this indicator truly reflects the quality of care that we are providing to eligible veterans.

There are numerous examples of our efforts to provide quality services to eligible veterans. Last year, we initiated retirement workshops with Fort Gordon to provide VA benefits and eligibility information for soldiers who were in the process of leaving active duty, including those who were retiring. We also responded to the needs of veterans when they returned from Operation Desert Storm. Since then, we have evaluated 981 returning veterans. Using the Gulf War Veterans Registry protocol exam, 110 veterans have had specific health care concerns reviewed and health services for a number of these veterans have been provided.

One of the highest priorities for care in our system is the timely completion of Compensation and Pension (C&P) examinations. We work closely with the Veterans Benefits Administration regional offices in Atlanta and in Columbia, South Carolina, to assure timely services to the veteran. The average C&P exam workload has dramatically increased due to the high visibility and concerns related

to mustard gas exposure, Agent Orange exposure, the Persian Gulf War, and the increasing number of female veterans completing active duty. The efforts of DOD to right-size its active duty forces is expected to continue to exacerbate this trend. Our workload has almost doubled to approximately 200 exams a month. The VA's maximum process time for C&P examinations is 35 days. VAMC Augusta averages less than 20 days. We manage to create ways to accommodate the veteran's work schedule and process examinations on evenings and Saturdays. The innovation of our staff is to be commended and our commitment to quality has resulted in expanded work schedules. The staff has also recruited a number of specialty physicians to conduct these exams when it is most convenient, again, for the veteran. The clerk who schedules these exams is a recently retired Army veteran and exemplifies the innovation and dedication of our employees to veterans.

I could continue but I am sorry I ran over my time.

Dr. ROWLAND. That is all right. Your entire statement will be submitted for the record.

Mr. AYRES. I want to thank you for the opportunity to be here to participate on the panel.

[The prepared statement of Mr. Ayres appears on p. 83.]

Dr. ROWLAND. Thank you very much, Tom.

Dr. Douglas Skelton, a good friend and I would say the savior of our surgical unit here at the VA Hospital—I really am grateful for the affiliation that this surgical unit now has with the Mercer Medical School. We appreciate that more than we can tell you, and I really appreciate you coming this morning too. If you will proceed.

STATEMENT OF DR. W. DOUGLAS SKELTON

Dr. SKELTON. Chairman Rowland——

Dr. ROWLAND. He is Dean of the Mercer Medical School, let me say.

Dr. SKELTON. Chairman Rowland, I appreciate those kind comments. I am also pleased that Congressman Collins and Congressman Linder are here. I am reflecting that it has been 10 or 12 years since I have been privileged to testify before you and Congressman Linder in your previous roles in the Georgia General Assembly, and it is about time we got around to that again. Maybe there will be more of it.

I want to start by noting what you already know, that probably somewhere around two-thirds of all the Veterans'Administration medical centers in this country have affiliations with medical schools. This is the youngest one here and I am very privileged to serve as Chairman of the Deans Committee for the VA Hospital. And as Mr. Edgar indicated, we are trying to do some very positive things together that I think will improve services for veterans, which is your goal, Mr. Edgar's goal, the Administration's goal, and will improve medical education and research which is tied into our activities are Mercer.

If you think about that nationally, you are going to realize that some 50 percent of the physicians in this country had some of their training in VA medical centers and that these programs are involved with the training of over 30,000 residents every year in this country, 20,000 to 25,000 medical students involved in these pro-

grams across the country. So there is a very important intersection between the goals of the VA, in terms of staffing their facilities and providing services, and our goals to educate medical students and residents to become the physicians of tomorrow. That partnership has been a strong and viable one and one that we need to continue.

We also need to recognize, I think, in this, that the VA deals with a very complicated patient population. I believe I would be correct—there are people here on the panel who could correct me if I miss—but I believe that the population is older, that it is sicker and it is less economically advantaged than the rest of the country. And it has problems that cause the VA to focus on very special services, many of them mentioned here, that are not available in the private sector and would not be available, in my judgment, in any kind of health care reform that comes down the line. So some of the issues about spinal cord injury, mental health services to the degree they are needed, the aging population—the veterans' population is about 10 years ahead of the general population in terms of the aging issues. So there are some programs there that I do not think are likely to be well-met in the general health care service system.

On the research side, I have been very concerned, as I know you have, about the Administration's budget and some $26 million being reduced to research. You know what is happening up there in terms of how the rules are worked out in appropriations. I understand there is some effort to restore that, and that seems to be moving positively at the moment. I just want to say that I hope it works out that those funds can be restored. As I understand it, it takes $26 million to keep the research level as it is now, and if it is cut that much, it is going to have a serious impact. And a lot of people do not understand the leveraging impact of these research programs because they bring good quality physicians and other health care professionals into the system to help take care of our veterans and I think that is a very important issue.

We know as well, in terms of changes in the veterans' population that there is a patient decline going to occur over time, which means the system has got to look at what do you do when populations of certain kinds decline in terms of entitlement. There are others out there that are not covered now that could be brought into that system. So what do you do? You adjust the size of the VA system. Do you downsize generally? Do you focus on specialty services? Do you revise eligibility? And there are a number of choices that that would lead one to.

I will give you two and tell you my preference. One would be that the system provide complete coverage in the sense of being a comprehensive insurer and care deliverer to a cohort of individuals, likely to include veterans exclusively. Or be reoriented as a system that provides specialized services to veterans and others under some kind of contractual arrangement. Now some of both can be done, but I favor principally the first option. I think that the kind of population that I sense is in the VA system demands a response in terms of primary care and generalist medicine, and it is that core of services that ought to be there under-girding veterans' medical services and the special services built on that, either within the

system, some of these special things, or outside the system where the private sector can provide appropriately.

Then as we look at health care reform—the date keeps moving forward when we are going to see something here, but I am pleased to hear that the VA leadership has been involved in the task force work because there is a lot of things about the VA, about the system, that ought to give people some lessons as they design the future, the biggest global budget health care in this country in the VA system. It has learned things about centralized management, about how to deal with high technology, about how to replace facilities, about quality assurance of patients that ought to be available to everyone and used in redesigning the system.

The location of many VA facilities—you read a lot these days about managed competition and what is that going to do to 30-40 percent of America that does not have the kind of resources to even participate in the managed competition model. Many of the veterans in those areas are served by very distinctive VA facilities. I think the catchment area of this hospital fits into that category very well because people would not have access to care if it were not for this hospital's presence.

And then some 12 percent of the residents in this country that deliver the kind of care veterans need are trained in veterans' hospitals. Somehow as we think about how many specialists do we need, how many generalists do we need, the VA has to be a major player in thinking through those kinds of things.

I would like to close with just one comment. The reason that brings Mercer Medical School to the Carl Vinson VA Medical Center, at least in terms of my career, and the directions I have gone about in my professional life, have to do with what I call the servant role of medicine. Mercer Medical School exists because you and other State leaders at one time said we had a need in our State that should be met by a medical school focused on a particular mission. The VA focuses on a particular mission. Both of those missions involve a servant role to take care of people. That does not mean to be passive, but it means to serve and that is such a positive aspect of what we are doing here with Mr. Edgar, Dr. King and the VA leadership in Dublin. I am very pleased at where the relationship is. I look forward to it expanding in the future. And I look forward to responding to your questions.

[The prepared statement of Dr. Skelton appears on p. 90.]

Dr. ROWLAND. Thank you very much, Dr. Skelton.

John Linder, who is the Representative from the 4th Congressional District and also a member of the Veterans' Affairs Committee is here and John, I want to thank you very much for coming this morning. As you indicated earlier, John and I served together in the Georgia House of Representatives for a number of years, so we have a long-standing good friendship. Thank you very much.

Dr. LINDER. Thank you, Mr. Chairman. I will submit a couple of pages of a written statement for the record. I want to thank you for holding this hearing and for your contribution to national health care for veterans over many years. I am delighted to see my friend Doug, of almost 20 years now—that scares me—here, and I look forward to listening to the rest of the testimony and I do have some questions. Thank you.

Dr. ROWLAND. Let me start off with some questions here and ask all of you, if you will, you know there is a changing concept about the way that we provide medical care in our country, moving more towards outpatient care and less inpatient hospital. And of course, Pete Wheeler, Director of Veterans Services in our own State of Georgia, has said that the VA needs to become less hospital-oriented and more focused on outpatient long-term care.

I would like to ask you to respond to that if you will. Mr. Miller.

Mr. MILLER. Thank you, Mr. Rowland, and yes, I strongly believe in that statement that we should move towards more outpatient care and long-term care. However, I think there are some things that we must consider, some caveats, as we move in that direction. I think that it is recognized that if you increase outpatient activities, that those outpatient activities are going to continue to demand acute care in a number of instances, they will get admitted to the acute care hospital. It is a proven medical fact that people in our long-term care beds and that modality of care, during their episodes of long-term care, need acute care treatments. I think we recognize and we have heard statements today that acknowledge that we are under tremendous resource constraints and we are expanding the walls and attempting to treat the outpatient workload that is presently presenting itself to many of our facilities and particularly in the Southern Region. So with those caveats, I would say that what we would strive to do and what we should strive to do is to create that appropriate balance of outpatient care, long-term care and acute medical care.

Thank you, sir.

Mr. EDGAR. As a follow up to Mr. Miller, that appropriate balance that he talks about, I think I would identify as comprehensive care to our veterans. I think our particular hospital here in Dublin has been moving toward the opinion that Pete Wheeler expresses. If you look at our workload, you can see that, as I mentioned before, in the decade of the 1980s, we're treating about 5,100 veterans on an inpatient basis and the last 3 years that has gone down to somewhere in the neighborhood of about 4,900. I think one of the primary reasons is because we're treating more veterans on an outpatient basis to obviate the need for hospitalization.

We have been focused for some time now on long-term care at our facility. We know that our veterans, as Doug said, in terms of age is about 10 years ahead of the population and we realize that our veterans are getting older at a faster rate, and with that in mind, we have planned to expand our long-term care capabilities. An example of that again, as I mentioned, we're currently renovating a ward that we previously used for extended care, we are now converting that into a nursing home care ward with oxygen supplied there. So that will expand our capability.

We have also, again as I mentioned, been funded for what we call a wandering ward, and we are currently designing that and we will add another 40 beds. So I tend to agree with what Pete said, I know on many occasions he has mentioned the need for care for Alzheimer patients and this 40-bed nursing home care unit that we are currently designing will go a long way toward helping take care of those patients. So yes, I guess I agree with Pete. I also agree with Mr. Miller, we really need acute care, we really need com-

prehensive care and our hospital is moving in the direction of providing comprehensive care with a real emphasis on long-term care.

Dr. SKELTON. One of the reasons this facility is so attractive from an educational point of view is the outpatient clinic and the increased focus on ambulatory care. We are involved across the board, but as medical education changes, we try to turn out more generalist physicians. We have got to focus on comprehensive care. The system, as I see it, in the VA is trying to put a package together for primary care through long-term care. I doubt that any health care reform package, whatever that comprehensive benefit package, is going to cover all of that. It will cover some portions of that. But I think the trick is going to be to provide the care to veterans in such a way that it does not get fragmented. If care is fragmented so the entitlement tells you you can get hospital care but you cannot get certain other things, it makes it very difficult, I believe, for any kind of organized system of care, the VA or otherwise, to have any control over the overall quality of care that those patients receive, and over the overall resources expended for their care. So there has got to be ambulatory care, there has got to be some comprehensiveness and there has got to be some accountability about patients' care over time.

Dr. ROWLAND. You know, the Mercer Medical School's primary goal is to turn out more primary care physicians. You have indicated that the VA's graduate medical education efforts need to be more integrated with broader efforts to change to the generalist/specialist mix that now exists as well.

Dr. SKELTON. Right.

Dr. ROWLAND. Mr. Ayres.

Mr. AYRES. I think the issue has been very well covered. The only thing I would like to re-emphasize is the importance of keeping our tertiary care capability intact to support the long-term care needs. You cannot sacrifice one for the other, but keeping that balance intact is extremely important.

Dr. ROWLAND. Thank you.

Dr. Linder.

Dr. LINDER. Mr. Edgar, where is the VA 171-hospital system going to be in 25 years absent another large war? You have 10 years in aging over the general population now. Are you moving toward a more nursing home environment?

Mr. EDGAR. In my opinion, I think our system 25 years from now will really be in a situation of comprehensive care. That is my opinion. I think we will be still providing multi-level care and of course I think we do have to consider the age of our veterans, the fact that people are living longer and they are in relatively good health longer. So I think there is going to be a greater need for long-term care in our facility. But still, as Mr. Ayres says, we have to have tertiary care—have to have primary, secondary and tertiary care. I think our system will remain intact, I do not believe the national health care reform will do away with the VA system. I think that is very critical. I think it is a managed care system, that seems to be the direction that health care reform is moving. We have been doing managed care for a long time. I think we do a good job of that. But I guess my concern would be with resources, I just hope in 25 years we can continue to get resources adequate to take care

of the needs of our veterans, because after all, our system is for them. I like to think of our veterans as having prepaid insurance, and I think we must have a viable VA hospital system to take care of those veterans because of the special persons they are.

Dr. LINDER. Dr. Skelton, I read your statement on the way down here this morning. You suggest the lessons learned by the VA will be instructive for national health care reform. You talk about resource allocation and use of facilities, which seems to imply a thinking toward a single-payer kind of centralized control system. Am I misreading that?

Dr. SKELTON. Somewhat. What I believe we are looking at is headed toward a number of managed care models, if you think about what people are describing as alliances and accountable health plans. You are trying to get more systematic control and accountability and responsibility in that, and trying to do it with some idea of the overall resources you have available. Now the hope is that you can do it with the competition that we value in this country, but at least the VA, I think, has had to struggle with a global budget, has had to struggle with mandatory requirements to take care of people who have needs, and they have then had to come up with systems of how do they use their resources, which technology do they replace and on what kind of schedule, what facilities do they replace on what kind of schedule, how do they do quality assurance and utilization review.

One of the great hopes in everything I hear about health care reform is that there will be more attention to practice parameters, outcomes research, quality assurance and utilization review.

I got in trouble back in the years when I served in Georgia State government by making a statement at one time that I thought organized systems of care, kind of like the Health Department, had a chance to provide better quality than a free-standing private system because there are more people looking over your shoulder all the time.

Dr. LINDER. I have never seen you worry about getting in trouble about what you said.

Dr. SKELTON. I just said it again. But I do think there are some lessons there that I hope are being used. Personally I do not favor a single-payer concept because it seems to me to mean—you gamble so much of your hope for the future in health care reform on one approach. And I do not think we know enough to do that. I hope whatever we have will have great State flexibility in it and I hope, for goodness sake, that in terms of the VA, we will remember what these men and women have done for our country, the kind of quality system they have now, despite the fact that it needs more resources.

I think a little about Central State Hospital. We went through the issue there that that population is coming down, everybody wanted to take the money out and spend it somewhere else. But they needed the money to provide quality care for the people who were remaining. I think that may be a lesson for the future in terms of the VA.

Dr. LINDER. Let me ask you one more question about it. I do not think any of us know exactly what is going to come out of the health care reform debate and I think it is unfortunate that Dr.

Rowland, who knows more about health care than anyone in the Congress, has not been asked to be on the task force. But if we come out with health purchasing alliances and competitive arrangements, number one, it is going to be centered pretty much on primary care gate keepers—it will have to be—and number two, the competition for the purchasing alliances would ultimately result in potentially very large corporations.

Do we have enough primary care physicians in America, number one? And number two, what happens to our rural hospitals?

Dr. SKELTON. Number one, we do not have enough primary care physicians and there are changes occurring in all medical schools to change that, but it takes a lot of time. There are a lot of primary care resources, not necessarily primary care physicians. If we can get the professions to work better together so that the physicians, nurses that can provide good quality primary care, can work together in team arrangements—I am not talking about independent practice, prescribing authority and admitting to hospitals by nurses, but I am talking about working in what has been well-researched extension of primary care services using physicians, nurses and other health providers as far as a team. I think that is the only way to remedy that kind of problem.

There was a second part to your question.

Dr. LINDER. The second part was what happens to our rural hospitals? I envision half the rural hospitals in America not being able to keep up.

Dr. SKELTON. Well some of that is happening already. Our goal is to try to save as many of them as makes sense in terms of delivery of health care in those communities and for other reasons. There are some that in terms of the way health care is delivered, that they cannot deliver what is really quality inpatient care and need to be modified, as I see it, to other health care resources to serve their communities. It may be long-term care, it may be ambulatory centers, but not hospitals. You cannot get managed competition into that market, you have got to look at some other way to do it.

I would just have to say I have a lot of trouble with all these terms coming out and all this talk. It does seem to me that what is happening right now is that some people are realizing—and there are a lot of smart people who have been trying to figure this problem out a long, long time. And if it had been easy, they would have figured it out before. These delays indicate to me that some people in high places in this country are realizing it is not easy.

Now I wish they would talk to Dr. Rowland, but I also wish they would look at the Hawaii system. That is a pretty good system, it goes on what we have as strengths in this country already, covers 96-98 percent of the Hawaii population. There is a fine VA system out there.

For goodness sake, let us use something that has worked instead of invent some totally new approach.

Dr. LINDER. Thank you.

Dr. ROWLAND. Mr. Collins.

Mr. COLLINS. Thank you, Dr. Rowland.

Mr. Miller, how much of the resident work allocation in terms of dollars has gone to each of the individual medical centers in Geor-

gia and how does this compare with other medical centers in the Southern Region?

Mr. MILLER. Mr. Collins, that compares very favorably with the rest of the region. Let me give you some numbers. Atlanta received $1.6 million and approximately 51 FTEE and Augusta received a little over three quarters of a million dollars and 31 FTEE and of course at the time, Dublin did not have any residents and did not have a need to be supported in that arena.

But to give you a view on how that reflects with the other hospitals in the region and the other 40 hospitals in the region, the average of FTEE per medical center was 31, but I think more important, the ratio of FTEE per resident that was provided, the region average was at .39 or .38, the Augusta hospital received a ratio of .39 and the Atlanta hospital received a ratio of .50. I think it is important to recognize that the hospitals presented their needs and based on those needs proportionately we provided resources as a result of the total amount of resources that were available, and naturally we did not get the total resources that were required.

But let me say that the first part of the residency workload limitation was to remove the basic routine care responsibilities from our residents. We established things like phlebotomists, we established IV teams and some physicians and other physician extenders. And we are getting back tremendous feedback from our resident affiliations that the establishment of those teams of phlebotomists and IV teams not only have removed them from routine duties, but there has been much belief that they have improved dramatically on the quality of care. And we look forward now to some support and implementation of our additional parts that will help us with resident supervision and reduce extensive hours of emergency care duty by our residents. Perhaps Dr. Higgins would like to expand on that.

Dr. HIGGINS. I would. Thank you very much, Dick.

Mr. Collins, we have just redone our entire policy for resident supervision in the VA and we have taken on a much deeper commitment in terms of having human resources available to supervise residents than I think anybody has ever done. The funding that is coming with this resident supervision package is going to be absolutely crucial and really could not be coming at a better time. So the doctors in the VA are very grateful for this, we think it is really going to help us provide the type of supervision of residents that we would all like to do.

Mr. COLLINS. Mr. Miller, you mentioned a $3.9 billion budget for the Southern Region, is that right?

Mr. MILLER. Yes, sir.

Mr. COLLINS. Being new to Congress, how many regions do we have in VA?

Mr. MILLER. We have four regions. The Southern Region has approximately 29 or 30 percent of any activity, no matter how you measure it, whether it be by patient demand, whether it be by recurring dollars or just any measure that you can think of. My numbers are not totally accurate but they are reflective of the dispersion. The Western Region has, I believe, around 32 or so hospitals but they have a larger internal geographic distance. The Region II, in the Central Region, has 34 medical centers—I am sorry, 38 med-

ical centers. The Northeastern Region, which has the larger population has one more medical center than I do, but we have got one under construction in Florida.

Mr. COLLINS. What is the total budget? If it's $3.9 billion for Southern Region, what is the total budget?

Mr. MILLER. The total budget for health care now is approximately $14.4 billion. It is interesting you ask that question, if you reflect on what that dollars is, and people talk about well let us do something with the veterans' health care system and look at all that money that is available. This country has surpassed or is approaching $900 billion a year in health care. That is two point something billion dollars a day. The Veterans Health Administration budget is used up in about 7 days. My $3.2 billion is used up in less than 3 days. And with that, we treat 6.6 million outpatient visits and three hundred and some thousand inpatient visits. I think that is a darn good return for the buck, sir.

Mr. COLLINS. Thirty percent of that $14.4 billion is $4.4 billion.

Mr. MILLER. I said about 29 percent, sir.

Mr. COLLINS. We are close.

Mr. MILLER. Right. Those numbers are gross.

Mr. COLLINS. I find that very interesting when a 1990 survey showed that we spend over $5 billion a year subsidizing illegal aliens in this country.

Dr. Skelton, being from Mercer, the private sector sort of, versus government, how do you compare the VA service—medical services there—to Medicare?

Dr. SKELTON. Medicare?

Mr. COLLINS. In comparison of performance results for the dollars spent.

Dr. SKELTON. I do not know if I can give you the kind of comparison you want. Let me start by saying this, I spent some of my own education in the VA system at the old Atlanta VA, working for one of the toughest physicians that I have ever worked for in my life, named Jim Crutcher, who was the Medical Director of the VA at one time. And I saw nothing but high quality care in the old Atlanta VA. I have been impressed with the efforts by the VA staff, physicians and others, to provide high quality care, given limited resources.

I would put it this way, I am not aware of quality of care discrepancies between the way a Medicare recipient is treated and the way veterans are treated. I think there is good quality care in the system. I am concerned about the trend over the last 8 to 10 years of resources not being able to keep up with the need, and I am concerned about the fragmentation that is involved in the way veterans get kinds of services. I think the eligibility—looking down the other end of the table here—I think the eligibility issues, to me, can create quality of care issues that are not the responsibility of the administration and the professional staff and that that ought to be one of your efforts to iron out those things, which would, to me, carry it back to say this is the group we take care of. If we take care of this group, we take care of them comprehensively. If it is fragmented, there is a quality of care problem caused by the fragmentation, not by the quality of personnel. I think that is about as good as I can do with that question.

Mr. COLLINS. Thank you.

One last question to the hospital directors. The House recently passed a bill, H.R. 2034, which will require the VA to establish clearly defined mission statements for all of its facilities. As a facility manager, would you agree that the system-wide establishment of facility missions is a necessary first step in preparing for the changes that will result from the national health reform?

Mr. EDGAR. Yes, I will respond to that. Yes, in my opinion, I would say that we would and should establish a mission statement. Of course, we would have to know the direction that the national health care reform is going. Once we know that, we could evaluate that and then determine whether there is any need for a mission change.

Mr. COLLINS. Thank you.

Dr. ROWLAND. Would you like to say something?

Mr. MILLER. If I may, Mr. Collins, I would like to add to that. I think the first step—and we have taken efforts on this in national review of what we call our national health care plan that is placed on hold until we see what type of form our total national health care plan would have.

But I think it is imperative, if we are going to deliver equal access, if we are going to deliver comprehensive care through a network of inter-related hospitals, and we have an ideal example of a very effective one here between our Georgia hospitals and our South Carolina hospitals, that the first thing we must do is truly identify through appropriate planning factors, through appropriate standards of care, the type of care we will deliver and provide that in a consortium, in a network of medical centers to serve a given population so that we do not have any overlaps or duplications except where redundancies are appropriate. But at the same time when we review those mission changes, we also must look at those gaps in services we do not have in that given area. And we are progressing in a small way towards that.

Mr. COLLINS. Following up on that, speaking of a gap in services, I ran into a gentleman a couple of days ago named Forrest Turner. I do not know if you know Forrest, I am sure some of you do, Mr. Turner has been in the dental work for a number of years. He was voicing his concerns about the fact that a lot of veterans have problems receiving dental care versus the fact that we house several hundred Cubans in the Atlanta Federal Penitentiary and they have constant needs provided for them, including dental care. Where are we with dental care for our veterans?

Mr. MILLER. Well as you are aware, we have the largest hospital dental service in the country, but at the same time we also have very restricted eligibility rules relative to providing dental care and I am sure that is a concern of a number of veterans. But we provide very comprehensive dental care within the eligibility laws that we have.

Mr. EDGAR. Let me speak to that just a bit. We recognize that problem, and as Mr. Miller says, the eligibility is extremely complicated for dental care and a lot of our veterans do not understand that eligibility. I can tell you I do not totally understand that eligibility myself. Let me say at our hospital, we have had some problems in that area. I am glad to let you know that recently we added

an additional dentist to our staff, so sometime in July we will add an additional dentist, and I hope we can help resolve perhaps that issue maybe for that particular gentleman.

Mr. COLLINS. Thank you, sir.

Dr. ROWLAND. I just want to make one comment about the loss of those medical research funds that all of you are aware of and how severely I think that would adverse the ability of the VA to attract top notch people into the VA. So we are working, as you know, to get that restored and I think that we are going to have to try to get more than just the $26 million restored because it does not take into account inflation and other factors. So we will be working with Lewis Stokes, who is Chairman of that subcommittee of Appropriations to try to deal with that.

There are a good many more questions that we want to ask, but we do not have time for. We want to hear from the veterans' service organizations and so we will submit these for the record and will ask you to respond, if you will.

I want to thank all of you very much for your testimony here this morning.

Our next panel is A.V. "Bubba" Akin, who is a service officer for the Department of Georgia for The American Legion, a friend who I have known for a number of years; and William Coward, who is a Hospital Service Coordinator for the Disabled American Veterans and he is accompanied by Avery Swain, Southern Area Executive Committeeman for the DAV as well. If you gentlemen will come to the table, we will appreciate it.

Gentlemen, thank you very much for being here this morning, we do appreciate it. Bubba, if you would open up. I would ask you to limit your statements to 5 minutes and your entire statement will be submitted for the record.

STATEMENTS OF A.V. AKIN, SERVICE OFFICER, DEPARTMENT OF GEORGIA, THE AMERICAN LEGION; WILLIAM COWARD, HOSPITAL SERVICE COORDINATOR, DISABLED AMERICAN VETERANS accompanied by AVERY SWAIN, SOUTHERN AREA EXECUTIVE COMMITTEEMAN, DISABLED AMERICAN VETERANS

STATEMENT OF A.V. AKIN

Mr. AKIN. Thank you. Good morning, Mr. Chairman and members of the committee. It is a pleasure to appear before you to offer the position of The American Legion, Department of Georgia, on the subject of the Department of Veterans Affairs (DVA) medical care delivery system's role in national health care reform.

