J. DAVID COX, R.N., NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

STATEMENT BY

J. DAVID COX, R.N.
NATIONAL SECRETARY-TREASURER
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS
OVERSIGHT HEARING ON VA CONSTRUCTION

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The American Federation of Government Employees, AFL-CIO (AFGE) thanks you for the opportunity to testify today on VA medical facility construction, specifically, recent Veterans Health Administration (VHA) plans for medical facility leasing and other contractual arrangements for providing veterans' healthcare. AFGE represents over 160,000 members of the VA workforce, more than two-thirds of whom are on the front lines caring for veterans at VA hospitals, clinics and long term care facilities.

In March 2008, the VA quietly issued a radical new approach to providing inpatient and outpatient facilities: the "Health Care Center Facility Leasing Program" (Leasing Program). Despite its far reaching impact, the VA initially provided veterans' groups with very limited information about the concept and gave no specifics as to when or where it would implemented. Lawmakers in the targeted states and unions representing VHA employees received no initial information about the new program.

The impact of the Leasing Program only became evident after the VA announced its plans to eliminate and/or downsize standalone VA medical centers in several locations, including Denver, CO and Salisbury, NC, and instead provide services through leasing arrangements with non-VA facilities and standardized, large outpatient facilities called "Health Care Centers". The VA did not disclose its list of 22 proposed sites for enhanced leasing until October 2008; they did so only in response to requests made by Chairman Akaka and Senator Rockefeller.

When faced with strong opposition from lawmakers and stakeholders at several of the proposed sites, the VA appeared to put its leasing plans on hold. However, AFGE has recently received reports that VHA is still actively considering the leasing option for a number of locations in need of new or replacement medical centers.

At some of the sites, the first "warning sign" of the Leasing Program has been a significant reduction in inpatient and emergency room (ER) services. These cuts result in the diversion of a greater number of veterans to non-VA hospitals for inpatient care (at a higher cost to the VA). In addition, veterans with medical and mental health emergencies are forced to use overcrowded emergency rooms at non-VA hospitals that do not specialize in veterans' conditions, and often face enormous medical bills for treatment of non-service connected conditions.

The loss or imminent loss of core inpatient services sends VA medical centers into a downward spiral:

• Physicians, nurses and other staff leave because of the facility's uncertain future and limited services;
• Due to staff shortages, more patients have to be diverted to non-VA facilities;
• Loss of services also impacts the facility's capacity to conduct diagnostic tests;
• Uncertainty also leads to deferred maintenance and postponement or cancellation of facility upgrades;
• These conditions cause more staff to leave;
• The facility's services become so limited that often, permanent outsourcing becomes the only viable option.

This scenario is all too familiar. In its 2007 study of deteriorated conditions at Walter Reed Army Medical Center, the Congressional Research Service discussed a convergence of events – a "perfect storm" – that led to that crisis: increased demand for services from returning OIF/OEF troops, privatization threats, and a base realignment decision to permanently close the facility. At the VA, the announcement of plans to permanently cut and privatize core hospital services through leasing, coupled with increased demand from returning troops and newly eligible Priority 8s, is having a similar impact.

Health Care Centers provide the perfect vehicle for the "Walter Reed-ization" of the VA because they permanently siphon off the "critical mass" of VA medical centers. The danger they present for VA's unique capacity to treat veterans cannot be overstated. The VA has evolved into a national health care leader because it relies on a single, integrated system that concentrates its resources and expertise to provide comprehensive, high quality, cost effective specialized care in tandem with invaluable academic affiliations and specialized research. The VA's teaching mission produces significant benefits for patient care. Similarly, "[b]ecause more than 70 percent of VA researchers are also clinicians who take care of patients, VA is uniquely positioned to move scientific discovery from investigators' laboratories to patient care" (citing 2007 testimony by Dr. Joel Kupersmith before this Committee.)

The Leasing Program utilizes an entirely different and untested delivery model – a model that has not been used by either the private or public sector to date. Currently, VA medical centers operate as the "hub" supporting small, community based outpatient clinics (CBOCs), telehealth, limited fee basis care and other "spokes". In contrast, the only "hubs" available to support the outpatient services provided by Health Care Centers are non-VA hospitals that often struggle financially to serve the general population, including large numbers of the uninsured and underinsured.

