REPORT

OF

THE NEW JERSEY VETERANS' HOSPITAL TASK FORCE

The following report is rendered pursuant to P. L. 2011, c.21 (S1189 2R). It reflects the efforts of the following members of the New Jersey Veterans' Hospital Task Force:

Senator Jeff Van Drew	New Jersey Senate
Senator Christopher Connors	New Jersey Senate
Assemblyman Matthew Milam	New Jersey Assembly
Assemblywoman Dianne Gove	New Jersey Assembly
Raymond L. Zawacki	New Jersey Department of Military and Veterans Affairs
Mary E. O'Dowd	New Jersey Department of Health and Senior Services
Frank Carlini, BG (Ret)	New Jersey Department of Military and Veterans Affairs
Col. Debra Burr	Public Member
Barbara Chamberlain	Public Member
Vincent Deprinzio	Public Member
James F. Donahue	Public Member
Bernard Epworth	Public Member
Robert Looby	Public Member
Eugene O'Grady	Public Member
Diana Pitman	Public Member
Richard A. Pitman	Public Member
Isaac J. Rucker	Public Member

Mr. Robert McNulty was appointed Consultant to the Task Force at a meeting held on March 13, 2012.

The Task Force conducted meetings on October 6, 2011; March 13, 2012 and May 29, 2012 during which comments were made by a number of Veterans and their family members regarding their experience with regard to obtaining health care from existing VA resources. The majority of those making statements expressed displeasure with the existing process and expressed a strong desire to establish a process that offers greater convenience to the Veteran who requires health care services from the VA. On May 22, 2012 the Task Force visited the Community Based Outpatient Clinic in Northfield, New Jersey and was briefed by VISN 4 Director Michael Moreland. A working session of the Task Force was held on June 28, 2012 and the final meeting was conducted on December 11, 2012 at Cumberland County College.

The Task Force determined early on that the cost associated with providing health care services to the men and women who have served in the United States Armed Forces should continue to be borne by the federal government as has been the case historically. The State of New Jersey cannot support the extensive expense that is inherent in the construction and/or operation of a separate hospital exclusively for the Southern New Jersey Veterans Population. The United States Department of Veterans Affairs (VA) has a long-standing history of providing for the medical needs of Veterans and this is accomplished through a variety of VA facilities and health care providers at VA Medical Centers and VA Community Based Outpatient Clinics. The health care is provided primarily at such VA facilities but where extenuating circumstances are identified specific to an individual Veteran the VA has, and as can be seen later in this report, will continue to authorize the procurement of health care from non-VA providers.

An illustration of the high cost of constructing and operating a hospital can be found in a VA initiative to construct a 110 bed primary care facility in Louisville, Kentucky. The facility will provide primary, surgical and mental health care as well as a geriatric/extended care program, a home-based primary care program and a substance abuse residential rehabilitation treatment program. It is estimated that the cost of this facility will approximate $883 million and that amount will not include future operational costs.

The Task Force, therefore, issues the following findings and recommendations on a point-by-point basis:

It shall be the duty of the Task Force to:

a. Estimate the capital, operational and administrative expenses associated with establishing a new veterans' healthcare facility in southern New Jersey, or contracting with an existing healthcare facility to provide medical services to veterans;

As it was determined by the Task Force that there would not be a new VA operated veterans' healthcare facility in the form of a Medical Center coming to southern New Jersey any time in

the future, any costs that could be established would be estimates only that in all likelihood would not accurately reflect operational or administrative expenses. Capital expenses would be dependent upon the size of the facility and what services would be made available accordingly. Whereas a new veterans' healthcare facility in southern New Jersey is not supported by the VA; a determination as to the size of the building and equipment required to provide health care services for veterans could not be established.

b. Obtain and review statistical data on the number of veterans residing in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem counties and the number of veterans receiving medical services at hospitals within those counties in the past five years in order to determine a central location for a veterans' healthcare facility;

The VA does not record and make available publicly statistical data that would be useful for review by the Task Force. Some partial data from other reports covering parts of FY2009 and FY2010 was obtained for Atlantic, Cape May, Cumberland and Salem counties. Recent information (2011) provided by VISN 4 Director Moreland covered those four counties along with Burlington, Camden and Gloucester Counties. Ocean County is part of VISN 3 and information for Ocean County was included in the report provided by Director Moreland.