Mr. Chairman, The Legion firmly believes that the Department of Veterans Affairs health care delivery system can and must continue to exist in any future national health care environment. Events regarding national health care reform are rapidly unfolding. The issue of eligibility for VA care is being studied, appropriations negotiations are in progress and VA's national health care plan is about to be unveiled. Each of these important changes could be pivotal to definition of the role of VA in health care in this country, but none will deter the steadfast resolve in this Nation to care for our sick and disabled veteran patients.

There is presently a great deal of discussion regarding the impact of global budgeting and spending caps on health care costs. There are those who would say that such caps on spending would drive aggregate health care costs down and reduce the percentage of the gross domestic product which is devoted to health care. Mr. Chairman, the Veterans Health Administration has operated under a global budgeting scenario for years. Such dollar constraints do force the system to become more efficient and create increased accountability for those who fiscally plan for veteran patient care. But to accomplish this, corners must be cut and funds from other medical programs are cannibalized. The ultimate result is that which would occur in the private sector as well—rationing of care.

Fewer and fewer veterans are being treated in the VA, while for a variety of reasons, the costs of that care continue to escalate. Any health care reform package which would encompass global budgeting and price caps would allow the VA to operate at something of an advantage but, unfortunately, would perpetuate the rationing of care and reduction of population of veterans served, if quality is not to suffer.

The role of the Veterans Health Administration under a managed competition scenario of national health care reform is less clearly defined because of our inability to determine the final form such a plan would take. Be that as it may, Mr. Chairman, we believe that VA, given free rein as far as their internal reform is concerned, could fare well under managed competition. Several mitigating factors must be clearly understood.

First, a major portion of the costs of VA health care is based upon care mandated by law to certain groups of veterans such as those with service-connected disabilities, those exposed to herbicides and ionizing radiation, those too poor to pay for their care, and others. Since the care for those deserving veterans is mandated by law, it must remain available and those costs cannot be factored into a competitive package cost. Secondly, some of the cost of care in the VA is that created by the delivery of long-term care. Since it appears that long-term care may not be a portion of the basic benefits package which will be the basis for competition, the VA must separate out those costs as well. The existing prohibition against VA's collection of Medicare reimbursement will place a limit on VA's ability to compete.

Mr. Chairman, The American Legion believes that a plan to afford universal access to health care under reform would impact upon the VA in several ways. If health care consumers were to have their health care vouchered under a universal access plan, some veterans might move to the private sector for their care. These moves could be counter-productive for several reasons. In regard to keeping costs down, the private sector has never been proven to be able to deliver quality care at a cost equal to or lower than that delivered by VA. Thus, any mass move could increase rather than decrease costs nationwide.

On the other side of the matter, many veterans who had not previously taken advantage of VA health care, might move to the VA for their care simply because the ideal of getting quality care at less cost may be an attractive option. The unknown in the voucher

equation is the number of veterans who would, taking advantage of their opportunity for choice, pick one or the other option.

Regardless of what form a new national health care delivery mechanism takes, it is important, we think, to remember that the Department of Veterans Affairs has over 60 years of experience in delivering health care nationally. During these years, VA has learned some important lessons.

The doctors and hospitals in the VA system have made some serious mistakes, to be sure. But they have also made some remarkable scientific discoveries which have benefited all Americans.

Mr. Chairman, we believe that the Department of Veterans Affairs health care system could act as a model for national health care reform, in particular after eligibility reform is achieved. The VA has a proven track record in the ability to deliver quality health care at a cost well below that of the private sector. Recent studies have demonstrated that health care of equal quality can be delivered by the VA at costs which are 20 to 40 percent lower than that delivered by affiliated university hospitals. Any plan to reform the Nation's health care delivery system should utilize the cost-containment experience of the Veterans Health Administration.

Mr. Chairman, in your announcement of this hearing, you suggested comments on VA medical care delivery here in Georgia. We of The American Legion, Department of Georgia, have a long-established close working relationship with our medical center directors. We are cognizant of their problems with budgetary constraints and their diligent efforts to provide quality medical care for our Georgia veterans is appreciated. We applaud each of them and comment them for their cooperative attitude. And Mr. Chairman, this applies especially to this Dublin facility which you and I are most familiar with.

That concludes our statement, Mr. Chairman. Thank you very much.

[The prepared statement of Mr. Akin appears on p. 98.]

Dr. ROWLAND. Thank you very much, Bubba.

Mr. Coward, I am really pleased to see you and Mr. Swain here this morning. I do appreciate you coming. Do you have any statement that you wish to make?

STATEMENT OF WILLIAM COWARD

Mr. COWARD. Mr. Chairman, I appreciate the opportunity. I was not given enough time to prepare a statement, but we agree with Bubba here on the points that he brought out and we will be glad to answer any questions that we can.

Dr. ROWLAND. Very good. Let me start off with some questions then for all of you. From the standpoint of a patient, from the patient's perspective, what are the greatest areas of need that you see here at Dublin and in Augusta hospital, Bubba?

Mr. AKIN. I feel like, sir, that—sure we have problems, and I feel like due to the dedication and the experience of the people in high places in the VA, regardless of what lies down the road, I think we can live and care for our veterans in a quality way with quality care. That is my personal opinion after careful study for many years.

Dr. ROWLAND. Mr. Coward.

Mr. COWARD. Mr. Chairman, we are concerned about the needs of our older veterans. Being Hospital Service Coordinator, I have an opportunity to see more and more World War II and Korean veterans coming into this VA facility here in Dublin for the first time. We have started a bus running from Albany, Georgia to the Dublin VA Medical Center. And one day out of the 14 people that came up here, 11 of them had never been in a VA facility, which means that it caused more work because they had to start right from scratch to make a folder for them, send them to x ray, send them to lab, and do all the preliminary work that most of the veterans have here. And more and more we are seeing this and it is putting a strain. They do not have enough people to take care of them, they do not have enough doctors, and I think it comes back to the same bottom line—cut, cut, cut on the money that they give the VA facilities to do the job that they need to do.

Dr. ROWLAND. You think even then, in spite of the fact that we have got this new outpatient facility, that there is still not enough personnel to take care of the demand that is being placed?

Mr. COWARD. Well sir, it is included in the demand, I think we were not geared up to accepting all the people for the first time.

Dr. LINDER. Mr. Chairman, may I follow up on that?

Dr. ROWLAND. Yes.

Dr. LINDER. These 11 out of 14 people who were first time visitors to the facility from Albany, were they not coming because it was inconvenient for them or because they did not know about it or were they using other health care facilities and regular health insurance and now just as a matter of financial concern, they are coming here?

Mr. COWARD. Sir, most of them had no way to get here. And we have been working on this now for years, as you know, with our transportation system throughout the country.

Dr. LINDER. In your relations with other veterans' service organizations, is that a common complaint around the State, the difficulty of getting to a facility?

Mr. COWARD. Yes, sir. They do not have the funds and most of them fit in the category where they have to take care of them, and they do not have the funds. They get $300 or $400 from Medicare and that is it.

Dr. ROWLAND. I am aware of the transportation possibilities that the Disabled American Veterans are doing, as you mentioned, throughout the country. I know in the lower part of the District, in Waycross down there, they really do a good job in providing transportation for veterans and I commend the Disabled American Veterans for what they do in that respect.

That is one of the principal problems that you see at this point then is transportation. And Bubba, one of the problems you see is not adequate personnel to staff the facility that we have here, is that right?

Mr. AKIN. That is correct. It all comes down, Mr. Chairman, to dollars, we all understand that. It takes funds to operate.

Dr. ROWLAND. Right. John—Mr. Swain, I am sorry.

Mr. SWAIN. Mr. Chairman, just to add a few points to that, the veterans that I have encountered, which I cover most of the southeast. I get to go all over to the smaller chapters. The biggest prob-

lem that I have run into is the fact that these people, for the first time are living on Social Security with very minute income and it is restricted income. For the first time in their life they are letting price get into it. And their health deteriorates to a point and having no transportation creates a problem in getting them into the system. So they have some coverage on the Social Security side of the house, they have some coverage under Medicare and also eligible to come under VA and they are seeking medical care wherever they can find it. But most of it, as Bubba alluded to, is dollars. That is the biggest problem of rural America that I see in the people that I talk to. It is a conglomeration. I hear the people and I feel sorry for them. Really they have three options available to them, yet none of them are satisfactory, it is just a conglomeration.

Dr. ROWLAND. Would you say it is imperative that a hospital like this continue to exist to provide the care to those kind of people that you are talking about and you are not transporting to this hospital here?

Mr. SWAIN. Mr. Chairman, it is my opinion that this hospital, it is imperative that it stay in operation and that it receive not only the service-connected disabled but those people who have worn the uniform and have served this country, pull theirselves up by their bootstraps and now find themselves at an age and have no health coverage, to be able to come into this facility and get quality care.

Dr. ROWLAND. Let me ask—I want to make a comment about something that has been looked at, and I might want to ask Mr. Miller about this as well as Mr. Edgar, about the feasibility of a mobile medical clinic to be an outreach to those veterans that are having the kind of problem that you are talking about right now. Could you talk loud enough, Mr. Miller or Mr. Edgar, to speak to that?

Mr. MILLER. Yes, sir, I certainly can. We have six, I believe pilot, mobile clinics now under test in the system. Those mobile clinics proved themselves as a provider of access to primary care during our recent disastrous hurricane. As you know, we transported all of them down to Florida after Andrew struck, and they proved themselves very well. I am delighted to have our mobile clinic in Fayetteville, North Carolina that is providing outreach there, primary care accessibility in under-served and rural areas. After we get the information from the four or five that we have in the system, under the pilot test program, I think then we will probably learn that they are an excellent outreach for providing primary care to under-served areas. And as you know, they would be an excellent access to some of our Primary Care measures such as screening and other things.

Dr. ROWLAND. Mr. Edgar, you are interested in this activity, I believe.

Mr. EDGAR. Yes. First let me second everything that Mr. Miller said. As a matter of fact, a lot of people do not realize when you live in a rural community, the difficulty with transportation—we have a lot of people that have to work off the bus schedule. As a matter of fact, we have people——

Dr. ROWLAND. A little louder, if you will. The recorder here is having trouble hearing your comments.

Mr. EDGAR. As a matter of fact, we have people in rural Georgia that have an appointment at my hospital tomorrow, because of the transportation schedule, they have got to come here today so they can be here tomorrow. And that ends up as a problem for us as we try to accommodate them.

But health care reform, one of the premises is access, that is one of the keys to national health care reform. And access is a real problem in the rural community and I think the mobile clinic would be an excellent solution. As a matter of fact, we have even gone to the trouble to explore the cost of a mobile clinic and you really can get into a mobile clinic for less than a million dollars; buy the clinic, hire the staff, even have computer access that you could hook up directly to the hospital so you could access data in the hospital. So I think it is a very viable means for, as Mr. Miller said, expanding our primary care capability. Hurricane Andrew was an excellent trial for that and it proved to be an exceptional vehicle to provide care when you take that care to the source of the need. And we need to do that, I think, in rural Georgia.

Dr. ROWLAND. Thank you very much.

Mr. Collins.

Mr. COLLINS. Mr. Akin, in your comments you mentioned that fewer and fewer veterans are being treated by the VA for a variety of reasons, and we have heard the part about the transportation and I find that very interesting, particularly because the cost of care continues to increase. You also stated that under any health care reform package which would encompass global budgeting price caps, the VA would operate at something of an advantage but unfortunately would perpetuate the rationing of care and the reduction of the population of veterans who are actually served.

What other concerns do you have regarding the impact on VA by pending national health care reform proposals? We will also refer this to the other two gentlemen.

Mr. AKIN. Congressman, I feel like having had 35 years as a service officer in this particular area of Georgia, we are finding more and more veterans who we consider to be eligible, in serious need of care, are being turned away. Our hospital directors are faced with the problem of making dollars do and they have to sometimes—to use an old expression—rob Peter to pay Paul. They have to shuffle money and they have done an excellent job, but at the same time, they have turned away a lot of people.

I can easily understand why the overall population has dropped. I do not know if it will ever get any better under the present system, but I do believe, as I said, that the VA is better prepared through long experience to operate in an internal arrangement, and we just feel like that they should be left completely out of any national reform plan. We have got a system, it is working and we need to—if it ain't broke, let us not try to fix it. And I feel like that we do not need to get the VA involved in national reform unless it is used as a model. I think personally, and The American Legion feels, that it is definitely a model for anyone on any task force trying to plan for national coverage.

Mr. COWARD. Mr. Collins, I would like to just make a statement that what is wrong with what Bubba said and also expound on the transportation. We also have a DAV van that comes from Macon

every Tuesday to this hospital and they bring from six to 14 people every Tuesday. We are trying to work with the hospital to get people, their appointments to coincide with our transportation, as well as alternates. We have future plans to have one come up from Waycross up in this direction, and from Vidalia. These are the cities right around here where we have the most problem getting veterans to the hospital. But there again, once we get them here—and I feel that there are veterans out there, because we also have a van that tours the whole State of Georgia once a year to do claims work and it covers the whole State of Georgia, and they find also that people in the small rural areas have no way to get to a claims office even though the State Department of Veterans Services has services in a lot of these cities in Georgia, they still, in the rural areas, it is hard to get to. That is why we try to cover it with the van once a year. We see from 50 to 100 people at each of these locations filing claims to try to get them help with the VA, compensation.

This hospital, as far as I know, Mr. Edgar said that they had a homeless veterans program, I see homeless veterans coming in my office every day that have nowhere to go. Of course our homeless veterans program, 40 beds, is a start, but it is not enough. We have homeless veterans over in Macon, in Albany and areas that this hospital is supposed to cover and there is no way we can get them in because we do not have the funds. This hospital does an outstanding job when they can get them in and do it, but they have two wings closed at this hospital because of the nurses shortage and the doctors, they do not have the funds. If they could open that up, that would help. It is the long-term and the aging veterans, that is our main concern now.

Mr. COLLINS. Very good.

I want to ask each of you a two-part question, but before I ask the question, I want to say this; I find it very interesting the amount of money that the VA has to operate on versus the number of patients that it serves, and the care that it delivers. I think they are stretching their dollars far and production and results are good based on the dollars that they have. But we have talked about the VA being kind of a guidepost or something to look at as far as a pattern for national health care reform. The question is, do you think that providers in the private sector would accept the national health care reform or a national health care reform that is patterned after the VA?

Mr. AKIN. Sir, my thinking on that is it is going to be up to the Congress and I think we are blessed in Georgia, we have one long time member of the House committee, our Chairman here this morning. And in Georgia, we are blessed to have two more—two additional members, Congressman Linder there and Congressman Bishop over in Columbus. And I believe whatever happens—no one seems to know out in the boondocks, we are just guessing—but surely we in Georgia are well represented on the committee and whatever happens will happen. I wish I could enlighten you, but I cannot.

Mr. COLLINS. It is a tough one to answer. What about Mr. Miller or some of the directors, what is your opinion on how the private

sector providers would accept a program or national health care reform that is patterned after the VA?

Mr. MILLER. Congressman, as you said, that is a very, very complex question and it not only deals with acceptance of one health care system, but it deals with changing history and values of our citizenry and I think the answer to that and the following question—I think whatever health care system finally comes out of the Congress, we will be able to deal within that very well, and I would say that we offer tremendous strengths of experience in certain deliveries of care. We have dealt under a global budget, we are a national system with centralized national administration and direction and financing. We can go down a whole list of things that we have tremendous expertise and I would hope that the wisdom of the years and the citizenry will develop the appropriate national health care system that meets the three criteria, and that is access, financing and quality of care. I wish I had the vision to answer that very complex question.

Dr. HIGGINS. Sir, if I could, I would like to add just a little bit. One thing is that many doctors in the private sector have spent some time with the VA so I think they understand our strengths in the areas where we still need to improve. One of the things, as a physician, that I really like about the VA is that once a patient gets into our system, we can do anything we want to without having to worry about whether the patient can afford it or whether his insurance is going to cover it—we just do it. And that is great, I think doctors in private practice envy us for that.

On the other hand, getting into our system can be difficult. We do have to wait for appointments and we are still wrestling with what the proper eligibility is. I think that is an area where we would need to improve if we were going to be used in a demonstration project for a private sector health care program.

Mr. AYRES. I think also that you gentlemen can be of great assistance to us by marketing the VA, by meeting the hospital directors in Augusta or meeting them here in Dublin, as you frequently do, to make sure that people in the various disciplines understand the value of the VA. It is kind of a hidden giant out there that needs, I think, more focus in the sense of publicity regarding the positive things we do. We could extol our virtues for several hours here on things that we have been able to accomplish. But, we have never been in a position of "positive marketing," like military recruitment, on television and so forth. We have been restricted in advertising our value and I think you gentlemen could be of extreme value to us in citing the positives of the VA.

Mr. COLLINS. Thank you, Mr. Ayres and Dr. Higgins, I appreciate your comments. I think the comments that each of you made just reinforces the fact that you all should be heard from when it comes to discussion of national health care reform package. You have a lot of valuable experience and could have a lot of valuable input.

But the second part of the question, we asked about the providers, but how do you think the general public would accept a national health care reform patterned after the VA? Who wants to answer it?

Mr. COWARD. Mr. Chairman, I would like to give you my opinion. I do not believe private sector doctors would put up with a system because they are trained in the VA, but they do not stay there because the VA does not pay as much as they can make in the private sector now. They go out there and they make two or three hundred thousand dollars a year and they see about 30 patients a day where our outpatient clinic alone sees 70-plus a day. So I do not think the private doctors would accept it, I really do not.

Mr. COLLINS. How about the public, the people?

Mr. COWARD. I do not believe the people would either, sir. Because the way I see it—and I do not know much about this plan, I cannot get any—I do not know whether it is secret or what, but any time you go into the private sector, you have a doctor out there that people love, I mean they love him, and they go tell other people, they want to come to him. If you turned this over where—I do not know whether the doctors are going to have to accept a certain fee or what, but you are going to have a line 10 miles just to get to one doctor and this other doctor is not going to have anybody. People may not like his looks or the way he combs his hair or whatever. I do not believe it is going to work.

Mr. COLLINS. Mr. Swain.

Mr. SWAIN. Congressman, alluding to that, I just want to state that I have a nephew that has just now become a doctor and he went through the VA system. In talking to him after he set up his practice, he was offered a huge sum of money after he completed medical school—of course it took him 12 years and I realize it took a large part of his time, but I asked him the question of how much it cost him to collect his money from the Medicare system since he is in an area that relies heavily on Medicare/Medicaid system. And it is costing him right at 18 cents on the dollar to collect his money from the Federal sources. I think this is one of the factors. And secondly, I do not think that the public will accept the VA model and it all comes down to money and insurance. And this is my personal opinion in going through both systems.

Mr. COLLINS. Thank you, Mr. Chairman.

Dr. ROWLAND. Thank you very much.

I want to thank you all very much for your testimony this morning. We have some questions that we would like to submit to you. I want to recognize a couple of people, Mary Lou Keener, who has recently been confirmed as General Counsel for the Department of Veterans Affairs is with us today. And also Nancy Terrell who is a field representative for Sanford Bishop. I want to thank both of you for being here this morning as well.

We have a little time left, so if there is anyone in the audience who would like to make a comment, we are certainly receptive to you doing that at this time.

Mr. HALL. Mr. Chairman, I would like to make a statement on just what you are talking about. I am a veteran——

Dr. ROWLAND. Would you identify yourself? I know who you are, but maybe the other people do not.

Mr. HALL. My name is Harold Hall, I am a member of all of the veterans' organizations that will let me in and some that do not. I have been a long-time patient of the VA Hospital. I started when

they did not have VA hospitals, they had barracks with a nurse and two ward boys.

I do appreciate the care that I have had. I have had 139 surgical procedures. I have had heart surgery, I have had just about everything there could be. The VA has been real good to me and because of the treatment that I have gotten from the VA is why I am standing here and I am 76 years old, and I hope to be here another 25 years with the good care that the VA has given me.

I have been in the private sector, it is not like VA. The VA doctors are dedicated people. They are not there for the money, they are there because they love people and want to do what the doctor says to treat people. And that is what they do in the VA Hospital. I appreciate them, all the doctors and the personnel that I have come in contact with over the years. I have been in a number of hospitals, I have visited just about all 172 of them because I have worked with them, as you know, and I do appreciate your recognition of me and the Golden Age Gang. I believe that that is what has kept the VA what it is, working with the Congress and doing these things in the programs that they have.

Do not change the VA system. Put more money in it and you will get more health care from that.

Dr. ROWLAND. Thank you very much, Harold, we appreciate that. That was good testimony.

Anyone else have any comments that they would like to make? You maybe need to come down to the front here where you can be heard because we have a recorder here and he cannot hear you from the back.

Thank you for coming down. Just have a seat and talk into the microphone there. Identify who you are, if you will.

Mr. VEREENS. Thank you, Congressman Rowland, distinguished visitors. My name is Roger Vereens, I am a patient here at the VA.

I felt that I might have something to contribute concerning public or non-veteran acceptance of a medical plan based on the VA profile. I do not believe that eventually the public is going to be happy with the seemingly long waits we have in processing new patients. A patient comes in at 8 a.m., by the time he goes through the various things, it may take him until 4 p.m. The public that I am familiar with, that I see, have—they have things to do. If nothing else, they want to get home and watch the television. But they do not want to sit and wait for a long time. This is going to affect the attitude of the so-called general public in regards to health care. I believe within a reasonable time, they can learn to adjust to the VA system.

First of all, our doctors, as has been pointed out, do manage a great many more patients. Most of our doctors, as has also been pointed out, are not into the money business as much as they are in the private sector. I saw a thing on the cover of BUSINESS WEEK about 2 months ago, I think, with the highest paid executives in the United States. Of the four top executives, three of them were making more than $120 million per year. They were in the health care business. Those people are really going to scream if we go into a system where we are going to be a little more social and a little more—if we are going to follow the VA system, nobody in

the VA, as far as I know, is making a fraction of that kind of money, not even in The American Legion.

(Laughter.)

Mr. VEREENS. I am sorry about that. I am in the DAV myself, I had to say that.

I really believe that the problem is going to be delivery of services. I think it is going to be an educational process, which is going to require teaching the people that if they want reasonably priced health care, they are going to have to spend some time waiting until they can be served. As far as the VA is concerned, I have no question in my mind that the VA is providing the very best service that they can or that I need, which is probably more important than what they can. And I do believe that the VA does provide good service and personally I believe they do it at a reasonable price. I do not think that our care here is expensive compared with any other equal care, let us say.

And I think I have talked long enough. Thank you, Congressman Rowland.

Dr. ROWLAND. Thank you very much, we do appreciate it.

Mr. COLLINS. I think one reason they want to get home as early in the afternoon as they can, is so they can watch C-Span.

(Laugher.)

Mr. COLLINS. All the talk shows are over in the morning and Congress is on from 12 o'clock on.

Ms. RAMSEY. My name is Beth Ramsey, I am a veteran and a resident of domiciliary area here.

Dr. ROWLAND. Pull the mike up close to you.

Ms. RAMSEY. Thank you.

My name is Beth Ramsey, I am a veteran and a resident of the domiciliary area here. I am relatively new in dealing with the VA system.

The first comment I would like to make, I think, deals with the public's acceptance of a VA-based system as well as the veterans problems. And the second has to do with what really concerns me most, is retaining veterans within the VA system if we do indeed go to whatever it is the Clinton Administration deals with.

I believe that by the general public as well as veterans, that the perception and the reality of the quality and availability of care through the VA are very divergent. I think from the veterans' perspective, the image is not going to change without some frank, open meetings with the veterans. We veterans do not always feel that our input is sought often enough, and again very frankly, whether perception or reality, we do not believe it is given much weight when it is sought. And I think again, perception for the general public, unfortunately some of the problems with the VA have been in the forefront rather than the successes.

One of the major problems confronting the VA now is again, from our viewpoint as patients, the seemingly inaccessibility of timely care. Often even urgent care in terms of consults and appointments takes months, literally, to begin. This is especially frustrating for female veterans. We understand that this is an overworked, understaffed system, but unless this can somehow change fairly soon in light of projected time and possible implementation of the Administration's health care plan, I believe you are going to lose

many patients to alternatives in health care because their perception will be the timeliness of care will be much quicker. And one example is a patient here who has enough problems that she has to get around in a wheelchair because of back and nerve problems. Her appointment in Augusta I believe is either September or October. I do not know the answer to it, but I think unless those two things are addressed, you are going to have a great deal of problems retaining veterans within our system, which is a good system.

Dr. ROWLAND. I would like to ask for a response from maybe some hospital directors to address the question of why does it take so long to get an appointment for a specific thing. I guess that is what you are talking about, you are concerned that if that does not in some way become addressed in a new system, that people might choose to go to the other system. Would somebody care to address that? Tom?

Mr. AYRES. I am Tom Ayres. Bill and I, as we usually do, confer about problems areas. One of the areas that this young lady might be referring to could be OB-GYN or other specialty areas, also orthopedics, in the past, has been a problem. What we have tried to do through our new relationships, both with the Medical College of Georgia and with the Eisenhower Army Medical Center is to try to capture the resources of both of those places and unify it under one contract, thus reducing the down time to a reasonable point, like 4 weeks. Three weeks is what is acceptable usually in our own case, mine or my wife's. But those particular problems for the female veterans are very real and our network, which is composed of the hospitals in South Carolina and Georgia, are working on those issues now. We have submitted a network initiative to deal with the comprehensive care of female veterans but I am glad that you brought this to our attention this morning. I think about my own personal health care, which right now is received outside the VA, and it is not uncommon for me to wait in my physician's office for 3 or 4 hours for a scheduled appointment. I think on the average that waiting time is a problem with the VA in our outpatient programs. However, we do have other outlying situations with five or six hour occurrences, that we all try to remedy.

But this young lady is absolutely right, especially in the area of female veterans, we have to do a better job of providing specialized care in clinics, and we are working towards that now.

Dr. ROWLAND. Thank you very much. Mr. Edgar?

Mr. EDGAR. I would have to agree that certainly on occasions we do have problems with timeliness of care. For example, at our hospital in Dublin, we do not have an orthopedist or an ophthalmologist, so we rely very heavily on our Augusta hospital. I think they do an excellent job, but we also have some difficulties in recruiting those specialties. I think a lot of times when we have a problem with timeliness of care, it is exacerbated by our problems with recruiting specialists such as orthopedists and ophthalmologists. So I have to agree, but I also will say we continually do studies of our time frame, the time it takes us to process our veterans through our outpatient ambulatory care area. Generally at my hospital, we are able to process our patients and make a diagnosis within about 2 hours. There are exceptions and certainly I know on rare exceptions that it does run into 3, 4, 5 hours. I will tell you we look at

each one of those exceptions and we try to find out why that happened and if it is within our control to correct it, we do that.