Therefore, AFGE urges the Committee to conduct an immediate investigation into the Leasing Program and its impact on VHA and the facilities facing plans for substantial changes in their delivery infrastructure: For example:

Salisbury, NC:

The Hefner VA Medical Center has a 150 acre campus and is centrally located in the state. Originally created after World War II as a large psychiatric facility, the Salisbury VA has evolved into a full service, 484 bed facility that supports several outpatient clinics, long term care and an extensive research program. The Salisbury VA is primarily affiliated with the Wake Forest University School of Medicine/Baptist Medical Center and offers residency training in eight practice areas, and in total has 78 affiliations with academic institutions.

Over the past four years, the Salisbury VA has undergone a significant transformation, including new operating rooms and intensive care units, and recruitment of additional physicians and

nurses.
In September 2008, management made a surprise announcement that it was eliminating acute care, intensive care (ICU) and emergency room care (ER) services, to be replaced by leasing arrangements with community hospitals and two new Health Care Centers. The Salisbury VA would retain long-term care and outpatient services and add a mental health center of excellence. Management did not consult with or provide advance notice to veterans' groups or employees. Some members of the North Carolina Congressional delegation were also completely taken by surprise. At the time, stakeholders were not aware that Salisbury was one of the 22 proposed sites for enhanced leasing.
Management stated that this change was justified by an extensive study but would not share the results of the study with stakeholders. Once the study became available, AFGE learned that the contractor reviewed five options, including renovation or expansion of the facility, before reaching its recommendation for leasing, contracting and Health Care Centers. The contractor never met with veterans' groups or front line employees providing the care or their representatives even though it conducted a "two-day stakeholder site visit". Researchers acknowledged that this option "does not promote the inpatient veteran community or culture that veterans value".

In addition, during the same period, the VA put out a $34.5 million bid solicitation for "potential health care sources…to provide inpatient hospital medical and surgical services" including personnel, facilities and equipment.

Many of the recently hired physicians and nurses responded to management's announcement by leaving for more secure jobs elsewhere.

After veterans, labor and some lawmakers expressed strong opposition to the leasing plan, the VA appeared to change course. In December 2008, it issued a revised plan that "provides that no changes to the health care delivery services at the Salisbury VA Medical Center will be made until 2013, nor will there be any staff reductions." (VA Press Release dated December 11, 2008).

Despite the VA's commitment, the facility continues to implement policies that are leading to more uncertainty, service reductions and staff resignations. Specifically:

- Management is not filling physician and nurse vacancies on the acute care unit;
- One of the facility's two surgeons has been detailed to a non-patient care unit;
- Recruitment bonuses are not being used to attract new psychiatrists, even though current mental health caseloads are unreasonably large;
- Management has abandoned longstanding renovation plans for one building and converted another building recently renovated for patient care services into office space and an outpatient endoscopy clinic (even though another endoscopy unit in excellent condition is available elsewhere);
- Management has also abandoned plans to remodel the emergency room (ER) and has announced that the ER will be downgraded to an urgent care unit;
- Plans for a new outpatient clinic in Hickory have been cancelled;
- There have also been early reports that the facility is facing a large deficit due to the increased use of costly contract care;
- Patient satisfaction scores have recently dropped;

- Due to inadequate nurse staffing, the Medical Unit currently has fewer than 30 beds; previously it had 42 beds;
- Management eliminated the facility's Center for Excellence for Women's Health;

If these policies remain place, the Salisbury VA's "critical mass" will be essentially depleted by 2013, and leasing with non-VA facilities may be the only remaining option.

Denver, CO:
Although this VA medical center is not on the "proposed site" list, in April 2008, the VA cancelled longstanding plans for a replacement standalone facility in downtown Denver – plans that evolved through extensive analysis and consensus-building. Instead, veterans would receive care from a mix of VA and University health professionals at leased bed and research towers on the University of Colorado campus. Under the new plan, the size and scope of long term care and mental health programs would be reduced and the facility's spinal cord injury program would be bifurcated into two separate buildings.