The information compiled for FY2009 and FY2010 indicates the numbers of veterans who traveled to Philadelphia and to Wilmington from Atlantic County, Cape May County, Cumberland County and Salem County by major diagnostic category. No other information was available for the other counties or for other fiscal years.

c. *Determine the size and staffing levels necessary for a veterans' healthcare facility to provide a full range of primary care and medical and surgical subspecialty care to eligible veterans;*

VA uses what is known as the Enrollee Health Care Projection Model (EHCPM) to develop most of its health care budget estimate, an estimate based on three basic components:

- Projected enrollment in VA health care,
- Projected use of VA's health care services, and
- Projected costs of providing these services

The EHCPM makes a number of complex adjustments to the date to account for characteristics of VA health care and the veterans who access VA's health care services. These adjustments take into account

- Veterans' age
- Veterans' gender

- Geographic location
- Reliance on VA health care services as compared to other sources such as health care services paid for by Medicare or private health insurers

The ability to determine size and staffing requirements was not met by the Task Force due to the inability to determine which of the potential out-patient treatment services such as, but not limited to, the following could be made available: allergy and immunology, audiology, bariatric clinic, cardiology, CT scans, endocrine ear-nose-throat, GI gynecology, hematology/onc, MRI, neurology, neurosurgery, nuclear medicine studies, nutrition, oncology, ophthalmology, optometry, orthopedics, pain clinic, podiatry, primary care/med, psychology-ind, renal/nephrology, rheuma/arthritis, sleep study, surgery, urology and women's health. The variables were too extensive to provide a definitive estimate as to size and staffing requirements.

The most recent data provided by Director Moreland supports VHA's position that there is not sufficient inpatient workload demand in this region to necessitate building a VA operated inpatient facility or entering into an agreement with a private hospital to provide additional beds for inpatient care.

d. Review various methods of financing a veterans' healthcare facility through public, private and public-private partnership financing systems; and

The VHA operates the nation's largest integrated healthcare system, and provides care to over 5 million inpatients and outpatients at its vast network of hospitals, outpatient clinics, nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers.

Enrolled veterans are assigned to one of eight priority levels (P1 through P8) based on their service-connected disabilities, income levels, and other factors. Under this priority system, the Secretary of Veterans Affairs decides each year whether VA's medical budget is adequate to serve veterans in all priority groups who seek care.

Historically a healthcare system serving only veterans with service-connected disabilities, the VA is now open to all qualified veterans and has become an important "safety net" for many low-income veterans who would otherwise be uninsured. The impact of the recent Supreme Court ruling on the Affordable Care Act may serve to drive additional veterans to the VA health care system. Whereas the mandate for insurance does not take full effect until 2014, it may be some time before the impact of the ruling on the VA health care system is evident.

e. Investigate opportunities for the State to enter into collaborative agreements with the federal government to ensure the most efficient use of funds and resources related to the operation of a veterans' healthcare facility.

The Task Force was unable to review any collaborative agreements between states and the federal government to ensure the most efficient use of funds and resources related to the operation of a veterans' health care facility to use as a guideline to establish a joint venture with the VA here in New Jersey. The Task Force is aware of a number of VA/DoD Joint Ventures such as, but not limited to

- VA Clinic Pensacola, Florida Joint Ambulatory Care Center
- Joint Venture between 99th Medical Group and VA Southern Nevada Healthcare System (VASNHS)
- The Alaska VA Healthcare System VA/DoD Joint Venture with the 3rd Medical Group, Elmendorf Air Force Base, Alaska
- The integration of the former Naval Health Clinic Great Lakes and the former North Chicago VA Medical Center into the Capt. James A. Lovell Federal Health Care Center
- The El Paso VA Health Care System joint venture with William Beaumont Army Medical Center (WBAMC)
- VA Palo Alto Health Care System Monterey Joint VA/DoD Ambulatory Care Center

This calls into question the collaborative opportunities review and the study that reported opportunities for VA/DoD collaboration between McGuire AFB and Philadelphia and Dover AFB and Wilmington were explored by the VISN and DoD and were not found to be viable as noted in the CARES report for the Eastern Market of VISN 4.