Dr. ROWLAND. Thank you very much. Any of you have any——

Dr. LINDER. I would just like to close by saying thank you to these gentlemen with the service organizations who have dedicated so much of their lives to helping veterans. We see them all the time in Washington when they come to hearings. It is amazing how many hours you folks give to your fellow veterans, and I as a fellow veteran appreciate it.

Dr. ROWLAND. I see one other person here. We have got time maybe for one other person who would like to make a comment.

Mr. ANDRE. I was a patient in Augusta——

Dr. ROWLAND. You need to talk loud enough for the reporter to hear or come down to the table here, if you will.

Mr. ANDRE. Thank you very much for recognizing me.

I was a patient in Augusta and I was treated royally. The hospital was excellent, the service was outstanding.

Dr. ROWLAND. Would you identify yourself?

Mr. ANDRE. John Andre.

Dr. ROWLAND. Thank you.

Mr. ANDRE. I'm from McRae, Georgia, I am also a member of Chapter 39 in the DAV.

Getting back to my confinement in the hospital, it was great, but I do have a little bit of a gripe. While in the hospital, they closed—they discontinued the veterans entertainment, I mean the recreation department, shut it down. They said they needed the space for dialysis or something. And of course I made a similar suggestion that they could have continued bingo, for example, which is the most outstanding part of it, in like the cafeteria or something where they have seating arrangements already there. They shut it down in the evening and it would be available. And of course the DAV, The American Legion, the VFW, all the organizations were leaving with tears because they look forward to coming over to entertain the veterans. They were turned away, discontinued, they said they needed the space. I was in the hospital—it shut down in March. I was due to come out of the hospital this month, the 21st, and in peeking through the blinds, the pool tables, the piano, everything is still as it was several months ago. I mean we need some money, they said they could not afford it. Well maybe somebody could come up with a couple of dollars for somebody to turn the key and open the door. The organizations put on the show, do you know what I mean? It meant a lot to the patients, I certainly missed it.

Thank you very much for allowing me to make this comment.

Dr. ROWLAND. Thank you for those comments.

Mac, do you have anything else?

Mr. COLLINS. Thank you, Dr. Rowland, Mr. Chairman.

I think this hearing has been very valuable, it has been a very good experience for me especially. I have learned a lot about the VA and the services that you perform. In addition, I have learned some of the restraints that are placed on you that are not your fault, and I think you are to be commended for the services that you are rendering considering what you have to work with and how you do have to cope with certain restraints.

I think the lessons that you have expressed have indicated that you have learned the hard way. In Washington, I am known as Mac Collins, RFD, that is rural free delivery, because the only university that I have ever attended is the university of hard knocks. So I have learned a lot of my lessons the hard way also and they are very valuable. And I think that is all the more reason that you should be included in the talks of the task force.

I also find it very interesting that 50 percent of the doctors, physicians and providers of health care at some point in time have been involved with the VA or with the Department of Defense. I think that too speaks to how important it is to have their input and they too should have been advised and included in the national health care reform task force.

Dollars are always a problem, that is the biggest restraint that you have that causes you not to be able to do some of the things that you would like to do. That is where Congress comes into play. Having only been there now 5 months, going on 6 months, it has been an eye-opener, even though I served 4 years in the Georgia General Assembly and also have served in local government. But an example of what I have witnessed and seen happen in Congress happened last week. We had two supplemental bills that came before the House of Representatives. The first supplemental bill was for $1.8 billion. It was all deficit spending and it was all going to motherhood and apple pie, things that were very necessary. Defense, VA, Education, Department of Justice, Agriculture, $8.6 million went into agriculture to help the Farm Home Loan guarantee program which was four million of the eight—just a lot of good programs that needed funding. The SBA loan guarantee money was there. Again, all of it was deficit spending.

Supplemental bill number two followed supplemental bill number one on the floor, one right behind the other, both last Wednesday afternoon. Supplemental number two was a $920 million expenditure but it was not deficit spending. The monies were being spent on what I call enhanced welfare and some pork barrel projects, probably some payback for political reasons. Where did we get the $920 million since it was not deficit spending? We went right back to the Department of Education, the Department of Agriculture, the Department of Justice, Department of Transportation and took out $920 million total—and one or two other departments. And used those funds for that purpose, funds that had just been appropriated as deficit spending, funds that could have been used in those departments, and other funds being transferred for the real necessities that were in the first supplemental bill such as the VA, the CHAMPUS insurance, even the Department of Defense had come before the Armed Services Committee and declared that they could get by without $750 million in their funding. They may need it before the end of their fiscal year, but they did not need it that day.

But that is an example of what has happened, as I see it and it has probably happened a number of times in the last few years. I am not going to take up for any administration that has been there. Congress has been there and a President has been there, but I think that is an example of what has happened and why we are in the mess we are in and why you are restrained from having the

dollars you need to fulfill the services that you need to provide. The fact is that we have deficit spending for things that we could have been transferring funds for, but we did not. But we will transfer funds from those very same departments and use it for projects that we could have gotten by without.

Mr. Chairman, I appreciate you including me in this hearing this morning, it has been very valuable to me. I appreciate the dedication of you gentlemen who serve our veterans, I appreciate you in the Department of Veterans Affairs hospitals and the work that you all do. You can call on us, and God bless you for your service.

Dr. ROWLAND. Thank you very much, Mac. I appreciate very much you coming and John Linder as well. I want to express my sincere appreciation for the people who work so hard in the Department of Veterans Affairs here, for the veterans groups that have come to be here this morning, and for those of you in the audience who came and talked about those things that are of concern to you and how you feel the Department of Veterans Affairs fulfilling its responsibilities.

Thank you all very much for being here this morning. We stand adjourned.

[Whereupon, at 10:05 a.m., the subcommittee was adjourned.]

NATIONAL HEALTH CARE REFORM

FRIDAY, JUNE 4, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Atlanta, GA.

The subcommittee met, pursuant to call at 9:30 a.m. in the Woodruff Health Sciences Center Administration Building, Emory University, Atlanta, GA, Hon. J. Roy Rowland (chairman of the subcommittee) presiding.

Present: Representatives Rowland, Linder, Bishop.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Dr. ROWLAND. I want to thank all of you very much for being here this morning, and I am especially pleased to be in John Linder's District here this morning as well, and I want to thank all of you for coming to be witnesses for us here this morning.

With all the debate in Washington regarding the current VA health care system and potential changes that may occur under national health care reform, I believe it is imperative that Members of Congress hear from the individuals who would be directly impacted by any actions that might be taken. It is critical that your voices be heard and that is why we are here this morning.

As I mentioned, John Linder and I have known each other for a long time. We were together in the State House for some 6 years and became close friends there, and I am really pleased to be in his District this morning.

At this morning's hearing, we will receive testimony regarding the current operations of the Department of Veterans Affairs medical centers in the State of Georgia, in particular the facility located here in Atlanta. The subcommittee held a similar hearing yesterday in Dublin, GA to receive testimony regarding the operations at the Dublin and Augusta VA medical centers. It is my hope that this hearing will provide a valuable look at such issues as access to care and the availability of services to Georgia veterans. In addition, we will focus on the issue of impending national health care reform and what impact such reforms might have on the operation of the VA health care system.

As the debate on national health reform progresses, it is critical that we focus on the VA as an integral part of any reforms. It is also necessary that we understand the current state of the VA health care system, both its strengths and its weaknesses. As the country's largest health care system, the VA should provide a model for health care reformers to consider.

However, all of us know the current reality facing many veterans who seek their care from the VA. While most Category A veterans seeking inpatient care are treated on a timely basis, long waiting lines for many outpatient care services have become commonplace. In some areas, VA has been forced to cut back on outpatient services to many veterans who previously received their care from the VA, because VA simply does not have the resources to continue to provide them care. Are these veterans being treated in some other setting? Do they have access to alternative forms of health care? I do not know, but more importantly, I do not think the VA knows.

I do not want to unfairly criticize the VA; after all, it is not the Department that ultimately determines the size of its own budget. My reason for raising what many of us already know is that it is time for all of us to acknowledge the current realities facing the system. For too long now, VA has been asked to provide more services and programs with less overall funding. Years of funding shortfalls have taken their toll. This cannot continue.

This morning, we will hear testimony from the Director of the Atlanta VA Medical Center as well as the Director of the Southern Region. I look forward to the insights that they will provide regarding the current operations at the Atlanta facility in terms of their ability to meet the demands for health care of Georgia veterans.

With regard to the larger issue of national health care reform, VA officials have been deeply involved with the President's national health care reform task force. From all indications that involvement is not mere token representation. VA has been on many of the task force working groups and Secretary Brown's credentials as an advocate help assure us that veterans are getting a fair hearing in this planning effort. There is much that the Secretary and his team can bring to the table from the VA's own experience.

However, the point must be made that under national health care reform veterans, like other Americans, will be given the opportunity to access one of several health care options. Given a range of choices, some veterans currently using the VA system may decide to seek their health care someplace else. It is imperative that we recognize this fact and work to ensure that VA remains an attractive, high-quality health care option for our Nation's veterans.

As many of you know, the immediate challenge ahead is the budget and the annual effort to secure an adequate level of funding for the VA health care system. We have a lot of work ahead of us and I look forward to working with you to help the committee and the Congress achieve its goals.

I look forward to hearing the testimony of our distinguished witnesses here this morning. Now I want to recognize my colleague John Linder.

OPENING STATEMENT OF HON. JOHN LINDER

Dr. LINDER. Thank you, Mr. Chairman. Let me first of all thank you for taking time out of your busy schedule to come and bring this hearing into the 4th District. Let me also welcome my friend Sanford Bishop, who is on the committee from Columbus, GA; and two important people that I have known for years, in the audience, Pete Wheeler, head of our Veterans' Department and Mary Lou Keener, who I have known for 18 years, who is now going to be the

new counsel for the Veterans Affairs Department in Washington. We welcome her too.

Since being elected as a Member of the 103rd Congress, I have witnessed the VA Medical Center in Decatur transform from a medical center with serious problems, sexual harassment and quality and low morale problems to a medical center where employees can take pride in their work and the quality of the health care they are delivering to our community's veterans.

On May 21 of this year, I had the opportunity to visit the VA Medical Center in Decatur. I was impressed with the improvement in the overall atmosphere at the center. I was further pleased that the Office of Inspector General's disciplinary recommendations were implemented in an expeditious and timely manner. I think we all can agree that sexual harassment in any form is reprehensible. It is apparent that throughout the investigation, the center and the Department of Veterans Affairs fully cooperated with the OIG. All the individuals who were found responsible for sexual harassment have left the VA system. The Department of Veterans Affairs has also set out in an aggressive manner to eradicate sexual harassment in the VA. I would like to commend Larry Deal for his leadership and for meeting the difficult challenges which he faced when he first arrived at the medical center. My 2 or 3 hours there were very fruitful for me, Larry, and the questions that I raised have been answered in a white paper that you provided for me, with specific attention to the questions that I raise, and I will, with your approval, submit those—that paper and those answers to the record too.

Our hearing today focuses on the local concerns of Georgia's veterans and the current operations at the Department of Veterans Affairs Medical Center and the regional office in Atlanta. We will also address an issue of significant importance to the veteran community—national health care reform.

It is clear that the future of the veterans' health care system will face many challenges. Clearly, maintaining the status quo will only result in the continued erosion of the Department of Veterans Affairs health care system. The VA needs a realistic, achievable strategic plan, which includes eligibility reform to meet the health care needs of a rapidly aging veterans' population. Specifically, the nature of VA services must adapt to a changing environment and population. By the year 2000, nine million veterans will be over the age of 65, yet the VA's long-term care resources and planning are inadequate at this time to meet the needs of this population.

Addressing the issue of eligibility reform for VA health care is the number one priority of the House Committee on Veterans' Affairs this session. I think we can all agree that the current system is fragmented, difficult to understand and does not provide a full continuum of services for many veterans. However, committee members are also sensitive to the fact that they cannot change the current system in isolation of current health care reform initiatives.

I believe today's hearing is a step in the right direction. The Department's positive and negative experiences, as well as the resources already established by the system, should be a part of the discussions over health care reform proposals. The VA health care

system is a national resource and must not be overlooked. However, this does not mean that there is no room for improvement in the Department of Veterans Affairs health care system. The VA must also define a strategy of their own for inclusion in national health care reform.

I want to emphasize that I am strongly committed to maintaining a separate health care system for this Nation's veterans and I would oppose any plan which would seek to destroy that system. Maintaining the independence of the VA health care delivery system is an achievable goal. However, the VA must realign itself, reform eligibility criteria and provide for expansion of services in some areas while possibly narrowing services in underutilized areas if it is to compete in the health care reform arena.

Mr. Chairman, I appreciate your commitment to our veterans and your willingness to use valuable subcommittee resources for this hearing. As a physician, you are a recognized leader in the national health care debate and a strong advocate for veterans. Oh, how I wish they would have included you in the debate.

Thank you, Mr. Chairman, I look forward to hearing the testimony of the distinguished witnesses.

Dr. ROWLAND. Thank you very much, John.

I want to recognize my good friend Sanford Bishop, who has just joined us. Sanford and I have known each other for a long time. He was also in the House of Representatives. John, Sanford and I are all alumnae of the Georgia House of Representatives and now we are all on the House Veterans' Affairs Committee. So it is real good to be able to renew old friendships and to work together for the veterans, as we will be doing. Sanford.

OPENING STATEMENT OF HON. SANFORD BISHOP

Mr. BISHOP. Thank you very much, —Mr. Chairman, my distinguished colleague, Mr. Linder in whose District we find ourselves this morning. Let me say greetings to all those who are here, especially the distinguished panel of witnesses from whom we will hear today.

I am very much concerned about the delivery of health care services to all Americans, but specifically, through the jurisdiction of this committee, to our veterans. I feel that affordable, accessible quality health care is a necessity and in light and in the context of our health care reform efforts which will be revealed nationwide within the next few weeks, we certainly would like to have input from such distinguished witnesses as we have here today.

I look forward to hearing your testimony, I look forward to sharing ideas with you so that we can, together, work in a cooperative effort as a team to create the best possible, and the highest quality of health care for our veterans, and ultimately for all Americans.

Dr. ROWLAND. Thank you, Sanford.

I want to recognize Mary Lou Keener, who has just been confirmed as VA General Counsel. We were pleased to have you in Dublin yesterday and here this morning as well.

Our first panel is Dr. Jeffrey Houpt, who is Dean of the Emory University Medical School; Richard Miller, who is director of the Southern Region of the Veterans' Health Administration, he is accompanied by Charles Wickes, who is the director of the Atlanta

Regional Office of the Veterans' Benefits Administration and Dr. John R. Higgins, chief of staff of the Southern Region, and Larry Deal, director of the VA Medical Center here in Atlanta. Thank you all very much for being here this morning. We would ask that you limit your presentation to 5 minutes, if you will, and your entire testimony will be placed in the record. So we will start with Dr. Houpt first. Thank you very much.

STATEMENTS OF JEFFREY HOUPT, M.D., DEAN, EMORY UNIVERSITY SCHOOL OF MEDICINE, ATLANTA, GA; RICHARD P. MILLER, DIRECTOR, SOUTHERN REGION, VETERANS' HEALTH ADMINISTRATION, ACCOMPANIED BY CHARLES WICKES, DIRECTOR, ATLANTA REGIONAL OFFICE, VETERANS' BENEFITS ADMINISTRATION, JOHN R. HIGGINS, M.D., CHIEF OF STAFF, SOUTHERN REGION AND LARRY DEAL, DIRECTOR, VA MEDICAL CENTER, ATLANTA, GA

STATEMENT OF JEFFREY HOUPT, M.D.

Dr. HOUPT. Thank you, Mr. Chairman, members of the subcommittee. It is my pleasure to welcome all of you and your staff members to Atlanta and to the Emory campus. We appreciate your interest in veterans' health issues.

My interest in the VA health system has been stimulated by serving on the VA Liaison Committee of the American Association of Medical Colleges. As one of five medical school deans who provide counsel regularly to the Director of Medicine for the VA, we continually work to improve the quality of care of veterans that they receive at our VA medical centers throughout the Nation. My comments today, however, are my own. I speak only as the Dean of Emory School of Medicine and not for the Liaison Committee.

The Emory School of Medicine's relationship with the VA Medical Center in Atlanta is entering its 47th year, the origin of this valuable affiliation dating back to 1946. During the 1991–1992 fiscal year, we provided health services for 8,542 inpatients and 166,613 outpatients, and during this period, 129 out of the 132 physicians held faculty appointments in the Emory School of Medicine.

This morning, I would like to emphasize the value of affiliations between VA hospitals and academic health centers, both for the veterans we serve and our students and faculty, and I would like to stress the critical importance of maintaining adequate VA funding for medical care and research. I would be happy in the question period to speak also about the VA role in health care reform.

Why should the Department of Veterans Affairs encourage affiliation with medical schools and academic health centers? Who benefits? Is this a self-serving venture that only provides a means of training medical students, residents and fellows? It seems to me that the value of these affiliations is repeatedly questioned as if one side enjoys substantial benefits and the other consistent losses. In the brief time I have this morning, I hope to convince you of the importance and value to all parties that results from these affiliations.

In my opinion, the major benefit to the VA is the quality of physician which makes the affiliation with an academic health center

possible. Academic appointments have been major factors in enticing extremely well-qualified and dedicated physicians to the VA, and encouraging their retention. As a result, veterans utilizing these services are afforded a better quality of health care than would be possible otherwise.

Let me expand on these issues of recruitment and retention. A physician's choice of where to practice depends, to a significant degree, on working conditions. The potential interest in working in the VA is often dampened by the perception that the VA is chronically under-funded or at least always in jeopardy of losing funding, and overly bureaucratic. The salaries paid have been viewed in the past as inadequate, though recently they have been raised to a more competitive level. In my opinion, it is the opportunity for an academic appointment, the opportunity to teach, to contribute to a new generation of physicians and the opportunity to pursue a research career that pushes talented physicians to a positive decision to work in the VA. It overcomes that final reluctance and thus brings a quality to the physician workforce not otherwise possible. An optimistic expectation of reasonable funding will be essential to maintain this recruitment advantage. Uneven funding or funding in constant jeopardy only creates uncertainty and drives the brightest and best elsewhere.

An affiliation with a medical school provides the VA Medical Center access to physicians who serve most of the medical needs of the veterans' population. Concern has been raised throughout the VA system about whether the physicians provided the VA by academic health centers, preponderantly specialists, really meet the VA needs. Specifically, questions are raised with regard to supply of primary care physicians, geriatricians and the needs of women veterans. These are legitimate concerns. A proper partnership implies an open discussion and a willingness on the part of the academic health center to meet VA needs. At Emory, we are happy to participate in such discussion.

Early in my deanship, we developed the Emory Geriatric Center. Presently a number of the center faculty also serve the Atlanta VA Medical Center. Such a center provides a potential resource for the geriatric veteran made possible only because of that affiliation with a medical school. We are also preparing to focus on the special needs of women within the VA system. Since we have been designated as one of the NIH women's health centers, we feel we are in an excellent position to serve women veterans whose health needs have, to this point, been partially addressed.

And finally, within the School of Medicine, we are starting a family practice residency to compliment our programs and general internal medicine, general pediatrics and general obstetrics and gynecology. This commitment to primary care, as well as an increased emphasis on ambulatory medicine in our curriculum can only enhance the patient care provided at the VA.

I would like to comment briefly on the role of sub-specialists in VA medical care. Considerable criticism has been wielded at academic health centers for contributing to the over-supply of sub-specialists across the country. We in the academic community are taking that criticism seriously; yet, I must stress that from the perspective of the VA, at least in my opinion, the availability of sub-

specialists is a major benefit of the affiliation with a university medical center. Patients in our VA center have access to services ranging from highly technical neurosurgical methods to the most advanced cardiovascular care they could find anywhere in this country. By its affiliation with Emory, the VA Medical Center is able to maintain professional relationships with sub-specialists on a part time basis that would not be affordable if the VA had to hire these people on a full time basis. This is not a one-way street. Our School of Medicine does derive tremendous benefits from this association. Last year, 770 residents and medical and dental school students received training at the Atlanta VA Medical Center.

Early in my appointment as dean of the Emory School of Medicine, I was faced with a VA Medical Center dilemma. Funding was inadequate, physician morale was low, and my ability to recruit and retain faculty that would serve the needs of this center was almost at a standstill. A lack of basic equipment in a number of settings made it almost impossible for a physician to adequately or efficiently look after patient needs. Students and residents noticed the difference between the VA hospital and other teaching hospitals. Due to a series of efforts, including concern expressed by members of this subcommittee, the situation at the Atlanta VA Medical Center has improved many-fold. Our clinical addition is underway and critical professional and staff positions are now or shortly will be open for filling.

I am particularly concerned that our improved status become the norm, that we can count on reasonable growth in budgets as service needs dictate to ensure the elevated level of care.

In summary, maintaining medical school/VA medical center relationships is a plus for all parties. All parties to the agreement derive benefit to justify taxpayer concerns and serve the vital needs of an aging veterans' population. I respectfully request that all of you do whatever is in your power to help the VA system. To maintain a viable VA medical care and research budget, an optimistic expectation of reasonable continued funding will be essential, a better health care staff will be recruited and retained and for the veteran, we will see better health care.

Thank you for your interest. Please call on me if I can be of any assistance to the subcommittee or any time you feel my expertise is needed. Again, thank you for allowing me this opportunity to speak with you today.

[The prepared statement of Dr. Houpt appears on p. 104.]

Dr. ROWLAND. Thank you, Dr. Houpt.

Mr. Miller.

STATEMENT OF RICHARD P. MILLER

Mr. MILLER. Thank you, Mr. Chairman and members of the subcommittee. I am delighted to be here and participate in this hearing this morning relative to the concerns of health care, the VA in general and particularly in the State of Georgia.

You have my prepared statement, so I will not read from those, but I would like to give you an overview of what the Southern Region is. We are one of four geographic regions within the VHA, we span 11 States from Texas and Oklahoma on our west; Arkansas, Tennessee and North Carolina on our north, down the east coast

to Florida with the Gulf of Mexico on our southern boundary and we also include Puerto Rico and the Virgin Islands.

In addition to the three centers in Georgia, we include 40 other hospitals, plus one independent outpatient clinic, 32 nursing homes, nine domiciliaries and 36 satellite or outpatient community clinics. In our geographic area, we include 7.2 million veterans and in fiscal year 1993, over 6.6 million outpatient visits are planned and we anticipate treating 308,000 in patients.

Let me put that in perspective because that means on a given day in the Southern Region, we encounter in excess of 20,000 outpatient visits and approximately 1,150 inpatients per day. And when you consider that adds up to a significant number of multiple contacts and encounters in our system with these patients each and every day, it is remarkable what we accomplish with approximately 60,000 employees and a budget of $3.9 billion. Incidentally, in the State of Georgia, we have a total budget of in excess of $320 million with 4,700 employees.

The functions of the region is that we have responsibility for supporting and monitoring each facility's programs in the area of resource management, strategic planning, equal employment opportunity, human resources, consumer affairs, construction, fire and safety, industrial hygiene, automated data process, nursing, pharmacy, consolidated procurement, emergency medical preparedness, radiation safety, women's veterans' programs and quality assessment.

We have many strengths in our health care system and we have a long history of providing a continuum of care. We have a networking among our medical centers where hospitals relate to one another and provide efficient, effective high-quality care. We are leaders in delivering certain types of care in non-traditional care modalities. We provide effective utilization of resources that we have. I do know that we have challenges in our system and are in a tremendous transition of change. But I am confident, as we have in the past, we will continue to meet those challenges and prove our worth as a health care delivery system in whatever form of national health care system that may emerge.

Let me say in closing that I am proud to be a part of the VA and I consider our job to be a very noble one in which we care and deliver health services for our Nation's veterans.

Thank you, and I look forward to participation on the panel.

Dr. ROWLAND. Thank you very much, Mr. Miller.

Dr. Higgins.

Dr. HIGGINS. I do not have any opening comments. Thank you, sir.

Dr. ROWLAND. All right. Mr. Deal.

[The prepared statement of Mr. Miller appears on p. 69.]

STATEMENT OF LARRY R. DEAL

Mr. DEAL. Thank you, Mr. Chairman, members of the subcommittee and distinguished guests. Thank you for giving me the opportunity to appear before your subcommittee today to discuss the issue of providing quality medical care to Georgia's veterans. I have already provided my formal statement for the record and I

will not repeat that at this time, but I would like to make a few additional comments.

The health care environment in the USA, and indeed the entire world, is obviously changing very rapidly. I believe that by the turn of the century, in just 7 short years, we will witness changes that none of us would deem imaginable even today. I believe it is axiomatic that the VA will change just as dramatically as the rest of American health care. I believe the Atlanta VA will be well-positioned to deal with that change. All three phases of our clinical addition project should be completed by late 1996. This will give us a state-of-the-art physical plant and the latest in high-tech equipment which combined with an outstanding staff will give us the right ingredients to deal with the coming changes. Although I believe we will need other things such as increased local flexibility to respond to change, by and large, the future appears very bright for the Atlanta VA and for the veterans of North Georgia.

That concludes my remarks, and at your convenience, I would be glad to respond to any questions you or the subcommittee members may have.

[The prepared statement of Mr. Deal appears on p. 107.]

Dr. ROWLAND. Thank you very much.

There is one thing I want to get us involved in here for the record, and that is the relationship or the nexus between research and clinical application. And I think it is very important for particularly Members of Congress to understand that relationship.

As all of you know, the research budget was cut $26 million and we are in the process right now of trying to restore that and in addition to get more funds.

I would like, Dr. Houpt, if you would address that question, and let us know what is the importance of research to clinically taking care of people.

Dr. HOUPT. Thank you very much, Mr. Chairman, I appreciate the opportunity to respond to that.

I am very concerned in the whole issue of health care reform, not only the VA, but the entire issue, that the role of bringing research advances to the bedside is being lost, and the importance of certain regional referral and tertiary care centers in implementing those changes and making the transition from the laboratory to the bedside not be lost in health care reform.

The research budget at the VA is a very important aspect of our activities and it permits us not only to recruit the very best people to the VA and to retain them, but also to implement new technology and new advances in patient care at the VA.

In 1970, the medical and prosthetic research appropriation expressed as a percent of the total medical care budget was 3.5 percent. In 1992, that had dropped to 1.5 percent and the proposal of $206 million this year drops it almost to one percent. Restoring it to $232 takes it back to 1.5 percent, and while that is a very important improvement over $206 million initially proposed, it still would not allow any new merit review projects to go forward at the VA. This will have a very deleterious effect because it means that no new research can be initiated, no attempts to initiate new applications of treatments at the VA, and will be demoralizing to those people who have given their lives to the VA in terms of recruiting

research funds. That does not account for the potential four percent inflation level that we are looking at in this year.