Here too, secrecy prevailed. The VA did not consult with members of the Colorado Congressional delegation, veterans or employees prior to reaching its decision to shift major construction dollars away from the existing plan and use them to radically transform the facility. The VA contended that this untested model was the product of reliable data and projections but never made these studies available.
In response to strong opposition from lawmakers and stakeholders, the VA completely reversed itself a year after the initial announcement and reinstated plans for a new standalone, full service VA facility in Denver.
Other locations:
South Texas: Local veterans' groups have sought a standalone VA medical center in the Rio Grande Valley for many years. The VA had other plans for South Texas. Last year, it opened the South Texas Health Care Center, and announced plans for expanded contracts with local hospitals for inpatient and emergency care.

Fargo, ND: This facility is on the "proposed site" list. This month, management reported that a proposal was considered, but then rejected, to move specialty care clinics and Ambulatory Surgery off site to a large outpatient facility resembling the Health Care Center model. Under this proposal, inpatient care would have been provided to veterans through contracts with non-VA hospitals.
Iron Mountain, MI: Last year, the VA medical center director announced plans to eliminate surgery, intensive care and emergency room services, requiring veterans to use local non-VA facilities or travel to Chicago for VA care. After pressure from Michigan lawmakers and local stakeholders, these plans were put on hold. However, management continues to incrementally erode the facility's capacity: several ICU beds have been closed and plans to downgrade the ER to urgent care are still pending. In addition, uncertainty about the future and unfair human resource policies are causing physicians to leave; the facility currently has no surgeons, requiring contracting out of all surgical procedures.
Northern Indiana: The VA Northern Indiana VA Health Care System has announced plans for Health Care Centers in Fort Wayne and South Bend. "Inpatient medical care will be provided primarily in partnership with community hospitals in Fort Wayne and South Bend." (NIHCS

website).
Fort Worth, TX: Last year, the VA awarded a contract to build its largest outpatient clinic to date in Fort Worth. It appears to offer a similar array of services as the Leasing Program's Health Care Centers.
AFGE fully supports the VA's efforts to adapt its health care infrastructure to changing patient needs and new technologies. However, the use of secrecy, exclusion and unsupported assumptions based on shoddy research is simply bad policy. This Program may also represent bad law; it appears to be proceeding without adequate statutory authority. The VA contends that one of the Program's selling points is that "[n]o authorizing legislation [is] required to initiate [this] program". VA relies on its existing authority under 38 USC § 8153 to "make arrangements, by contract or other form of agreement" for the sharing of health-care resources between the VA and other entities.

However, the VA has not offered evidence to support a finding that it has satisfied either test under Section 8153. More specifically, the VA has failed to show that VA resources are not available to provide these services in-house or that leasing is necessary to effectively utilize other health-care resources. In addition, we question whether the VA's intention to use "information and planning" bids to lay the foundation for leasing, as in the case of Salisbury, constitute a valid use of this sharing authority.

The other critical question is whether the VA has the authority to use major construction dollars for an entirely different delivery system without Congressional approval. Although Congress has granted the VA substantial discretion to build and renovate medical facilities, it has not authorized the VA to engage in large scale privatization of its health care system.

RECOMMENDATIONS
AFGE urges greater Congressional oversight of the VA's Leasing Program and other large scale initiatives to shift the bulk of veterans' health care services to non-VA providers. Leasing raises many of the same concerns about the long term impact on this world-class system as Project HERO, which uses a contractor to arrange and manage VA's contract care. (AFGE's concerns about HERO were provided to the Committee following the April 22, 2008 legislative hearing.) The most critical question of all is whether leasing and contract care are truly necessary means of filling gaps in the VA health care system, or whether these gaps are merely the result of misused health care dollars and poor staffing policies, and unnecessary privatization worsens these gaps. If the VA is truly going to adapt to changing needs and changing times, it must stop operating in secrecy. AFGE and its members on the front lines of VA health care want to work with the VA to develop the most effective options for keeping the system viable. All stakeholders – including veterans' groups, employee representatives and academic affiliates – must be part of the planning process. Congress also needs to play an active, ongoing oversight role in all VA efforts to significantly alter its health care delivery system.
Finally, Congress should oversee research conducted to identify needed changes in the VA's delivery model in order to ensure the neutrality and reliability of these studies. Thank you for the opportunity to presents AFGE's views on this issue.