Moving Forward

Change in how we, as a nation, provide health care to our veterans is inevitable if we promote the changes that are possible and with that in mind, we would do well to make sure we play a major role in shaping these changes to benefit those veterans in New Jersey.

The Task Force recognizes that the modern VA health care system is an extremely complex structure. With the rapidly evolving technologies that are reshaping medical knowledge and how diseases are detected and managed, veteran healthcare will become even more complicated. Yet, despite its complexity and the many systems that support it, from care providers to veteran patients, the only real focus needs to be on one person: the veteran patient.

In the civilian world, while there are undoubtedly pockets of innovation, many systems suffer from underperformance, large variations in the delivery of care, and inconsistent outcomes due to gaps in available evidence. These inefficiencies have negative implications on the core tenets of health care: quality, cost and access. Most importantly, these inefficiencies impact the safety of the patient – the person at the epicenter of this complex system. The seminal report by the Institute of Medicine (IoM) highlighted the fact that, in the United States, a large number of

deaths each year (44,000-98,000) are due to preventable medical errors and that these had an associated cost of $17-$29 billion.

Often, the greatest areas of inefficiencies are in the transition points between different care providers and in the continuity of care for the patient. In the future, these areas—continuity and collaboration—will become as important as the traditional core tenets of quality, cost and access. The complexity of healthcare creates an environment that may compromise continuity of care. The Task Force recognizes that without an effective platform to drive continuity and collaboration, the transfer of information can become fragmented, leading to vital data falling through the cracks.

As chronic conditions with multiple morbidities such as, but not limited to diabetes, become ever present, the need to address preventive care and long-term disease management will become central to veterans' healthcare. By ensuring that transitions between care settings and through the different phases of disease progression are smooth and effective, the quality of care improves. The concept of a healthcare system 'without walls,' essentially a new support network of innovation, will help drive this continuity and cultivate collaboration. The Task Force supports this innovation.

Legislation such as HR1298 – Veterans' Efficiencies Through Savings Act of 2011 or VETS Act of 2011 – which directs the Secretary of Veterans Affairs to conduct a cost-benefit analysis of the provision of medical care by the Department of Veterans Affairs (VA) for: (1) any 75 square mile area where three or more VA outpatient clinics are located; and (2) any 100 square mile area where two or more VA hospitals are located which was introduced by Congressman Frank LoBiondo [NJ-2] March 31, 2011 and co-sponsored by Congressmen Robert Andrews [NJ-1], Jon Runyan [NJ-3] and Christopher Smith [NJ-4] has the potential to provide an additional focus on providing health care to veterans in their communities. The legislation was referred to the House Committee on Veterans' Affairs. On April 15, 2011 it was referred to the Subcommittee on Health, of which Congressman Runyan is a member.

The Task Force recognizes there is a lot of work to be continued beyond the presentation of a final report as set forth in P.L. 2011, c.21. The Task Force strongly recommends the establishment of a committee to act as an advocate for veterans' health care to effect:

- Efforts to increase health care availability awareness in the veteran community through improved education and communication
- Increased access to local services for veterans
- Request that VA investigate the need to provide additional treatment services to veterans locally
- Creation of a liaison with the VA to provide a better understanding of veteran healthcare options

- Establishment of a veteran healthcare information clearing house to gather and share veteran healthcare information
- To obtain VA inpatient workload and trend analysis for New Jersey veterans
- To establish and maintain a liaison with the Directors of VISN 3 and VISN 4 (North, Central and Southern New Jersey)
- To provide available data for legislation that will seek to address the above listed concerns