As I said earlier, I think that the most important thing that the subcommittee could do would be to establish a pattern of consistent funding that could be counted on, so that people know that they can count on this funding and that they can develop careers there. And I would respectfully suggest that you look at the possibility of increasing the research budget by half a percent a year or an even smaller amount, whatever amount you can do a year, until you can finally sustain it at three percent of the total budget. And I believe that if you look at it as a percent of the total budget and you maintain that, you will find people who wish to commit themselves to the VA and you will find the implementation of research that is needed in that system.

Thank you.

Dr. ROWLAND. Thank you very much.

Dr. Higgins.

Dr. HIGGINS. Yes, sir, I would really like to add a comment.

Mr. Chairman, before I joined the Region, I was Chief of Staff of the Dallas VA and as just one example, the Chief of Medicine there edits the major textbook on gastroenterology and is an international figure in ulcer disease. He was originally attracted to the VA because of the research opportunities, but he participates in patient care every day. What that means very simply is that when a patient with a complicated stomach problem is in the Dallas VA, he has access to one of the finest physicians in the entire world to handle that. And that is what I think we should demand for our veterans, that they get care that is second to none. And also then the physician is training the new generation of physicians that have equal expertise.

I have seen that over and over. I am sure that the dean could give you examples of world figures that practice here at the Atlanta VA too. And the research opportunities are what attracts that type of physician. Once we get them in our system, we also benefit tremendously by their clinical skills. And so I strongly support what the dean has said.

Dr. ROWLAND. Thank you. Would either of the other of you care to make comments about that particular issue?

Mr. MILLER. No, sir.

Dr. ROWLAND. Okay. You know, it is interesting that more than half of all the physicians that get their education in the medical schools in this country get some of their training in the VA. I know that I did and I was talking with Dr. Linder yesterday about it and he said that he did not realize that, and then it occurred to him that he had gotten some of his training as a dentist at the VA.

Dr. Linder.

Dr. LINDER. Thank you, Mr. Chairman.

Dr. Houpt, why did you pick the number three percent? Is that a universally accepted number in terms of overall budget, or is that just a——

Dr. HOUPT. That is a percent that a number of people in academic medicine have been working around as a way to constructively become involved in the discussion.

Dr. LINDER. We know that the average VA patient is 10 years older than the population in general and aging rapidly. I mentioned, I think it was six or seven million, maybe it is nine million, will be in the year 2000. This is going to change the way we practice VA medicine, absent another great war, which we of course hope does not come to save our system. That implies to me some limits and changes in the way we deliver health care in the VA system; limits in some areas and maybe additional influence and attention to other areas. What would you suggest you are going to see in 10 years?

Dr. HOUPT. Well I agree with you entirely. I think that in 10 years, absent another great war, that we will see a very large predominant geriatric population in the VA. I would have these thoughts with regard to that, we are hurtling forward towards managed competition at this time. I am personally not convinced——

Dr. LINDER. Maybe you could define that for us, because I have heard 40 or 50 different definitions of that term.

Dr. HOUPT. It refers to organizing a health care system into affiliations or collections of providers in a way that they can compete with each other over price to provide quality health care.

Dr. LINDER. What will that do to the rural areas and the rural hospitals?

Dr. HOUPT. It would make it very difficult to carry out in a rural area because there are not enough physicians to compete with each other, and it obviously is a model that is not applicable to rural areas in its entirety.

Dr. LINDER. And that system implies a system of gatekeepers, primary care physicians, and it is my understanding that there simply are not enough in this country at the present time.

Dr. HOUPT. That is correct.

Dr. LINDER. What changes do you anticipate you will see in the kinds of services delivered at a VA Hospital? For example, you mentioned, and we heard this yesterday, that we are sorely lacking in care for women's medicine. Would it be cost-wise to establish a basic women's health care treatment center within the VA system or pay private hospitals that have fully established OB-GYN centers and women's health systems to take care of those women?

Dr. HOUPT. I think it would be an issue of volume. And I think the answer to that should be that decisions about how the VA delivers services in a certain area should be determined region-by-region and it would depend on the region. I do not think you can have a cookie cutter approach to that. There are some areas where I think that the way that the VA provides care should be designed differently in other areas, depending on the volume of people. And it should be provided in a quality way, but in a cost-effective way.

Dr. LINDER. Mr. Miller, knowing how difficult it is to have independent initiatives at the local level in a government system where we tend to go for cookie cutters, do you see that as a workable situation?

Mr. MILLER. I think that any time you talk about a cookie cutter in a system as large as ours, it is not going to work. And I think that we need that flexibility at the local level, within the regional level, with firm guidance and policy coming out of our Central Of-

fice. And let the best solution relative to the care needs of the patient be developed at the caregiver level, at the local level, who knows best how that is to be delivered.

Dr. LINDER. Are we doing very well at that now?

Mr. MILLER. We are doing some of that. We have any number of methods across the Southern Region, depending on what is accessible for treating special needs such as women's veterans and/or AIDS or any other esoteric disease of that nature or high level disease. We are trying to deal with that within the resources we have and dealing with our own resources, our own facilities as well as tremendous sharing resources with our affiliation in the community.

Dr. LINDER. Mr. Deal, you said that with the finishing of the clinics in 1996 and the new equipment, MRI and other CAT, the mix of technical and clinical arrangements will be well-prepared to meet the new challenges of the next—of the changes in the system coming in the next century. That inclines me to think that you have some way of knowing what those changes are going to be, and I would like you to describe them for us.

Mr. DEAL. I do not. I only know what I read in the papers, to coin an old phrase. But I would suspect that whatever model we see is likely to be one in which the VA will be forced more into a competitive mode for its patients. And it will be one that will then require us to have state-of-the-art technology and facilities to market them to those potential patients in order to attract them or to retain them in the VA system.

Dr. LINDER. An argument could be made—not that I intend to make it—that since we have several open heart surgery centers that are highly regarded here; Emory and St. Joe's and things, that some of the facilities probably could be farmed out easier than used in the VA in building up your own system. How do you argue against that?

Mr. DEAL. I would sort of argue both sides of that equation. I think your premise is right. I think that all of medicine needs to look at itself as a consortium and the VA should be included in that consortium. And that it would behoove all of the hospitals; for instance, in the metro Atlanta area to look at the range of services that are provided and the consumption of those services, to see whether or not the duplicative efforts that we now have are necessary, and to sort of evolve into a product line management type of scheme whereby some hospitals would provide certain services and other hospitals other services, rather than all of us trying to be the Mayo Clinic.

How would you deal with the problem we are going to have clearly, in my judgment, in rural America—and yesterday we heard testimony in Dublin of people being bused now by the service organizations, who get buses and bring them to Dublin. Of the 14 people on the first busload, 11 who had been needing care for some time had never been introduced to a VA hospital because they could not get there. That is a problem we are going to see across rural America, it seems to me, with any kind of managed care program or competitive program. You experience it every day in the VA system. How are we going to deal with that?

Mr. DEAL. I am not sure that there are easy answers to that. As you know, I moved here to Atlanta from South Dakota, and our nearest tertiary care referral hospital was some 450 miles away in Denver. And so everything is relative, I guess. It was a way of life for people, and that was not just true of veterans, it was true of non-veterans as well. There just were not tertiary care facilities in that part of the Dakotas and one had to go to either Denver or Minneapolis and Minneapolis was 600 miles away.

There are not easy answers to the question of rural health care. I think probably improved preventative medicine, improved primary care will help some of that. I think some of the technology that is now evolving for remote diagnostic capabilities, digitalizing of radiology and other kinds of technologies, may help to facilitate the expansion of quality care to the rural areas, but it is a tremendous logistical issue that is not easily solved in my opinion.

Dr. LINDER. Let me move from the sublime to the ridiculous. Last night at a town hall meeting an individual came up to me and told me a story that was relative to our meeting yesterday in Dublin. He has a brother-in-law who is an alcoholic, he has been sober for 9 years but he has got mental problems, he is homeless. He came to your facility, I believe, and was referred to the Dublin facilities, which we learned yesterday has a homeless—a portion of their beds are for homeless. He got a bus down there on Wednesday, was checked in at the appointed out, he was scheduled in and said we will have a bed available for you tomorrow and was left on the streets of Dublin, made a phone call, they went back, brought him back. We heard stories yesterday from people in the facility in Dublin about the waiting lines and things, and it seems to me these are the kinds of things that give the veterans system a bad name.

If they could enter this fellow into the logs and register him in the hospital, it seems they might have found a place for him to sleep that night. Is that an unfair question?

Mr. MILLER. I would like to comment on that, Mr. Linder.

Certainly that is the desirable outcome. The medical system in the VA is one of the only systems that have paid tremendous attention and continues to pay tremendous attention to meeting the health care needs as well as the social needs of the homeless. We have a number of programs within the Southern Region relative to compensated work therapy where we provide jobs for homeless, where we provide care for them in substance abuse, where we provide care for them in domiciliaries for the homeless and programs for the chronic mentally ill, and are making such advances as providing that most recent program in Dublin. Sometimes it is just a matter of not having the resource to adequately do the job.

Dr. LINDER. For my last question, I would like to just get something on the record. Mr. Deal, I would like you to address a problem that you and four other hospitals have in America, under a statute where you are required to charge for parking, and under an adjudication from a court, it seems to me in a labor dispute, you were told you cannot charge for parking. So the only people paying for the parking are the administrators like you and the people not bright enough to get it taken off their payroll deduction. It causes

you more headaches than it brings you in money. Just explain that and maybe we can get something changed here.

Mr. DEAL. I am not sure I can be more eloquent than you have just been, Mr. Linder. It is indeed a quagmire and a nightmare that was created. There are six VA medical centers all total I believe that are impacted by the legislation. As a result of labor relations disputes and decisions by arbitrators, we now find ourselves with two different levels of payment for parking and we are headed potentially to five or six different levels, because we have had one arbitration hearing with one of the bargaining units at the medical center and we have four separate bargaining units. So potentially all four separate bargaining units could litigate and end up with an arbitrated settlement with a different parking fee, and then those of us who do not belong to any bargaining unit could have yet another parking fee. It is not only a serious problem from a logistical standpoint and sort of a problem of morale, having an adverse impact on morale, but it is also a serious issue with respect to recruitment and retention of staff. The VA is generally chasing the eight ball in terms of salaries being competitive for many physicians, technologists, technicians, and to have to exacerbate the gap that already exists with something like paid parking is an unnecessary burden on our recruiting and retention efforts and certainly appreciate you calling that problem to our attention this morning and hope that we can get some legislative relief from that.

Dr. LINDER. Is it not also true that people who pay for parking often do not find parking spaces in there when they get there?

Mr. DEAL. That is correct.

Dr. LINDER. Is it worth the time to collect the parking fees for your administrative——

Mr. DEAL. In my humble opinion, no.

Dr. LINDER. Well maybe the staff will take note and we can find that bill over in the Senate and change that. Thank you.

Mr. DEAL. Thank you.

Dr. ROWLAND. Thank you. Before I go to my good friend, Mr. Bishop, I want to pursue the—every time Dublin is mentioned, my ears always perk up. I have found over the 10 or 11 years that I have been involved in the VA Committee in hearings around the country that so many times something happens, that some sort of ancillary personnel deal with something and they do not deal with it in an efficient and proper manner. Who would have been responsible for trying to take care of that veteran that came to the hospital homeless? Does someone want to address that for me?

Dr. HIGGINS. Yes, sir, Mr. Chairman. We have a social work service at all our hospitals and I know Dublin is very active, that will work with individual veterans who do not have a place to stay. Sometimes we will board the veteran overnight, often we have homes that will take the veteran in, or missions. I feel confident that the individual that Mr. Linder mentioned is an exception, but that is the way we learn. We are not perfect, we continuously need to improve and when exceptions like that are called to our attention, we have then an opportunity to try to patch some gap that must surely have existed, and hopefully that will not happen again. But in answer to your question, that is one of the major things that

our social work services do to assist veterans in their human needs while they are getting their medical needs attended.

Dr. ROWLAND. I know some things fall through the cracks and apparently some unthinking person sometimes does something that reflects poorly on the VA. For the most part, I do not hear a great deal of criticism about the quality of care that is given by professionals in the VA, but it is usually something like that that focuses attention, that is not very good for the VA.

Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman.

I have heard some queries about the quality of care and I did kind of want to pursue that. First, I would like to ask Mr. Miller, how long have you been in your current position?

Mr. MILLER. I have been a regional director now for going on 10 years, but I have been in the current position as the Regional Director of the Southern Region since August of 1990, Mr. Bishop, when we moved from Dallas. We were formerly seven regions, we organized into four and we moved the Southwestern Region, Region 7, and I took over Region 4 in Jackson, MS.

Mr. BISHOP. Thank you. So it has been a couple of years roughly.

Mr. MILLER. Yes, sir.

Mr. BISHOP. Getting close to quality of care, I have heard the complaint from a number of veterans, and I represent areas with Fort Benning, Warner Robins, the Albany Marine Base, Moody Air Force Base, and I have heard veterans complaining from time to time about the inability to communicate with their physicians because many of them are foreign born. What is the demographic breakdown in terms of your foreign trained physicians who are staff VA physicians? I have had the complaint registered with me that many of them have difficulty communicating with language barriers. And that would appear to me to be an inhibiting factor in terms of quality of care. If the patient and the physician are unable to communicate with one another because of language barriers, it is going to certainly, I would think, inhibit the quality of care. What is the percentage or the level of foreign trained, foreign born physicians? Are those physicians licensed under the States in which they are practicing, or do they have provisional licensure, waivers—what is the level of training of those—what is the percentage and what is the level of training?

Mr. MILLER. Yes, there are a number of questions there, Mr. Bishop and maybe Dr. Higgins can help with the one specific to percentages.

I do not have exactly those numbers but I would venture to guess that I believe it probably would be less than five percent foreign trained. We have requirements relative to language competency that we put our foreign physicians through when they come in. We do have some areas where we run into that problem, there is no doubt about that.

But let us address the credentialing or licensing and privileging. No other health care system has the demand of credentialing and privileging and oversight of that program than the VA does. And it is a very rigid review of the credentials of our physicians that work for us and the privileges that we allow them to perform. And

I tell you that in the Southern Region, our numbers of compliance within those requirements exceed 98 percent.

I would also like to address in a broad way the quality assurance that we have or the quality indicators. Granted, we do not have in the health care system a lot of those data bases or indicators, but we do go through the review by the Joint Commission for Health Care organizations and in fact, in just the last year we had surveys of 19 hospitals in our eastern part of the region, which the hospitals in Georgia were part of that. The average score out of 100 from the hospital accreditation program from the Joint Commission, in the Southern Region is approximately 88, and that does not reflect the appeal that some of our medical centers have submitted, and I am confident that that number will go up because of the appeal. For instance, here in Atlanta, their score was 88. They have been told by the Joint Commission some appeals they have made in their recommendations have been honored, and I expect those scores to go up. Our score in Augusta was 89 and our score in Dublin was 90.

At the same time, private sector scores given by the same Joint Commission averaged 80. We are now going through the same reviews of the remaining 24 hospitals in the central and western part of the region and we have staff that accompanies those reviews, and I can tell you the feedback I am getting from my staff is that I expect the same accomplishment and maybe even a little better coming out of the hospitals that are presently undergoing that review.

Dr. Higgins, do you have a comment?

Dr. HIGGINS. Mr. Bishop, if I could add just a couple of comments. One is I agree with everything Mr. Miller said, and I would point out that some of our really talented physicians have been foreign born and they have to be fully trained when they come to the United States, in the United States. But sometimes the inability to successfully communicate is really more of a characteristic of a physician than from where his national origin is. I know sometimes my wife says that she cannot understand anything I say.

One of the things again in our continuous improvement that we try to do is make sure that patient representatives are available to every single patient. So if a patient does not understand his doctor or or his nurse or his technician, he has a friendly face that he can seek out. That is augmented by our volunteers, including people from the VSOs, but ultimately the Chief of Staff at each hospital is responsible for making sure that a patient who is having trouble gets with somebody he can understand. I know that Dr. Bailey Francis, who is the acting Chief of Staff here has frequently taken on that role. When any of us is guilty of talking technical jargon, it is good to hear somebody who can put it into plain English what the doctor is trying to do. And that is an area where we are trying hard to improve.

Mr. BISHOP. If I might follow up. I have got a couple of other quality assurance questions and I will be brief.

One of them has to do with long-term care for patients who are on ventilators. Obviously you do not have the facilities to treat all of them and to provide the long-term care. Do you have an adequate quality assurance program to monitor on a regular basis—

I guess you have contractors who perform those services for you, the long-term ventilator care, or is it completely left up to the placement of the veteran himself to find a facility that will serve his or her needs?

Dr. HIGGINS. Mr. Bishop, Mr. Deal may want to comment on the local situation. We have both situations, we do have hospitals that provide long-term care for patients on ventilators. Because once a hospital takes in a patient like that, he may occupy a bed for decades——

Mr. BISHOP. Right.

Dr. HIGGINS (continuing). Our capacity is quickly met or even exceeded.

Mr. BISHOP. Right.

Dr. HIGGINS. And in those cases we have to then contract. I know in the particular hospitals where I have been involved with contracting, we contract only after a very careful look at the agent that we are going to use. Maybe Mr. Deal can comment about the local situation.

Mr. DEAL. Yes, thank you, Dr. Higgins.

Mr. Bishop, you have put your finger on what is one of many serious issues, I think. There is a tremendous shortage of care facilities, caregivers, that are willing to take ventilator-dependent patients at any price. It must not be a profitable business to be in or I am convinced the void would have been filled. But it is a very serious business.

We do a combination of things at the Atlanta VA. We provide some in-house care to those types of patients, our social workers spend hours looking for private sector facilities to take those kinds of patients. Some we are able to maintain in the home, depending upon the state of their physical well-being. We are also in the discussion phases of establishing a ventilator-dependent unit at our medical center. We are approaching that issue very carefully, however, because the fact of the matter is that one could probably fill almost an unlimited number of beds with ventilator-dependent patients, especially if you accepted referrals from other VA medical centers. And with both space and technology and resources being limited, the question would be what is an appropriate number to sustain.

Mr. BISHOP. Thank you very much for that.

On my third level of questions, one of the things that the President's health care reform task force is going to recommend as a part of the health care reform package, is that there be a mechanism within there for patients to give a report card, a report of feedback on the quality of care that they received from their physician, as a means of accountability. Does the VA system now have such a system in place to get that feedback directly from veterans as opposed to having to get it through your actual caregivers, so that it can go around the caregiver directly to someone who would not necessarily be subjective in seeing that we are giving the best possible care?

I say that in the context of also wanting to know the relative comparison between the quality of care, vis-a-vis infection rates, mortality rates at VA hospitals as compared to civilian hospitals in terms of quality of care. Whatever the measurements are, and I am

not a physician and I do not know what the unit of measurements that you use for determining infection rate or mortality rates for the provision of certain procedures, but is it higher—do you have a higher infection rate at VA hospitals, for example with open heart surgery, than you would have say at Emory or other private caregivers? Do you have a higher mortality rate? What kind of relative comparisons do you get there with the VA quality of care versus private quality of care? Do you have statistics that reveal that?

Dr. HIGGINS. Mr. Bishop, you are asking some very good questions. Yes, we follow statistically a wide variety of things. Mortality after open heart surgery is certainly a good example, as are post-op infection rates. And in our 44 hospitals from time to time, we do become high in some area. When that occurs, we have got a scheme of surveillance so we detect that right away and then we study why. Now sometimes it is just a statistical blip and other times there is a problem that needs to be solved. One of the things that we take pride in is that our quality management surveillance tools have now allowed us to detect problems early on and to make any corrections that need to be made.

And so again, getting back to the continuous quality improvement, we can't assure you that there will never be times when we are on the high side. What we can assure you is that we are constantly looking at that and if a problem occurs, we address it as rapidly as humanly possible.

But that is only part of the equation. Possibly even more important is how the veteran perceives his care. We can be scientifically correct, but if the veteran does not think he is getting good care, then we have failed. And we are trying to look at it in a variety of ways. We do have a satisfaction survey that we do. Many hospitals have a box where veterans can drop in a letter that goes directly to the Director that the Director answers. We rely a great deal on the service organizations. They hear from the veterans, we meet regularly with them, they tell us what our problems are or what the perceptions of problems are. And believe me, we listen to that and try to address each and every one of them. But the one thing that we have to accept is, as large as we are, no matter how many holes in the dike we have got our finger in, another one is always going to spring up. And our job is to try to detect those as early as possible and then step in and do something about it.

Mr. BISHOP. What I have found is that generally the veterans prefer to go to VA medical care facilities and the question that I have—and I get the feedback from families who wonder why their loved ones insist on going to VA hospitals when the families themselves question the quality of care, but the veterans on the other hand, have an esprit de corps about that, they get to see other veterans while they are waiting for their care, they get to tell war stories and talk about the things that have happened over the years, and they prefer that, I guess as ventilation therapy while their families are concerned that they are having a higher infection rate and a higher mortality rate and the families are mortified. So you have got the veteran happy and the families who are not necessarily as happy.

Mr. MILLER. I would suggest, Mr. Bishop, part of the role of continuous quality improvement is to identify those things and correct

them, but I would suggest that our numbers relative to occurrence screening and adverse events are equal or less than, in some cases, the private sector. That's a perception that we need to tell our story and overcome, and we can start with, as I mentioned, the Joint Commission scores have dramatically increased relative to the private sector, and we need to tell that story.

Dr. HIGGINS. I think that we are held to a higher degree of public scrutiny than any other hospital, and that is exactly the way it should be. But that means that any time we have a problem, it is right out front, where as if private hospital has a problem, they are allowed to solve it without it being in the public eye. But we believe as public servants, that is the way it should be. We are proud of the fact that we address these problems, but there is no question they come up, they will continue to come up, and what we have to assure you and our veterans is that when they come up, we will not try to sweep them under the rug, we identify them early and we do our best to correct them.

Mr. MILLER. I would like to just re-elaborate. I mentioned in my opening remarks that just in the Southern Region, we experience on a daily basis 20,000 contacts a day in the outpatient arena and 1,150 in the inpatient arena, and just multiply that by the number of encounters that we have with people. And sometimes that is what we see in the paper, that one or two encounters, that we need to know about, we need to judge and we need to fix. And as Dr. Higgins said, I do not believe there is any other health care system in the world that has the sunshine we do, and we are pleased with that and we want that, but we identify those things and we correct them.

Dr. ROWLAND. Any additional questions or comments?

(No response.)

Dr. ROWLAND. I want to thank all of you very much this morning for appearing here. Thank you for the time and information that you have given to us.

Our next panel consists of Pete Wheeler, a long time friend of mind, who is commissioner of the Department of Veterans' Services; Pat Phillips, who is commander of the Department of Georgia, The American Legion; Jackie D. Hanshew, commander of the Department of Georgia, Disabled American Veterans and he is accompanied by James Phagan, who is hospital service coordinator for the DAV.

Thank all of you very much for being here this morning. We would ask that your opening statements be limited to 5 minutes and an additional statement be put in the record. Mr. Wheeler.

STATEMENTS OF PETE WHEELER, COMMISSIONER, DEPARTMENT OF VETERANS' SERVICES, STATE OF GEORGIA; PAT PHILLIPS, COMMANDER, DEPARTMENT OF GEORGIA, THE AMERICAN LEGION; JACKIE D. HANSHEW, COMMANDER, DEPARTMENT OF GEORGIA, DISABLED AMERICAN VETERANS, ACCOMPANIED BY JAMES PHAGAN, HOSPITAL SERVICE COORDINATOR, DAV

STATEMENT OF PETE WHEELER

Mr. WHEELER. Thank you, Mr. Chairman.

I am happy that we had an opportunity to listen to some of the questions this morning and some of the answers, and I would like to have an opportunity to comment on some of them before I leave.

Mr. Chairman, members of the committee, on behalf of the more than 684,000 veterans residing in Georgia—and they are growing each day, each month, several thousand each month—we want to thank you and the members of the committee, particularly you, Mr. Chairman, Mr. Rowland, and your chairman, Mr. Sonny Montgomery, who is I think the greatest chairman that we have in the Congress of the United States of any committee. And I know——

Dr. LINDER. So do we.

Mr. WHEELER. I know it must be an honor for you Congressmen to be working with such an outstanding American, loyal, patriotic, dedicated American as Sonny Montgomery, and I did not want to pass up this opportunity to say that he is certainly well thought of by us here in Georgia, as you know.

Dr. ROWLAND. I know that very well and I agree with everything you said.

Mr. BISHOP. Ditto.

Mr. WHEELER. Thank you, Congressman Rowland, for the work that you have done through the years for the veterans of this State. I have worked with you, Mr. Bishop and Mr. Linder while you were learning the process of government in the Georgia State legislature training school for boys and girls.

(Laughter.)

Mr. WHEELER. You learned well and we are proud of what all of you have accomplished.

I appreciate you giving me the opportunity to appear before you and provide our thoughts and our ideas regarding the VA's role in national medical health care reform and VA medical care delivery in Georgia. Of course you do not know and I do not know what it is going to be.

Dr. ROWLAND. That is correct.

Mr. WHEELER. It has been a big secret so far and many of us, including many Members of Congress, have kept in the dark, many of the medical associations have been kept in the dark as to what is going on in this—what they are going to come out with. I do not know. The only thing we are definitely sure of is that something will come out and the people that are now paying for Medicare for themselves will be paying it for others that are not now receiving it—that is what it will amount to, and it is just how you are going around to get the money to do this.

First and foremost, the VA health care system, as Mr. Linder indicated earlier, and I was happy that he did, must be maintained as a separate, independent and exclusive health care option for veterans. The VA must continue to be the source of the unique health care for veterans that veterans require. Once this position is accepted, and I think it has been, then steps must be taken to improve and expand the VA health care system to open it up to all honorably discharged veterans; that is, in the event that a plan that none of us know too much about comes about. Maybe eventually they will tell us what is is going to entail.

Eligibility reform is one of the most pressing issues facing VA health care. Eligibility needs to be clarified to define who is eligible

for VA care and the scope of services that will be provided. VA must become more customer oriented and offer more timely and all-encompassing treatment.

I want to expand on that just a minute. What is customer-oriented? And the VA is certainly going to have to learn if they have to compete with the private hospitals and other hospitals in America, they have got to learn what that word means. If Mr. Walton of Wal-Mart was here this morning, he probably could explain it better than any other man in America. If Mr. Woodruff, who this building was named after, the Coca-Cola Company, they could explain what customer-oriented means.

It was mentioned here by one of the doctors a minute ago that they are sending out a survey. It was the first I had heard about it, I was going to suggest that they start getting into this field more—I call it a patient-focused satisfaction survey. How are you going to know whether you are going to be able to get these people in VA hospitals unless you know how they feel about the service that they are getting at VA hospitals now. The veteran needs to be asked "what do you think about the care you received during your stay here in this VA hospital, what do you think about it?" Number one, how was the food, was it well-prepared, was it hot or was it cold, was it clean? Was your room clean? Did the ceiling have blood in the top of it, did it need cleaning, were the house people all sitting down the hall asleep or are they keeping the place clean and neat, which a hospital should be kept? How do you feel about it, Mr. Veteran? The nursing staff, were they courteous or did they feel like they were doing you a favor coming down and taking your temperature and asking you a question? How did you feel, Mr. Veteran, about the nursing care that you received in this hospital, was it prompt, was it courteous, was it friendly?

You do not know how really to improve your service unless you ask the patient and his family about the care that they are now receiving. Now I do not know anything about any survey that has been made of this type. If the VA is doing it, I would like to have a copy of it. I am sure your committee would like to know what they are doing in this regard. But we cannot go on with business the same old way. We are going to have to take a lesson from Sam Walton, we are going to have to be friendly when they come into the hospital. We are glad to see you. The person working in that hospital is going to have to say welcome. If that veteran did not come in this hospital, I would not have a job. He is my boss, and we ought to treat him that way.

Taking care of the veteran with service-connected disabilities, low-income veterans, POWs and other veterans currently defined as Category A, must continue to be, of course, the VA's primary responsibility. However, all honorably discharged veterans, if this new health care system comes about, should be eligible for care at VA facilities. No longer should the degree of service-connected disability be a factor in determining the eligibility for care in a VA facility. When providing care to non-Category A veterans, the VA should be granted the authority to determine—to be reimbursed for the care provided to the veteran, who are beneficiaries from other federal programs; Medicare, Medicaid and other federally funded health care financing systems must be considered as third-party

payers and be expected to reimburse the VA for care provided to non-service connected veterans. The funds collected for medical care services must go to the VA, or more appropriately to the VA facility that has provided the care, not to the general fund of the U.S. Treasury.

Any veteran who suffers catastrophic illness or injuries, the cost of care for which would render him or her financially destitute should receive care in VA without charge.

To provide appropriate care for Category A veterans, legislation must be enacted to ensure VA receive sufficient annual funding to provide service. The funding should be based on the veterans population meeting eligibility requirements for the care that must be provided. Regardless, the VA must retain its exclusive Congressional appropriation support for Category A veterans. It is time that the VA in Washington realize that most of the veterans today are moving to the southern States. They are moving away from the eastern States and the money should move down here with them when they move down to Florida or Georgia or South Carolina or Alabama, where they are coming in droves. The money should come with them down here to take care of these veterans and we should take a careful look at the reduction of veterans in some of the northern States and take some of that money and bring it down here to take care of the veterans who have moved down here.

Funding for non-Category A veterans should be determined after considering the reasonable expected collections or reimbursements from various payers.

Where feasible, we would like to see increased cooperation between VA medical installations and active duty military facilities. I believe a sharing of expensive medical equipment and highly skilled medical personnel would help reduce operating expenses and also provide better service for both the veteran and active duty military personnel. I would even go so far as to say that I would be happy to see the VA take over a great deal of the military medical care. Maybe not all of it, but a great deal of it could be handled by the VA.

In addition to eligibility requirements, VA must evaluate and modify the type of care it provides. VA needs to be come less hospital-oriented and focus more on outpatient and long-term care of veterans. Health care delivery must expand to include preventive care. A veteran should not have to be seriously ill to receive some type treatment that might prevent him from becoming a permanent patient in a VA hospital if it is caught early enough.

With an aging veterans' population, which has been referred to here earlier, VA must prepare now for an increased number of older veterans. This means that beds for long term or extended care must be increased. Maybe some of the vacant hospital beds could be used for this. Instead of paying architects and engineers to build more, we could use some of the beds that we have now that are vacant for that. Acute care beds, ambulatory care capabilities and such services as adult day care—adult day care and domiciliary care must be adjusted as the veteran population changes.

Plans must be made to provide specialized treatment for diseases of aging veterans such as that is required for Alzheimer's disease. That is the number one problem if you want to know what the

number one problem is, what to do with the Alzheimer's veteran who is able to walk and move around and wander. You can take care of this man if he is in a wheelchair or in a bedridden condition, but a man who is walking with Alzheimer's requires 24 hour a day service, as you know, and special security in the building. Right now, nursing homes do not want them. The veteran may hit a man or woman who is paralyzed there, if he is wandering around. He may wander out in front of an automobile and be run over. That is the man that we cannot do anything for right now, we are stymied and we have done very little to correct this problem.

We would like to see the VA to expand teams that provide in-home treatment for veterans living in close proximity to VA medical centers or clinics. Also, the VA needs to expand its hospice facilities where veterans with terminal illness can go for care and for counseling. These facilities assist the veteran to cope with their condition and allow him or her to die with dignity and not become a burden on their families.

If a veteran comes to my office this afternoon—probably one will, or his family—has incurable cancer, about the only place I know really—the VA is doing a very limited work in this field, but the Catholic Church operates a place near the stadium and that is about the only facility in the Atlanta area that provides were a man or woman can go and die in peace and in comfort. And we are not doing enough in that field to take care of that veteran and let him die honorably and well.

Dr. LINDER. Pete, our chairman is too polite to say this, but he has got an important appointment coming up. Can we ask you to——

Mr. WHEELER. I conclude my remarks, Mr. Chairman.

Dr. LINDER. We will put it all in the record, if you do not mind. Thank you.

Dr. ROWLAND. Mr. Phillips, commander of the Department of Georgia.

STATEMENT OF PAT PHILLIPS

Mr. PHILLIPS. Mr. Chairman, members of the committee, I want to thank you on behalf of the more than 44,000 members of The American Legion here in Georgia. Mr. Akin testified yesterday, gave you our statement, but I do want to summarize just on two areas.

Mr. Chairman, The American Legion firmly believes that the Department of Veterans Affairs health care delivery system can and must continue to exist in any future health care environment. Events regarding national health care reform are rapidly unfolding. The issue for eligibility for VA care is being studied, appropriations are in progress and VA's national health care plan is about to be unveiled. Each of these important changes could be pivotal to the definition of the role VA does in the health care in this country. But none will detour the steadfast resolve in this Nation to care for our sick and disabled veteran patients.

Mr. Chairman, in your announcement also of this hearing, you suggested comments on the VA medical care delivery in Georgia. We of The American Legion, Department of Georgia, have had a

long established relationship, working relationship, with the directors in the VA medical centers here in Georgia. They have done an outstanding job with the budget restraints that they have been under and we appreciate them because of the job they have done.

I am a full time working service officer for the Department of Veterans Affairs here in Georgia, and I want to comment on the VAMC-Decatur. That facility has done a good job and has been under a lot of pressure and we appreciate them for it. Mr. Deal has quarterly meetings now with the veterans' organizations and he asks for our input and we appreciate it.

Thank you.

Dr. ROWLAND. Thank you.

Mr. Hanshew—and I apologize for not pronouncing your name correctly a few moments ago.

STATEMENT OF JACKIE D. HANSHEW

Mr. HANSHEW. That is fine, Mr. Chairman, I am used to everyone having difficulty with it. My name is Jackie D. Hanshew, I am the department commander for the Disabled American Veterans, Department of Georgia. I am also a national service officer for the Disabled American Veterans. In addition to that, I am a Vietnam combat wounded veteran and I am one of those who seek and receive treatment at the VA medical center, in spite of the fact that I have private insurance to take care of that.

The reason I go there, sir, is to learn exactly what other veterans face when they go to the VA medical center. When I sit down there in a chair and I wait 5 or 6 hours for an appointment or my appointment is canceled and I am not notified of it, I share that problem with all the veterans in this State and in this Nation.

The DAV's main concern is with the waiting period that veterans experience every day in that medical center. As a matter of fact—I am not trying to focus on me, sir, but I have an eye condition in which I am in the process of losing my sight. My right eye was enucleated following my service in Vietnam, my left eye has prevented me from driving. I have a great deal of difficulty reading and recently I was there for a diabetic appointment, which I am also service-connected for, and the doctor indicated to me at that time that I should have an eye exam. Yesterday, I got my appointment, it is for November of 1993. Needless to say, I am very concerned about that delay, I feel that it is unwarranted in my particular position because I do not think they look at any veteran other than as an appointment in the future sometime down the road. There is no personal concern for veterans on an individual basis. And I am not saying in its entirety, but it feels many times that they do not provide services that are necessary and are warranted for specific conditions, they merely make an appointment and that appointment is made at the earliest opportunity they have in that clinic. It is unbelievable that you have to wait 6 or 7 months for an appointment. That is not a criticism of the hospital, sir, it is a criticism of the system.

Also, the pharmacy wait—I mean this has been improved greatly, but you still run into problems at the pharmacy because certain prescriptions have to be countersigned by a doctor and the first thing that happens is they send the veteran to find the doctor. It

is not the veteran's job to go find that doctor and have that doctor verify what he has requested there.

The lack of funding in the VA system and particularly in the hospital system, is atrocious. It causes a reduction in the employees that are available to serve veterans, it causes inadequate service to veterans, it causes low morale in the medical center which in fact influences the amount of respect that is shown to a veteran when he walks through the door of that hospital. He is treated with ill will by those who feel that he is there taking up their time.

The DAV, American Legion and the Veterans of Foreign Wars have presented to Congress a budget for the last several years where we have recommended necessary funding levels for the VA. To this point, we have been very dissatisfied, all of the veterans' organizations, with the funding for veterans' health care, not only in this State but in this Nation. The lack of adequate service is not helping the veteran himself because it does not benefit his overall health picture. When he goes into the hospital he becomes frustrated, he is angry, he views the VA medical center, from my position as a receiver of those services, as his enemy, as somebody that he has to do combat with to get what is rightfully his deserved treatment in that VA medical center.

Disabled veterans need quality timely service with respect. It is imperative the image of the Department of Veterans Affairs, period, overall, that their image be changed in the eyes of the veterans of this country and that the services that are provided to them be provided to them with dignity and respect rather than as a welfare system.

This committee should be commended for its stand to see that the Department of Veterans Affairs health care system should remain as a separate system where it serves only those who have served in the defense of this Nation. DAV's commitment to the transportation program, to volunteerism, to monetary support to the VA medical center in this locale, for example, a refrigerator was purchased by the Disabled American Veterans for $600 and a check was handed to Mr. Deal at the VA Medical Center, to provide the hospital with a refrigerator that they could not afford to buy themselves because of budget restrictions.

We have also with Chapter 1, the William E. Tate Chapter here in Atlanta, donated enough money to buy a brace machine which was needed for the prosthetic services. The DAV is proud to do all of these things, but we feel that the government is the one that should provide these types of equipment and services that we're providing. And we travel, as you know, sir, many, many thousands of miles, we transport thousands of veterans every year at our own expense and have donated vans to the VA medical center for that purpose. We want to see that our veterans get quality care, they get timely care, they get the care when they need it and they get the respect they deserve.

Thank you, sir.

Dr. ROWLAND. Thank you very much. I want to thank all of you for your testimony.

There is one question I want to ask before I go to Dr. Linder. In the reconciliation process that we had, we had a target that we had to meet under the budget resolution and to meet that target one

thing that was done was to take into account funds that come from health insurance for service-connected veterans. Would all of you care to comment on that? Do you understand just what I am talking about? Now funds come from insurance for non-service connected veterans, but this is a significant amount of money from service-connected.

Mr. HANSHEW. Well, sir, since I was already talking, I have no objection if a veteran has private health insurance that will pay for those services, but it may jeopardize that patient's insurance. Myself, I have had private insurance for the last 8 years and I do not use it because I go to the VA facility. The reason I go there is because the government owes that to me, sir. They promised me that when I went in the service, they promised me that when I got out. And they did not tell me there would be a baseball game where they would change the rules in the middle of the fifth inning when I was at bat. And I do not think it is fair. For a service-connected veteran to be billed in any manner by this government for the care for his service-connected disabilities, I think it is very inappropriate and uncalled for, and it provides him with a great disservice. This country owes him that, sir. Veterans have been begging for years for proper care and proper treatment at the VA medical center. That is all they ask, is to be treated with dignity, the honor they deserve, and to receive care for those service-connected injuries that were incurred in war time, free of charge. If they charge me a co-payment for a non-service connected disability, then that is fine. I will pay that $2.00 co-payment because it is cheaper than the drugstore, that is for sure. But the problem is when you are dealing with a service-connected veteran who was injured in combat, he should receive full treatment without charge of anyone for those disabilities. Thank you.

Dr. ROWLAND. I think everybody on this panel agrees with that. I guess the question is, is there objection to the VA collecting that money, not to bill the veteran, but for the VA to collect that money.

Mr. HANSHEW. That is what I am talking about, even to bill his insurance company, sir, because if it is an extensive amount of care that he receives and the bill is enormous—I saw a bill the other day the VA had written the veteran a letter and they were going to charge him $101,000 for the services that were rendered to him through his insurance company. The insurance company, of course, is going to cancel his policy because they are not going to carry him.

Dr. ROWLAND. Any other comments about that? Pete?

Mr. PHILLIPS. Mr. Chairman, at The American Legion, we certainly do not support charging the insurance companies of the service-connected veterans for a service-connected disability. We do not believe that would be right. But on the third-party reimbursement on non-service, we have got no problem with that.

Dr. ROWLAND. You have got no problem with third-party reimbursement——

Mr. PHILLIPS. Non-service connected.

Dr. ROWLAND (continuing). Non-service connected. Pete.

Mr. WHEELER. Well at the risk of taking up too much of Mr. Linder's time, he apparently has another appointment or something, I do not want to infringe on the committee's time any longer.

Dr. ROWLAND. We want to hear what you——

Mr. WHEELER. I feel like maybe I have already said more than I should have to the committee. It looks like we have been pushed a little too fast here this morning. Not by you, Mr. Chairman, but by Mr. Linder.

Dr. ROWLAND. We are going to take the time, Pete, that we need to.

Mr. WHEELER. I for one did a great deal of work and study on this testimony and I do not appreciate being cut off in the middle of my testimony, and if he is too busy to listen to me, maybe he will listen some other time.

Dr. LINDER. Let me just explain, Pete. The instructions that were given was 5-minute testimony and you could submit the written testimony for the record. And it is the chairman who has the appointment and was too kind to interrupt and I just thought that maybe we could submit the rest for the record. I apologize for offending your sensibilities.

I have a question for you that I would like answered. You raised an important point in the discussion about money moving south with the vets moving south. Do we have current data on a regular basis that these vets register somewhere so that we could, on an annualized or census basis determine where those vets are?

Mr. WHEELER. We have data that shows that we—getting back to Georgia, about six or seven thousand new veterans each month. I am sure the other States have similar information. I think the VA can make available to you the figures that will show that the veterans' population without a doubt has moved south and continues to move south, and the money has not flowed south with the veteran. And that is what I was driving at. And I think the figures are available, yes.

Dr. LINDER. I think it is an important point. Where do you get your numbers from?

Mr. WHEELER. I get my numbers from my office, Mr. Linder. The veterans' discharge has a little slip on his discharge when he is discharged from service. He can put a little check on there—there is a place he can put a little check when he is discharged that he wants that record to go to the State director of veterans affairs and become a permanent record in his file in the State. And we receive that many discharges, copies of discharges each month into our office in Atlanta. And each State in the union receives the same. And we actually have the discharges.

Dr. LINDER. Okay, thank you. I think that is a good point.

Mr. WHEELER. I do not know of any better evidence than the discharge as far as giving you the number.

Dr. LINDER. I appreciate that.

Jackie, do you carry all those veterans around on your motorcycle?

Mr. HANSHEW. I beg your pardon, sir. I did not understand your question, sir.

Dr. LINDER. It was just facetious. Pete Wheeler raised an important point about patient surveys that the hospital could have a survey of patient satisfaction. Have you ever seen one of those surveys?

Mr. HANSHEW. No, sir, I have not, but I receive dozens of letters in our office that have a memorandum attached to them and are sent directly to Mr. Deal at the VA medical center when these problems come up. We receive a lot of letters, we receive a lot of telephone calls and complaints. I try to direct those veterans to Mr. Deal's office so that that hospital is aware of what those problems are, where they occur and how often they occur. I do not know how many of the veterans respond.

Dr. LINDER. Okay. We are painfully aware of the problems our local VA Hospital has had over the last several years and it has been in the newspapers, and that kind of a problem, particularly with the sexual harassment, has created a problem with morale in the hospital and it is probably fair to assume that those problems have spilled over into quality of care and everything else in that hospital. Is it fair from your observation to say that things are improving there, including care and morale of caregivers?

Mr. HANSHEW. I think one of the biggest problems right now is the parking problem. That was addressed earlier. I do not think that is ever going to go away. I do think in some respects and in some areas, in fact care has improved as far as the relationship with the client himself. However, there are instances where—one of the things that bothers me most is in Georgia they have a law, if a veteran becomes upset in the VA medical center and he is—I will give you one example and it is well-documented—he is 100 percent service-connected because of a head injury that he received in World War II. He goes to the VA medical center, he does not get the respect, the care and the consideration that he thinks he deserves, whether that is warranted or not is not the point, he thinks so. So when they do not give him that, he gets upset and angry, he becomes very abusive, tells them that he is going to go out into the parking lot and blow his brains out. They immediately handcuff him—and this man is in a wheelchair—throw him on the gurney and haul him to the Georgia Mental Health Institute. There he is incarcerated for 3 days and at the time his family gets him out, the veteran pays for his care because he is in the Georgia mental health system because the VA medical center cannot commit, is what I am told. If there is a veteran there who is service-connected, 100 percent, for a mental condition and he becomes distraught and unmanageable, the VA medical center cannot put him in the hospital and restrain him. I think that is inappropriate and it happens a lot.

Dr. LINDER. Thank you.

Mr. HANSHEW. So in those cases, no, I do not think there has been an improvement.

Dr. LINDER. My last comment is—and Dr. Rowland heard me say this yesterday—I am constantly impressed and moved by people like you folks who have spent your lifetime caring for other veterans. And as a veteran, I just want you to know we appreciate it, we could not do it without you.

Dr. ROWLAND. Thank you.

Mr. Bishop.

Mr. BISHOP. I do not have any questions for this panel. I just want to make one brief comment, I want to echo what Dr. Linder said. I am very pleased and am always pleased to hear from the

veterans' representatives, both in Washington at our hearings and your representatives are very diligent there. It really helps us to know, and I appreciate, Mr. Hanshew, the candor of your remarks because what you are saying is what I hear.

Mr. HANSHEW. Thank you.

Mr. BISHOP. I want to commend you for your work. Someone said that you make your living by what you get, you make your life by what you give. And you gentlemen are giving and making a life for yourselves as well as for the thousands of veterans who receive the benefit of your advocacy, and I appreciate it as a member of this committee and I appreciate it as a citizen on behalf of the veterans in the State of Georgia.

Thank you.

Dr. ROWLAND. Thank you. I do have one question that I want to ask specifically about Atlanta here. And you have given us already some of the information, Mr. Hanshew.

From a patient perspective, what are the greatest areas of need at the VA Center here in Atlanta? Any of you care to answer that?

Mr. PHAGAN. I will answer that, sir. I am James Phagan, I am the Hospital Service Coordinator at the VA Hospital. Bill Coward, my constituent in Dublin, you know him, and we are on the firing line. We are not back away from veterans as they come in, we catch it. That hospital deals in misery, both physical and mentally. And it is all related to one problem, and it is money. That is where it all comes from. He comes in, he does not know the system, he does not understand the system and nobody has told him what the system is. I take them in tow, explain the system to them, calm them down and can get what they need because I have the time. For one man, I can give 8 hours or 12 hours or 12 minutes. I do not have anybody that I am responsible to for my time. This is what the veterans hospitals need to do, explain to the veteran what is needed. He does not understand it. If you ask me what a committee meets with, I will tell you, but ask the average veteran, he will say what is that. He does not know, you have not told him. He is confronted with the most disastrous situation in his life at that time, he is hurting, he is in need and it is not there.

You heard the statement, you made the statement, do not rock the boat. Well I tell you, Mr. Chairman, do not rock the boat—turn it over. Because then you will not be afraid to get your feet wet. You and the rest of the gentlemen on your committee are to be praised and praised highly for what you do, but do a little bit more, turn that boat over and find out where the problems are. You are confronted with the most terrible situation in your life, where do you get this money from—you do not, period. They allot you and give it to you. But what are you going to do for the little bitty man who does not understand anything. That is our veterans.

You say expand the services. World War II veterans are now flooding the VA system. They are retired—and I am the baby of that crowd and I am 65. And to call myself a baby at 65 is quite an honor. But those poor old guys need medication, they do not need treatment so much, but the VA will not provide medication for them; $300 out of a $700 monthly income, guess what that does to your food bill, it eliminates it. We need for these veterans to be explained to them, we need somebody—we have what they call now

patient representatives in these VA hospitals, they are doing a fine job. Mr. Deal at this hospital has got something going now, what he calls total quality, I call it quality control, I have lived it all my life. I flew and I depended upon it. I would not be here today if I had not.

But let us get these little people down here and let them know what it is about. Let them know what it is about. And when you use $10 words, he is going to look at you and say "yeah." That is all he is going to say, he is not going to ask a question.

I thank you and I commend you. Mr. Linder has presented himself to us at our Chapter before, we know him personally, we approve of him, we voted for him and we are glad he was elected, and we would like for you to turn that boat over.

Dr. ROWLAND. You say then I guess, lack of communication is one of the big problems, the veteran not having an understanding of just what is going to take place or what to expect, is that right?

Mr. PHAGAN. That is it. My God, do not use $10 words on them, tell them, get your toocus in gear and get on this line over here and get signed up and get in here. Do not tell him well we have got appropriations over here to set you up over here for this clinic, get you there, get you here. He does not even know where a clinic is or what it is.

Dr. ROWLAND. It is really fear of the unknown, he just does not understand.

Mr. PHAGAN. The whole human race fears the unknown. We do not know what it is—the whole human race fears it.

Dr. ROWLAND. There needs to be more attention focused on that veteran coming into the system——

Mr. PHAGAN. That is the man that we have got to deal with. We do not deal with them out there, we deal with him when he comes in that hospital. And being on this firing line, when I started out, I was 6'4", 280 pounds, I am 5'4" now and 160.

(Laughter.)

It will take its toll on you. And I do not have much hair left either, they pulled it all out.

But let us communicate with them.

Mr. HANSHEW. Mr. Chairman, I would like to say to you, sir, thank you, first of all, to all of you for coming, we certainly do appreciate your interest. We need it. The biggest problems in that hospital that are the most irritating situations to a veteran is walking in there in the morning with a 7:30 appointment and leaving that hospital at 4:30 or 5:00 at night. He sits for hours, he is in pain, he is in misery, he has to pay for his lunch, he has to pay for his dinner, he has to drive 200 or 300 miles round trip that day because he cannot afford to stay in a motel room. We have vans—last month, our van here in Atlanta, and we have three of them in this State, traveled 21,107 miles and it transported 586 needy veterans to this VA medical facility right here in Atlanta, and there were 426 hours that that van was in operation. These are real figures and these are down to earth and this is straight-forward and simple. We do this because we care and of course, Congress knows that. The DAV has shown that in the past. But a veteran comes in there at 7:30, he leaves at 5:30 or 6:00 at night, and many times without even having seen a doctor. And I have been

there myself, I can testify under oath to that, the fact that I went to the hospital into the waiting area, I was weighed, blood pressure checked, temperature taken, I sat there from 7:00 in the morning until 6:30 at night and I went home without seeing a doctor. And it is not just me, there are many others who have that same problem. They schedule all the veterans to come in at the same time, everybody comes in and then they take first-come, first-served. If there is a VA employee who can receive treatment in that hospital, he is treated before anyone else so that he can go back to work. This is an unfair system, sir, it is unfair to those who sacrificed in service. That is what we are concerned about.

Dr. ROWLAND. We know about your transportation network and I have for a number of years. It is all over our State and the Disabled American Veterans do an outstanding job in getting folks to a medical facility.

Pete, what do you hear from folks about this? I know you must hear from a lot of folks.

Mr. WHEELER. Well at the risk of—John looks like he is getting very uneasy, I guess he has got to go somewhere, why do you not excuse him and we can go ahead with this hearing.

Of course, nursing care, the shortage of nurses, is a problem in every hospital in America, not only in the VA hospital but every other hospital. And one of the things I had hoped to say here this morning was a solution to that problem in the Atlanta hospital before I was cut off.

Dr. ROWLAND. Well tell us now. I would like to hear what you have got.

Mr. WHEELER. The severe shortage of nurses is affecting the care of veterans at the Atlanta VA Hospital and all other VA hospitals. It is hard to attract nurses. There is land available in the vicinity of the Atlanta VA Hospital. We apparently have lost the land right next to it to public television but there is land across the street. We propose that we make working conditions more attractive to nurses and the other employees of the VA hospital and have a day care center for the children, the small children of nurses, and we could attract more nurses in that way.

Dr. ROWLAND. Let me ask you something, Pete. Is there not a day care center available for employees here now, VA employees?

Mr. WHEELER. I will have to let Larry Deal speak to that. I have never heard of it, sir.

Dr. ROWLAND. Maybe I am thinking of another hospital.

Mr. WHEELER. They have them in some areas, but not here, that I know anything about.

Dr. ROWLAND. Okay.

Mr. WHEELER. And also I would like to see a day care center for Alzheimer patients, where the family would have some relief during the day and a place to drop off their veteran, male or female, in a day care center for Alzheimer's in addition to the nurses and the other people having places to drop their children off—not in the same location and not in the same building, but have a day care center for Alzheimer's and a day care center for the employees' children.

Also, I would like to see a VA Regional Office built on this site and get a one-stop service for all veterans in the area and in the

State. The chances of losing records—you could eliminate duplication of many services and a reduction in employees perhaps, and save money by having a VA Regional Office adjacent to the VA Hospital. It is working well in many communities.

Those are some of the things that I wanted to mention to you this morning, and I appreciate you giving me a chance to say something about it now.

Dr. ROWLAND. It is good to know. I do not know of anybody more knowledgeable than you about the veterans in our State.

Mr. PHILLIPS. Mr. Chairman, I would just like to say this, as you know, any person, when they go into a government agency, they are on the defensive because of the bureaucracy, and that could be—a lot of the gripes could be cut down, I was thinking about what Mr. Wheeler said awhile ago about Wal-Mart. If they are instructed when they get there and they are treated with more respect, it would cut down a lot of the gripes that you hear. I am not just talking about one hospital, I am talking about the system, the entire system.

Thank you.

Mr. WHEELER. Mr. Chairman, you walk into a Wal-Mart, you ask where are the lightbulbs, the employee of Wal-Mart says "sir, I will take you to the lightbulbs." In other stores, they do not say that. VA needs to get more of that attitude, "sir, I will take you to the proper place that you need to go and I will help you get this service", that is what we need to do, get an attitude, change the attitude.

Dr. ROWLAND. I am sure you are aware of the bill that we just passed in the House which addresses some of the things that you are talking about specifically right now, to look at providing some adult day care facilities in a pilot program for alternatives to institutional care too, which I think is real important. We see our whole health care delivery system changing and I think the VA needs to change and move for what is going on in general, and adapt to that.

I want to thank all of you very much for being here this morning. Is there any additional comments?

Dr. LINDER. Thank you for being here.

Mr. BISHOP. Thank you very much.

Dr. ROWLAND. I really do appreciate it very much. I think the only way that we can learn is to come and talk to the folks who are involved. We appreciate the opportunity. We will carry this information back and we will keep fighting. Since I have been in the Congress, there has been a constant battle about funds for the VA, you all know that. We battle all the time trying to keep those from being reduced to the point—and of course it has impaired the VA's ability to provide the kind of care that we would like to have.

Thank you all very much for being here this morning. We stand adjourned.

[Whereupon, at 11:21 a.m., the subcommittee was adjourned.]

APPENDIX

JUNE 3, 1993

PREPARED STATEMENT OF CHAIRMAN ROWLAND

It's a pleasure to be here with you this morning. I want to thank all of our witnesses for coming today and I would also like to thank the many veterans who came out for this morning's hearing.

With all the debate in Washington regarding the current VA health care system and potential changes that may occur under National Health Care Reform, I believe it is imperative that Members of Congress hear from individual who would be directly impacted by any actions that might be taken. There is no better place than here at home to hear from you. It is critical that your voices be heard and that is why we are here this morning.

With us today is John Linder, of the Fourth Congressional District, who is a member of the Veterans' Affairs Committee. We also have Mac Collins of the Third Congressional District. John and I served in the State House together for a number of years and I look forward to working with him again as a member of the Committee.

At this morning's hearing we will receive testimony regarding the current operations at Department of Veterans medical centers in the State of Georgia, in particular those facilities located here in Dublin and in Augusta. It is my hope that this hearing will provide a valuable look at such issues as access to care and availability of services to Georgia veterans. In addition, we will focus on the issue of impending national health care reform and what impact such reforms might have on the operation of the VA health care system.

As the debate on national health reform progresses it is critical that we focus on the VA as an integral part of any reforms. It is also necessary that we understand the current state of the VA health care system, both its strengths and its weaknesses. As the country's largest health care system, the VA should provide a model for the health care reformers to consider.

However, all of us know the current reality facing many veterans who seek their care from the VA. While most Category A veterans seeking inpatient care are treated on a timely basis, long waiting lines for many outpatient care services have become common-place. In some areas, VA has been forced to cut back on outpatient services to many veterans who previously received their care from the VA, because VA simply does not have the resources to continue to provide them care. Are these veterans being treated in some other setting? Do they have access to alternative forms of health care? I do not know, but more importantly the VA does not know.

1 do not want to unfairly criticize the VA, after all it is not the Department that ultimately determines the size of its own budget. My reason for raising what many of us already know is that it is time all of us acknowledged the current realities facing the system. For too long now VA has been asked to provide more services and programs with less overall funding. Years of funding shortfalls have taken their toll. This cannot continue.

This morning, we will hear testimony from the directors of the Dublin and Augusta VA medical centers as well as the Director of the Southern Region. I look forward to the insights that they will provide regarding the current operations at their facilities in terms of their ability to meet the demand for health care of Georgia veterans.

With regard to the larger issue of national health care reform, VA officials have been deeply involved with the President's national health care reform task force. From all indications that involvement is not mere token representation. VA has been on many of the task force working groups, and Secretary Brown's credentials as an advocate help assure us that veterans are getting a fair hearing in this plan-

ning effort. There is much that the Secretary and his team can bring to the table from the VA's own experience.

However, the point must be made that under National Health Care Reform, veterans like other Americans will be given the opportunity to access one of several health care options. Given a range of choices some veterans currently using the VA may decide to seek their health care someplace else. It is imperative that we recognize this fact and work to ensure that VA remains an attractive, high-quality health care option for our Nation's veterans.

As many of you know, the immediate challenge ahead is the budget and the annual effort to secure an adequate level of funding for the VA health care system. We have a lot of work ahead of us and I look forward to working with you to help the Committee and the Congress achieve its goals.

I look forward to hearing the testimony of our distinguished witnesses. I would now like to recognize my colleagues for any statements that they would like to make.

Thank you.

JUNE 3, 1993

Prepared statement of Congressman Linder

Thank you Mr. Chairman, I would like to thank you for this opportunity to participate in the Subcommittee's field hearing in Dublin. I also would like to join you in welcoming the witnesses and thank them for their participation.

The hearing today focuses on the local concerns of Georgia's veterans and the current operations at the Department of Veterans Affairs' Medical Center in Dublin and Regional Office in Atlanta. We will also address an issue of significant importance to the veteran community—National Health Care Reform.

I would like to reiterate my strong commitment to this Nation's veterans. All of our veterans have taken an oath to protect this country and the freedoms that we hold dear, and we as Americans owe these dedicated men and women a debt of gratitude. As a member of the House Committee on Veterans' Affairs, I can assure you that I will continue to work towards maintaining an independent health care system for this Nation's veterans.

However, in order for the VA health care system to compete in the health care reform arena, it is imperative that the Department of Veterans Affairs realign itself, reform eligibility criteria and establish long-term goals to address the needs of an aging veterans' population.

Mr. Chairman, I appreciate your continuing commitment to our veterans. As a physician you are a recognized leader in the national health care debate, and a strong advocate for veterans.

Thank you, Mr. Chairman, I look forward to hearing the testimony of the distinguished witnesses.

STATEMENT OF MR. RICHARD P. MILLER
DIRECTOR, SOUTHERN REGION
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
GEORGIA HEARINGS
JUNE 3 AND 4, 1993

Mr. Chairman, members of the committee, I am pleased to be here today to discuss healthcare services provided to veterans in the State of Georgia.

REGION OVERVIEW

The Southern Region is one of four geographic regions within Veterans Health Administration (VHA). It spans approximately 1.2 million square miles in the 11 states of Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Florida, Georgia, North Carolina and South Carolina, as well as the Virgin Islands and the Commonwealth of Puerto Rico.

The region includes four regional division offices, one independent outpatient clinic, 32 nursing homes, nine domiciliaries, 36 satellite and community based clinics, ten outreach centers, and 42 medical centers (plus one under construction), with over 60,000 employees (includes medical care and research) and an operating budget of approximately $3.9 billion. The Southern Region includes 7.2 million veterans within its boundaries. In FY 93, over 6.6 million outpatient visits are planned and it is anticipated that over 308,000 inpatients will be treated. The region monitors each facility's programs in the areas of resource management, strategic planning, quality assurance, internal review, risk management, nursing, construction, fire and safety, industrial hygiene, automated data processing, equal employment opportunity, human resources, consumer affairs, pharmacy, emergency medical preparedness, consolidated procurement, radiation safety, and women veterans programs.

The Resident Work Limits initiative was created to improve the working conditions and supervision of the VHA residency program. Under this initiative, the Southern Region has received $25.95 million and 913.7 FTE through FY93. We have been asked to gather new cost data for the unfunded FTE needed to ensure compliance with limits on resident work hours, supervision requirements and limited emergency room duty. This new cost data is necessary to update the original dollars that were based on FY91 information. Originally, the Southern Region was scheduled to receive a total of $79.9 million.

Not only does the Southern Region provide up-to-date health care services, we strive to further expand current services with creative and innovative initiatives. Four such examples would be:

1. Consolidated mail-out pharmacy (CMOP);
2. Tele-radiology;
3. Homeless programs; and
4. Over $15 million in sharing agreement reimbursements in FY93.

The Southern Region places the highest priority on promoting the quality of patient care delivered to the region's veteran patients. This is accomplished through an array of programs and functions. For example, the region conducts a large number of visits to facilities to review their status of evaluating patient care and making necessary changes based on these evaluations. We work closely with the facilities, providing them with support to continuously improve their patient care monitoring activities. We provide consultation and training to assist in the preparation for the Joint Commission on the Accreditation of Healthcare Organization surveys. These surveys provide an important indication of the facility's ability to deliver high quality patient care. We carefully monitor a large number of patient incidents and occurrences for severity and trends. We review facility investigations related to these events. The region maintains an extensive database containing indices relevant to patient care. Extensive analysis is conducted to detect patterns and share the results with facilities. In summary, through numerous site visits and ongoing data analysis, the region manifests the high priority it gives to the quality of patient care delivered within its facilities.

GEORGIA OVERVIEW

There are three (3) VA medical centers located in the State of Georgia. They are in Atlanta, Augusta (Uptown and Downtown Divisions), and Dublin. A satellite outpatient clinic is located in Savannah (under VAMC Charleston, SC) , an outreach clinic located in Columbus (under VAMC Tuskegee, AL) and two (2) Veterans Centers located in Atlanta and Savannah.

All three VA medical centers located in Georgia fully participate in the Network #2 (Georgia and South Carolina) activities aimed at providing a continuum of care for veterans, facilitating patient referrals, and planning for veterans health care services in a cost effective manner. Network #2, under the leadership of the Network Council chaired by Mr. Thomas L. Ayres, Director at VAMC Augusta, is one of the most progressive in the Region.

Among the issues important to veterans' health care being addressed by the Network, the following are particularly noteworthy:

1. Consistency in Policy/Procedures for Transfer of Patients between Network facilities

2. Assessment of Clinical Service Availability and Outpatient Clinics Appointment Availability

3. Development of a Network Information System

4. Management of the Community Nursing Home Program

5 Management of Nursing Home Ventilator Dependent Patients

6. Network Hospice Program

7. Medical Staff Communication

8. Care of Female Veterans

9. Long Term Psychiatry

10. Long Term Care

The Southern Region encourages activities aimed at improving veterans' health care, and closely collaborates with the Network and the individual VA medical centers included in the Network through staff located at the Southern Regional Division Office in Atlanta.

The three medical centers received a total of $320.2 million and 4,646.2 FTE for FY93 compared to $293.9 million and 4,616.4 FTE in FY92. As of March these facilities had a total of 347,000 outpatient visits and 20,103 inpatients treated. Georgia VA medical centers have a total of 1,455 hospital beds, 266 nursing home care unit operating beds and 344 domiciliary operating beds.

Atlanta and Augusta have received Resident Work Limits resources totaling $2.4 million and 82.1 FTE through FY93. When the Resident Work Limits program is completely funded, the Atlanta and Augusta facilities will receive a combined total of $5.4 million and 120.5 FTE.

Currently there are two active major construction projects totaling $79.4 million and one pending approval for $30 million planned for the Georgia facilities. The approved minor construction projects total $5 million for FY93 and tentative minor construction projects for FY94 total $4.7 million. A total of $2.2 million was approved for NRM in FY93. Tentative amount for NRM in FY94 is $4. 6 million.

Each VA Medical Center is making progress in assuring that women veterans have access to health care. Health care for women veterans is primarily provided at the VA Medical Centers in Georgia through sharing agreements with medical school affiliates or arrangements with the Department of Defense. Physical examinations, including gender-specific cancer screening for women veterans are also provided on contract or fee basis with non-VA providers or on a consultant basis. Each VA Medical Center has an established outreach program to apprise women of their veteran status, to assist them in identifying themselves as veterans, and to inform them of gender specific services available to them. A Regional Women Veterans Coordinator has been hired and this position will network with a like position at each medical center to assist them in establishing specialized women veterans health clinics and health education programs. Educational programs have been provided to the staff on counseling for sexual trauma. The Atlanta Vet Center provides individual and group counseling and therapy for post traumatic stress syndrome (PSTD) and readjustment. Patient privacy and physical facilities for the treatment of women veterans have also received special attention.

Dublin

The Dublin VAMC's FY92 medical care budget totaled $52.2 million which included activation funding for an outpatient clinical addition project and 833.3 FTE. The FY93 medical care budget as of March 1993 is $50.9 million and 847.3 FTE. The facility currently has 692 operating beds compared to 710 average operating beds in FY92. During FY92 they attained a workload of 4,358 inpatients, 67,527 outpatient visits, 122 nursing home patients and 717 domiciliary patients. The FY93 planned workload includes 4,666 inpatients, 65,000 outpatient visits, 123 nursing home patients, and 700 domiciliary patients.

Dublin currently has an active major construction project for FY93, Outpatient Clinical Addition, funded for $9.4 million and three approved NRM projects totaling $621,291 for FY93. One minor construction project, Convert Building 10C to Nursing Home Care Unit, is also approved for $2.6 million in FY93. Dublin has three non recurring maintenance projects and two minor construction projects scheduled for FY94.

Dublin was one of 33 VAMC's across the nation with a smaller surgical service whose surgical mission was questioned by the VA Inspector General. As a result, VHA conducted a review of the Dublin surgical program and made several recommendations to enhance the program. The medical center has implemented all of the recommendations and has been approved to maintain a full primary surgical program. As a primary surgical program, Dublin provides general surgery, recognizes and treats emergent and urgent surgical disorders, and refers more complex surgical cases to secondary or tertiary facilities. By enhancing their surgical program, Dublin provides a much needed and improved service to its veteran population.

The following are strategic initiatives as proposed by VAMC Dublin in the FY92 draft VHA National Health Care Plan which have been recently funded, implemented, or are still in the planning phase:

1. Establish 10-bed Geriatric Evaluation and Management Unit;
2. Establish a Level B HBHC Program;
3. Establish 10-bed Hospice Program;
4. Establish 42-bed Homeless Domiciliary Program.

Augusta

The Augusta VAMC's FY92 budget totaled $125.6 million and 2,317.4 FTE. The FY93 budget is $130.5 million and 2,294.6 FTE. Augusta currently has 897 operating beds compared with 898 in FY92. FY92 workload consisted of 9,564 hospital inpatients, 88 nursing home care unit patients, and 130,867 outpatient visits. FY93 planned workload includes 10,000 hospital inpatients, 91 nursing home care unit patients, and 131,000 outpatient visits.

In FY92 Augusta received $1.3 million and 26.1 FTE to hire additional nursing staff as part of the distribution to the sixty most complex medical centers.

Augusta has six approved NRM projects totaling $584,000 in FY93. Two minor construction projects, renovation of the MICU/CCU and installation of an MRI Clinic, are approved for $2.4 million in FY93. Augusta has submitted four NRM projects for FY94 and has a pending major construction project for Spinal Cord Injury.

The following are strategic initiatives as proposed by VAMC Augusta in the FY92 draft VHA National Health Care Plan which have been recently funded, implemented, or are still in the planning phase:

1. Establish 15-bed Blind Rehab Clinic
2. Designate 23 Intermediate Beds for Geriatric Evaluation Unit
3. Establish an HBHC Program
4. Designate 10 Intermediate Beds for Hospice
5. Replace Existing Cardiac Cath Lab
6. Establish 30 Oncology Beds With Chemotherapy
7. Obtain a MRI
8. Increase SCI Bed Service from 60 to 88

Atlanta

The Atlanta VAMC's FY92 budget totaled $116.2 million and 1,462.2 FTE. The FY93 budget is $138.8 million and 1,504.3 FTE which includes activation funding for a clinical addition and parking garage. The facility currently has 476 operating beds compared with 489 in FY92. FY92 hospital inpatients totaled 8,542, nursing home care unit patients equaled 202, and outpatient visits totaled 166,613. The FY93 planned workload includes 8,400 hospital inpatients, 148 nursing home care unit patients, and 151,000 outpatient visits.

In FY92 Atlanta received $1.03 million and 20.6 FTE to hire additional nursing staff as part of the distribution to the sixty most complex medical centers.

Atlanta has seven approved NRM projects totaling $902,000 and a major construction project for a clinical addition and parking garage totaling $70 million in FY93.

The following strategic initiatives as proposed by VAMC Atlanta in the FY92 draft VHA National Health Care Plan are still in the planning phase:

1. Establish Respirator Dependent Unit;
2. Establish 16-bed Med/Surg Stepdown Unit;

CLOSING

The Southern Region is committed to the goal of providing the highest quality care available to this nation's veterans. We are also committed to utilizing our fiscal resources in the most effective manner to achieve this goal.

Thank you, Mr. Chairman. I would be pleased to answer any questions the Committee may have.

PREPARED TESTIMONY BY
MR. WILLIAM O. EDGAR, MEDICAL CENTER DIRECTOR
FOR THE
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE FIELD HEARING
CARL VINSON VA MEDICAL CENTER AUDITORIUM
JUNE 3, 1993 - 8:00 A.M.

GOOD MORNING! THANK YOU FOR ALLOWING ME THE OPPORTUNITY TO OFFER TESTIMONY REGARDING THE CURRENT AND PLANNED PROVISION OF CARE PROVIDED AT THE CARL VINSON VA MEDICAL CENTER LOCATED HERE IN DUBLIN, GEORGIA. I WANT TO START BY SAYING THAT FOR ME PERSONALLY IT IS A PLEASURE TO APPEAR BEFORE YOU AND THE SUBCOMMITTEE TODAY AS A REPRESENTATIVE FOR THE CARL VINSON VA MEDICAL CENTER, AND IT IS INDEED AN HONOR FOR OUR MEDICAL CENTER TO HOST THIS VERY IMPORTANT HEARING.

SIMPLY STATED, OUR MISSION AT THE CARL VINSON VA MEDICAL CENTER IS TO PROVIDE CONTINUOUS QUALITY HEALTH CARE TO OUR VETERANS IN A COMPASSIONATE AND EFFICIENT MANNER.

CARL VINSON VA MEDICAL CENTER IS A 366-AUTHORIZED BED PRIMARY AND SECONDARY CARE FACILITY WHICH PROVIDES MEDICAL, PSYCHIATRIC, SURGICAL, REHABILITATIVE CARE, AND DIALYSIS. EXTENDED AND GERIATRIC CARE IS ALSO AN IMPORTANT COMPONENT OF THE PRIMARY BED PROGRAMS. IN ADDITION, AN 86-BED NURSING HOME CARE UNIT (NHCU) AND A 344-BED DOMICILIARY ACTIVELY COMPLEMENT THE HOSPITAL TREATMENT PROGRAMS. COMPREHENSIVE OUTPATIENT CARE IS PROVIDED.

THE MEDICAL CENTER CURRENTLY HAS 262 PRIMARY AND SECONDARY CARE OPERATING BEDS, EXCLUDING THE DOMICILIARY AND NURSING HOME CARE UNIT (NHCU). WHEN THESE BEDS ARE INCLUDED, WE HAVE 692 OPERATING BEDS. THE MEDICAL CENTER HAS 81 OPERATING BEDS IN MEDICINE, 15 BEDS IN REHABILITATION MEDICINE, 31 BEDS IN SURGERY, AND 75 BEDS IN EXTENDED CARE. THE MEDICAL CENTER HAS A 30-BED DRUG AND ALCOHOL DEPENDENCE TREATMENT PROGRAM WITH AFTERCARE SERVICES PROVIDED THROUGH THE DOMICILIARY ALONG WITH A 30-BED INPATIENT PSYCHIATRY PROGRAM. THE OVERALL MEDICAL CENTER OCCUPANCY RATE FOR FY 1992 WAS 79.5%.

PATIENTS TREATED HAVE AVERAGED 4,900 THE PREVIOUS THREE YEARS AND AVERAGED 5,100 FOR THE DECADE OF THE 80'S. TO MINIMIZE THE NEED

FOR INPATIENT CARE, THE CENTER HAS INCREASINGLY USED OUTPATIENT ALTERNATIVES. OUTPATIENT VISITS IN FY 1980 WERE 21,807; FOR FY 1992 THEY WERE 67,527.

I AM PLEASED TO REPORT THAT IN SEPTEMBER 1992, THE CARL VINSON VAMC WAS SURVEYED BY JCAHO AND WE RECEIVED A HOSPITAL ACCREDITATION PROGRAM SCORE OF 90 AND A LONG-TERM CARE SCORE OF 94. MAXIMUM SCORE IS 100. WE FEEL WE PROVIDE EXCELLENT QUALITY PRIMARY AND SECONDARY MEDICAL CARE TO THE VETERANS WHO COME TO US FOR THEIR HEALTH CARE NEEDS.

WE HAVE JUST RECENTLY COMPLETED AN OUTPATIENT CLINICAL ADDITION WHICH WILL PROVIDE ADEQUATE SPACE TO SERVE THE 67,000 OUTPATIENT VISITS WE PROJECT TO HAVE THIS FISCAL YEAR. THE NEW CLINICAL ADDITION WAS ACTIVATED IN OCTOBER 1992 AND OFFERS STATE-OF-THE-ART EQUIPMENT.

THE OUTPATIENT PROGRAM PROVIDES A WIDE RANGE OF SERVICES FOR OUR RURAL VETERANS. THESE INCLUDE AMONG OTHERS: MEDICAL, SURGICAL, MENTAL HYGIENE, ALCOHOL AND DRUG, COMPENSATION AND PENSION EXAMS, DENTAL, PODIATRY, POST TRAUMATIC STRESS DISORDER GROUP THERAPY, OPTOMETRY, REHABILITATION, DIALYSIS, DERMATOLOGY, DIETETIC, CLINICAL PHARMACY, CARDIOLOGY, AND DIABETES. PRESENTLY, OPHTHALMOLOGY, UROLOGY AND ORTHOPEDICS ARE PROVIDED ON A REFERRAL BASIS BY VAMC AUGUSTA.

THE 86-BED NURSING HOME CARE UNIT REMAINS CONSISTENTLY AT PLUS 90% OCCUPANCY WITH A ONGOING WAITING LIST OF VETERANS AND THE MEDICAL CENTER'S OVERALL OCCUPANCY RATE HAS AVERAGED JUST UNDER 80% SINCE FISCAL YEAR 1989.

SPECIAL MEDICAL SERVICES INCLUDE: NUCLEAR MEDICINE, ULTRASOUND, GAMMA CAMERA, COMPUTERIZED TOMOGRAPHY, PODIATRY, PULMONARY, PSYCHIATRY, DETOXIFICATION, RESPIRATORY CARE UNIT, RECREATION THERAPY, INTENSIVE CARE, DIALYSIS AND GYNECOLOGY. THE MEDICAL CENTER HAS AN ACTIVE SHARING AGREEMENT WITH WARNER ROBINS AIR FORCE BASE, GEORGIA, WHICH PROVIDES COMPUTERIZED TOMOGRAPHY, NUCLEAR MEDICINE SERVICES AND A CONSULTING MEDICAL RECORDS SERVICE. IN

TURN, MAMMOGRAMS ARE PERFORMED AS RECOMMENDED BY THE AMERICAN CANCER SOCIETY BY WARNER ROBINS. A NEW VETERANS AFFAIRS/DEPARTMENT OF DEFENSE (VA/DOD) SHARING AGREEMENT BETWEEN THIS FACILITY AND THE U. S. ARMY RESERVES UNIT AT FT. GILLIAM, GEORGIA, WAS ALSO RECENTLY APPROVED. THE AGREEMENT INVOLVES CERTIFIED REGISTERED NURSE ANESTHETIST SERVICES PROVIDED TO VAMC DUBLIN BY THE RESERVE UNIT AT NO CHARGE.

VAMC DUBLIN HAS OUTSTANDING SUPPORT FROM THE 19 VA VOLUNTARY SERVICE ORGANIZATIONS ACTIVE AT THE FACILITY. OVER 27,000 VOLUNTEER HOURS WERE PROVIDED BY MORE THAN 550 REGULAR AND OCCASIONAL VOLUNTEERS DURING THE PAST YEAR.

CARL VINSON VA MEDICAL CENTER IS ONE OF THREE VA HOSPITALS IN THE STATE OF GEORGIA. THROUGH A COOPERATIVE ARRANGEMENT, SCARCE AND SPECIALIZED MEDICAL, SURGICAL AND CLOSED-WARD, PSYCHIATRIC CARE RESOURCES ARE ACCESSED THROUGH THE REFERRAL PROCESS FOR VETERANS IN DUBLIN'S PRIMARY SERVICE AREA (PSA) AT THE AUGUSTA VA MEDICAL CENTER. THE VA MEDICAL CENTER IN DUBLIN ACCEPTS PSYCHIATRY AND DOMICILIARY REFERRALS FROM WITHIN THE REGION AND UTILIZES THE AUGUSTA VA MEDICAL CENTER AS THE PRIMARY REFERRAL CENTER FOR PATIENTS IN DUBLIN'S PSA IN NEED OF TERTIARY CARE.

THIS MEDICAL CENTER HAS ONE OF NINE COOPERATIVE HEALTH MANPOWER EDUCATION PROGRAMS (CHEP) IN THE VA SYSTEM, THE GEORGIA CHEP/AREA HEALTH EDUCATION CENTER (AHEC). CHEP IS AN EDUCATIONAL PARTNERSHIP BETWEEN THE CARL VINSON VAMC AND VARIOUS COMMUNITY HEALTHCARE ORGANIZATIONS AND AGENCIES LOCATED IN A 39 COUNTY SERVICE AREA. CHEP HAS RECEIVED SYSTEM WIDE PROMINENCE WITH OVER 250 EDUCATIONAL PROGRAMS OFFERED IN FY 1992, WHICH SERVED MORE THAN 9,400 PARTICIPANTS. THE GEORGIA CHEP/AHEC IS THE PRIMARY TRAINING ARM FOR THE CARL VINSON VAMC AND SERVES BOTH VA AND NON-VA MEDICAL PROFESSIONALS IN SOUTH CENTRAL GEORGIA. IN THE ABSENCE OF A LARGE ACADEMIC AFFILIATION, THIS CHEP SERVES AS A PRIMARY TOOL FOR PROVIDING NECESSARY CONTINUING MEDICAL EDUCATION AND SERVES AS A COHESIVE AGENT FOR ALL MEDICAL PROFESSIONALS IN THE GEOGRAPHICAL AREA. THE GEORGIA CHEP HAS HELPED TRAIN VA PROFESSIONALS

THROUGHOUT THE REGION AND IS AFFILIATED WITH THE MOREHOUSE SCHOOL OF MEDICINE AS A RURAL-BASED AHEC. EMPLOYEES FROM VAMCS DECATUR AND AUGUSTA ATTEND CHEP SPONSORED EDUCATION PROGRAMS.

MEDICAL AND NURSING SCHOOL AFFILIATION UPDATE

AS YOU MAY KNOW BY NOW, THE DUBLIN VA MEDICAL CENTER NOW HAS AN ACTIVE MEDICAL SCHOOL AFFILIATION WITH MERCER UNIVERSITY SCHOOL OF MEDICINE IN MACON, GEORGIA. PRESENTLY, THE AFFILIATION INVOLVES SURGERY RESIDENTS AND THE PLAN IS TO EXPAND THE AFFILIATION TO INCLUDE PSYCHIATRY AND MEDICINE RESIDENTS IN THE FUTURE.

CURRENTLY, A SURGICAL RESIDENT FROM MERCER UNIVERSITY ROTATES THROUGH THE SERVICE EVERY TWO MONTHS. AFTER THE FIRST OF THE YEAR, TWO RESIDENTS WILL ROTATE CONCURRENTLY THROUGH THE SERVICE. PHYSICIAN ASSISTANT STUDENTS FROM MEDICAL COLLEGE OF GEORGIA AND FROM EMORY UNIVERSITY ROTATE APPROXIMATELY EVERY EIGHT WEEKS.

SOCIAL WORK SERVICE IS AFFILIATED WITH TWO MAJOR UNIVERSITIES, THE UNIVERSITY OF GEORGIA AND FLORIDA STATE UNIVERSITY. OUR STAFF PROVIDES INTERNSHIP TRAINING FOR 7-10 GRADUATE STUDENTS PER YEAR.

NURSING SERVICE IS PROUDLY AFFILIATED WITH MIDDLE GEORGIA COLLEGE SCHOOL OF NURSING, GEORGIA SOUTHERN UNIVERSITY SCHOOL OF NURSING, GEORGIA COLLEGE SCHOOL OF NURSING, AND SOUTH GEORGIA COLLEGE SCHOOL OF NURSING.

RESEARCH AND DEVELOPMENT

OUR DIRECTOR OF SURGICAL RESEARCH AND COORDINATOR FOR RESEARCH AND DEVELOPMENT IS SETTING UP PROGRAMS IN WOUND HEALING, THE MAJOR RESEARCH EMPHASIS OF THE DEPARTMENT OF SURGERY AT MERCER UNIVERSITY SCHOOL OF MEDICINE. IN ADDITION, HE IS DEVELOPING AND UTILIZING NON-INVASIVE TECHNOLOGY, INCLUDING THE DETERMINATION OF CARDIAC OUTPUT, FOR THE MEASUREMENT OF OXYGEN DELIVERY IN CRITICALLY ILL PATIENTS.

MEDICAL SERVICE IS PARTICIPATING IN A RESEARCH STUDY ON WARFARIN AND ASPIRIN IN SECONDARY PREVENTION IN NEWLY DIAGNOSED MYOCARDIAL INFARCTION PATIENTS. THIS STUDY IS FUNDED THROUGH THE VAMC, WEST HAVEN CONNECTICUT AND ENDORSED BY VA CENTRAL OFFICE, RESEARCH SERVICE.

DOMICILIARY CARE HOMELESS VETERANS PROGRAM

I AM PLEASED TO INFORM YOU THAT ON MARCH 26, 1993, I RECEIVED A PERSONAL LETTER FROM OUR NEW SECRETARY, JESSE BROWN, INFORMING ME THAT THE CARL VINSON VA MEDICAL CENTER HAS BEEN APPROVED FOR A HOMELESS VETERANS TREATMENT AND ASSISTANCE PROGRAM. WE WERE ONE OF 43 VA MEDICAL CENTERS OUT OF MORE THAN 130 VA MEDICAL CENTERS THAT APPLIED FOR THE PROGRAM TO RECEIVE APPROVAL. THE NEW PROGRAM WILL PROVIDE A WIDE RANGE OF TREATMENT AND ASSISTANCE SERVICES FOR HOMELESS VETERANS FROM THROUGHOUT THE STATE OF GEORGIA, AND WE LOOK FORWARD TO PROVIDING THIS SERVICE TO THE VETERANS OF OUR STATE IN THE NEAR FUTURE.

RESPITE AND HOSPICE PROGRAMS

OUR RESPITE PROGRAM WHICH WAS IMPLEMENTED IN MAY 1992 OFFERS CAREGIVERS A TWO WEEK REPRIEVE BY ADMITTING PATIENTS WHO ARE USUALLY CARED FOR BY THE FAMILY AND FRIENDS AT HOME.

A HOSPICE PROGRAM WAS IMPLEMENTED IN MAY 1992 WITH THE ESTABLISHMENT OF OUR MULTIDISCIPLINARY HOSPICE CONSULTANT TEAM. WE HAVE ASSISTED MANY PATIENTS AND OUR GOAL IS TO FURTHER ENHANCE THIS PROGRAM IN A COOPERATIVE EFFORT WITH THE LOCAL COMMUNITY IN THE FUTURE.

FEMALE VETERANS COORDINATORS

DUBLIN VAMC HAS THREE EMPLOYEES ASSIGNED AS FEMALE VETERAN COORDINATORS. ALL FEMALES WHO ARE ADMITTED TO THE MEDICAL CENTER ARE SEEN BY ONE OF THESE INDIVIDUALS IN ORDER TO DISCUSS ANY SPECIAL NEEDS OR RESPOND TO QUESTIONS OUR FEMALE VETERANS MAY HAVE.

THE NAME, TITLE AND PHONE NUMBER OF ALL FEMALE VETERAN COORDINATORS ARE NOW POSTED ON ALL UNITS AS WELL AS IN THE OUTPATIENT CLINIC. A "WELCOME PACKET" SPECIFICALLY DESIGNED FOR FEMALE VETERANS HAS BEEN DEVELOPED. THIS PACKET WILL BE GIVEN TO ALL FEMALE VETERANS UPON ADMISSION.

IT SHOULD BE NOTED THAT ALL FUTURE AND ONGOING BED SPACE RENOVATION PROJECTS WILL INCLUDE ONE OF OUR FEMALE VETERAN COORDINATORS AS PART OF THE DESIGN COMMITTEE. THIS ADDITION TO OUR COMMITTEE GIVES ADDED EMPHASIS TO THE SPECIFIC NEEDS OF OUR FEMALE VETERANS.

CONSTRUCTION

IN ADDITION TO OUR NEW CLINICAL ADDITION WHICH WAS PREVIOUSLY MENTIONED, THE FOLLOWING CONSTRUCTION PROJECTS ARE PLANNED OR ARE UNDERWAY:

WE ARE NOW FINALIZING PROJECT NO. 557-92-120 WHICH RENOVATED WARD 19A TO PROVIDE APPROPRIATE SPACE FOR 30 NURSING HOME BEDS. THIS PROJECT, AT A COST OF APPROXIMATELY $130,000, WILL CONVERT 30 EXTENDED HOSPITAL CARE BEDS TO NURSING HOME BEDS TO ALLOW CARE FOR OXYGEN DEPENDENT VETERANS.

OUR FIVE YEAR FACILITY PLAN INCLUDES A SECOND FLOOR TO THE CLINICAL ADDITION TO PROVIDE SPACE FOR A NEW SURGERY SUITE, RECOVERY AND ICU/RCU. THIS PROJECT WILL ALLOW US TO UPDATE OUR SURGICAL SUITE TO MEET ALL CURRENT STANDARDS. THIS WILL ALSO ALLOW OUTPATIENT SURGERY TO BE PERFORMED. TO DATE THE ABOVE PROJECT HAS NOT BEEN OFFICIALLY APPROVED.

ANOTHER MAJOR NEED PLANNED IS THE RENOVATION OF BUILDING 34 TO HOUSE OUR PSYCHIATRIC PROGRAM. THE EXISTING PSYCHIATRIC WARD WAS ESTABLISHED AS A TEMPORARY AREA UNTIL THE RENOVATION OF BUILDING 34, BUT UNFORTUNATELY THE RENOVATION PROJECT FOR BUILDING 34 AT A COST OF 2.8 MILLION DOLLARS HAS NOT RECEIVED FUNDING.

WE HAVE RECEIVED DESIGN FUNDING TO RENOVATE WARD 10A TO CONVERT DOMICILIARY BEDS TO 40 NURSING HOME BEDS. THIS RENOVATION AT A COST OF 2.6 MILLION DOLLARS WILL PROVIDE A MODERN FACILITY TO HOUSE THE MOST CRITICAL NURSING HOME PATIENTS INCLUDING THOSE WITH ALZHEIMERS.

THE NEW DOMICILIARY CARE HOMELESS VETERANS PROGRAM WILL PROVIDE CONSTRUCTION FUNDS TO RENOVATE BUILDING 25 FOR THE HOMELESS AND RENOVATION IN THE DOM FOR FEMALE VETERANS.

IN CLOSING I WANT TO ASSURE YOU AND YOUR DISTINGUISHED COLLEAGUES THAT I, ALONG WITH MY DEDICATED AND COMMITTED STAFF, WILL CONTINUE TO PROVIDE SERVICES TO OUR VETERANS IN A MOST COMPASSIONATE, CONSCIENTIOUS AND EFFICIENT MANNER.

MR. CHAIRMAN, THIS CONCLUDES MY TESTIMONY AND I WILL BE PLEASED TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

Statement of

THOMAS L. AYRES
MEDICAL CENTER DIRECTOR
VETERANS AFFAIRS MEDICAL CENTER
AUGUSTA, GEORGIA

Before the Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
U.S. House of Representatives

Dublin, Georgia - June 3, 1993

The VAMC in Augusta is a two-division, 1033-bed, Complexity Level I Medical Center. The Downtown Division is a 380-bed acute medical and surgical facility including a 60-bed Spinal Cord Injury Unit. The Uptown Division is a 653-bed psychiatric, intermediate medicine and rehabilitation facility and includes a 60-bed Nursing Home Care Unit. The VAMC in Augusta employs 2,300 staff members with an annual budget of approximately $130 million. I was appointed Director at Augusta in June, 1990. Since my appointment, I have worked diligently to renew and enhance VA/DoD relationships. Members of my staff and I have met frequently with the Commander and staff of the Dwight David Eisenhower Army Medical Center (DDEAMC) to create the VA/DoD Planning and Liaison Group. This is a group dedicated to enhancing opportunities for the cost-effective sharing of medical resources. The concerted efforts of this planning group have produced the following concerns, opportunities and recommendations. The specific recommendations are more clearly defined in a separate document titled the "Department of the Army/Department of Veterans Affairs Joint Venture for Shared Services."

In an era of constrained federal resources available for medical care, it is critically important that co-located federal institutions work together to maximize efficiency. Recognizing this, the Command of the Eisenhower Army Medical Center and the management of the Department of Veterans Affairs Medical Center in Augusta, Georgia, propose to develop an innovative shared services agreement to consolidate, where possible, their respective resources. The object of this consolidation will be: 1) to avoid duplication and thus to achieve economies of scale, and, 2) to take greater advantage of those situations in which one of the two institutions has ample resources for which the other institution has a defined need.

We jointly envision a coordinated effort to consolidate, where practical, the alignment of services and the contributions of the two institutions so that the consolidation results in an equal input of resources by each institution. Under this operational scenario, little or no actual money changes hands. It is our joint understanding and mutual commitment that all decisions to consolidate must make clinical good sense and this commitment is an absolute sine qua non of any past or future deliberations. We believe that these initiatives have great potential for real enhancement of the services which we provide to both our beneficiary populations. We further believe that this agreement has the potential to establish a viable example of federal

cooperation in providing "state of the art" health care, education and research opportunities for co-located VA and DoD medical care facilities nationwide.

I believe that by linking resources with other federal health care providers the Department of Veterans Affairs will be improving its ability to provide quality care to the greatest number of eligible veterans. Budget constraints are a fact of life in the provision of health care, whether that care is provided in the private sector or federal facilities. The minimal growth in VA funding has caused greater constraints to be placed on the number of veterans who can be cared for in any given VA Medical Center. During the last six months, the facility at which I serve, VAMC Augusta, was able to provide care to only 172 veterans who were not service connected or not Category A non-service connected veterans. This is a direct result of the limiting of resources which has occurred over the last several years.

As we strive to care for the greatest number of veterans, in the highest categories of priority, our resources will be almost entirely devoted to long term care, intermediate medicine, chronic psychiatry and some very specific programs such as the care of the spinal cord injured and treatment of Post Traumatic Stress Disorder. We should be able to provide our veterans comprehensive, quality care at competitive prices. We should be opening the system to receive additional veterans and I would hope that the

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task force on health care reform allows the VA to serve as a model of a managed care organization, cooperating whenever possible with other federal health care providers.

We are confident that the VA and other federal health care providers, such as DoD, can constructively cooperate to assure quality care to our beneficiaries. A couple of years ago when the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) made public their "Agenda for Change", we began the process of changing our traditional Quality Assurance program to the more progressive Continuous Quality Improvement (CQI) approach. We have integrated Total Quality Management (TQM) efforts with the CQI philosophy of our Quality Management Program. We have created a process where it is possible for any employee to suggest an idea or point out an issue that may benefit from an analysis by a CQI team. We have been focusing on more simple, straight-forward issues while our program and experience levels develop and mature. This CQI concept is also the basis of our coordinated efforts with Eisenhower Army Medical Center to develop future plans for sharing clinical resources.

An indicator of our successes with CQI teams and TQM is our most recent JCAHO survey results. As you may recollect, about three years ago, the VA system was publicly criticized for its low scores on JCAHO surveys when compared to private sector hospital scores. In the present round of surveys the VA has surpassed the average

score earned by private sector hospitals. VAMC Augusta earned a score of 89 from the Hospital Accreditation Program compared to the community hospital average score of 80. I am confident that this indicator truly reflects the quality of care we provide to eligible veterans.

There are numerous examples of our efforts to provide quality services to eligible veterans. Last year we initiated retirement workshops with Fort Gordon to provide VA benefits and eligibility information for soldiers who are in the process of leaving active military service, including those who are retiring. We also responded to the needs of veterans when they returned from Operation Desert Storm. Since then we have evaluated 981 returning veterans. Using the Gulf War Veterans Registry protocol exam, 110 veterans have had specific health care concerns reviewed and health services for a number of these veterans have been provided.

One of the highest priorities for care in our system is the timely completion of Compensation and Pension (C&P) examinations. We work closely with Veterans Benefits Administration Regional Offices in Atlanta and Columbia, South Carolina to assure timely services to the veteran. The average C&P exam workload has dramatically increased due to the high visibility and concerns related to mustard gas exposure, Agent Orange exposure, the Persian Gulf War, and increasing numbers of female veterans completing active duty. The efforts of DoD to right size its active duty forces is expected

to continue to exacerbate this trend. Our workload has almost doubled to approximately 200 exams per month. The VA's maximum permitted processing time for C&P exams is 35 days. VAMC Augusta averages less than 20 days to contact the veteran, arrange for the various examination appointments, conduct the exams, and process the results. The innovation of our staff and their commitment to quality has resulted in the expansion of work schedules to include Saturday and evening exams which are much more convenient to veterans who work. The staff has also recruited a number of specialty physicians to conduct these exams when it is most convenient for the veteran. The clerk who schedules these exams is a retired army veteran and exemplifies the innovation and dedication of our employees to the veterans we serve.

As Chairman of Network Council 2, which is composed of the VA Medical Centers in Georgia and South Carolina, I am responsible for coordinating this effort. The Council has identified over twenty specific issues that focus on equitable access for veterans, ensure consistency in service delivery, improve efficiency in utilization of available services and represent cost effective health care planning efforts.

Some of our accomplishments to date include:

1) the development of guidelines for uniformity in provision of care to Category C and Category A veterans.

2) publication of a standardized Network Transfer Policy which establishes consistency in the management of patient referrals and transfers.

3) template development which provides a comprehensive database of network in-house capabilities and a summation of shared resources and contract services to include an in-depth cost analysis of these services.

4) identification of outpatient clinics having excessive waiting time for routine non-emergent appointments for development of a standard of care for reasonable access.

5) establishment of a communication network with the creation of a mail group for Hospice Coordinators to ensure coordination in the development of facility hospice programs.

6) development of a multi-facility proposal for a Women Veterans Comprehensive Health Center.

Coupled with the efforts of Network Advisory Groups and Technical Advisory Groups established by the Council, we envision our accomplishments to continue to progress forward in meeting our Network goals of ensuring quality veterans health care and maximizing accessibility by the most cost effective means.

I would be pleased to answer any questions you may have.

ROLE OF THE DEPARTMENT OF VETERANS AFFAIRS IN NATIONAL HEALTH CARE REFORM AND IN VETERANS AFFAIRS MEDICAL CARE DELIVERY IN GEORGIA

Presented by:

W. Douglas Skelton, M.D.
Provost for Medical Affairs and Dean
Mercer University School of Medicine
Macon, Georgia

before the:

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
United States House of Representatives
Representative J. Roy Rowland, M.D., Chairman

Carl Vinson Medical Center
Dublin, Georgia
Thursday, June 3, 1993

Good morning, Mr. Chairman and Members of the Subcommittee. I am Doug Skelton, M.D., Provost for Medical Affairs and Dean of Mercer University School of Medicine. I also serve as a member of the AMA's Council on Scientific Affairs and of the Board of Directors of the Bibb County Medical Society. Several years ago I was privileged to serve as Georgia's Mental Health Program Director and Commissioner of the Department of Human Resources. I have positive remembrances of working with Congressman Rowland during those years in his role as a member of the Georgia General Assembly. I appreciate the opportunity to testify this morning on the role of the Department of Veterans Affairs in National Health Care Reform and in Veterans Affairs Medical Care in Georgia.

I have very positive recollections of my experiences as a medical student at the old, now-demolished Atlanta VA Hospital. Dr. James Crutcher, who later served as chief medical officer of the Department of Veterans Affairs, was my teacher. I owe a lot to the Atlanta VA experience and to Dr. Crutcher's commitment to making all of his students complete physicians. I serve now as chair of the Dean's Committee at this hospital, and am excited by the commitment of Mr. Edgar, Dr. King, and the Dublin VA leadership to a working relationship which further enhances care to veterans, assists in the education of tomorrow's physicians, and sees research as a critical aspect of quality patient care.

Currently, over 130 of the 171 VA medical centers (VAMC) are affiliated with 102 medical schools. The youngest of these affiliations, I suspect, is Mercer's affiliation with the Carl Vinson Medical Center. Each year, more than 30,000 medical residents and 22,000 medical students receive a portion of their education in the VA. Overall, half of the practicing physicians in the U.S. have spent some time training in the VA. The VA also participates in training a variety of other health care professionals, including nurses, dentists, and pharmacists.

The VA and national health care system intersect at two points. First, as the statistics I mentioned earlier indicate, the VA plays a critical role in the education and training of future U.S. health care professionals. Secondly, the VA contributes significantly to advances in medicine through a research program which has an impressive history of success and

innovation. Whereas training and research issues are of primary interest to medical schools, manpower and staffing issues are central to the VA's success in meeting its primary mission of delivering health care to veterans. The intersection of these two goals brought medical schools and the VA together officially in 1946 and continues to bring mutual benefit to both partners and to the nation. Changes instituted as part of health care reform need to consider the VA's special strengths and training responsibility, and look for ways to enhance these contributions to the nation's health.

The VA delivers quality health care to a very complicated patient population. Veterans treated by the VA tend to be older, sicker, and poorer than the general population. The aging of the veteran population is the most dramatic phenomenon facing the VA health care system. Patients enter the VA system with a greater number of diagnoses than patients entering non-VA health care facilities. The VA plays an absolutely critical role in offering access to care for a special group of Americans who are not likely to be as well served outside the VA.

To address the health care needs of veterans, the VA has developed nationally-recognized expertise in several areas, including geriatric medicine, mental health services, long-term care, and rehabilitation for spinal cord injuries and loss of limbs. Many of these efforts, e.g. with Post Traumatic Stress Disorder, spinal cord injury, geriatric care, would be hard to duplicate elsewhere.

To advance and complement the VA's clinical care missions, the VA supports an impressive research program. I note with alarm that the Administration's FY-94 budget proposal recommends an eleven percent cut in the VA research budget, from $232 million in FY-93 to a proposed $206 millions in FY-94. Research dollars can be thought of as a leveraged fund that involves substantial return on the initial outlay.

The VA Advisory Committee for Health Research Policy strongly believed that the research program of the VA was entirely appropriate to its clinical mission. The research primarily

supports physician investigators who are involved directly in patient care with orientation toward solving problems, such as PTSD, of special import to veterans. National health care reform requires data on outcome assessment and clinical trial follow-up; this type of research is much easier to accomplish in the VA system, as the VA is ideally suited for clinical and health services research. Multi-center trials and cooperative research also work well in the VA system.

The areas of specialization developed by the VA and supported by VA research can be divided into two categories -- those which will remain particularly important to veterans and those which will become increasingly important to the general population. The veteran population has a unique demand for rehabilitation and mental health services, in many cases related directly to military experience The extent and breadth of care in these areas is unlikely to be as relevant for the general population as for the veteran population. On the other hand, in areas related to aging, the VA has developed an expertise because of patient demographics, but this type of medicine will become more critical to the entire health care delivery system as the general population ages. The VA system has experiences in the care of the elderly which can inform and shape the national response to the continuing growth of the elderly population.

Demographic data show that the VA patient population will quickly begin to decline this decade. To avoid addressing this phenomenon would be fiscally unsound, but more importantly avoiding the issue will jeopardize the quality of care in the VA. Achieving an optimum workload in a health care setting is a delicate balance; under-utilization can be as injurious as overload. The reality of a declining patient base and the threat it presents to quality of care leaves policy makers with important decisions about the future of the system. Current and projected fiscal constraints on VA appropriations make the timeliness of such decisions even more dramatic.

There are several options for reforming the VA health care delivery system. Options considered should recognize the value of the VA and the special role it plays in the national

health care delivery system, as it relates to care for veterans and to medical education. Options which meet this criteria will revolve around two concepts -- range of services and patient population.

At the outset of considering options for retaining and reforming the VA, two main features must be defined: (1) a set of services to be provided; and (2) the population to be offered services. Numerous combinations or elements of these two essential decisions could be adopted for a final VA system.

In other words, a future VA system could be categorized as follows, but conceptualized in a variety of formats, electing elements of each category, to design an ultimate policy course:

1. **Adjust the size of the VA system** as the eligible veteran patient population declines. The range from this category could involve reducing the whole system, with all of its current services, to reflect diminishing patient demand. Or, decisions about the size of the system could address elimination of certain services (i.e. tertiary care) which veterans could receive outside the VA system. An option of the latter nature would direct the VA to focus on services of special import to veterans, or areas in which the VA has developed an expertise, including mental health, geriatric medicine, long-term care, and rehabilitation but continue to provide a broader range of services in those VA's which draw their patients from medically underserved areas, e.g. rural areas.

2. **Revise eligibility** for entering the VA system. In the short-term, this could involve opening the VA to veterans other than those currently entitled to mandatory care. In the longer-term, the VA could develop means to provide services to veterans who are not "entitled" to care, or to other patients, such as veterans' spouses and dependents.

Examples of approaches involving options from each of these categories could also be summarized as follows:

- The VA should be a system that provides complete coverage, in the sense of being a comprehensive insurer and care deliverer, to a relatively small cohort of individuals, likely to include veterans exclusively.

- The VA should be reoriented as a system that offers access to certain, limited services to a cohort of patients, giving priority to veterans, but to include other individuals also through well defined contractual relationships. This approach focuses on a set of buildings staffed by health professionals who provide specialized services that are not as accessible in the general health care delivery system.

Each of these approaches has a series of costs and benefits in health policy, financial, and political terms. The VA will need to carefully weigh the relevant advantages and disadvantages. What must not be compromised is veterans' access to quality health care, which I believe is linked to the continued success of VA-medical school affiliations.

From another view, the experience of the VA can be analyzed from a variety of perspectives that may be helpful in informing the debate on national health care reform. The following outline presents examples of issues that could provide a framework for considering the VA as a model in which many important lessons can be learned.

1. The VA is the largest global budget for health care in the U.S. currently. What can the nation learn from the VA experience in areas such as:
   a. centralized management of resource allocation
   b. incentives and disincentives to control costs locally
   c. means of introducing new technology
   d. conversion of outdated facilities and replacement of equipment
   e. data collection for planning efforts
   f. quality assurance activities and measures
   g. the role of health services and outcomes research

2. The VA is ideally positioned to and striving toward providing a full continuum of services (primary through long-term care) to a discrete patient population. Is this a paradigm worth considering as a model for managed care?

3. How will the VA fit into a managed competition environment? Could the VA be organized as one national, or several regional, Health Insurance Alliances or Accountable Health Plans? How might the Department of Defense be involved?

4. To address its clinical care mission, the VA has developed an emphasis in specialized areas of health care that are of more predominant importance to the VA patient population than to the general population, namely mental health and rehabilitation for spinal cord injuries and loss of limbs. Because the veteran population is aging at a rate approximately ten years ahead of the general population, the VA has also developed an expertise in geriatrics and long-term care. A relevant question for health care reform would be to consider how the nation can capitalize on these strengths of the VA.

5. The location of many VA facilities, particularly certain rural and inner-city medical centers, provide a valuable resource to that community. These VA facilities create exceptional opportunities for building partnerships or networks to offer access to health care to underserved populations.

6. The VA graduate medical education efforts, approximately 12% of all U.S. residency positions in the disciplines relevant to veterans' care, must be integrated with broader efforts at changing the generalist/specialist mix to better serve the nation's needs. The VA must be a major player in these decisions.

And lastly, I want to simply comment on the need for medical education to stress the servant role of physicians. All schools, and all physicians, in my view, have a social responsibility along with the responsibility for each patient. Mercer Medical School was founded in

response to that social responsibility, and to needs in Georgia for more physicians; especially in Family Practice, General Internal Medicine, and General Pediatrics, in our smaller communities.

Our success in that effort, and in meeting Georgia's needs for physicians in Psychiatry, Obstetrics and Gynecology, General Surgery, and Emergency Medicine requires that we develop common bond with other institutions which are dedicated to the servant role and willing to share ideas, efforts, and resources toward common goals. The relationship between Mercer and the Carl Vinson Medical Center is one of those bonds which continues to grow stronger.

I will be happy to answer any questions.

STATEMENT OF

A. V. "BUBBA" AKIN

DEPARTMENT SERVICE OFFICER

THE AMERICAN LEGION

DEPARTMENT OF GEORGIA

BEFORE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

CARL VINSON D.V.A. MEDICAL CENTER

DUBLIN, GEORGIA

JUNE 3, 1993

Good Morning, Mr. Chairman and Members of the Committee:

It is a pleasure to appear before you to offer the position of the American Legion, Department of Georgia on the subject of the Department of Veterans Affairs (DVA) medical care delivery system's role in national health care reform.

Mr. Chairman, the Legion firmly believes that the Department of Veterans affairs health care delivery system can and must continue to exist in any future national health care environment. Events regarding national health care reform are rapidly unfolding, the issue of eligibility for VA care is being studied, appropriations negotiations are in progress and VA's National Health Care Plan is about to be unveiled. Each of these important changes could be pivotal to definition of the role of VA in health care in this country, but none will deter the steadfast resolve in this nation to care for our sick and disabled veteran patients.

There is presently a great deal of discussion regarding the impact of global budgeting and spending caps on health care costs. There are those who would say that such caps on spending would drive aggregate health care costs down and reduce the percentage of the Gross Domestic Product which is devoted to health care. Mr. Chairman, the Veterans Health Administration has operated under a global budgeting scenario for years. Such dollar constraints do force the system to become more efficient and create increased accountability for those who fiscally plan for veteran patient care. But, to accomplish this, corners must be cut and funds from other medical programs are cannibalized. The ultimate result is that which would occur in the private sector as well....rationing of care.

Fewer and fewer veterans are being treated in the VA, while, for a variety of reasons, the costs of that care continue to escalate. Any health care reform package which would emcompass global budgeting and price caps would allow the VA to operate at something of an advantage but, unfortunately, would perpetuate the

rationing of care and reduction of the population of veterans served if quality is not to suffer.

The role of the Veterans Health Administration under a managed competition scenario of national health care reform is less clearly defined because of our inability to determine the final form such a plan would take. Be that as it may, Mr. Chairman, we believe that VA, given free rein as far as their internal reform is concerned, could fare well under managed competition. Several mitigating factors must be clearly understood.

First, a major portion of the costs of VA health care is based upon care mandated by law to certain groups of veterans such as those with service-connected disabilities, those exposed to herbicides and ionizing radiation, those too poor to pay for their care, and others. Since the care for these deserving veterans is mandated by law, it must remain available and those costs can not be factored into a competitive package cost. Secondly, some of the cost of care in the VA is that created by the delivery of long-term care since it appears that long-term care may not be a portion of the basic benefits package which will be the basis for competition, the VA must separate out those costs as well. The existing prohibition against VA's collection of Medicare reimbursement will place a limit on VA's ability to compete.

Mr. Chairman, the American Legion believes that a plan to afford universal access to health care under reform would impact upon the VA in several ways. If health care consumers were to have their health care vouchered under a universal access plan, some veterans might move to the private sector for their care. These moves could be counter-productive for several reasons. In regard to keeping costs down, the private sector has never been proven to be able to deliver quality care at a cost equal to or lower than that delivered by VA. Thus, any mass move could increase rather than decrease costs nation wide.

On the other side of the matter, many veterans who had not previously taken advantage of VA health care, might move to the VA for their care simply because the idea of getting quality care at less cost may be an attractive option. The unknown in the voucher equation is the number of veterans who would, taking advantage of their opportunity for choice, pick one or the other option.

Regardless of what form a new national health care delivery mechanism takes, it is important, we think, to remember that the Department of Veterans Affairs has over 60 years of experience in delivering health care nationally. During these years, VA has learned some important lessons.

The doctors and hospitals in the VA system have made some serious mistakes, to be sure, but they have also made some remarkable scientific discoveries which have benefited all Americans.

Mr. Chairman, We believe that the Department of Veterans Affairs health care system could act as a model for national health care reform, in particular, after eligibility reform is achieved. The VA has a proven track record in the ability to deliver quality health care at a cost well below that of the private sector. Recent studies have demonstrated that health care of equal quality can be delivered by the VA at costs which are 20 to 40 percent lower than that delivered by affiliated university hospitals. Any plan to reform the nation's health care delivery system should utilize the cost-containment experience of the Veterans Health Administration. Mr. Chairman, in your announcement of this hearing you suggested comments on VA medical care delivery in Georgia. We of the American Legion, Department of Georgia have a long-established close working relationship with our three Medical Center Directors. We are cognizant of their problems with budgetary constraints and their diligent efforts to provide quality medical care for our veterans is appreciated. We applaud each and commend them for their cooperative attitude and this applies especially to this Dublin facility, that you and I are most familiar with.

Mr. Chairman, that concludes our statement. Thank you.

JUNE 4, 1993

PREPARED STATEMENT OF CHAIRMAN ROWLAND

It's a pleasure to be here with you this morning. I want to thank all of our witnesses for coming today and I would also like to thank the many veterans who came out for this monrning's hearing.

With all the debate in Washington regarding the current VA health care system and potential changes that may occur under National Health Care Reform, I believe it is imperative that Members of Congress hear from the individuals who would be directly impacted by any actions that might be taken. It is critical that your voices be heard and that is why we are here this morning.

With us today are, John Linder, of the Fourth Congressional District, and Sanford Bishop, of the Second Congressional District.

At this morning's hearing we will receive testimony regarding the current operations of the Department of Veterans Affairs medical centers in the State of Georgia, in particular the facility located here in Atlanta. The Subcommittee held a similar hearing yesterday in Dublin, Georgia to receive testimony regarding the operations at the Dublin and Augusta VA medical centers. It is my hope that this hearing will provide a valuable look at such issues as access to care and the availability of services to Georgia veterans. In addition, we will focus on the issue of impending national health care reform and what impact such reforms might have on the operation of the VA health care system.

As the debate on national health reform progresses, it is critical that we focus on the VA as an integral part of any reforms. It is also necessary that we understand the current state of the VA health care system, both its strengths and its weaknesses. As the country's largest health care system, the VA should provide a model for health care reformers to consider.

However, all of us know the current reality facing many veterans who seek their care from the VA. While most Category A veterans seeking inpatient care are treated on a timely basis, long waiting lines for many outpatient care services have become common-place. In some areas, VA has been forced to cut back on outpatient services to many veterans who previously received their care from the VA, because VA simply does not have the resources to continue to provide them care. Are these veterans being treated in some other setting? Do they have access to alternative forms of health care? I do not know, but more importantly the VA does not know.

I do not want to unfairly criticize the VA, after all, it is not the Department that ultimately determines the size of its own budget. My reason for raising what many of us already know is that it is time all of us to acknowledge the current realities facing the system. For too long now VA has been asked to provide more services and programs with less overall funding. Years of funding shortfalls have taken their toll. This cannot continue.

This morning, we will hear testimony from the director of the Atlanta VA Medical Center as well as the director of the Southern Region. I look forward to the insights that they will provide regarding the current operations at the Atlanta facility in terms of their ability to meet the demand for health care of Georgia veterans.

With regard to the larger issue of national health care reform, VA officials have been deeply involved with the President's national health care reform task force. From all indications that involvement is not mere token representation. VA has been on many of the task force working groups, and Secretary Brown's credentials as an advocate help assure us that veterans are getting a fair hearing in this planning effort. There is much that the Secretary and his team can bring to the table from the VA's own experience.

However, the point must be made that under National Health Care Reform, veterans like other Americans will be given the opportunity to access one of several health care options. Given a range of choices some veterans currently using the VA system may decide to seek their health care someplace else. It is imperative that we recognize this fact and work to ensure that VA remains an attractive, high-quality health care option for our Nation's veterans.

As many of you know, the immediate challenge ahead is the budget and the annual effort to secure an adequate level of funding for the VA health care system. We have a lot of work ahead of us and I look forward to working with you to help the Committee and the Congress achieve its goals.

I look forward to hearing the testimony of our distinguished witnesses. I would now like to recognize my colleague on the panel for any statements he would like to make.

Thank you.

JUNE 4, 1993

Prepared statement of Congressman Linder

Thank you, Mr. Chairman. Let me first thank you for agreeing to hold this most important hearing in Georgia's Fourth Congressional District. I welcome you and our other House colleagues here. I also owuld like to welcome all the witnesses and thank them for their participation.

Since being elected as a Member of the 103rd Congress, I have witnessed the VA Medical Center in Decatur transform from a medical center with chronic sexual harassment and low morale problems to a medical center where employees can take pride in their work and the quality of the health care they are delivering to our community's veterans.

On May 21st of this year I had the opportunity to visit the VA Medical Center in Decatur. I was impressed with the improvement in the overall atmosphere at the medical center. I was further pleased that the OIG's disciplinary recommendations were implemented in an expeditious and timely manner. I think we all can agree that sexual harassment in any form is reprehensible. It is apparent that throughout the investigation the medical center and the Department of Veteran's Affairs fully cooperated with OIG. All the individuals who were found responsible for sexual harassment have left the VA system. The Department of Veterans Affairs has also set out in an aggressive manner to eradicate sexual harassment in the VA. I would like to commend Mr. Deal for his leadership and for meeting the difficult challenges which he faced when he first arrived at the medical center.

Our hearing today focuses on the local concerns of Georgia's veterans and the current operations at the Department of Veterans Affairs Medical Center and Regional Office in Atlanta. We will also address an issue of significant importance to the veteran community—national health care reform.

It is clear that the future of the veterans health care system will face many challenges. Clearly, maintaining the status quo will only result in the continued erosion of the Department of Veterans Affairs health care system. The VA needs a realistic, achievable strategic plan, which includes eligibility reform to meet the health care needs of a rapidly aging veterans' population. Specifically, the nature of VA services must adapt to a changing environment and population. By the year 2000, 9 million veterans will be over the age of 65, yet the VA's long-term care resources and planning are inadequate to meet the needs of this population.

Addressing the issue of eligibility reform for VA health care is the number one priority of the House Committee on Veterans' Affairs this session. I think we all can agree that the current system is fragmented, difficult to understand and does not provide a full continuum of services for many veterans. However, committee members are also sensitive to the fact that they cannot change the current system in isolation of current health care reform initiatives.

I believe today's hearing is a step in the right direction. The Department's positive and negative experiences, as well as the resources already established by the system, should be a part of the discussions over health care reform proposals. The VA health care system is a national resource and must not be overlooked. However, this does not mean that there is no room for improvement in the Department of Veterans Affairs health care system. The VA must also define a strategy of their own for inclusion in national health care reform.

I want to emphasize that I am strongly committed to maintaining a separate health care system for this Nation's veterans and I would oppose any plan which would seek to destroy that system. Maintaining the independence of the VA health delivery system is an achievable goal. However, the VA must realign itself, reform eligibility criteria and provide for expansion of services in some areas while possibly narrowing services in underutilized areas if it is to compete in the health care reform arena.

Mr. Chairman, I appreciate your commitment to our veterans and your willingness to use valuable subcommittee resources for this hearing. As a physician, you are a recognized leader in the national health care debate, and a strong advocate for veterans.

Thank you, Mr. Chairman, I look forward to hearing the testimony of the distinguished witnesses.

STATEMENT OF JEFFREY L. HOUPT, M.D., DEAN, SCHOOL OF MEDICINE, EMORY UNIVERSITY, ATLANTA, GEORGIA

My name is Jeffrey Houpt, and I am Dean of the Emory University School of Medicine. I wish to welcome the Subcommittee members and their staff members to Atlanta and to the Emory campus. We appreciate your interest in Veterans' health issues.

My interest in the VA health system has been stimulated by serving on the VA Liaison Committee of the Association of American Medical Colleges (AAMC), as one of five Medical School deans, who provide council regularly to the Director of Medicine for the VA. We continually work to improve the quality of care our veterans receive at VA Medical Centers throughout the nation. My comments today, however, are my own—I speak only as Dean of Emory School of Medicine and not for the Liaison Committee.

The Emory School of Medicine's relationship with the Atlanta VA Medical Center is entering its 47th year, the origins of this valuable affiliation dating back to 1946. At the Atlanta VA during fiscal year 1991–1992, we provided health services for 8,542 inpatients and 166,613 outpatients. During this period, 129 out of the 132 physicians held faculty appointments in the Emory School of Medicine.

This morning, I would like to emphasize the value of affiliations between VA hospitals and Academic Health Centers—both for the veterans we serve and our students and faculty, and I'd like to stress the critical importance of maintaining adequate VA funding for Medical Care and Research.

BENEFITS OF THE AFFILIATION

Why should the Department of Veterans Affairs encourage affiliation with medical schools and academic health centers? Who benefits? Is this a self-serving venture that only provides a means of training medical students, residents and fellows? It seems that the value of these affiliations is repeatedly questioned, as if one side enjoys substantial benefits and the other consistent losses. In the brief time I have this morning, I hope to convince you of the importance and value to all parties that results from these affiliations.

In my opinion, the major benefit to the VA is the quality of physician which makes the affiliation with an academic health center possible. Academic appointments have been major factors in enticing extremely well qualified and dedicated physicians to the VA and in encouraging their retention. As a result, veterans utilizing these services are afforded a better quality of health care than would be possible otherwise.

Let me expand on the issue of recruitment and retention. A physician's choice of where to practice depends, to a significant degree, on working conditions and pay. The potential interest in working in the VA is often dampened by the perception that the VA is chronically underfunded—or at least always in jeopardy of losing funding—and overly bureaucratic. The salaries paid have been viewed in the past as inadequate, though recently they've been raised to a more competitive level. In my opinion, it is the opportunity for an academic appointment, the opportunity to teach—to contribute to a new generation of physicians—and the opportunity to pursue a research career that pushes talented physicians to a positive decision to work in the VA. It overcomes that final reluctance and thus brings a quality to the physician workforce not otherwise possible. An optimistic expectation of reasonable, continued funding will be essential to maintain this recruitment advantage. Uneven funding or funding in constant jeopardy, only creates uncertainty and drives the brightest and best elsewhere.

This is why my faculty and I write so many letters to you regarding the VA Research budget, as well as the Medical Care budget. Sometimes when we communicate with you, we fear we are viewed as only self-interested. Yet, VA research dollars accomplish much. Advances in rehabilitation medicine, as just one example, particularly in the development of prosthetics, can very often be traced to basic VA medical research. However, just as important in my opinion, as previously stated, when we look to attract the best doctors to the VA System, we've found we must provide incentives in the form of opportunities to teach and do research.

In my opinion VA hospitals must be maintained at a level equivalent to that found at other teaching hospitals. If students, residents and fellows are forced to train in a substandard facility, they tend not to want to return to that environment to pursue their professional careers. Our students at Emory, like students across the country, rotate through various training sites. We must show them within our VA

hospital and same capacity to provide quality care that they find at our other affiliate hospitals.

An affiliation with a medical school provides the VA Medical Center access to physicians who serve most of the medical needs of the veteran population. Concern has been raised throughout the VA system about whether the physicians provided the VA by academic health centers, preponderantly specialists, really meet the VA needs. Specifically, questions are raised with regard to supply of primary care physicians, geriatricians and the needs of women veterans.

These are legitimate concerns. A proper partnership implies an open discussion and a willingness on the part of the academic health center to meet VA needs. At Emory, we are happy to participate in such discussion.

Early in my deanship, we developed the Emory Geriatric Center. Presently a number of the Center faculty also serve the Atlanta VA Medical Center. Also, one of the nation's first geriatric hospitals—Wesley Woods—is closely affiliated with the Emory School of Medicine.. Such a Center provides a potential resource for the geriatric veteran—made possible only because of that affiliation with a school of medicine.

We are also preparing to focus on the special needs of women within the VA System. Since we have been designated as one of the NIH Women's Health Centers, we feel we are in an excellent position to serve women veterans, whose health needs have to this point been inadequately addressed.

And finally, within the School of Medicine, we are starting a family practice residency to compliment our programs and general internal medicine, general pediatrics, and general OB/GYN. This commitment to primary care, as well as an increased emphasis on ambulatory medicine in our curriculum can only enhance the patient care provided at the VA. I'd like to comment briefly on the role of subspecialists in VA Medical care. Considerable criticism has been wielded at academic health centers for contributing to the oversupply of subspecialists across the country. We in the academic community are taking that criticism seriously. Yet, I must stress that from the perspective of the VA, the availability of subspecialists is a major benefit of the affiliation with a university medical center. Patients in our VA Center have access to services ranging from highly technical neurosurgical methods to the most advanced cardiovascular care they could find anywhere in this country. By its affiliation with Emory, the VA Medical Center is able to maintain professional relationships with subspecialists on a part-time basis that would not be affordable if the VA had to go and hire these people on a full-time basis.

This is not a one-way street. Our School of Medicine does derive benefits from this association. Last year 770 residents and medical and dental students received training at the Atlanta VA Medical Center. Their training is excellent, and the VA is a very positive factor in our ability to recruit the best residents and students. This last year, we had 6,400 applicants for the 110 positions in our medical school; some of our residency programs had 100 applicants for each position. Hopefully, a number of these young physicians will seriously consider a career with the VA system of health care. Besides training residents and students on a clinical level, having such a diverse and talented faculty, enhances our entire program. Cooperative activities prevail, enhancing both quality and interest, that both our institutions benefit from.

Early in my appointment as dean of the Emory School of Medicine, I was faced with a VA Medical Center dilemma. Funding was inadequate, physician morale was low, and my ability to recruit and retain faculty that would serve the needs of this Center was almost at a standstill. A lack of basic equipment in a number of settings made it almost impossible for a physician to adequately or efficiently look after patient needs. Students and residents noticed the difference between the VA hospital and other teaching hospitals.

Due to a series of efforts, including concern expressed by members of this Subcommittee, the situation at the Atlanta VA Medical Center has improved many fold. Our clinical addition is under way, and critical professional and staff positions are now or shortly will be open for filling.

I am particularly concerned that our improved status become the norm, that we can count on reasonable growth in budgets as service needs dictate to ensure the elevated level of care.

In summary, maintaining Medical School/VA Medical Center relationships is a "plus" for all parties. All parties to the agreement derive benefits that justify tax payer concerns and serve the vital needs of an aging veterans population. I respectfully request that all of you do whatever is in your power to help the VA system maintain a viable VA Medical Care and Research budget. An optimistic expectation of reasonable, continued funding will be essential. A better health care staff will be recruited and retained, and for the veteran, we will see better health care.

Thank you for your interest. Please call on me if I can be of any assistance to the Subcommittee, or if at anytime you feel my expertise is needed. Again, thank you for allowing me this opportunity to speak with you today.

STATEMENT OF
MR. LARRY R. DEAL
DIRECTOR OF THE ATLANTA V.A. MEDICAL CENTER
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE OF VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ATLANTA, GEORGIA
JUNE 4, 1993

Mr. Chairman and members of the subcommittee:

Thank you for giving me the opportunity to tell you about our Medical Center and what we are doing to provide high-quality health care to the veterans in our primary service area.

We are one of 171 VA Medical Centers, which along with a number of free-standing outpatient clinics, domiciliaries, and nursing homes, collectively had almost one million discharges from inpatient care and 23 million outpatient visits in Fiscal Year 1992.

The Atlanta VAMC operates 356 acute care and 120 nursing home beds and has more than 2,000 employees. Our annual operating budget for FY92 was 116.2 million dollars and for FY93, 138.8 million dollars. Last fiscal year, we treated 166,613 outpatients, 8,542 inpatients, and 202 Nursing Home Care Unit patients at our Medical Center. We are a tertiary care hospital which provides acute medical, surgical, and psychiatric inpatient care, intermediate care, long-term nursing home care and both primary and specialized outpatient services. We serve approximately 445,000 veterans in our primary service area. Our catchment area extends north to the Tennessee and North Carolina borders; west to Alabama, and as far south as Macon, in central Georgia. Our mission is multi-faceted, including patient care, research, medical education, and serving as a Federal Coordinating Center for medical emergency contingencies.

Patient care, however, is our first priority. Our clinical staff is comprised of more than 500 nurses, over half of whom are registered nurses. We have 130 paid staff physicians and dentists and 117 unpaid, without compensation, staff physicians at the Medical Center.

We are also a referral center with all appropriate major specialties and sub-specialties represented. Specialized programs include open-heart surgery and cardiac angioplasty. We are a regional resource for prosthetics which fabricates and supplies a number of mechanical devices such as artificial limbs to help patients from a large geographic area.

Another related program is STAMP, which stands for Special Teams for Amputation, Mobility, and Prosthetics. Prior to the recent decentralization of this program, we were one of only eight STAMP programs in the VA system. This program brings together several disciplines to integrate the care and rehabilitation of amputees.

We are extremely proud of our Nursing Home Care Unit (NHCU). Recently, it received a rating score of 97 (out of 100) from Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This unit is a rehabilitative nursing home, providing its residents with training and physical therapy with a focus on getting patients back to a self-care status. The home has full-time physician coverage and is involved with research and development programs for the aging.

The unit is also a teaching facility for medical residents, and pharmacy, chaplain and social work students, who provide a valuable service at minimal cost. Within the home, a resident council and a family-visitor council, plan and organize a number of activities for the patients. This premier facility has provided us with unique expertise in long-term patient care management.

In an effort to be more efficient and to provide the best possible care for each veteran, we have instituted a Hospital-based Home Care Program (HBHC) which provides supportive patient care in the veterans's home. A team of appropriate medical and support personnel are available to provide services required by the patient. Physicians, nurses, and technicians train family members to care for the patient before they are sent home. The staff then conducts regular visits to the home and on an as needed basis following the patient's discharge from the hospital. Many of the patients in this program are terminally ill. This service has grown significantly over the years and provides a special enhancement of caring for many of our patients.

Our Medical Center is also very involved with the treatment of HIV-positive and AIDS patients. We are in the top 20 VA Medical Centers in the number of HIV-positive patients treated. Since 1985, our HIV-positive population has increased six-fold, and by 1992, we were treating 492 patients, 166 of whom had full-blown AIDS. This was a 14% increase from 1991, alone. The economic impact of that increase on this Medical Center cannot be emphasized enough. Last year, drug costs alone for these patients were almost a half-million dollars, which was a 28% increase from the previous year.

As a teaching hospital, we have a major affiliation with the Emory University School of Medicine and are one of the six Emory University Affiliated Hospitals. Other affiliates include Grady Memorial Hospital, Emory University Hospital, Crawford W. Long Hospital, Henrietta Egleston Hospital for Children and Wesley Woods Geriatric Center.

Almost all of our staff have faculty appointments at Emory, and we fund 102 physicians and three dental residency positions. Last year, 445 physician residents, 15 dental residents, and 269 medical students spent a portion of their training time with us.

Overall, we have 30 affiliations with schools and universities involving 26 different training programs. Last year, we had a total of 1,141 trainees including 117 nursing and 89 pharmacy students.

Our research program is significant. The Atlanta VA Medical Center has one of the most active VA research programs in the nation. Our program has grown since 1980, when we had only two or three investigators and $80,000 in research grants, to a current program which now has 50 principal investigators, 120 research projects and a total grant funding of more than 12 million dollars. This places us among the top 10 VA Medical Centers in terms of research funding.

Our research deals with AIDS and other infectious diseases, cardiology, pulmonary medicine, genetics, and many other areas. One connection which is not often apparent, is the importance of research to our patient care effort. VA researchers, including several Nobel Prize winners have contributed greatly to our clinical knowledge which translates into better patient care.

Furthermore, the availability of funding, space, and time for research has been vital to the recruitment and retention of high-caliber academic staff physicians to our affiliated Medical Centers.

Major facility and equipment improvements at our Medical Center will help us meet the challenges of a changing medical environment and provide the highest quality of medical care to our veterans in the future.

The Atlanta VA Medical Center was activated in 1966. During the first 20 years of operation, the Medical Center experienced significant changes in clinical practice, mission, patient

demand and medical technology. In an effort to keep up with these changes, in 1984, a major clinical addition construction project was approved for design and award.

This is a multi-phase project currently under construction. It consists of three stages. A four-story parking structure, which was completed in 1991; a clinical addition building slated for completion in the summer of 1994; and the renovation and asbestos abatement on three floors of the existing main building where we expect to begin work in early 1995. The cost of the project is approximately $80 million in construction dollars and $50 million for new equipment. The clinical addition is scheduled to open in mid 1994.

Our Medical Center has about a 50% space deficit for clinical, administrative and research functions. The construction project will add 325,000 square feet of new space to help resolve this problem.

The new addition will add a second CT Scanner, a new MRI, two linear accelerators for radiation therapy, lithotripsy, and all new state-of-the-art X-ray equipment.

We will also have a new cardiac catheterization laboratory and non-invasive diagnostic cardiology equipment, and a new 10-bed coronary care, 12-bed medical and 12-bed surgical intensive care units and a new clinical laboratory.

Other advances provided by this project will include three additional operating rooms, to include ambulatory surgery capabilities. We will have a stat laboratory for immediate and consolidated responses on specific laboratory requests. Laboratory equipment will provide T.B. results in a quicker turnaround time. (Atlanta is one of the leading cities in the country for T.B. treatment and research). The co-location of intensive care units with their clinical support services

on the same floor will also benefit patient care.

The clinical addition project will truly provide our Medical Center with state-of-the-art facilities and equipment and provide future veteran patients with the best care available. Much of our new technology will exceed that which is available in many Atlanta-area hospitals.

Since there is an increased need for more and better healthcare for women veterans, we have organized a task force to develop a comprehensive plan to meet this need. There are approximately 32,000 women veterans in Georgia and 13,500 in the Atlanta metro area. At this time, seven percent of our outpatients are women. The percentage of women veterans is projected to increase in the future.

Programs currently in place to support women veterans include mammography screening, weekly GYN clinics and an outreach program which provides gender-related health care information. In an effort to personalize our care, every female inpatient is visited by a member of the Medical Center's Women Veterans Committee during their hospitalization. This committee was established to evaluate, monitor, and promote women's health care issues. We also have a Quality Improvement program which monitors health care to women veterans.

In an effort to maximize the effective use of VA medical resources, our Medical Center actively participates in a network system with other regional VA Medical Centers. These network activities are aimed at providing a continuum of care for veterans, facilitating patient referrals, and planning for veterans health care services in a cost effective manner. Through close coordination and management between participating medical centers, better care at a lower cost can be achieved.

Some of the issues to be examined by this program include the uniform management of discretionary and mandated workload, consistency in policy and procedures for transfer of patients between network facilities, and assessment of clinical service availability and outpatient clinic appointment availability. This program also seeks ways to better manage nursing home ventilator dependent patients, the network hospice program, care of women veterans, long-term psychiatry and long-term care.

These activities are aimed at improving veterans healthcare and serve an important role in the efficient management of regional veteran patients and resources.

In summary, the Atlanta VA Medical Center provides a full spectrum of high-quality medical care, from preventive medicine to long-term care for the aging. Our future is bright. With the completion of the clinical addition, we will be able to provide additional high-quality services to our veterans. The increase in space and high-tech equipment will provide state-of-the-art resources which will enhance patient care and attract high quality staff. We will be able to develop many new programs such as a comprehensive cancer center and chemosurgery programs. These significant improvements will help us meet the future challenges of a rapidly changing healthcare system.

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